Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday, 7th November 2024, commencing at 9:00am
Lecture Theatre 4, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY (9:00am-9:30am)							
1.	**24/25/208**	**9:30 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/209**	**9:31 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/210**	**9:32 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **26th of June and the 3rd of October 2024.**	**D**	Read enclosures
4.	**24/25/211**	**9.34 (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.	**24/25/212**	**9:35 (10 mins)**	**Chair's/Interim 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.	**24/25/213**	**9.45 (10 mins)**	**2030 Transformation Programme Update.**	K. Warriner/ N. Palin	To receive an update on the current position.	**A**	Read report
Operational Issues							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
7.	**24/25/214**	**9:55 (45 mins)**	**Evidence of Our Performance:** • **Flash Report, M7.** • **Integrated Performance Report for M6, 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
8.	**24/25/215**	**10:40 (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							
9.	**24/25/216**	**10:50 (10 mins)**	**Staff Influenza Vaccination Programme – Update.**	N. Askew	To receive an update on the current position.	**A**	Read report
10.	**24/25/217**	**11:00 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 23.10.24.** - **Approved minutes from the meeting held on the 25.9.24.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 25.9.24.	**A**	Read enclosures
Supporting our People							
11.	**24/25/218**	**11:05 (10 mins)**	**People Plan Highlight Report.**	M. Swindell	To receive an update on key areas and updates from the system on the workforce.	**A**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
12.	**24/25/219**	**11:15 (10 mins)**	**Equality Act:** • **EDI Highlight Report** • **Workforce Race Equality Standard Report.** • **Workforce Disability Equality Standard Report.**	M. Swindell	For noting.	**N**	Read report/ presentations
13.	**24/25/220**	**11:25 (10 mins)**	**Annual Report for the Armed Forces Network.**	N. Askew	To receive the Annual Report for the Armed Forces Network.	**A**	Read report
Strong Foundations (Board Assurance)							
14.	**24/25/221**	**11:35 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 10.10.24.** - **Approved minutes from the meetings held on the 20.6.24 and the 11.7.24.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 20.6.24 and the 11.7.24.	**A**	Read enclosures
15.	**24/25/222**	**11:40 (10 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's verbal update from the meeting held on the 28.10.24.** - **Approved minutes from the meeting held on the 30.9.24.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 30.9.24.	**A**	Read enclosure

Alder Hey Children's NHS Foundation Trust

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
16.	**24/25/223**	**11:50 (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							
17	**24/25/224**	**11:55 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
18	**24/25/225**	**11:59 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Lunch (12:00pm-12:30pm)							
Date and Time of Next Meeting: Thursday, 5th December 2024, 11:00am – 2:00pm, LT2, Institute in the Park.							

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

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M6, 2024/25	R. Lea

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
Confirmed Minutes of the meeting held on Wednesday 26th June 2024 at 16:15 via Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	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. J. Preece	Governance Manager	(JP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/101	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
Item 24/25/101	Mr. D. Spiller	Senior Manager, Ernst & Young	(DS)
Apologies:	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Ms. J. Revill	Non-Executive Director	(JR)

24/25/99 Welcome and Apologies

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

24/25/100 Declarations of Interest

There were none declared.

24/25/101 Draft Annual Report and Accounts for 2023/24

The Board received the Trust's Annual Report for 2023/24 which was prepared in accordance with the NHS Foundation Trust Annual Reporting Manual. The Board was provided with an overview of the report which was considered to be consistent with the information reported throughout the year and reflects the organisation's challenges and achievements. It was pointed out that a small number of adjustments have been made to the financial section of the report.
E&Y have reviewed the Annual Governance Statement and can confirm it is consistent with other information that they were aware of from the audit of the financial statements. It was confirmed that there are no other matters to report.

The Audit and Risk Committee (ARC) approved the 2023/24 Annual Report and Accounts on the 20.6.24. The Chair of ARC felt that the Annual Report was outstanding and drew specific attention to the sections relating to the organisation's volunteers, the Academy, and the Charity.

It was reported that the Trust has disclosed all of the required information and will lay the 2023/24 Annual Report and Accounts before Parliament after recess in September. Tribute was paid to those involved in compiling the Annual Report, in particular, Erica Saunders and Jill Preece.

Annual Accounts

The Board received the 2023/24 Annual Accounts for approval purposes ahead of submission to NHS England on the 28.6.24. An overview of the report was provided and the following key points were highlighted:

- The position that the Trust is presenting is an achievement of a £10.3m control total surplus with a reported deficit of £6.5m when taking into account exceptional items. This is in line with the financial performance that has been reported throughout the year, with no change to the income and expenditure position or the overall reporting position. Total income for the year remains at £416m with a cash balance of £78.2m.
- *Exceptional Items* – Attention was drawn to the impairment relating to the asset brought into use for Alder Care and the Catkin and Sunflower buildings. It was confirmed that this is an item of exception and has been included in the statutory accounts.
- The Trust's capital expenditure has been revised to a total of £23.1m which is a difference in respect to the figure that has been reported throughout the year. The Board was informed that there have been a number of challenges that relate to the valuation of the Trust's capital schemes and assets under construction that were identified throughout the audit in terms of the reporting of capital expenditure. This has resulted in the Trust being below its capital limit for the year by £2.2m (£25m > £23m) and losing CDEL due to being under target in 2023/24. The Trust is working with the ICB and NHSE/I to try and mitigate or resolve this risk. Discussions are also taking place regarding alternative opportunities.

The Chair pointed out that the loss of CDEL is a significant issue and suggested that time be set aside over the coming weeks to review the Capital Programme and understand the implications of this matter.

John Grinnell thanked everybody for their flexibility over the last few days whilst the Trust and E&Y have been finalising the work in relation to this issue.

Ernst and Young External Audit Year-end draft report, 2023/24 'ISA260'

The Board received the External Audit Results report for year ended the 31st of March 2024. The following key points were highlighted:

- *Changes in materiality* – It was reported that the planning materiality assessment was updated following receipt of the draft consolidated results and reconsideration of E&Y's risk assessment. Based on the materiality measure of operating expenditure, E&Y has updated its overall materiality assessment to £8.21m from £7.67m, and updated performance materiality, at 75% of overall materiality, to £6.16m.

- *Audit Differences* – There are uncorrected misstatements of £5.7m that have no impact on the surplus for the year before turnaround. Uncorrected misstatements of £0.4m do have an impact on the surplus for the year before turnaround. E&Y are of the understanding that the misstatement of £0.4m isn't going to be amended as it is based on extrapolation.
- *Reporting Responsibilities* – It was reported that there were no adjusted misstatements greater than £6.2m but as stated by the Director of Finance and Development, there is a significant adjustment in relation to capital of £2.3m.
- *Areas of Audit Focus* – It was confirmed that there are no significant risks identified in the areas outlined in the planning report or areas of focus.
- *Capital Expenditure* – Work to date has not identified any cases of inappropriate capitalisation of revenue expenditure, however the audit has identified capital expenditure that has been recognised in the 2023/24 financial statements which the auditors are not satisfied has been incurred prior to the balance sheet date.
  Control observations include recommendations for improvement of which management have responded to in terms of outlining the improvements they will be implementing. A discussion took place during ARC on the 20.6.24 about the recommendations and it has been agreed that the Committee will receive a report outlining the actions that are to be taken to address any weaknesses, particularly in relation to capital expenditure.
- *Value for Money (VFM)* – E&Y have completed its planned VFM procedures and have no matters to report by exception in the auditor's report. It was confirmed that there were no significant weaknesses identified which is a positive position for the Trust to be in. E&Y plan to issue the VFM commentary by the end of July as part of issuing the Auditor's Annual Report. It was pointed out that the audit won't be certified as closed until the Auditor's Annual report and VFM statement is issued.
- *Annual Report and Annual Governance Statement* – Two errors with the pay multiples were noted. These have been corrected via the audit process and by management. E&Y have reviewed the Annual Governance Statement and can confirm it is consistent with other information that they were aware of from its audit of the financial statements. It was confirmed that there are no other matters to report.

The Chair summarised the outcome of the external audit result report which indicates that the Trust is in a good position. The Chair advised of the Board's disappointment regarding the loss of CDEL but it was pointed out that the Trust will monitor this issue going forward.

The Director of Finance and Development provided the Board with an overview of the approach that has been taken in respect to the two audit differences raised by the auditors;

- *Uncorrected misstatements of £0.4m* – The initial error amounted to £600 but due to the extrapolation technique used it became £300k. It was confirmed that the misstatement of £0.4m isn't going to be amended as it is based on extrapolation.
- *Uncorrected misstatements of £5.7m* – This matter relates to an accounting treatment of a payment that was made for a capital scheme that is underway with the PFI. It was reported that E&Y are of the opinion that this should be treated as a pre-payment transaction as the asset has not yet been completed, therefore the Trust should recognise it as an asset under construction. From an impact perspective, amending this item will not materially affect the balance sheet for the reader as it would move between

2 lines – asset under construction and a pre-payment, however would reduce overall CDEL expenditure for the year. For this reason, it has been decided not to adjust this transaction. The Trust has shared its rationale and principles with E&Y and has confirmed that it is content with its accounting treatment for this transaction.

Letter of Representation
Resolved:
The letter of representation will be ready for signing on the 28.6.24.

The Chair of the Audit and Risk Committee (ARC) advised that the Committee had a good debate about the recommendations for improvement which were detailed in the external audit report, and the action plan for 2024/25 which will be monitored by ARC. Attention was drawn to the importance of understanding any potential year-end financial implications that may occur as a result of opportunistic capital and building this into the Trust's processes. It was confirmed that the Trust is still within its materiality threshold, taking into account the uncorrected adjustments, therefore the accounts remain true and fair.

The Chair asked Board members if they were in agreement to approve the accounts and for the letter of representation to be signed. Board members confirmed their agreement of this.

The Chair concluded the agenda item by offering thanks to Ernst and Young for the work that has taken place on the 2023/24 external audit.

Resolved:
The Board:

- Approved the Trust's Annual Report and Accounts for 2023/24
- Received and noted the External Audit Year-end draft report, 2023/24 'ISA260'.
- Agreed for the letter of representation to be signed on the 28.6.24.

24/25/102 Committee Annual Reports

The Board received the following Committee Annual Reports for 2023/24, noting that each Committee had fulfilled its Terms of Reference and managed its governance processes during the year; it also acknowledged the 2023/24 priorities for each Committee:

- Audit and Risk Committee (ARC).
- Safety and Quality Assurance Committee (SQAC).
- Resources and Business Development Committee (RABD).
- People and Wellbeing Committee (PAWC).
- Innovation Committee.

The Chair thanked each of the Assurance Committee Chairs for their leadership during the year.

Resolved:
The Board received and approved the 203/24 Annual Reports for each of the Assurance Committees.

24/25/103 Board Self-Certification of Compliance with Provider Licence

The Board received the 2024 Board annual self-assessment and self-certification of compliance with the NHS provider licence.

It was reported that as part of the regulation and oversight of NHS provider organisations, Foundation Trusts are required to make an annual self-certified declaration relating to compliance with NHS Provider Licence conditions.

The purpose of self-certification is for providers to evidence that they are compliant with this condition of the licence. There is no requirement to submit this evidence to NHS England (NHSE), but providers must ensure that the self-certification is signed off by the Board of Directors. NHSE typically conducts sample audits on selected providers to ensure the self-certification arrangements have been completed appropriately.

Resolved:
The Board approved the proposed confirmation of compliance against the NHS Provider Licence.

24/25/104 Any Other Business

There was none to discuss.

24/25/105 Review of the Meeting

The Chair drew the meeting to a close and conveyed thanks to the Executive Directors, Audit and Risk Committee chair Kerry Byrne, the teams and everyone involved in the work that has taken place to achieve a positive year end position.

Date and Time of Next Meeting: Thursday 4th July 2024, 11:00am, LT4, Institute in the Park.

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 3rd October 2024 at 9:00**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Mr. D. Powell	Development Director	(DP)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. N. Palin	Associate Director of Transformation	(NP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
Item 24/25/171	Ms. K. Birch	Director of Alder Hey Academy	(KB)
Item 24/25/171	Ms. S. Owen	Deputy Chief People Officer	(SO)
Item 24/25/171	Dr. J. Potier	Assoc. Director of Organisational Development	(JP)
Item 24/25/179	Dr. L. Crabtree	Beyond Programme Director	(LC)
Item 24/25/190	A. Chindiya	Chair of the REACH Network	(AC)
Item 24/25/192	K. Turner	Freedom To Speak Up Guardian	(KT)
Apologies:	Ms. B. Pettorini	Director of Surgery	(BP)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)

24/25/171 People Plan Discussion

The Chief People Officer, Melissa Swindell, provided a recap on the work and the thinking that has taken place since the beginning of the People Plan journey in May 2023, and the last update provided to the Board in June 2024.

It was reported that the Trust is looking at the needs of its people via the same lens as the needs for children and young people (CYP) therefore, as suggested during June's Board, both aspects of the vision have realigned. As a result of discussions/feedback from Board members work has been undertaken to develop the concept of 'One Alder Hey' in terms of combining all to give a sense of one team working together in the right direction with values reflecting one Alder Hey. The Board was advised that the three key strategic areas have remained unchanged since being identified in May 2023; **1.** Create an environment where people thrive. **2.** Focus on the future workforce to ensure they are ready for change. **3.** Learning organisation; create a learning environment in terms of education, development and growing.

A short presentation was shared with the Board to bring together the salient points of the People Plan, as follows:

- *One Alder Hey;*
  - 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, every day, everywhere, in every interaction.
  - One unifying approach for individuals, leaders, teams, organisation, reducing inconsistency of experience and performance.
  - One integrated safety culture.
- *Thriving at Alder Hey – By 2030 we will;*
  - Have values and behaviours that are clear, agreed, visible and translated into lived experience for every member of staff.
  - Have real time feed of staff and team functioning (measuring success and difficulty).
  - Intelligence is used effectively to create systems that continually improve the quality of management (and intervene early when problems arise).
  - Empower teams able to manage issues themselves with clear guidance on where to go if support is needed.
  - Have an integrated safety culture and system.
- *Future Workforce - By 2030 we will;*
  - Have a thriving and diverse workforce, with the right skills in the right place at the right time, within a budgeted establishment.
  - Be recognised for our inclusive approach to employability and employment.
  - Be digitally advanced to reduce high volume, transaction repetitive roles/task – supporting career growth and more efficient/productive ways of working.
  - Work flexibly and adaptively to respond to patient and service need, whilst establishing improved work-life balance.
  - Widening access, reducing avoidable employee harm, development of comprehensive workforce plans at Divisional level, development of a thriving MDT, reducing temporary workforce spend and building sustainable workforce models.
- *Professional Development Hub – By 2030 we will;*
  - Have made significant progress towards becoming a learning organisation.
  - Have personalised development plans covering the whole life cycle of people's time with the Trust, whatever their job role or level.
  - Have effective information, advice, and guidance in place to support those new to the organisation and under-represented groups, with Matrix Accreditation.
  - Have colleagues feeling supported, and able, to develop new skills, aligned to the organisation's core strategic priorities, and to adopt new ways of working.

The Chair of the People Committee thanked the team for the enormous amount of work that has taken place which has culminated in an evolutionary approach that will support the Trust in what is a volatile environment. It was pointed out that if the approach to our people isn't right and the culture isn't right, we can't get it right for our children and young people.

Board members provided their responses in terms of their thoughts and ideas to a question that was raised about what the organisation needs to do differently to make the People Plan successful.

The Chair drew the session to a close and thanked everyone for their contributions. It was felt that the feedback from Board members highlighted the key significance of having a positive culture across the organisation. There were also a lot of questions raised about true engagement in terms of the organisation's communities and diversity. Attention was also drawn to the importance of reflecting upon the levers that can be used to bring about change as the Trust will need to be well prepared going forward to continuously be in a good position.

The Board confirmed their support for the work that is taking place to progress the People Plan. It was felt that providing leadership for this area of work is vital to maintain it on an ongoing basis.

Resolved:
The Board confirmed their support for the work that is taking place to progress the People Plan.

Patient Story

The Chair welcomed Sam and Aaron who had been invited to October's Board to share their son's journey with Alder Hey. Charlotte Jarvis (*Associate Nurse Specialist in Endocrinology*) and Dr. Renuka Ramakrishnan (*Consultant in Paediatric Endocrinology*) also joined the meeting to support Sam and Aaron and provide a quick overview of Dantay's medical condition and the new trial drug that he is receiving.

Dantay is twelve years old and was diagnosed with Generalised Arterial Calcification of Infancy (GACI). Dantay has narrowing of both arteries supplying the brain and the constant fear for him and his family is that he may suffer from a stroke. Following a meeting for affected families which was organised by the pharma company currently trialling a new drug in a related genetic condition, Dr. Ramakrishnan approached them for considering her patient for the medication on a compassionate basis outside the trial. A lengthy process commenced before approval was given, but Dantay is now established on this drug and it's hoped that there will be no further progression of his condition. The Trust is monitoring Dantay's condition and the medication he is receiving and it was reported that his chemical levels have normalised as a result of the treatment.

Dantay's mum and dad described the positive experience that they've had with Alder Hey and offered thanks to everybody involved in Dantay's care. It was explained that the family live in Manchester and the Trust has managed to arrange for multiple appointments to take place on the same day which the family appreciate as it reduces their travelling time, cost, and childcare arrangements.

The Chair thanked Sam and Aaron for sharing Dantay's story and wished them all the very best for the future.

24/25/ 172 Welcome and Apologies

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

The Chair advised that October's meeting is Louise Shepherd's last Board as CEO of the Trust after 16 years. On behalf of the Board, the Chair wished Louise well in her new role as Regional Director for NHS England (North West Region) and thanked her for all that she has done for everyone connected with Alder Hey.

Congratulations were offered to the Trust's Chief Digital and Transformation Officer, Kate Warriner, on being nominated in the top one hundred Chief Information Officers across all sectors. Kate was placed at number ten and was the first woman in the ranking.

Congratulations were also offered to the Chief People Officer, Melissa Swindell, and her team who have been shortlisted for one of the HPMA Excellence in People Awards.

24/25/173 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.

24/25/174 Minutes of the previous meeting held on 5th September 2024

Resolved:

The minutes from the meeting held on the 5.9.24 were agreed as an accurate record of the meeting.

24/25/175 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 24/25/11.1: *Mortality Report (Look at how the Trust can benchmark itself following the change to the requirement for reporting deaths of CYP age 4 and above with a learning disability and/or Autism to the LeDeR programme)* – All LeDeR deaths are reported nationally but there is no form of benchmarking in place therefore the Hospital Mortality Review Group (HMRG) lead, Julie Grice is going to raise this matter with the National Committee. **ACTION CLOSED**

Action: 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)* – 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 w/c 7.10.24. **ACTION TO REMAIN OPEN**

24/25/176 Chair's and CEO's Update

The Chair informed the Board of her attendance at the launch of the Charity's CYP advocacy campaign on the 25.9.24. The Mayor of the Liverpool City Region, Steve Rotheram, chaired a panel of young people who clearly expressed their hopes and ambitions that children will have a warm and safe home, be treated as an individual, especially noting the importance of embracing neurodiversity and difference. The launch was also attended by the leader of Liverpool City Council, a local MP, and a number of young people who made an impressive contribution.

The Chair also attended the Cheshire and Merseyside (C&M) Health Care Partnership (HCP) meeting on the 1.10.24 where a report was received from the voluntary sector. Only 8% of the voluntary sector who engaged in this communication agreed that they have a positive relationship with the NHS in terms of partnership working. It was pointed out that the work that the Trust has been undertaking in the community is starting to have an impact and it is this type of contribution that the NHS can make collectively that will make a difference in terms of building relationships with the voluntary sector. The C&M HCP was also furnished with a paper on child and family poverty. It was pointed out that the HCP is concentrating on CYP and are going to hold a workshop during November's meeting to focus on child poverty.

Regional update - Louise Shepherd advised that the CEO of the C&M Integrated Care Board, Graham Urwin, has requested an Exec to Exec team meeting with the Trust to discuss how Alder Hey can become the convener for CYP and help the ICB develop a strategy for delivery. It was felt that this is a very positive step.

National update – The Board was advised that the Secretary of State, Wes Streeting, is visiting Alder Hey on the 4.10.24 to meet with regional leaders from across the North West, and staff who were involved in the major incident in Southport. The Secretary of State has also agreed to announce the formation of the Institute of Child Health and the Trust's partnership with the University of Liverpool.

It was reported that the Children's Commissioner visited the Trust on the 24.9.24 to discuss working in collaboration to influence the 10-year plan. There was also an opportunity to share the issues that are being experienced in terms of neurodiversity and ADHD medication shortages.

Louise Shepherd attended a national meeting where the NHS 10 Year Plan was discussed. It was reported that the plan is focused on improving quality and safety, reducing inequalities, improving patient flow, and transforming the way care is delivered. The plan will be developed with input from frontline staff, patients, their families, and other experts. The first step of engagement will commence in October and the aim is to publish the plan in the spring of 2025.

Attention was drawn to the challenges that are being experienced from a financial perspective across the C&M system and the tighter controls that are being implemented as a result of this. The system is also being challenged on urgent care, especially within the adult sector therefore it is imperative to drive forward the transformation programme. It was reported that Graham Urwin is going to take forward a conversation with the ICB about the CYP Strategy, and a discussion has taken place with the CEO of Lancashire and South Cumbria about how Alder Hey can share its leadership to help them develop their networks, for example, having a Beyond approach in Lancashire.

The Board was advised of the announcement of the 100,000 genomes programme that will commence to sequence the genomes of 100,000 newborn babies. It was reported that this will be the largest study of its kind, mapping a neonate's complete set of genetic instructions, with potentially profound implications for childhood medicine. This will provide Alder Hey and the Liverpool Women's Hospital, who are joint partners, with a big opportunity to work on the newborn genomes programme. The Board was informed that Louise Shepherd has been chairing the implementation of this work for the last eighteen months and it was confirmed that there are 25 sites up and running with 10 in the process of being launched.

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

24/25/177 Vision 2030 Strategy Deployment Update

The Board was advised that a lot of work has been undertaken to determine the shape of the organisation going forward, along with a stock take that focussed on design, improvement, and change. Further work is required on the economic framework and people therefore it was agreed to defer November's Strategy Board to the 5.12.24 so that time can be spent discussing the 2030 Strategy, the outcome of the stocktake and implications for longer term change.

During September a benefits review took place which confirmed that progress is being made. A number of gaps in relation to benefits were identified along with an opportunity to strengthen the realignment of financial planning and refocus strategic drivers. The benefits review was submitted to the Finance, Transformation and Performance Committee (FTPC) who endorsed the recommendations that were made as part of the review to adjust the strategic drivers and embed more programmes of work into the benefits programme such as Get Me Well and Personalise my Care. Attention was drawn to the importance of recognising the excellent work that is being done but it was felt that there is a need to create a platform for longer term change.

A discussion ensued and a number of points were highlighted about the under reporting of benefits, joining up with teams who are innovating to capture a solid view of clinical innovation and determine the gains being made, encouraging teams to engage with each other to share their innovative work in order to support each other and have consistency. It was pointed out that the Trust is working with some challenging teams who aren't open to change and it was queried as to how the organisation will re-organise itself to address this matter.

Resolved:
The Board received and noted the 2030 Strategy deployment update.

24/25/178 CMAST Joint Working Agreement and Committee in Common Terms of Reference

The Board received the updated CMAST Joint Working Agreement and Committee in Common Terms of Reference, for endorsement purposes; the CMAST governance documents had been reviewed following two years of operation. An overview of the updates was provided and it was agreed to endorse and approve the updated CMAST Joint Working Agreement and Committee in Common terms of reference as set out in the report.

Resolved:
The Board agreed to endorse and approve the updated CMAST Joint Working Agreement and Committee in Common Terms of Reference as set out.

24/25/179 Beyond Update

The Board received a quarterly update on the Beyond Programme. A number of slides were shared that provided the following information:

- Since its foundation, the Beyond Programme has reached over 53,000 CYP, families and professionals via 33 projects. Further reach will result from the mobilisation of the supervised toothbrushing programme.
- *Key progress;*
  - 65% of CYP say that they don't feel listened to when having a healthcare appointment. As a result of this a piece of work is being undertaken to address this issue. It was confirmed that this work is in the development stage.
- *2024/25 consolidation of delivery;*
  - 'All Together Smiling' supervised toothbrushing programme - Funding for dental was provided by the ICB.
  - Healthy Start, Brighter Future programme - Health inequality funding was received from the ICB for this programme.
  - Diabetes – New technology for patients.

- Epilepsy project 'Addressing Unwarranted Variation' – Funding for this project was provided by NHSE.
- Appropriate Place of Care – A business Case for this area of work has been developed and is in the final process of being approved.
- CYP delivery, oversight, and governance – Continuing to evolve and embed.

- *Celebrating success;*
  - Healthy weight and obesity (Halton Teen Health app) – This project has been nominated for a Health Service Journal award.
  - Alder Hey Star Awards nominees - 'Most Inspiring Colleague' Award and the 'Rising Star' Award.
- *Feedback from CYP, parents and carers;*
  - Participation and health equity feedback.
  - Respiratory projects feedback.

The Chair thanked Liz Crabtree for the update and drew attention to the fantastic work that is taking place. It was felt that the challenge is rolling the programme out at scale but regardless of this progress is being made.

Resolved:
The Board received and noted the quarterly update on the Beyond programme.

24/25/180 C&M Financial Position Update

The Board was provided with an update on the latest C&M financial position as at the end of August; including system efficiency plans, workforce and forecast for the full financial year. The following points were highlighted:

- C&M system is reporting a deficit of £166.9m at the end of August which is £48.5m adverse to the plan as agreed at the start of the year. The forecast for the year highlights a risk adjusted position of £213m deficit which is a £63m variance to the £150m deficit plan set. £9m of the variance relates to the cost of industrial action and it was reported that a national allocation of £4.3m has been received but is yet to be fed into the figures.
- Workforce numbers have reduced in-month; however a significant reduction is still required to hit the plan by the end of the year. A workforce efficiency group has been established internally at Alder Hey to lead on all the workforce actions, and workforce/financial dashboards are in development and will report on key metrics such as bank, agency, WTE, non-pay and efficiency, at Trust and Divisional level. From October onwards the dashboards will be submitted to the Executive meeting on a weekly basis and to the relevant Assurance Committees.

The Board was informed that the PWC report cannot be shared as of yet, therefore a number of slides were submitted that provided feedback from PWC, a system summary and an overview of the next steps.

It was reported that the Trust has received a letter from the ICB in the last 48 hours setting out their expectations for the next six months. A re-submission is required by the 4.10.24 for a financial reforecast to the end of March 2025 with actions required to close the gap for those trusts off plan including any ICB interventions. The Trust has also been asked to outline any additional actions required to improve the position by a further 0.5% to help address the C&M deficit.

A discussion took place and Board members raised concerns about the additional target, drawing attention to the risk it entails for the Trust. The Chair of the Finance, Transformation and Performance Committee (FTPC) was concerned that this additional stretch will put the organisation's clinical services at risk. The Chair advised the Executive team that they will need to maintain quality and safety and in the event the organisation goes off plan the Board will need to be briefed so that it can understand the reason for this. The Trust will respond to the ICB making it clear that Alder Hey will proceed on the basis of best endeavours to achieve the stretch target.

The Chief Operating Officer, Adam Bateman, advised the Board that the Trust isn't making any decisions that will compromise safety or quality, the risk is about whether the levels of activity can be sustained. This will need to be monitored and raised at Board level if there are any issues. It was suggested further risk assessments be undertaken as a follow up piece of work.

Resolved:
The Board noted the quarterly update on the C&M financial position.

24/25/181 Alder Hey – Autumn and Winter Emergency Response Plan, 2024/25

The Board received the Trust's Autumn and Winter Emergency Response Plan for 2024/25. It was reported that the plan outlines a comprehensive strategy to ensure the Trust is fully prepared to manage the increased demand during the winter period. By focusing on optimising capacity, improving patient flow, ensuring robust staffing, and enhancing collaboration with community partners, the Trust aims to provide safe, efficient, and high-quality care to all patients, even during peak pressure times. The following key points were highlighted:

- Owing to a number of estate development works, this winter the Trust will be operating with 7 fewer general and acute beds compared to the previous winter, inclusive of escalation beds. The Trust is trying to mitigate for this.
- Alder Hey will lose the current ED department waiting area in the new year owing to the neonatal estate development. The Trust is hoping to defer this for as long as possible without compromising the development and is looking at alternative options for waiting with the use of technology.
- With the return of all theatre sessions within the theatre schedule an increase in elective capacity is planned to combat elective waiting lists.
- It was reported that the four pillars of the plan are attendance avoidance, admission avoidance, capacity and flow, staff health and wellbeing. An overview was provided of the high impact initiatives that are in place and under development to ensure the delivery of the Winter Plan's aim, as detailed in the report.

The Chief Nurse, Nathan Askew, offered to facilitate flu vaccinations for the Board and asked that members confirm their preference in terms of arranging for this to happen during November's Board or via the drop in service.

24/25/181.1 Action: All

Attention was drawn to the national debate about the healthier together app and it was felt that this is something for the Trust to think about in terms of whether it continues with its established symptom checker which is to be promoted and further developed this winter to support self-care and management at home, or whether it links in with the national initiative. It was agreed to discuss this matter ahead of winter 2025.

24/25/181.2 Action: AB

Resolved:
The Board received and noted the 2024/25 Autumn and Winter Emergency Response Plan.

24/25/182 Evidence of Our Performance

Flash Report, M6

The Board received the Flash Report for September 2024. The following points were highlighted:

- *Outstanding Care and Experience;*
  - There were zero Never Events.
  - Family and Friends Test was at 95%.
- *Revolutionising Care;*
  - The number of patients waiting longer than 52 weeks for treatment have reduced from 737 to 432. Work will continue to reduce this figure to 0 in 2025.
  - The number of patients waiting longer than 65 weeks have been cleared with the exception of 1 patient and this was due to the patient's choice.
  - ED has treated 84.3% of its patients within four hours.
  - September's elective recovery YTD is at 123% versus a target of 119%.
- *Financial Sustainability;*
  - YTD the Trust is on plan.

Reference was made to the issue relating to coding and it was queried as to whether the Trust is confident that actions have taken place to support the mitigation of this risk. It was reported that the Trust is exploring an AI coding solution with a commercial partner that will assist coders to decipher complicated procedure codes. Two workshops have been scheduled for November to scope out the work for this project.

As a result of the work that has been undertaken to review past records and ensure nothing has been overlooked, the Trust has acquired additional data. There is to be a focus on the priorities the organisation wishes to address and a conversation will take place with the Medical Director and clinicians to progress this work.

Integrated Performance Report for M5, 2023/24

The Board received the Integrated Performance Report (IPR) for Month 5. An update was provided on the following areas of the IPR:

Outstanding Care and Experience – Safe and Caring

- 95% of families who completed the FFT said that they would recommend the Trust, and 94% of families said they would recommend ED. It was reported that this is the highest figure that the Trust has received in more than 12 months.
- There have been zero Category 2 pressure ulcers for the last nine months following the implementation of the Tissue Viability Action Plan.
- There has been a decrease in antibiotics administered within 60 minutes for sepsis; 85% of inpatients and 83% of ED patients. Teams and Divisions are reviewing the reasons for this.

Revolutionising Care – Effective and Responsive

- *Neurodiversity* – The number of patients waiting for an ASD or ADHD diagnosis continues to grow. A proposal has been put forward to source additional capacity in the private sector. It was reported that the ASD/ ADHD transformation programme is continuing with good engagement from teams and external colleagues

Pioneering Breakthroughs

- There has been an increase in Chief Investigator studies.
- The commercial income forecast for contract research activity remains ahead of target at the end of M5.
- A potential AI coding partnership has been identified with Phare Health.
- Pre-contract technical discussions are ongoing for the Ambient AI LyreBird project. Ambient AI is a technology which utilises AI (*natural language processing)* to listen to consultations and then create summaries of the session. The Trust is looking to roll this pilot out in October/November and will report on the benefits in due course.

Collaborate for CYP

- Work is taking place to look at how the Trust can measure social value in much more depth and is gaining in knowledge.
- The MMR vaccination programme has screened 395 CYP, checked the vaccination status of 340, contributed to the management of 42, and given 10 vaccines (to 9 children).
- The first vaping clinic for CYP is planned to commence in November and will take place at Alder Hey in the Outpatients department. It was reported that this matter was discussed at SQAC as it will be running contrary to the main NHS message aimed at adults.

Financial Sustainability: Well Led

- In August (M5), the Trust is reporting a position £0.2m away from plan (£3.4m deficit against a plan of £3.2m). This is due to industrial action.
- It was reported that MARS (*Mutually Agreed Resignation Scheme*) was paid in M5 which had to be offset. A discussion took place about testing whole time equivalent (WTE) numbers. It was pointed out that the Trust has seen a reduction in bank staffing which has been sustained in M6.

Non-Executive Director, Kerry Byrne, pointed out that financial risks are starting to score more highly on the organisation's risk registers and therefore it is imperative that the Divisions ensure that risk owners attend the respective risk validation meetings that are co-ordinated by the Governance team. The Board was advised that regular discussions take place at the Risk Management Forum with risk owners, and the issues are well known to the Divisional leads but that representation from all areas is vital. It was agreed to review attendance at risk meetings.

24/25/182.1 Action: ES

Community and Mental Health Division

- A piece of work is being undertaken to determine the number of patients that the Trust has seen in excess of the 1000 that it is commissioned to see.
- *ADHD Medication Shortage* – A meeting is taking place with NHSE on the 15.10.24 to discuss the shortage of ADHD medication and to share a small number of case studies with them.

Division of Medicine

- The work that was undertaken by the Chief Nurse and the Renal Dialysis Unit has culminated in the unit being open 24/7 for the last three months and releasing beds.
- *Areas of concern;*
    - The laboratory haematology/transfusion service is experiencing staffing issues. Work is taking place to mitigate this risk via the recruitment/training of three BMS staff by December 2024. It was pointed out that the next nine weeks will be critical for the service.
    - It was reported that the Emergency Department is experiencing a spike in consultant sickness.
    - The nuclear medicine department received an 'Improvement Notice' from CQC on the 19.9.24 detailing contravention of two of the IRMER regulations. The issues related to documentation; no safety concerns were identified. On receipt of the notice the Radiology department established a Nuclear Medicine Improvement Programme to ensure the delivery of all actions within the 12-week timeframe implemented by CQC, with oversight and support from Divisional leadership and the Director of Corporate Affairs.

Division of Surgery
There was nothing to raise in addition to what was in the IPR.

Resolved:
The Board:

- Noted the Flash Report for M6.
- Noted the content of the IPR for Month 5.

24/25/183 Alder Hey in the Park Campus Development Update

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

- *Neonatal Unit* – Progress is being made with the construction of the building and completion of the project is on track.
- *Alder Park* – The Trust is trying to mitigate the financial impact on the design and cost plan as a result of several unexpected issues being discovered on site including fire stopping and water safety compliance.
- *Springfield Park* – The main park is complete and the swale has been successfully tested. Discussions have taken place with the Friends of Springfield Park (FOSP) regarding their support for the development of the play area.

A discussion took place about the Trust's aspirations for a Health and Wellbeing Centre on the Campus and the opportunities that may arise via the organisation's partnerships, etc. It was suggested that a Board debate take place early in 2025 for a collective discussion on a partnership strategy for the Campus and the options available.

24/25/183.1 Action: DP

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

24/25/184 Safeguarding Children and Adults at Risk Annual Report, 2023/24

The Board was provided with an overview of Trust's safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding

Team from the 1.4.23 to the 31.3.24, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk. The following points were highlighted:

- It was reported that there has been an increase in referrals.
- Information on Safeguarding Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs) has been included in the report. In 2023/24 the Safeguarding Team has contributed to five Local Child Safeguarding Practice Reviews. It was reported that there have been some challenges and future work is to be noted.
- The Trust will shortly welcome its new Named Doctor for Safeguarding.
- Level 3 Safeguarding Children and Adults training has fallen below the 90% compliance target. It was confirmed that the team has reviewed and modified training to ensure it is fully compliant with changes. The feedback from staff is that the training has improved.

Resolved:
The Board approved the 2023/24 Safeguarding Children and Adults at Risk Annual Report.

24/25/185 Mortality Report, Q1.

The Board received the Mortality Report for Q1. The following key points were highlighted:

- The Q1 Mortality Report has been fully scrutinised by the Safety and Quality Assurance Committee (SQAC)
- There have been two potentially avoidable deaths in the 2024 cases reviewed to date. The avoidable factors were due to external elements and there were no issues relating to care received at the Trust.
- The mortality rate in PICU has returned to expected levels.
- Currently, there are no Medical Examiner (ME) services at the weekend or on Bank Holidays. This may impact adversely on members of the population in whom an early burial is required for reasons of faith. This service is meant to be a 24 hour service therefore this issue has been escalated the ME's office at LUFT who are working in collaboration with other services to find a solution.

Attention was drawn to the importance of SQAC supporting the HMRG lead with the undertaking of a piece of work on benchmarking following the change to the requirement for reporting deaths of CYP age 4 and above with a learning disability and/or Autism to the LeDeR programme. It is felt that it is really important to understand this area of work.

Resolved:
The Board received and noted the Mortality Report for Q1.

24/25/186 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 24.7.24 were submitted to the Board for information and assurance purposes.

During September's meeting the Committee focussed on the prior warning of national challenges regarding C difficile and the potentially worrying national trend relating to out of hospital cardiac arrests.

It was reported that SQAC has agreed the Safe Waiting List governance arrangements, and agreed to receive a Safe Waiting List update on a quarterly basis.

Resolved:
The Board noted the approved minutes from the meeting held on the 24.7.24.

24/25/187 Futures Committee

The approved minutes from the meeting held on the 26.6.24 were submitted to the Board for information and assurance purposes

During September's meeting there was a focus on Futures Implementation Programme and the four pillars; Discover, Develop, Grow and Transform.

Resolved:
The Board noted the approved minutes from the meeting held on the 26.6.24.

24/25/188 Collaborate for Children and Young People: Partnerships Update

The Board was provided with a quarterly update and information on the core relationships and system partnerships in which the Trust are engaged. The following points were highlighted:

- The Memorandum of Understanding (MOU) that governs the partnership with Manchester Foundation Trust/Royal Manchester Children's Hospital (RMCH) is being updated to reflect the progress in joint service development and partnership working. The updated MOU will be submitted to the Trust Board for approval in Q3.
- There is a lot of positive work being undertaken in terms of partnership working across the North West via the NW Paediatric Partnership Board (NWPPB) which the Trust leads jointly with RMCH.
- Alder Hey is working in partnership to progress its vision for new service models across the North West, and the Trust and RMCH is working with Spec Comm to look at what is required to develop a North West Strategy for CYP.

Resolved:
The Board received the quarterly partnerships update and noted the progress that is being made.

24/25/189 Liverpool Neonatal Partnership Governance

The Board was provided with oversight of neonatal activity for the Liverpool Neonatal Partnership (LNP), and oversight of Divisional Governance meetings for Liverpool Women's Hospital and Alder Hey Children's Hospital. The following points were highlighted:

- Business Intelligence data on the partnership is starting to be compiled and will eventually include information on transfers.
- *Mortality Data* – A detailed review of the mortality report and the action plan for the Neonatal Intensive Care Unit (NICU) is being undertaken. It is quite complicated to interpret the data therefore further work will be required before assurance can be provided. A request has been made for the sharing of data in a clearer format.

Reference was made to the challenges and difficulties being experienced in terms of interpreting mortality data provided by the LNP and it was felt that a formal conversation needs to take place between LWH and the Trust regarding this matter. A suggestion was made about trying to acquire data that supports trend and applying it to individual cases. It was reported that Alder Hey's attendees didn't receive any papers for September's Liverpool Neonatal Partnership Board.

24/25/189.1 Action: LS/DJW/KB/LWH

Resolved:
The Board noted the Liverpool Neonatal Partnership update.

24/25/190 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 August/September 2024. It was reported that there is a focus on the 2024 Staff Survey at the present time in terms of encouraging staff to complete the survey.

Workforce Equality, Diversity, and Inclusion Update

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

- There are six priority actions incorporated in the EDI Improvement Plan. It was reported that a progress update will be provided in November.
- Alder Hey's Anti-Racist Statement is in the final draft stage. It was reported that the Trust's Anti-Racist Statement will align with the organisation's values and support the work that's being embedded. Once it has been agreed it will be shared with the Executive team.

Black History Month

The Chair of the REACH Network, Audrey Chindiya, introduced herself and provided an overview of the REACH open day event that took place on the 30.8.24. The Board was informed that the event was successful and has helped grow the network, for example, there was a colleague who didn't have access to Teams but as a result of the event is now a member of the network. The feedback from the event is that the general mood is positive and colleagues are able to come together to support each other.

There is a big focus on growing the REACH network in order to give staff a safe space. Meetings are taking place on a more regular basis in person and via Teams. Supporting internationally trained nurses is high on the agenda, as is acquiring support for managers and leaders to enable them to help pockets of the organisation that are struggling.

Attention was drawn to 'Black History Month' which takes place in October. It was pointed out that this is a time for celebration and learning. A number of events will take place over this period ranging from blogs, short stories, African dancers, face painting based on flags that represent the countries of black colleagues, and a book club. A lunch and learn session is also taking place with guest speaker, Bea Freeman. The Trust will launch its Anti-Racist Statement as part of Black History Month, and a celebration has been arranged to take place on the 25.10.24.

Thanks were offered to Audrey Chindiya for accepting the Chair's role of the REACH Staff Network and for the wonderful work that is being undertaken by the network.

It was queried as to whether thought has been given to the North West BAME Assembly and whether the Trust should be taking any lessons from this. It was agreed to discuss this matter outside of the meeting.

24/25/190.1 Action: AC/LC

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

24/25/191 People Committee

The approved minutes from the meeting held on the 17.7.24 were submitted to the Board for information and assurance purposes.

During September's meeting the Committee received a position paper on overpayments and it was noted that all management actions and mitigations are in to support a reduction. The Committee also focused on the report that was submitted about improving the working lives of resident doctors. A conversation took place about the work that has been undertaken to look at protecting the learning time for trainees.

Resolved:
The Board noted the approved minutes from the meeting held on the 17.7.24.

24/25/192 Freedom To Speak Up (FTSU) Q2 Update

The Board was provided with a summary of the activities of the FTSU team for Q2 and the actions planned for the coming period. The following points were highlighted:

- Q2 figures have increased and further work is being undertaken to address the 35 of the 40 case that remain open. It was reported that there had been an increase in medical and dental staff using the FTSU route to raise concerns which is positive as it means that they feel safe to do so.
- The single case relating to patient safety was escalated to the senior leaders within that area. Assurance has been provided that mitigations are in place and therefore patient harm has been reduced. The concern related to training and development and the apparent lack of a robust process in managing/monitoring staff capability. This is scheduled to be reviewed.
- A FTSU survey has been conducted over a 3-month period and has provided FTSU with some valuable intelligence that will inform how the Trust will promote the service across the organisation. There are a number of gaps which indicate that staff don't understand what FTSU is or how to access it. There are also some staff who still don't feel safe raising a concern.
- *Lessons Learnt* - A review of the Organisational Change Policy is underway, the vision for this is to create a pathway to change that reduces the negativity currently associated with this process.
- The FTSUG visibility programme continues to be well received across the organisation and is a key component of the FTSU communication plan.
- FTSU mandatory compliance is high with good feedback being received from staff. It was reported that FTSU is now also part of the Trust's staff induction process.

- Speak Up month takes place every October, with the theme for this year being Listening. The staff networks have come together and will be in the atrium every Monday throughout October, promoting FTSU
- In response to the National Guardian's request for a pledge, the Trust's has pledged to understand the barriers that keep colleagues silent *(Won't be Silent).*
- The FTSU app is being progressed to provide a confidential route for raising concerns.
- The Board was informed that one of the Trust's consultants has agreed to become an FTSU Champion.

Non-Executive Director, Kerry Byrne, advised of her attendance with the Freedom To Speak Up Guardian (FTSUG) to a visit on ward 4C, where she was able to see the improvements being made by the nursing leadership team and how these improvements translated for the staff by engaging with them during the visit. A plea was made to Board members for their support with future visits.

A discussion took place about lessons learnt and a process for formalising recommendations to provide valuable insights on themes. It was suggested using a number of anonymised case studies on outcomes and highlighting how FTSU can be used to provide support to individuals.

The Chair thanked the FTSUG for providing a quarterly update and asked that Board members contact Kerry Turner if they wish to engage in the Visibility Programme.

Resolved:
The Board noted the FTSU update for Q2.

24/25/193 CQC Improvement Notice

Following a site visit by CQC on the 13.11.24 to inspect the nuclear medicine department at Alder Hey, the Trust received an improvement notice in relation to IRMER regulations 25, 61 and 65. The Board was advised that Alder Hey relies upon expert advice from LUFT on nuclear medicine therefore a number of the recommendations appertain to both organisations.

A task and finish group has been established and an action plan has been compiled to ensure that all recommendations are addressed within the 12 week notice period (*18.12.24*). Internal weekly meetings are taking place to review the CQC report and understand the breaches which relate to documentation and monitoring.

The Chair queried as to whether there is any evidence that a young person has come to harm due to the misinterpretation of guidance about accidental exposure. It was reported that CQC were clear that the service was safe and the recommendations relate to very technical elements. The organisation has been undertaking a lot of work around CQC regulations but this matter has highlighted that further learning is required for those areas that are subject to additional regulations.

Resolved:
The Board noted the update.

24/25/194 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 22.8.24 were submitted to the Board for information and assurance purposes.

2024/25 Top Key Risks

Attention was drawn to the five key risks captured on one page that the Committee review on a monthly basis. From a system perspective, it is felt that there is a risk of further restrictions and controls that may create a problem for the Trust.

In terms of capital, the allocation of CDEL is limited in 2024/25 yet significant capital investment and prioritisation is required. The Trust will have to be thoughtful about the use of its capital especially in light of the investment required for the renewal of medical equipment in 2025. It was reported that the 5 Year Capital Plan will be submitted to the Board in due course.

Resolved:
The Board noted the approved minutes from the meeting held on the 22.8.24 and the latest position of the 2024/25 top key risks

24/25/195 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:

- Finance risks are accurately described in the BAF but it will be necessary to reflect upon them as the financial situation evolves.
- It was reported that CQC has reviewed the operation of its new approach and revisions have been made to their strategy; relationship owners have been re-introduced, they are moving away from the scoring but keeping the quality statements.
- BAF risk 1.2: Children and young people waiting beyond the national standard to access planned care and urgent care – the work being undertaken on follow ups is to be referenced following discussions at assurance committees.
- Work will continue to ensure the EDI risk is updated on a regular basis.

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

24/25/196 Governor Election Results
Resolved:
The Board noted the governor election results for summer 2024.

24/25/197 Any Other Business
There was none to discuss.

24/25/198 Review of the Meeting

The Chair thanked everyone for their contributions and felt that the Board had covered a lot of important issues during the meeting.

Date and Time of Next Meeting: Thursday 7.11.24 at 9:00am, LT4, Institute in the Park.

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

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for November 2024							
5.9.24	24/25/142.2	Alder Hey in the Park Campus Development Update	Liaise with Fiona Ashcroft to gain information on charities who arrange for groups of people to go out into the community to litter pick.	Dame Jo Williams	7.11.24	Nov-24	**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. **ACTION TO REMAIN OPEN**
8.2.24	23/24/260.1	System Wide Update	Liaise with the Chairs of CMAST to discuss as to whether transition will be dealt with under mental health via CMAST.	Dame Jo Williams	7.11.24	Nov-24	**5.6.24 -** This action is being progressed. An update will be provided during September's meeting. **5.9.24** - There hasn't been an opportunity to address this action therefore the action is to remain open. **ACTION TO REMAIN OPEN**
5.9.24	24/25/148.1	Workforce Equality, Diversity and Inclusion Update	Discuss the issues relating to promotion across the Trust from an equal opportunity and fairness perspective.	Dame Jo Williams/ J. Revill	7.11.24	On track Nov-24	
Actions for December 2024							
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	5.12.24	Dec-24	**22.8.24** - Following discussion with LUFT/LWH it has been agreed to arrange for this meeting to take place at a later date. **27.9.24** - An initial meeting is taking place between Erica Saunders and Daniel Scheffer ahead of arranging a Board to Board meeting. 6.11.24 - A further meeting has taken place in November. Arrangements are yet to be made for a Board to Board meeting. **ACTION TO REMAIN OPEN**
5.9.24	24/25/140.1	Vision 2030 Strategy Deployment Update	Agenda item to be included on November's Strategy Board to discuss the outcome of the stock take exercise of the Trust's strategic goals to look at what is/isn't working in order to adapt the organisation's plans.	K. Warriner	5.12.24	Dec-24	**3.10.24** - The Trust Strategy Board has been deferred to the 5.12.24. **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	Dec-24	**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. **ACTION TO REMAIN OPEN**
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	

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for 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**
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	
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	
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							
11.4.24	24/25/11.1	Mortality Report, Q3.	Look at how the Trust can benchmark itself following the change to the requirement for reporting deaths of CYP age 4 and above with a learning disability and/or Autism to the LeDeR programme.	A. Bass	6.6.24	Closed	**4.6.24** - This action is in progress. An update will be provided in July. **3.7.24** - The Medical Director is awaiting an update on this matter therefore and update will be provided to the Board in September. **22.8.24** - The Medical Director is awaiting an update on this matter therefore and update will be provided to the Board in October. **3.10.24** - All LeDeR deaths are reported nationally but there is no form of benchmarking in place therefore the Hospital Mortality Review Group (HMRG) lead, Julie Grice is going to raise this matter with the National Committee. Going forward, SQAC will support the HMRG LEAD with the undertaking of a piece of work on benchmarking following the change to the requirement for reporting deaths of CYP age 4 and above with a learning disability and/or Autism to the LeDeR programme. **ACTION CLOSED**
3.10.24	24/25/181.1	Alder Hey – Autumn and Winter Emergency Response Plan, 2024/25	The Chief Nurse, Nathan Askew, offered to facilitate flu vaccinations for the Board and asked that members confirm their preference in terms of arranging for this to happen during November's Board or via the drop in service.	All	7.11.24	Closed	**4.11.24** - A drop in session has been arranged for the 7.11.24 to enable Board members to have a flu jab if required. **ACTION CLOSED**
3.10.24	24/25/190.1	People Plan Highlight Report	*Black History Month Update* - Discussion to take place about whether the Trust can learn from the work that has been undertaken by the NHS North West BAME Assembly.	L. Shepherd/ A. Chindiya	7.11.24	Closed	**30.10.24** - This action has been addressed. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th November 2024

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

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

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

0031

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

1. Executive Summary

This report outlines the progress made on Vision 2030 strategic goals during the period from September to October 2024, with a focus on the stock-take insights, programme adjustments, and strategic advancements informed by our Benefit Review (Sept 24). The stock-take, conducted collaboratively with Children, Young People (CYP), and key stakeholders across Divisional, Executive, and Trust Board levels, has provided actionable insights that directly inform and will support the **blueprint for the shape of Alder Hey by 2030 and roadmap for 2025-2030**.

Key insights from the stock-take emphasise a strengthened **focus on CYP *Areas of Need***, and a shift toward integrating Vision 2030 within the operational mainstream of Alder Hey. This evolution will enhance divisional alignment, strengthen governance, and support divisional and frontline staff to make improvements for CYP more effectively. These insights, coupled with our strategic goals, will inform a detailed blueprint to be presented at the December 2024 Strategy Board.

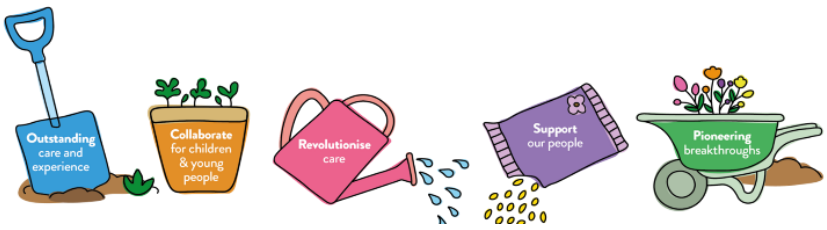
Recommendations to:

- **Review Key Actions**: Oversee remaining Q4 actions for 2024/25, ensuring alignment with financial goals and strategic direction.

2. Background

Vision 2030's aim creating a ***Healthier, Happier, and Fairer Future for CYP*** continues to drive our organisational transformation, aligning short-term actions with long-term strategic objectives. Our strategic programmes launched in April 2024 include objectives aligned with a £20m efficiency target, improvements in operational efficiency, and steps toward realising our clinical transformation goals. The latest stock-take further underscores the need to link divisional goals with the broader Vision 2030 framework, ensuring that each division is well-supported to meet the needs of the populations it serves.

3. Current Position and key highlights



Emerging Themes from the Stock-Take:

- **Focus on CYP Areas of Need:** Feedback has universally identified the need for a tighter focus on our core *Areas of Need*, facilitating alignment across our strategic programmes of transformation, clinical divisions and fostering a need led approach.

- **Strengthened Governance and Accountability*:*** An emerging recommendation is to formalise a “ward-to-board” accountability model, empowering staff at all levels to contribute directly to Vision 2030. Our November 14 Clinical Leaders’ Summit will showcase early wins, spotlighting clinical teams already driving impactful improvements aligned with Vision 2030.

- **Workforce Alignment**: The stock-take also noted the importance of Experience, Safety, and People as cross-cutting enablers, supporting a holistic approach to delivering better outcomes for CYP and enhancing our team’s well-being and productivity.

Strategic Blueprint for the ‘Shape of Alder Hey 2030’ and Roadmap: A comprehensive strategic blueprint is under development, combining stock-take insights with the Benefit Review (Sept 24), Executive and Senior Leaders’ Strategic Planning sessions, and insights from the Clinical Leaders’ Summit. This blueprint will set a clear, focused direction for the next five years, incorporating economic projections, divisional alignment strategies, and robust metrics to assess progress and ensure divisional accountability in Vision 2030’s deployment.

The blueprint aims to embed Vision 2030’s ambitions deeply into our operations, ensuring organisation-wide alignment and strengthening governance to support effective monitoring and continuous improvement. The roadmap will detail our multi-year transformation plan, providing clarity on the portfolio of programmes as we move into 2024-25.

Key Highlights delivery

The approval of the People Plan by the Trust Board in October 2024 marks a significant milestone, paving the way for progress in key programmes like the Professional Development Hub and Future Workforce.

In recent months, substantial efforts have been directed across our Strategic Goals to advance our journey toward Vision 2030. Each programme has established effective routines, with change initiatives either fully scoped or actively underway to support our strategic vision. Table 1 provides a snapshot of key initiatives implemented, aimed at **improving outcomes** and experiences for children and young people (CYP), **enhancing the well-being and effectiveness of our workforce**, and delivering positive **efficiencies** and direct financial benefits.

Table 1: Key Highlights

Quadruple Aim	Strategic Goal – Highlights
Experience: Children, Young People & Families	**Outstanding Care and experience:** • **Out- Patient Transformation**: Patient Journey Mapping completed with the Phlebotomy Service, CYPF, leading to opportunities to enhance the consistency of experience (identification included patients using two buses to attend, out of area patients' attendance and variable satisfaction around waiting experience). • **Virtual Tour Launch**: Positive feedback from uses and high numbers of views.
Experience: Our People	• **Futures**: **Ambient AI Test of Change:** Contract has been finalised with the supplier and the project board is established with a range of stakeholders. Pilot lined up for before Christmas and will include up to 25 clinicians which will include an agreed set of success criteria the clinicians will be assessing.
Improved Outcomes	• **Revolutionising Care:** Productivity has increased through targeted improvement actions linked to GIRFT and Model Hospital benchmarking, resulting in 118 patients treated as of September 2024. Additionally, there has been a 26% reduction in waiting times since April 2024 and a decrease in general anaesthetic procedures for children and young people. The digital pre-op process is also being rolled out across specialties, further enhancing efficiency and patient experience for CYP.

Challenges, and Risks

- **Key Milestone Delays and Risk Mitigation:** Milestone setbacks, such as the delay of “Martha’s Rule” and the “Improve My Life Chances” workshop, underscore the need for a flexible, agile approach to managing these projects. The Executive Team is aware and managing these delays, and revised timelines and risk mitigation actions are underway to ensure these projects get back on track.

- **BAF Risk and Assurance Level:** Following board review, the BAF risk score for the programme (Risk 3.2) has decreased to 12, indicating improvements in programme governance and assurance. The recent stock-take has also highlighted areas for enhanced oversight, particularly within decision-making agility and resource allocation to high-priority areas. The Programme Management team has adjusted resource forecasts to streamline efforts in high-impact areas while continuing to reduce pressure on individual clinical teams.

Recommendations

- **Review Key Actions**: Oversee remaining Q4 actions for 2024/25, ensuring alignment with financial goals and strategic direction.

Next Steps

1. **Blueprint Finalisation for the ‘Shape of Alder Hey’ for December 24 Strategy Board:** The strategic blueprint will incorporate divisional feedback, cross-functional inputs, and the specific recommendations from the Benefit Review to guide both our blueprint and governance plan. This roadmap will reflect operational realities and strategic priorities across Vision 2030’s core objectives, embedding Vision 2030 into our clinical services and ensuring alignment with financial and patient outcome goals

2. **Alignment and Accountability Mechanisms**: The blueprint will establish new accountability models that connect divisional workstreams directly to Vision 2030, ensuring that each teams / services have a defined role in our shared objectives. This alignment will empower our teams to take ownership within a unified framework, supported by measurable goals and clear benchmarks for success

Oct 2024

FLASH REPORT

Published 5th November 2024

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

Outstanding Care and Experience

0
Severe or Fatal Incidents/Never Events (0)

0
Number of PSIIs - Patent Safety Incident Investigations (0)

1
Number of Hospital Acquired Organisms (2)

91.4%
FFT - % Recommending Trust (92%)

Revolutionise Care

81.7%
ED: % treated within 4 Hours (77%)

401
Number of RTT Patients waiting >52weeks (687)

121%
Elective Recovery Volume vs 19/20 (112%)

90%
Diagnostic Performance (95%)

Support Our People

+75
Workforce Plan : 4307
Estimated WTE : 4382

10.5%
Staff Turnover (<10%)

Financial Sustainability

YTD - TBC

Forecast £3.3m surplus.

I&E Year End Forecast

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: October 2024

Contents

VISION 2030

Our Journey To 2030

IPR Summary

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

Variation	Assurance: Achieving Target	Assurance: Inconsistently Achieving Target	Assurance: Not Achieving Target
Special Cause - Improvement	IHAs, Level 1 patient safety training and Liquidity are consistently achieving target with an improving trend	RTT > 52 Weeks, DC Activity vs Plan, Severe/Fatal incidents, Cat 2 Pressure Ulcers, MSSA are inconsistently achieving target with an improving trend	
Common Cause	Category 3 & 4 Pressure Ulcers, Mandatory Training, Cancer Faster Diagnosis & Cancer Urgent Referrals, Liquidity and MRSA metrics are achieving targets	WNB Rate, Incidents, Complaints/PALs, Sepsis, ED 4hr,% Recovery, ERF, C.Diff, Sickness (Overall), F&F ED and risks within review date are inconsistently achieving target and are yet to evidence statistical improvement	Theatre Utilisation, Diagnostics, Long Term Sickness and PDRs, Medical Appraisal are not achieving targets and currently not demonstrating statistical improvement
Special Cause - Concern		Cancer 31-day decision to treat (x1 breach) .	

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

- We are consistently passing 25%* of our metrics.
  59% of the evaluated SPC metrics achieved the target in the month of September 2024.
- We are achieving 59.1% of our metrics inconsistently.
- We are not achieving the target for 15.9% of our metrics, 0 of these are showing special cause of concern.

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

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

Integrated Performance Report | October 2024

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

- 100% of inpatients received antibiotics within 60 minutes for sepsis and 89% of ED patients
- Zero C-diff infections reported in month following a spike of 3 in the previous month
- 90% of PALS responded to within the 5 day timeframe and 83% of formal complaints responded to within 25 working days

Areas of Concern:

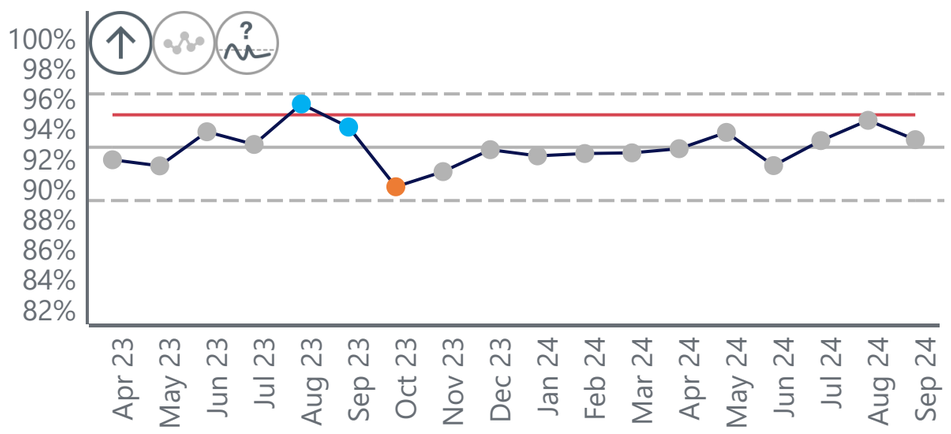
Static number of patients who deteriorate unexpectedly and require unplanned admission to Critical Care and increased number in month of unplanned admissions to PICU from HDU

Forward Look (with actions)

Plan to implement the Wellness Hub underway with support from charity partners from Citizens Advice and Health Junction

F&F Test - % Recommend the Trust

Target: Statutory



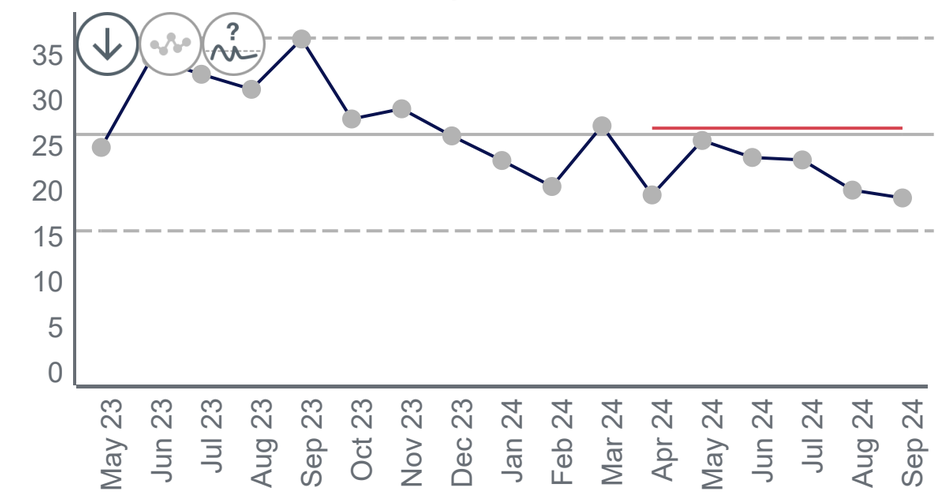
Technical Analysis:

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

Actions:

93% of families who completed the survey recommended the Trust. The FFT has been improved and is now accessible in more than 40 languages

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



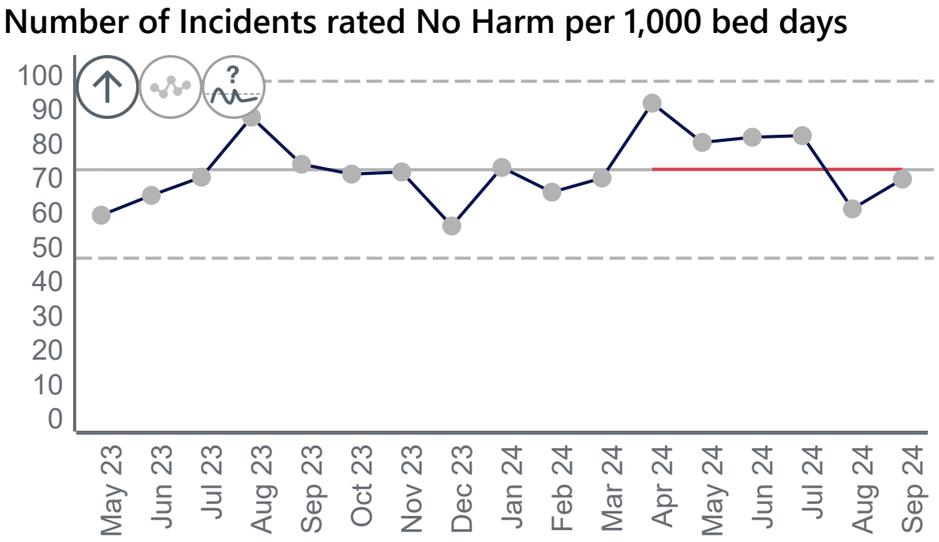
Technical Analysis:

Common cause variation has been observed with performance of 19 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:

Decreased number of incidents resulting in harm. Staff continued to be encouraged to report all incidents and near misses

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



Technical Analysis:

Common cause variation observed with 61 incidents of no harm per 1000 bed days, with a monthly average of 70. This incluces 28 incidents with no harm assigned due to not involving a patient directly. Incidents are now assessed on Physical and Psychological Harms and target is set against a 5% improvement on 23/24 with monthly target 71.

Actions:

Staff continued to be encouraged to report all incidents and near misses

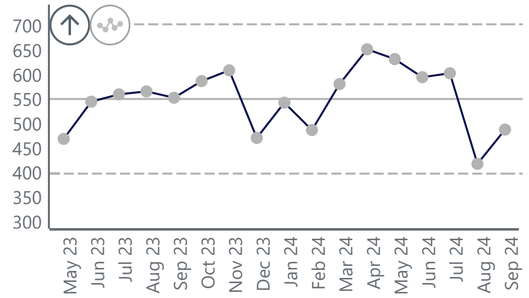
0040

Integrated Performance Report | October 2024

NHS
Alder Hey Children's
NHS Foundation Trust

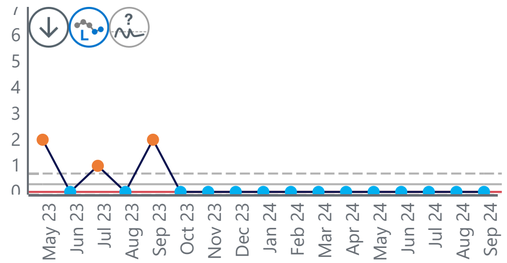
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



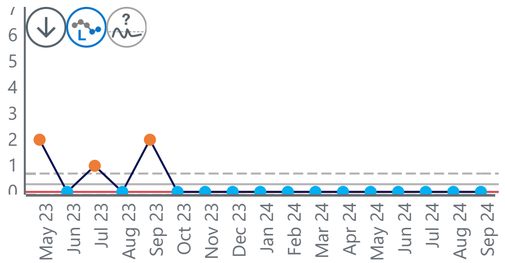
Severe or Fatal Incidents – Physical only

Target: Internal

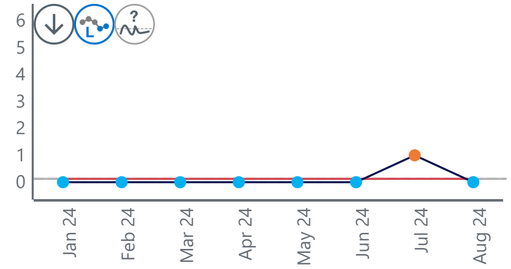


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

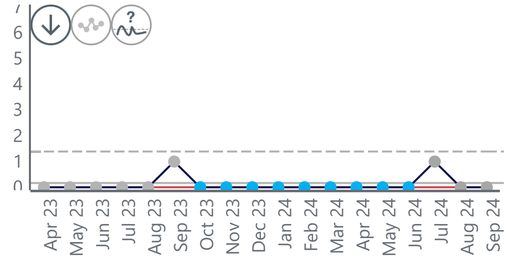


Number of PSIIs (Patient safety incident investigation) undertaken



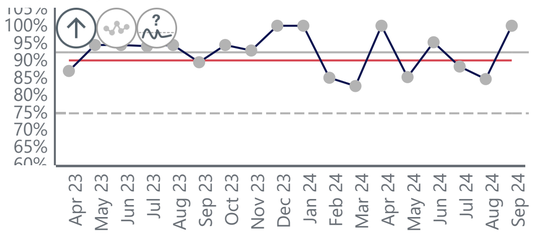
Number of Never Events

Target: Internal



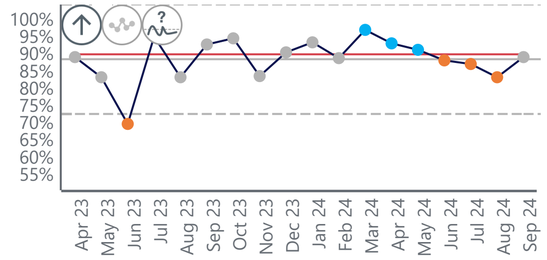
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

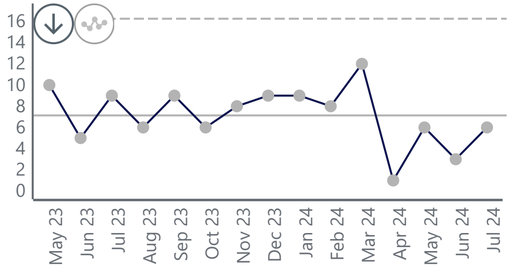


Sepsis % Patients receiving antibiotic within 60 mins for ED

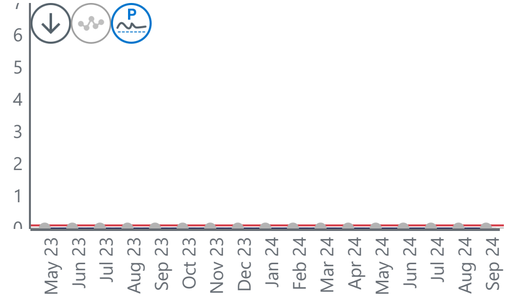
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

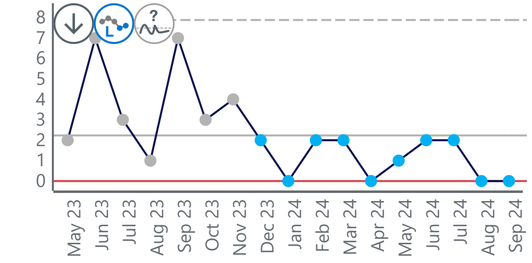


Pressure Ulcers Category 3 and 4

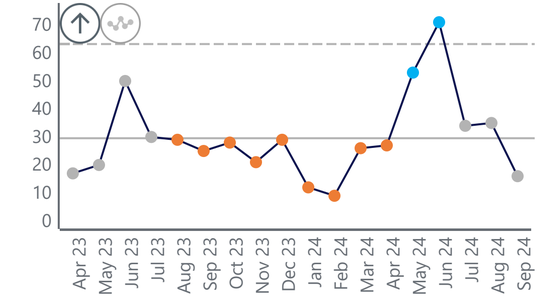


Pressure Ulcers Category 2

Target: Internal

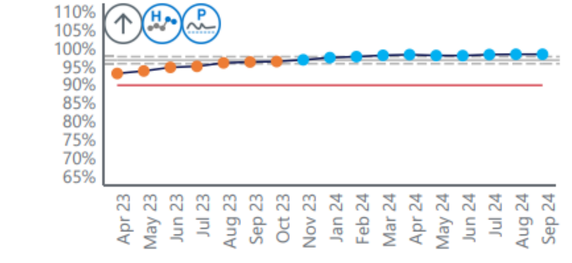


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



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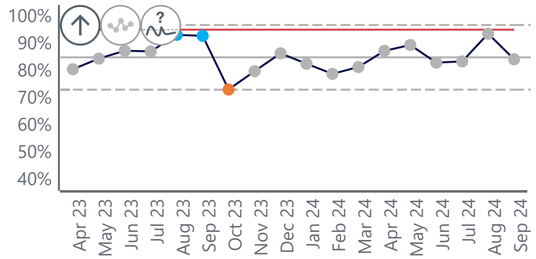
Integrated Performance Report | October 2024

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

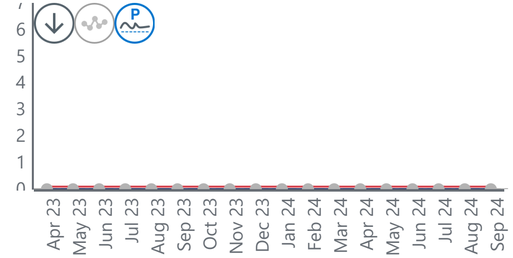
F&F ED - % Recommend the Trust

Target: Internal



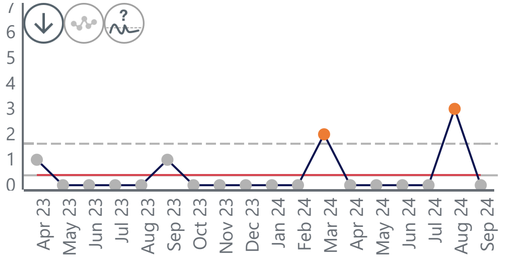
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



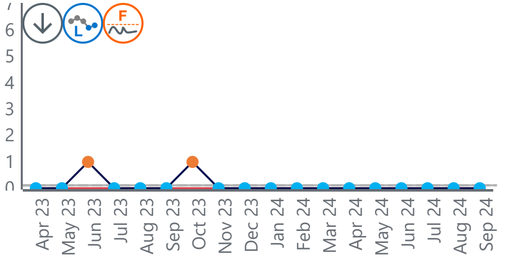
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



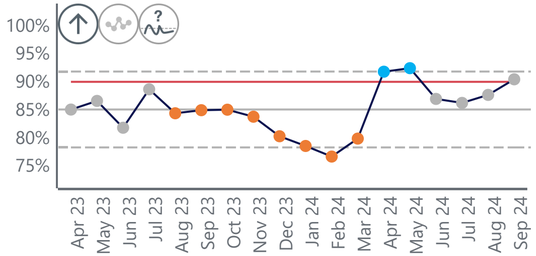
Hospital Acquired Organisms - MSSA

Target: Internal



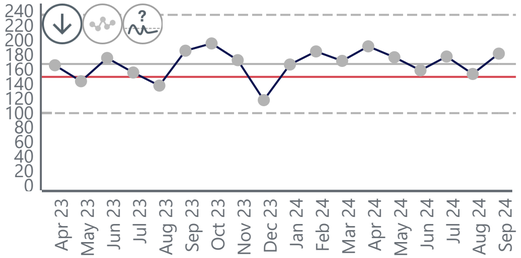
% PALS Resolved within 5 Days

Target: Internal



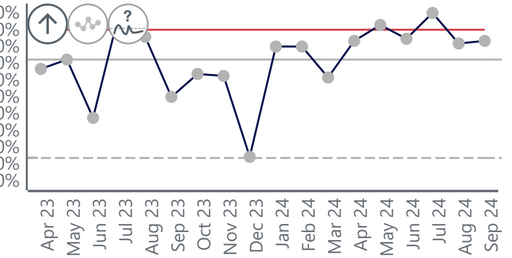
Number of PALs contacts

Target: Internal



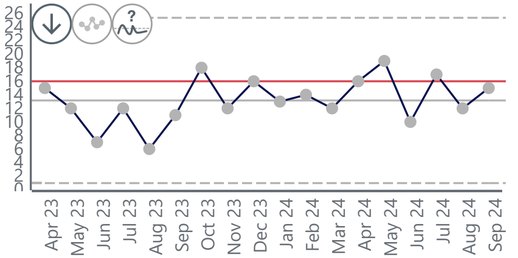
% Complaints Responded to within 25 working days

Target: Internal

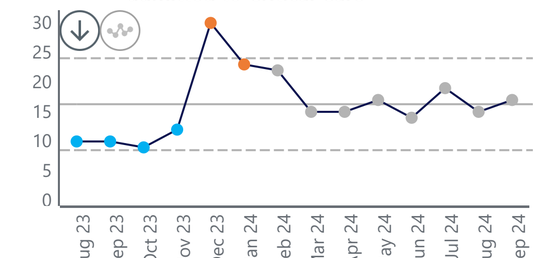


Number of formal complaints received

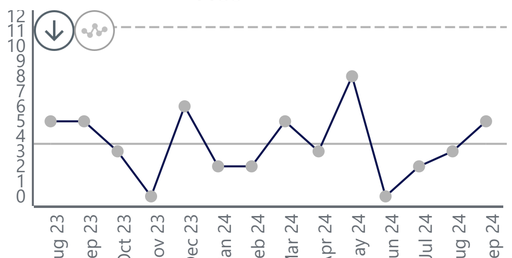
Target: Internal



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



Number of patients deteriorating from HDU admitted to PICU



Integrated Performance Report | October 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:

• Day cases and OP New & OPROC procedures remain above the 2024/25 operational plan • Sustained reduction in the number of overdue follow ups by 31st March 2025 • Slight reduction in the overall 'Was Not Brought' rate, reducing from 12% in August to 10% in September • Capped theatre utilisation achieved 79%, the highest utilisation rate of 2024/25 so far.

Areas of Concern:

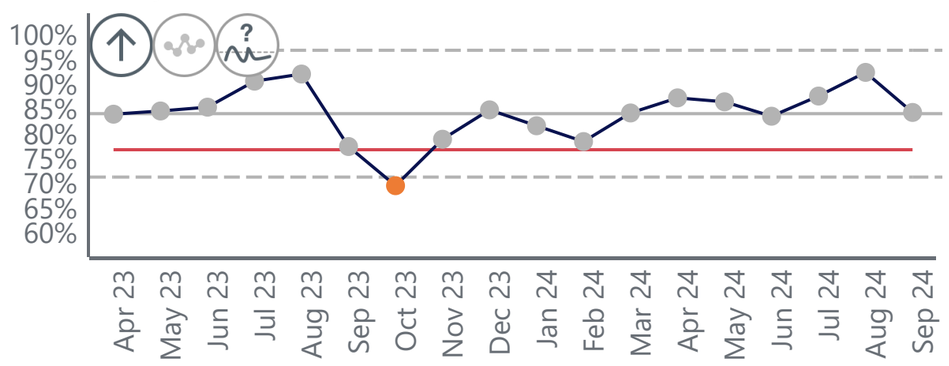
• The Trust has declared the first '31 day decision to treat to any cancer treatment for all cancer patients' breach since April 2023. This was due to administrative error when registering the referral
• The number of patients waiting for ASD or ADHD diagnosis continues to grow, now 3,173 patients are waiting. Transformation work is ongoing within the division • Elective activity remains below the 2024/25 operational plan. There are number of specialities with case mix changes where this is offset by an overperformance in day case activity.

Forward Look (with actions)

• Trajectory paper for DM01 performance to be presented at the October Operational Board by the Division of Medicine • Work is ongoing to reduce the number of overdue follow ups and will be incorporated into Safer Waiting List Management Oversight Group governance structure.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

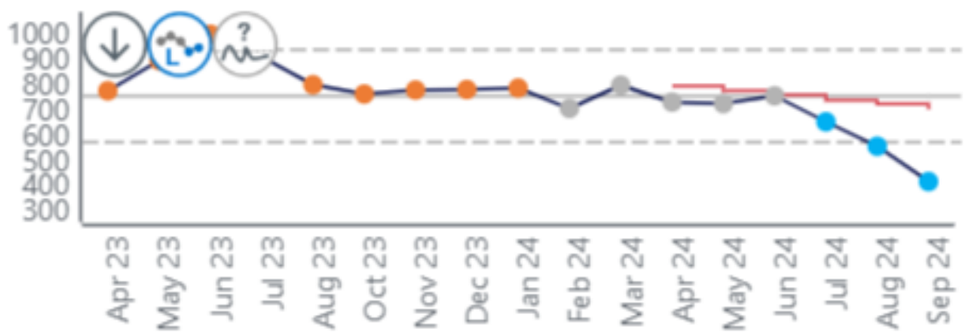
Trust is achieving the national target (>77%) in September-24. Common cause variation has been observed with performance of 84.5%. Decrease from Aug-24 (92.6%) which has less demand due to school holidays. Sept-24 performance is +6.9% compared to Sept-23 (77.6%) whilst Sept-24 seen only -89 less attendances compared to Sept-23. 2024/2025 performance to date is 86.9%

Actions:

Division of Medicine has prepared the winter plan, focussing upon: Attendance Avoidance, Admission Avoidance, Capacity & Flow and Staff Health & Wellbeing to sustain high performance going into winter months.

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

Target: Internal 24/25



Technical Analysis:

Demonstrating special cause variation of improving nature with number of patients waiting > 52 weeks at 420 for Sept 2024 against a trajectory of 707. Further decrease from Aug 2024 position of 560 and the 3rd consecutive month with a reduction. Top 3 services with waiters >52 weeks: Dentistry (n= 192), ENT (n=83) & Neurology (n=46). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

Actions:

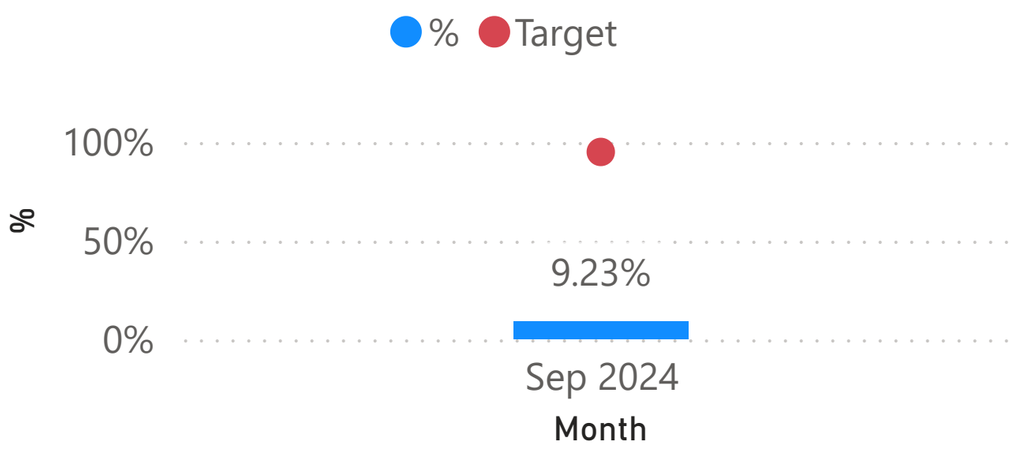
The Trust is focused upon reducing the number of patients over 52 weeks by March 2025. It is expected that this will be achieved in all but 5 specialties across both Medicine and Surgical Divisions.

Integrated Performance Report | October 2024

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 September the longest wait for ADHD assessment was 141 weeks and for ASD was 118 weeks. For those assessment completed in September, 94% of the ASD assessments and 67% of ADHD assessments were concluded within 104 weeks.

Actions:

The ASD and ADHD pathways continue to focus on concluding assessments for children and young people who have waited the longest. Currently 30% of those waiting are over 65 weeks and by concentrating on those who have waited longest, the number of pathways completed in less than 65 weeks each month will likely remain below the target of 95% until the maximum waiting time is significantly reduced.

0044

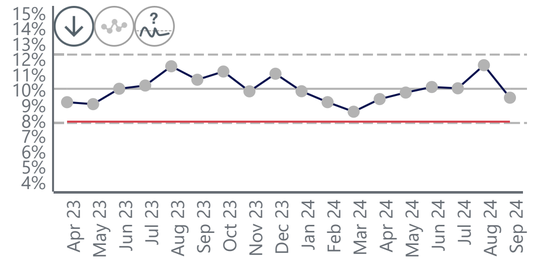
Integrated Performance Report | October 2024

NHS
Alder Hey Children's
NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

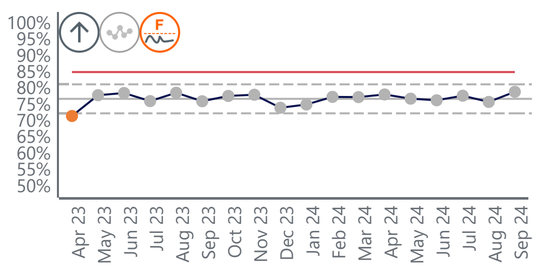
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

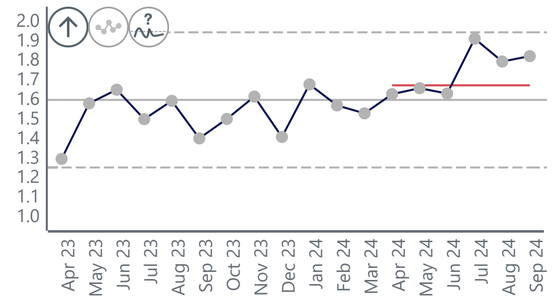


Theatre Utilisation (Capped Touch Time)

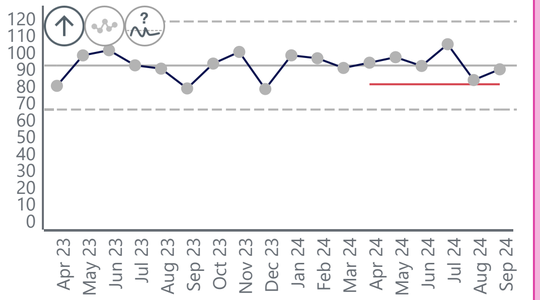
Target: Internal



Elective admissions (IP & DC) per clinical WTE

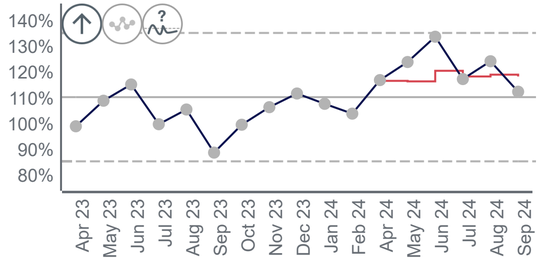


Outpatient attendances per Consultant WTE



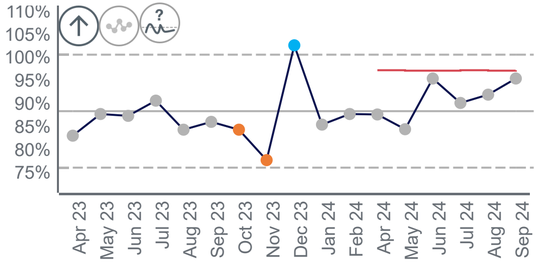
% Recovery for Daycase Discharges

Based on 19/20 baseline



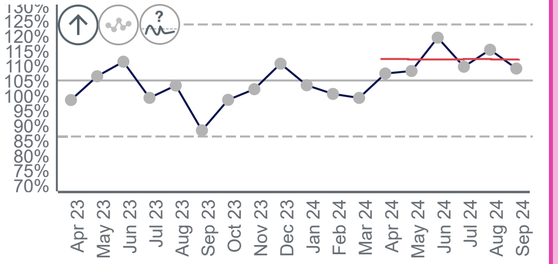
% Recovery for Elective Discharges

Based on 19/20 baseline



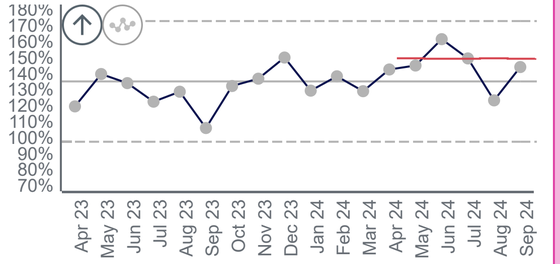
% Recovery for DC & Elec Activity Volume

Based on 19/20 baseline



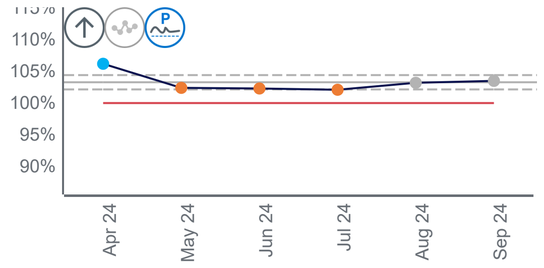
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline



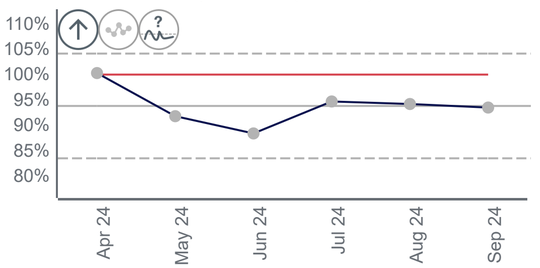
Daycase Activity vs Plan (YTD Position)

SLAM Performance (Volume)



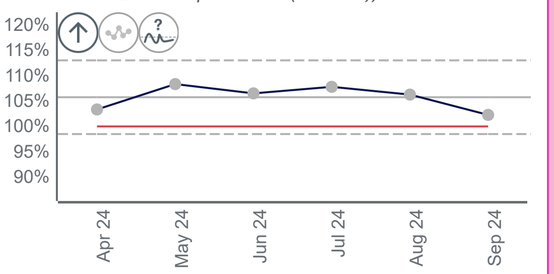
Elective Activity vs Plan (YTD Position)

SLAM Performance (Volume)

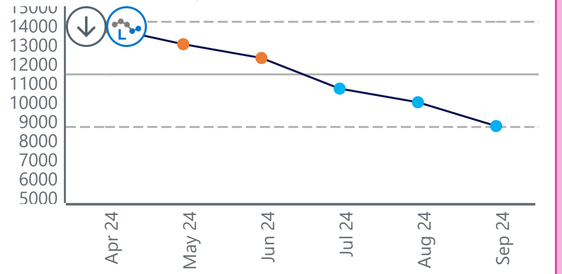


OP New & OPPROC Activity vs Plan (YTD Position)

SLAM Performance (Volume))



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



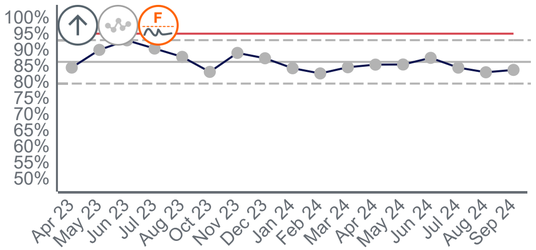
Integrated Performance Report | October 2024

Alder Hey Children's NHS Foundation Trust

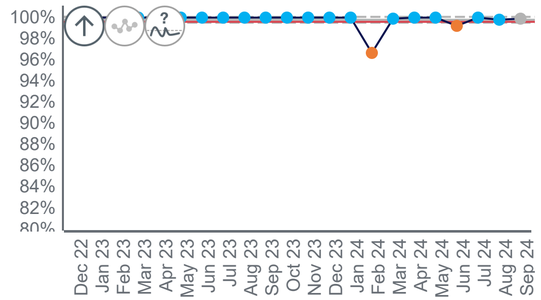
Revolutionise Care - Effective & Responsive - Watch Metrics

Diagnostics: % Completed Within 6 Weeks of referral

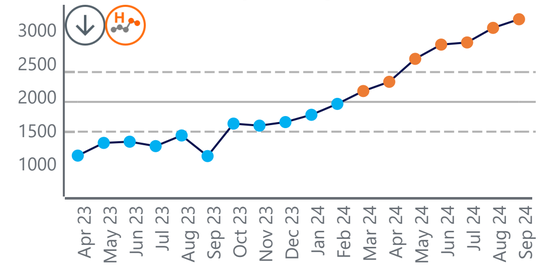
Target: Statutory



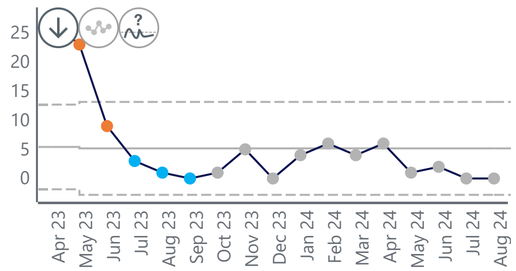
ADHD & ASD: % Referral to triage within 12 weeks



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

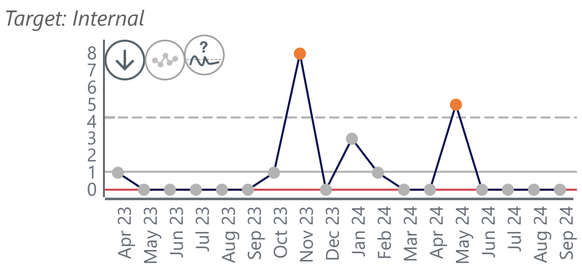


CAMHS: Number of children & young people waiting >52weeks



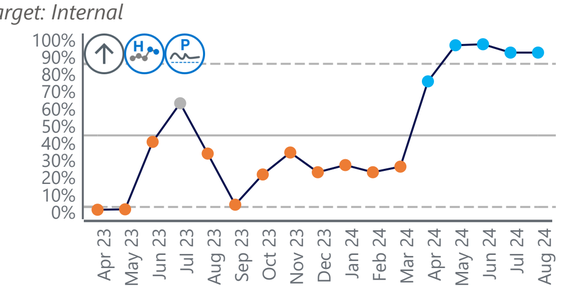
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



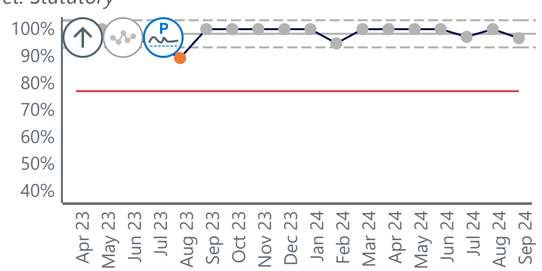
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



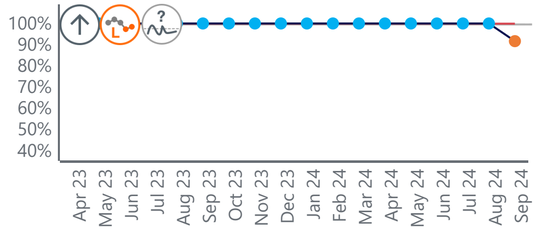
Cancer: Faster Diagnosis within 28 days

Target: Statutory



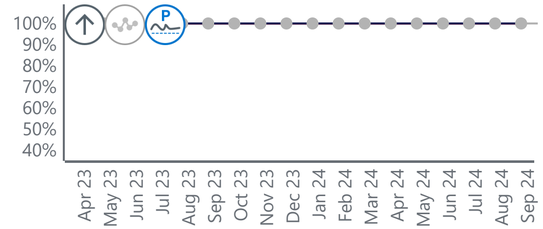
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)



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

Target: Internal (Stretch)



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

• Mandatory training completion remains over 90%

Areas of Concern:

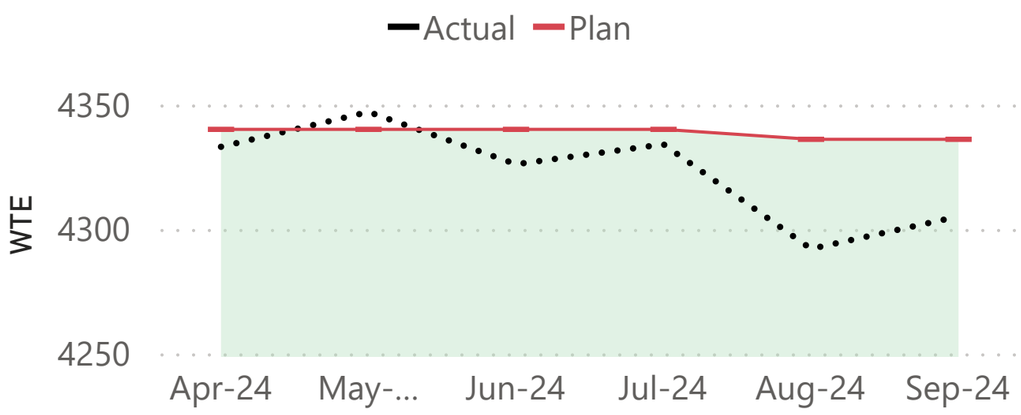
• PDR completion has remained below 90%; there are specific concerns with B7+ PDR compliance which were due to be completed by 31st July (which currently sits at 45% completion across the previous 12 months). PDR completion is being supported across the L&D and HR teams, with data regularly presented, with reports specifically on B7+ PDR completion going out weekly via email or phone call.

Forward Look (with actions)

• WTE continues to receive a lot of focus and is a challenging plan, with the plan/target reducing from October 2024 due required CIP. Additional measures to deliver this are being reviewed.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

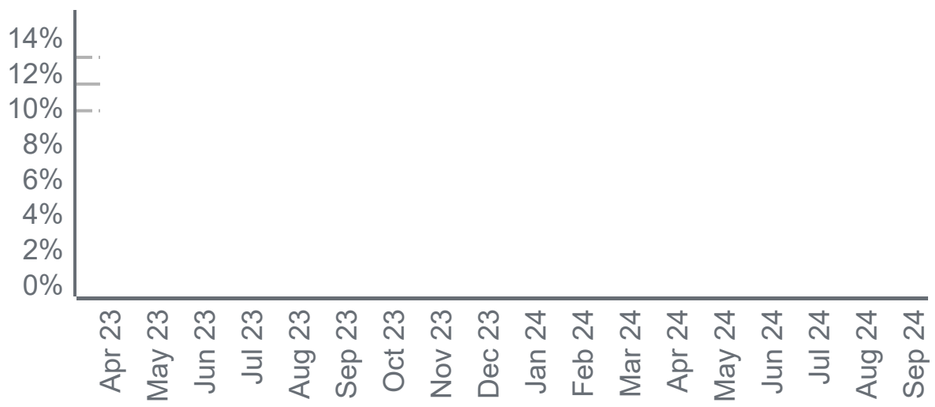
Total workforce for the end of September 2024 was 31.8 WTE below plan. Actual WTE was 4304 against a plan of 4339. 24/25 year end plan is set at 4273.4 WTE.

Actions:

Total workforce is the WTE staff in post, plus agency and bank usage (as WTE). The figure is not yet available for September. Of note, the plan/target begins to reduce from October 2024 due to required CIP. Additional measures to deliver this are being reviewed.

Staff Turnover

Target: Internal



Technical Analysis:

Data under review due to technical issue with automated ESR data into the IPR.

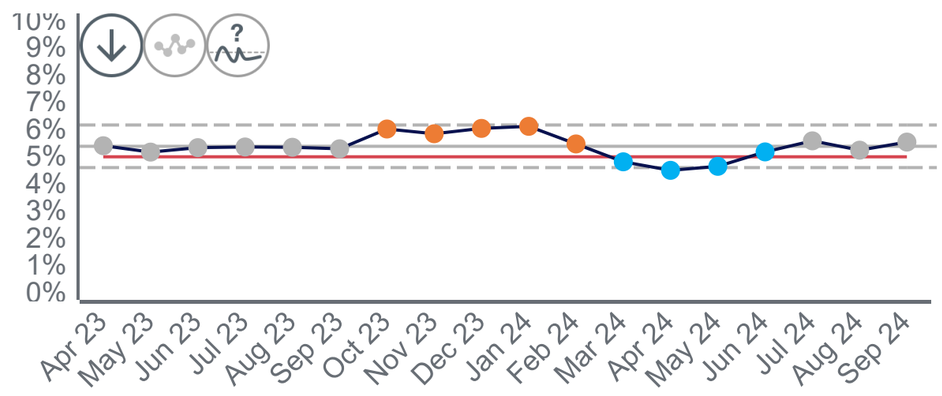
September 2024 performance was 10.9% against a target of 10%

Actions:

Analytics to resolve reporting

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in September 2024 is 5.54% which is above the 5% target. An increase from August 2024 at 5.24%. September 2024 performance comprises STS at 1.90% and LTS at 3.64%. Still demonstrating common cause variation, 4th consecutive month above the target in 24/25.

Actions:

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

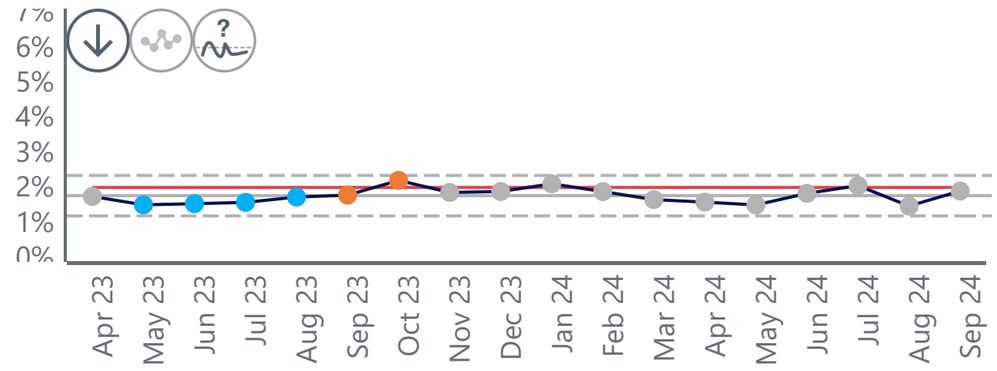
Integrated Performance Report | October 2024

Alder Hey Children's NHS Foundation Trust

Supporting Our People - Watch Metrics

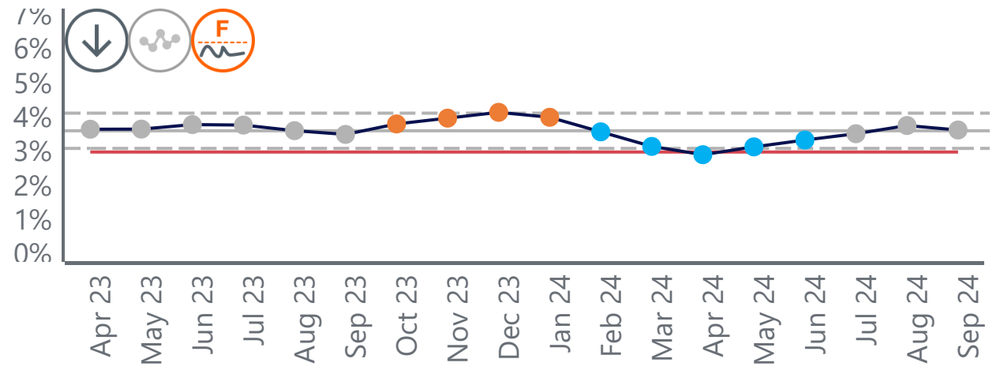
Short Term Sickness

Target: Internal



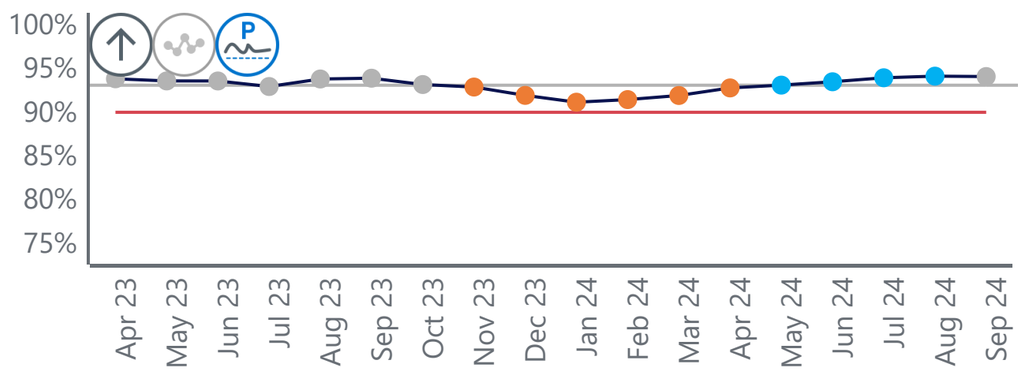
Long Term Sickness

Target: Internal



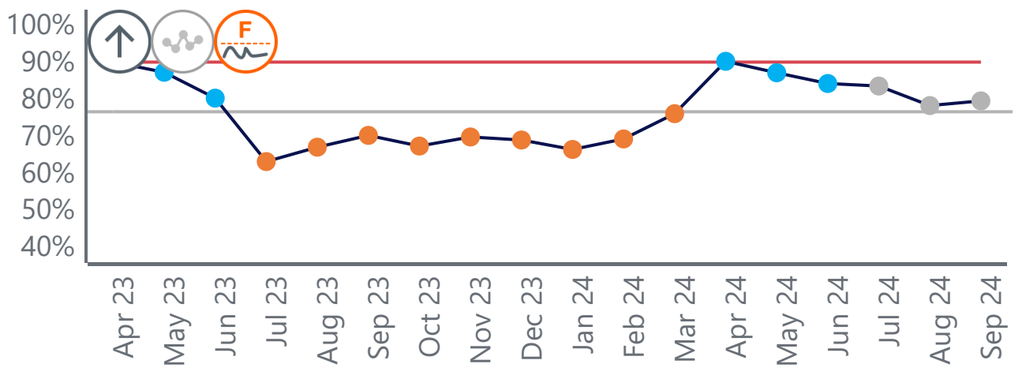
Mandatory Training

Target: Internal



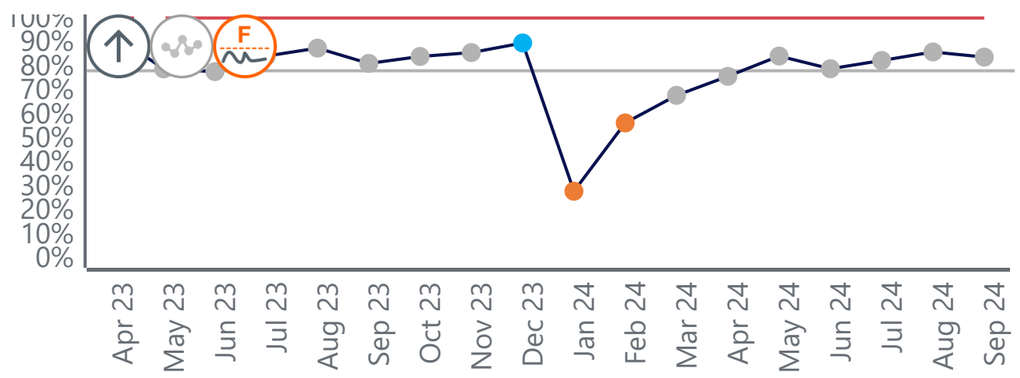
% PDRs Completed (Rolling 12 Months)

Target: Internal

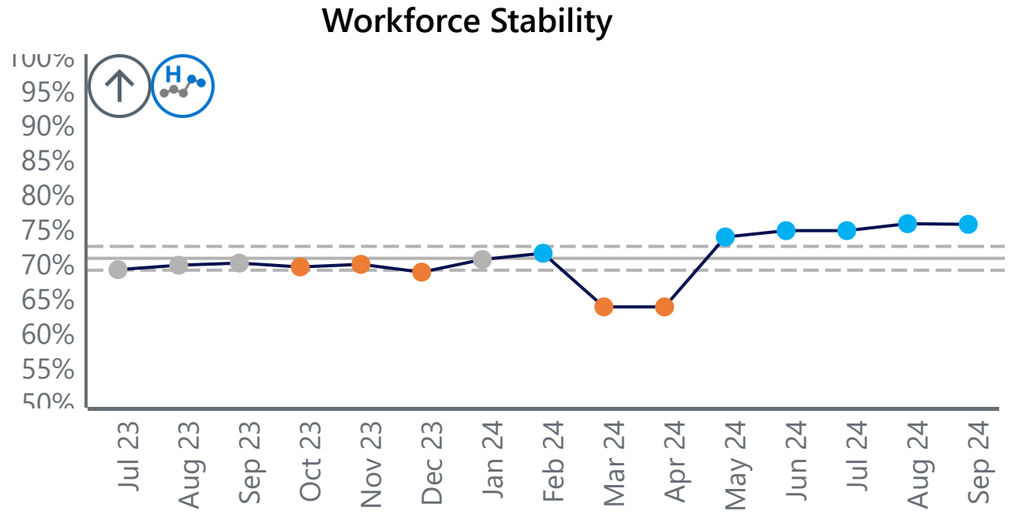


Medical Appraisal

Target: Internal



Workforce Stability



Integrated Performance Report | October 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:

- Business Case for Investment Zone funding (£4.1m) submitted.
- Grant awarded from British Heart Foundation for Little Hearts at Home (£130k plus £60k AH Charity support).
- NIHR Capital award confirmed and contract received.
- MRI scanner (NIHR funded) installed and operational.
- Contract negotiations nearing completion for Ambient AI tool.
- New AI coding opportunity with Phare Health identified.
- Overachievement of commercial research income target at M6.

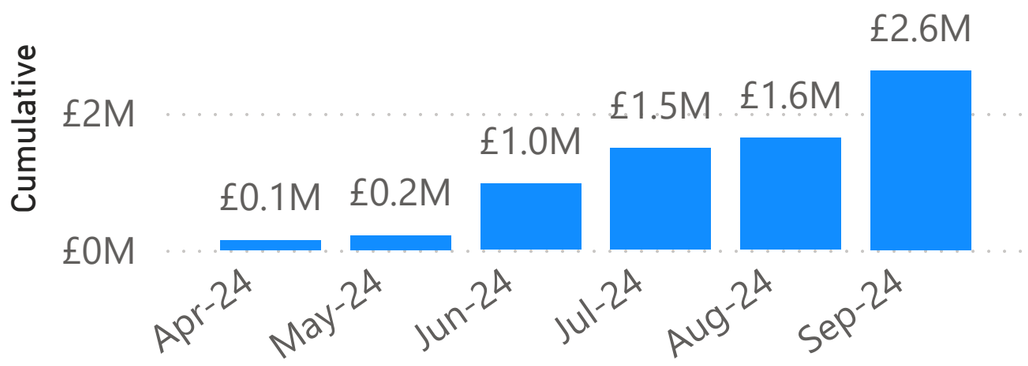
Areas of Concern:

Availability of legal support due to long term sickness

Forward Look (with actions)

- Review of RPA capacity ongoing in advance of prioritisation exercise.
- Starting Well seed corn funding call closed with 13 applications from across AH and LWH.

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



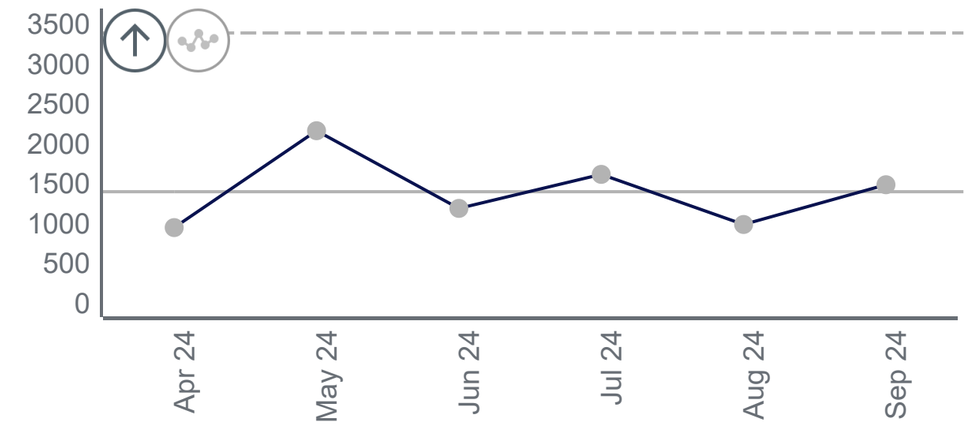
Technical Analysis:

This data is based on our current RPA solutions

Actions:

Horizon scanning review complete and actions underway to track grant opportunities, applications and outcomes across Clinical Research Division and Innovation

Manual hours saved through automation solutions - Monthly

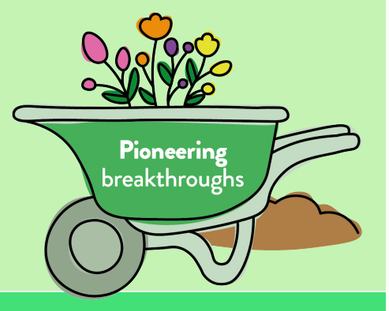


Technical Analysis:

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

Actions:

Planning and prioritisation meeting for RPA scheduled for 15th October with all Division and Corporate Services

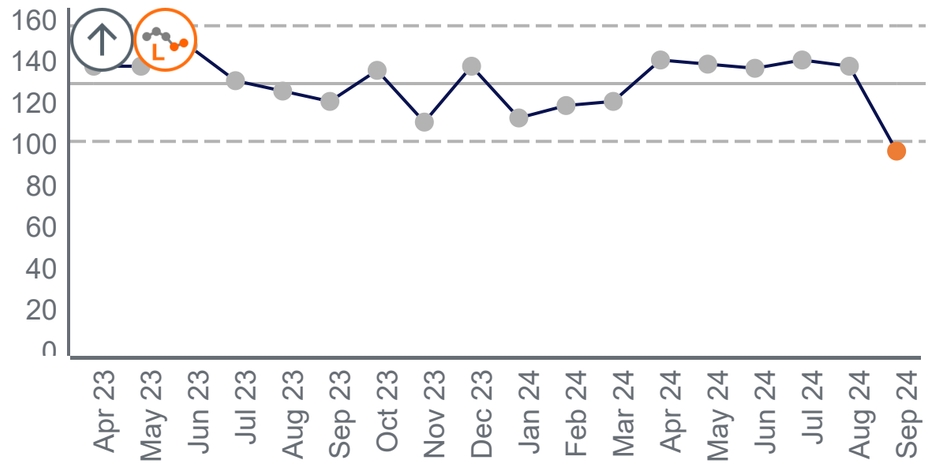


Integrated Performance Report | October 2024

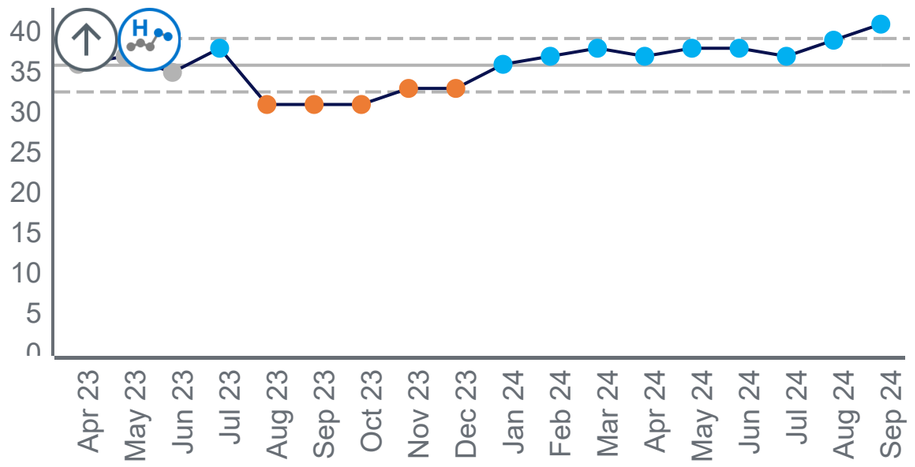
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

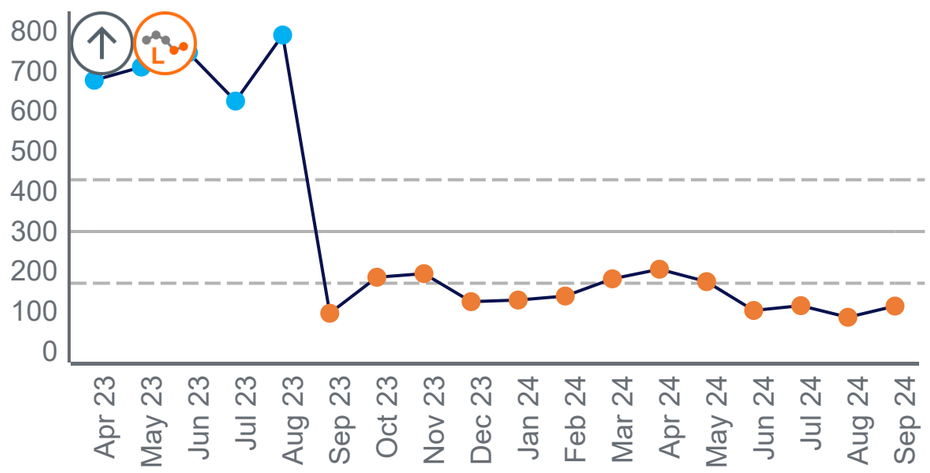
Number of Active (Open) Studies - Academic



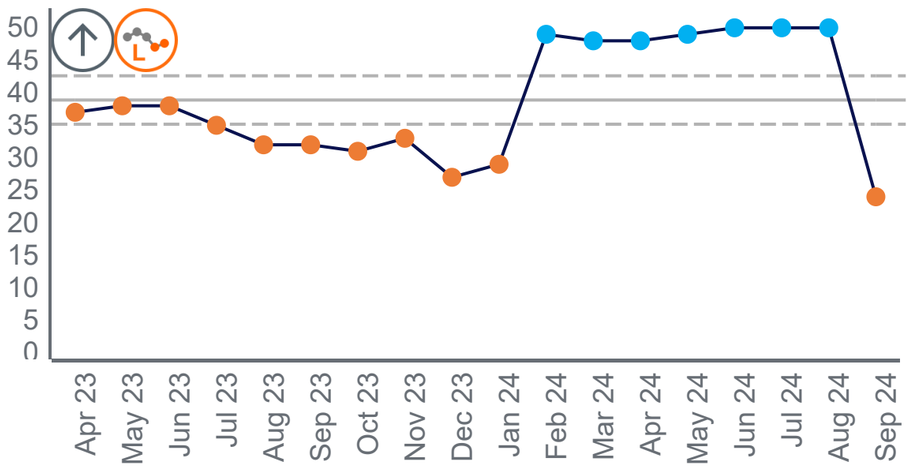
Number of Active (Open) Studies - Commercial

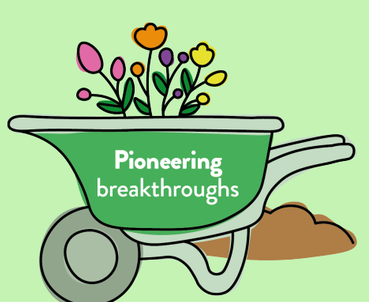


Number of Patients Recruited into Research Studies



Number of Chief Investigator led studies





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:

• Wellbeing Hub operational (soft launch)

• Opportunistic MMR vaccinations for inpatients / complex patients. The vaccination work will expand to cover inpatient 'flu and COVID.

• Mini mouthcare matters systematised across the Trust

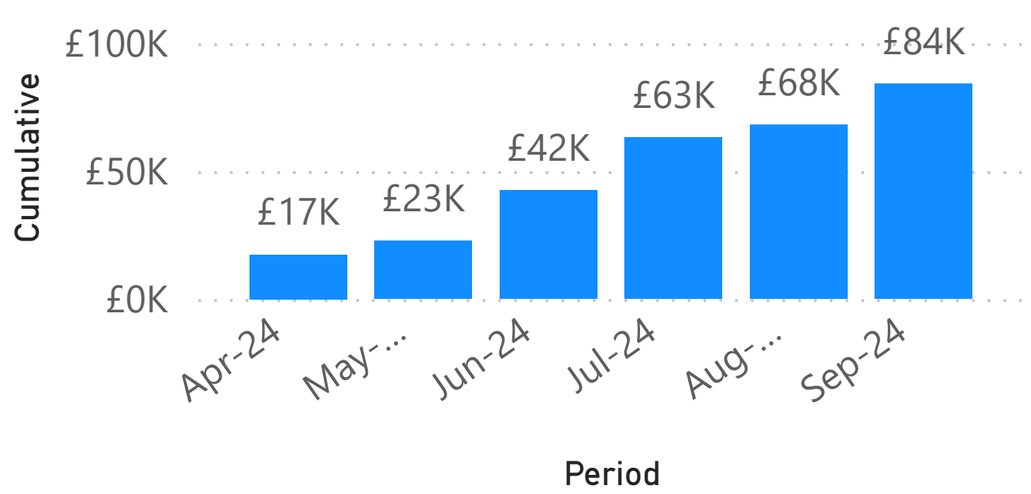
Areas of Concern:

Forward Look (with actions)

• The vaping cessation clinic for 11-15-year-olds will start 5/11/24

• Improve My Life Chances Summit re-arranged for March 2025

Social Value Generated - Cumulative



Technical Analysis:

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

Actions:

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

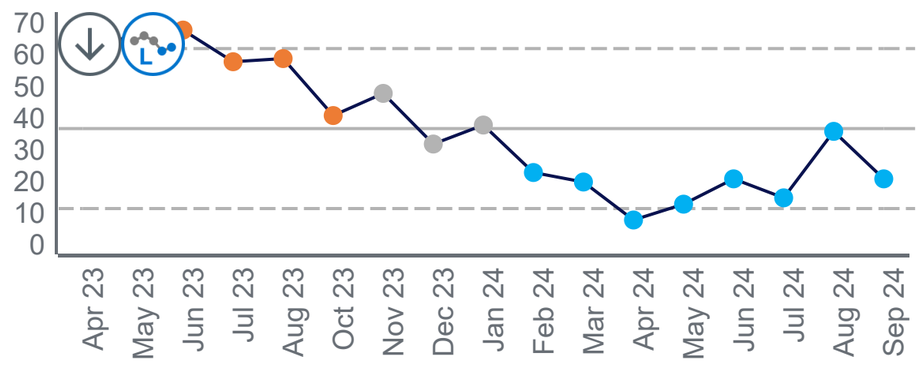
Integrated Performance Report | October 2024

Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

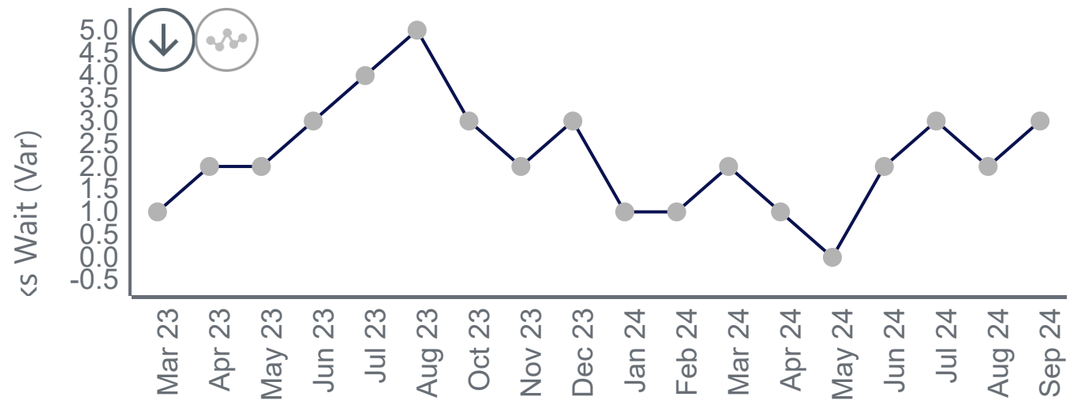
Oral Health: Number of children <10 years old waiting >52wks for tooth extraction

Sept-23 Unavailable

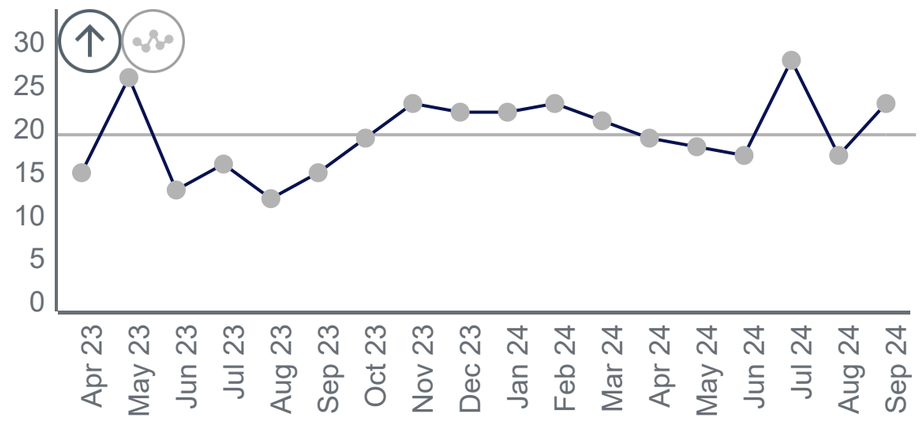


Median Waiting Time (RTT) - LD Waiters Variance (Wks) to Non-LD

Sept-23 Unavailable



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



Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

• £2.2m deficit, which is in line with plan • Notification received of industrial action funding (£0.3m) against costs/lost income of £0.5m • Forecasting to achieve £3.3m surplus, however, the Trust have indicated a commitment to deliver an £1m above plan, on a best endeavours basis • Divisional forecasts continue to highlight challenges and risk; however, the financial improvement plan has resulted in some significant primarily through technical workstreams • CIP above plan in M6, £12.9m CIP has been transacted in year, with £7m 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:

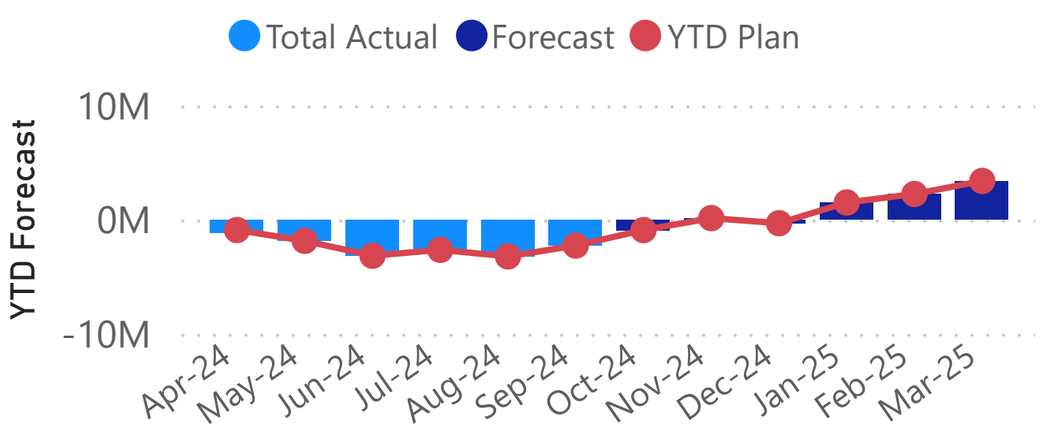
Work is ongoing to deliver full savings of £19.9m and significant progress has been made to date resulting in £10.1m of savings recurrently posted in M6. Divisional forecasts continue to highlight significant financial and operational challenges with medicines forecast deteriorating by £1.4m since Q1. All divisions off plan have been asked to provide mitigation plans to present at Ops Board and FTPC this month. 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:

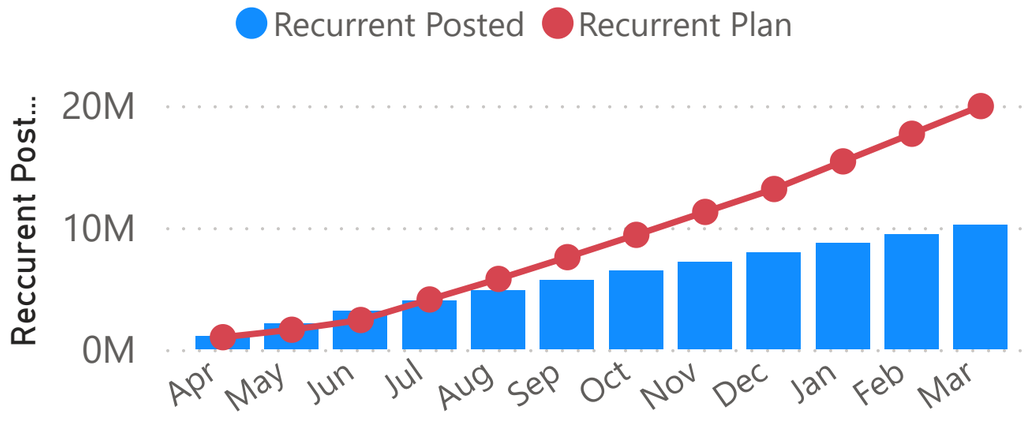
Current plan is £3.3m surplus (further £1m committed on best endeavours) however, initial forecast continues to highlight significant challenge. Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

Actions:

Continue to monitor efficiency schemes in progress and cost control for arising pressures to be managed through SDG meeting and divisional deep dives. A financial improvement plan has been launched with various sprints aimed at supporting achievement of the current plan. Progress is being managed through SDG meetings.

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

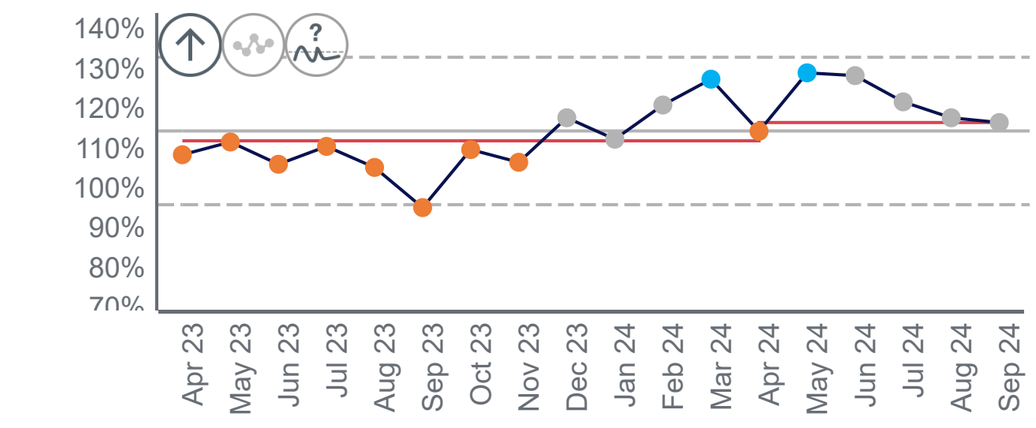
In year CIP identified and in progress is £17.8m whilst recurrent CIP is £14.1m

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:

September performance estimated at 116.6%.

Actions:

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

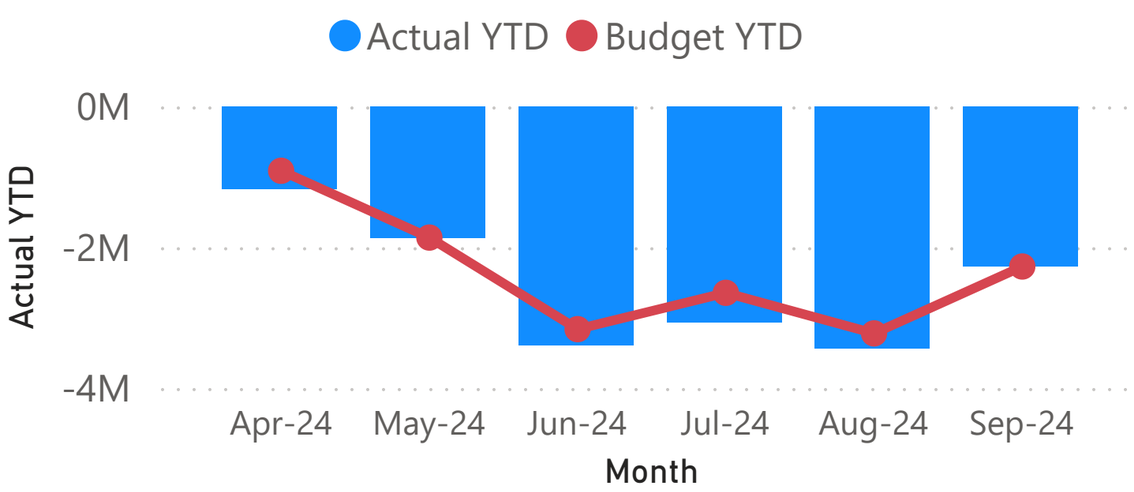
Integrated Performance Report | October 2024

Alder Hey Children's NHS Foundation Trust

Financial Sustainability: Well Led - Watch Metrics

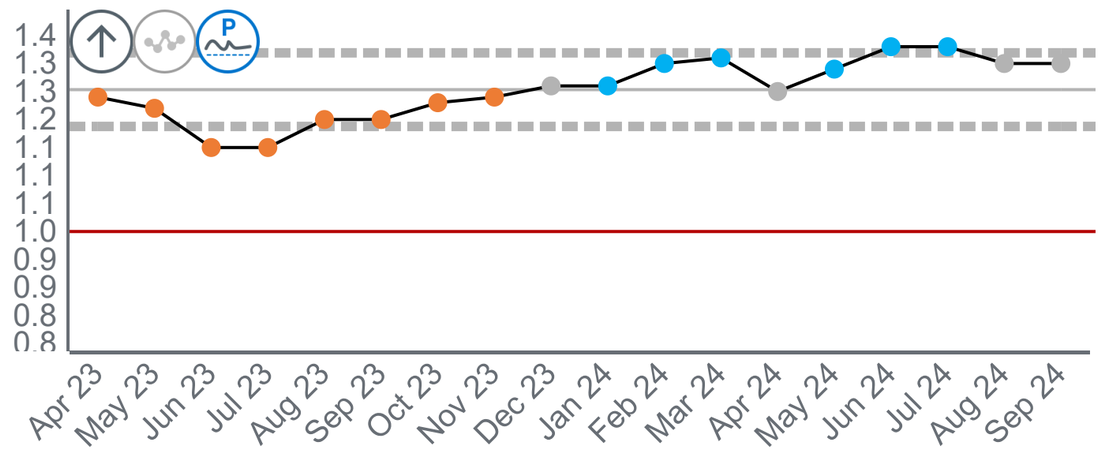
I&E distance from target (cumulative YTD)

Target: Internal

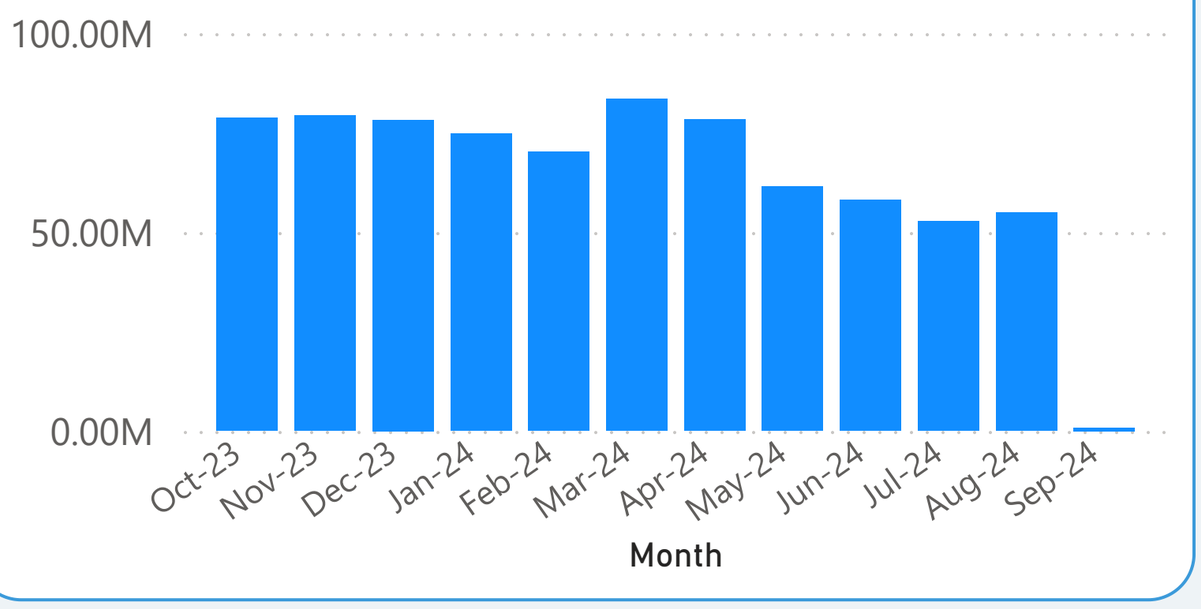


Liquidity

Target: Internal



Cash In Bank



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

- Positive engagement with teams/service/divisions at monthly risk oversight meetings
- Positive feedback on risk heatmap visualisation within sub board reports
- Oversight of risk reporting continues to be embedded within InPhase

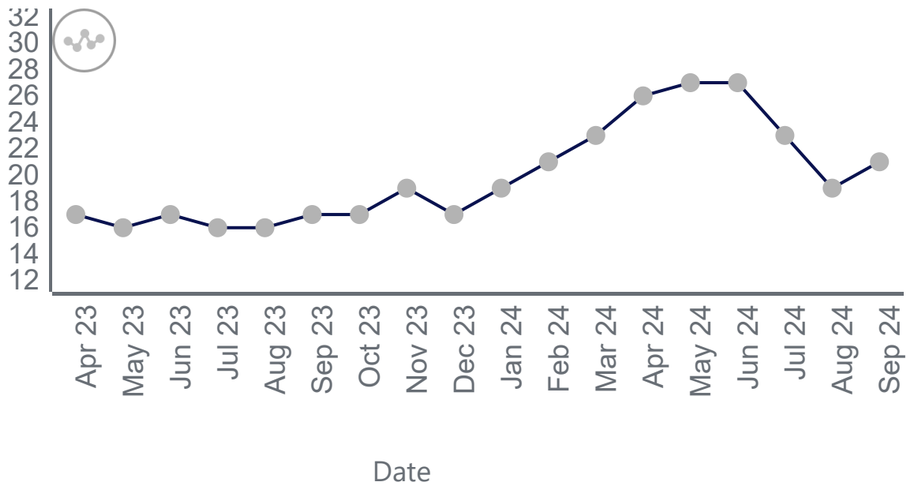
Areas of Concern:

No concerns of note

Forward Look (with actions)

- Following board approval work with risk owners and divisions to review risks within the agreed risk appetite agreements
- Due to commence review of risks aligned to risk appetite with Community & Mental Health division
- Development of risk notification functionality requested via InPhase

Number of High Risks (scored 15 and above)



Technical Analysis:

21 high risks reported on risk register as of end Sept 2024 a slight increase from the reporting period. Risks themed as follows:

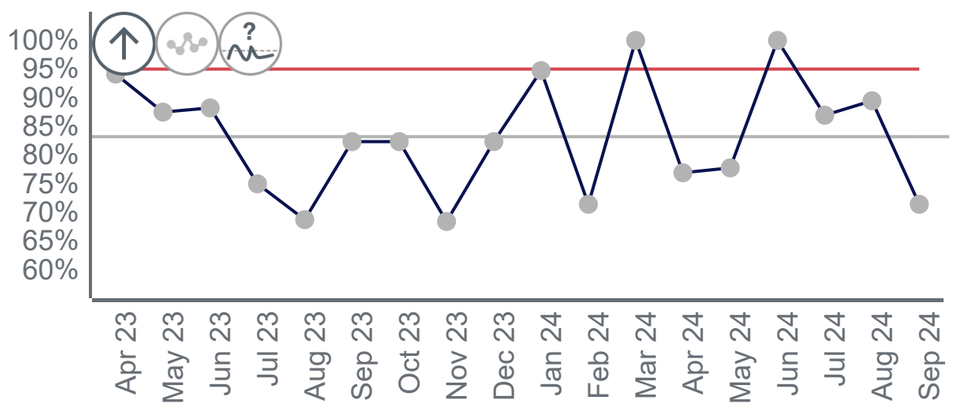
• Quality – Safety = 8 • Workforce = 6 • Compliance and Regulatory = 4 • Quality – Effectiveness = 1 • Reputation = 1 • Financial = 1

Actions:

All overdue risks have been escalated to risk owners for immediate action

% of High Risks within review date

Target: Internal



Technical Analysis:

% of High Risks within review date is demonstrating common cause variation with performance of 71% in September 2024.

Actions:

71.4% (15/21) risks within expected review date.

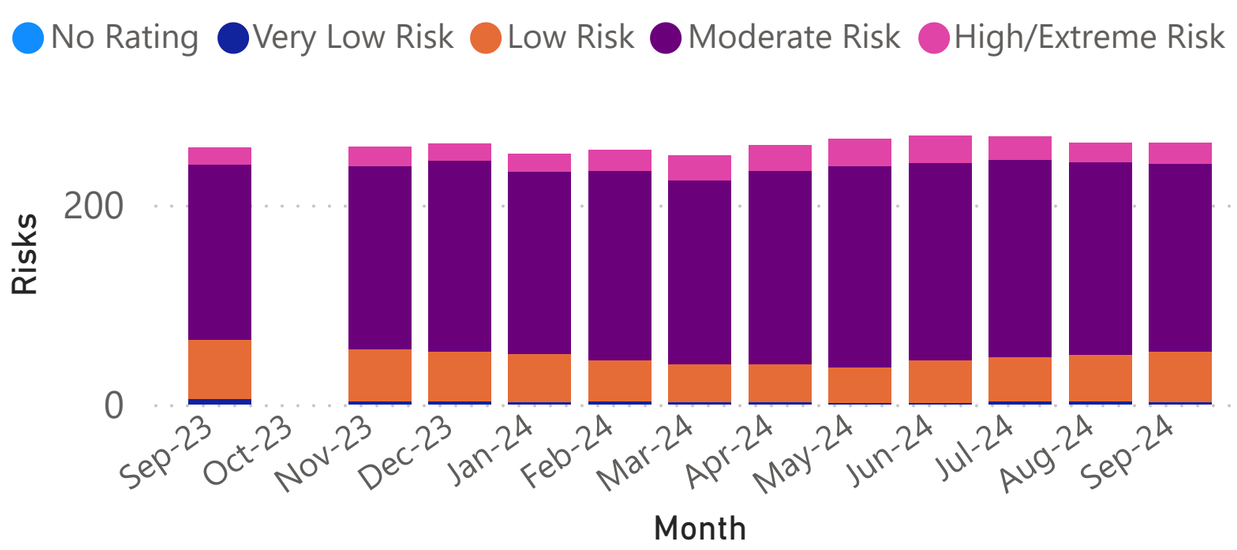
All overdue risks have been escalated to risk owners for immediate action

Integrated Performance Report | October 2024

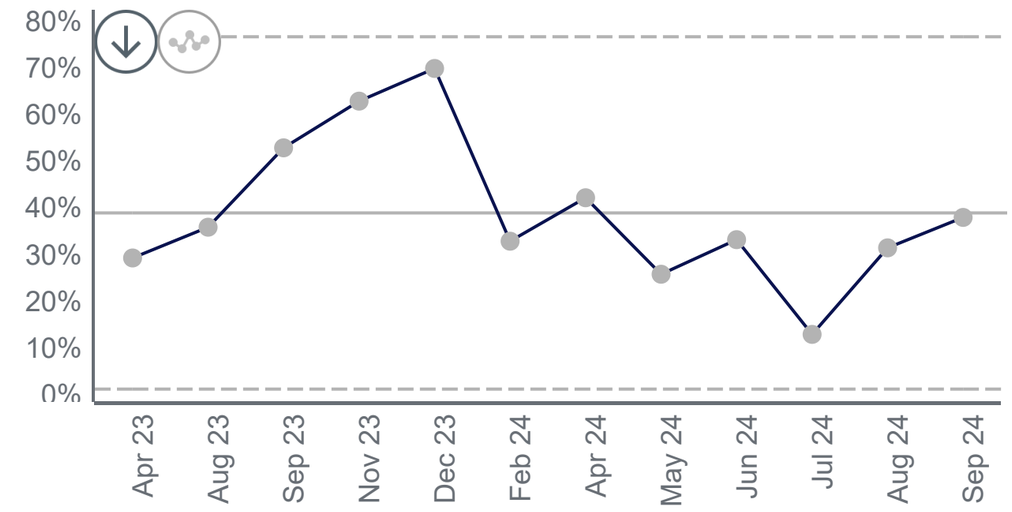
Alder Hey Children's NHS Foundation Trust

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

• No children and young people waiting over 52 weeks for CAMHS, community paediatrics and therapies.

• Reduction in CYP waiting over 104 weeks for conclusion of ASD diagnostic pathway, on track to have no CYP waiting over 104 weeks by November.

• Referral platform automation completed for ASD and ADHD – with notification for families about acceptance onto diagnostic pathway.

• Improvement in waiting time to access community dietetics – on track to reach 92% RTT by December 2024

• RTT for SALT has continued to improve (76%).

• Referral logging time for routine referrals remains within KPI (1 day)

Areas of Concern

• WNB rates across division remain above Trust targets

• Sickness absence has increased (6%) particularly in long term sickness (5%)

• ADHD will not meet trajectory target of no CYP waiting over 104 weeks by October 2024, revised target to max. of 117 weeks.

• 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. This has been escalated to executive team and BI team who lead this work.

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

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

Forward Look (with actions)

• Virtual ward – review underway with Meditech development resource to split out virtual ward and virtual care activity to aid data reporting.

• CAMHS PIFU discharge pathway – on track to go live in November 2024. Information leaflets and SOPs developed.

• ASD / ADHD transformation programme continuing with good engagement from teams and external colleagues with new pathway development due to take place in October.

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

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

• Demand and capacity work on going for new assessment (choice) capacity – Liverpool CAMHS. Trajectory completed with additional boost capacity identified to start in October 2024.

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

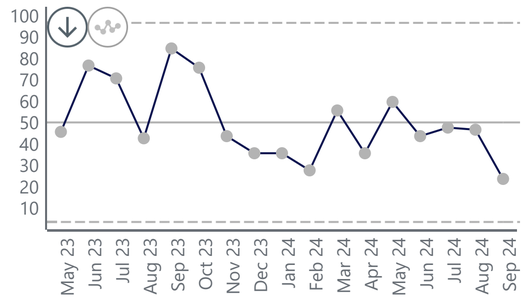
• Approval to proceed with independent sector capacity for ADHD assessments – to start October 2024

Integrated Performance Report | October 2024

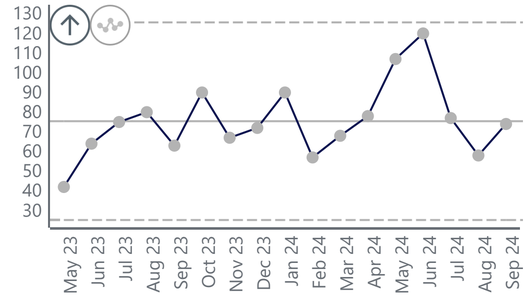
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

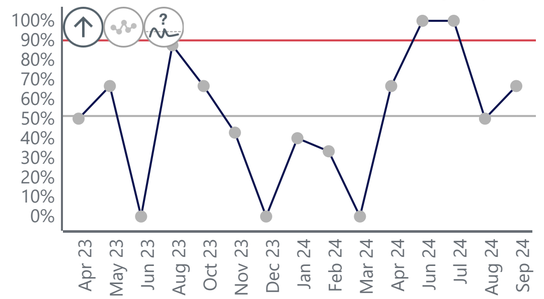
Patient Safety Incidents rated Low Harm & Above



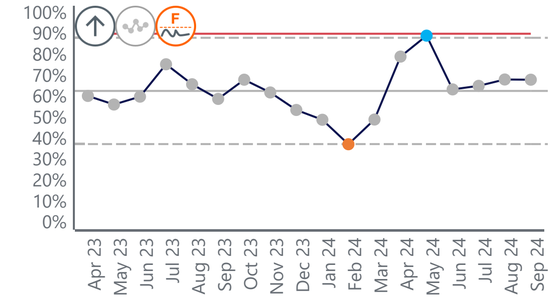
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

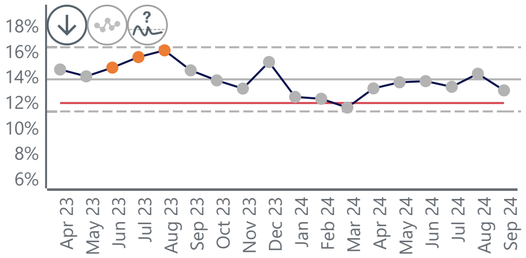


% PALS Resolved within 5 Days

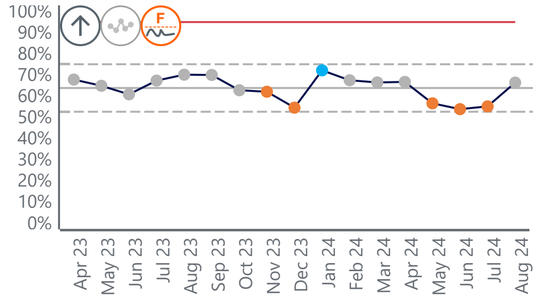


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

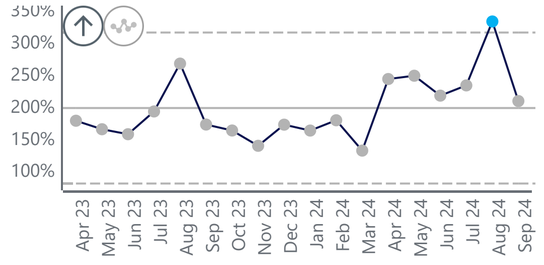


% of Clinical Letters completed within 10 Days

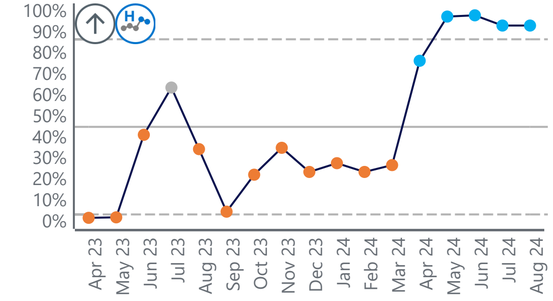


% Recovery for OP New & OPPROC Activity Volume

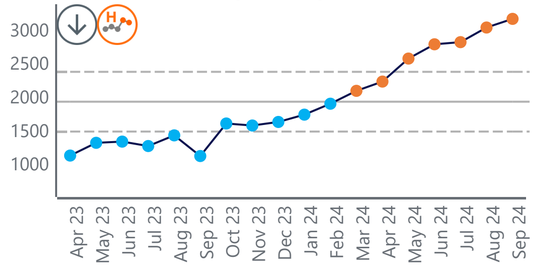
Based on 19/20 baseline



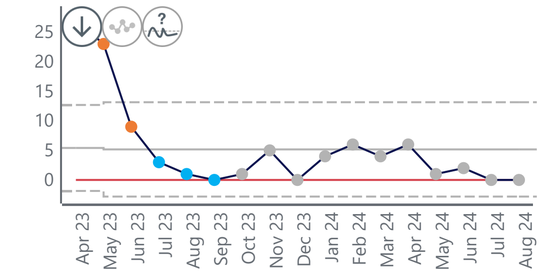
IHA: % complete within 20 days of referral to Alder Hey



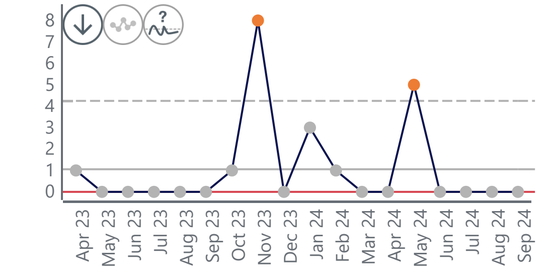
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



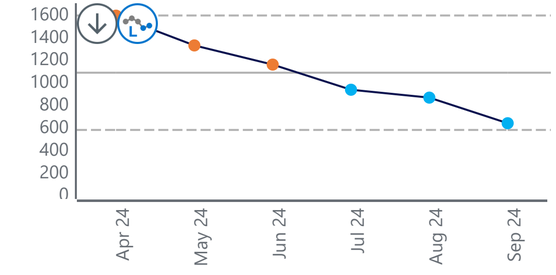
CAMHS: Number of children & young people waiting >52weeks



Number of Paediatric Community Patients waiting >52 weeks



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



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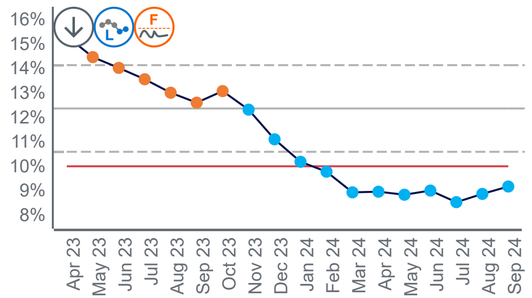
Integrated Performance Report | October 2024

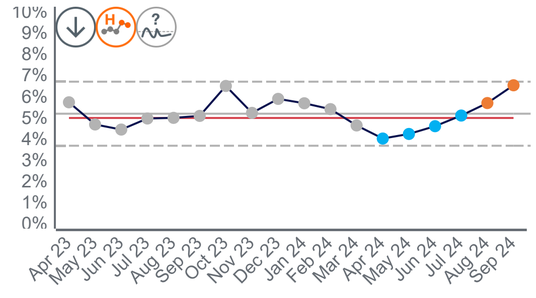
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

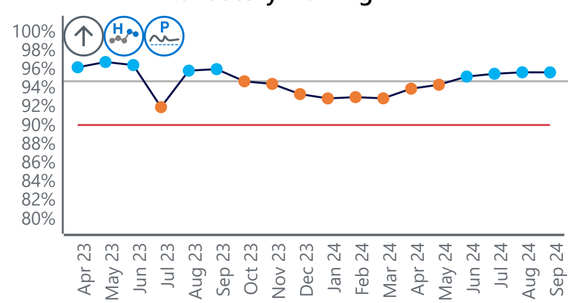
Staff Turnover



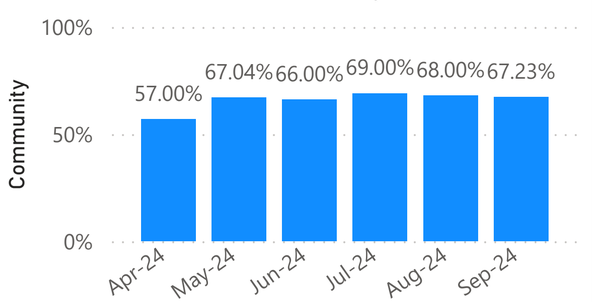
Sickness Absence (Total)



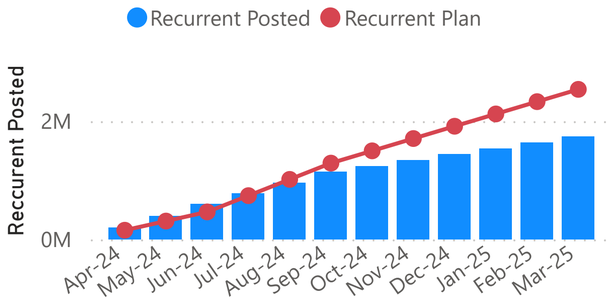
Mandatory Training



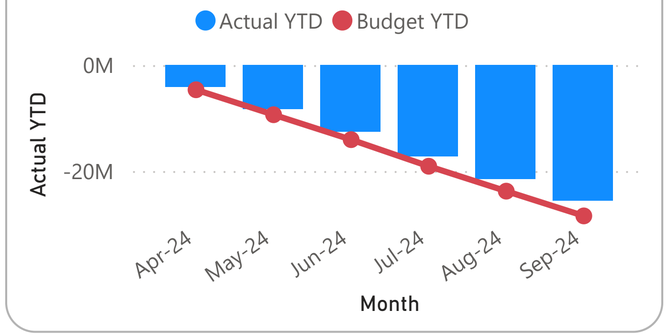
Workforce Stability



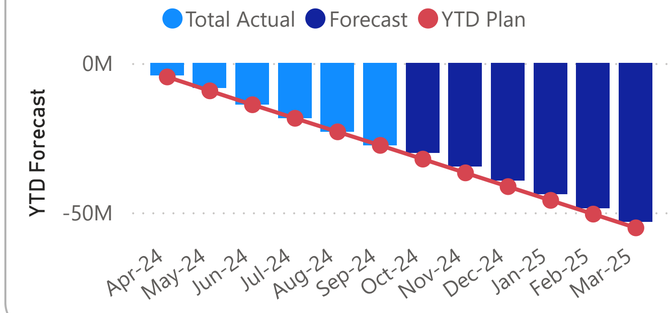
Recurrent Efficiency Plans Delivered (Forecast)



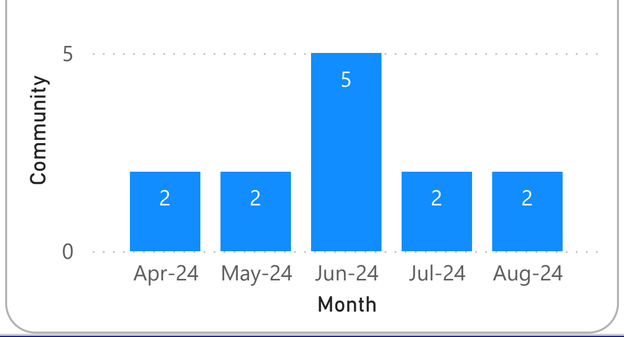
I&E distance from target (cumulative YTD)



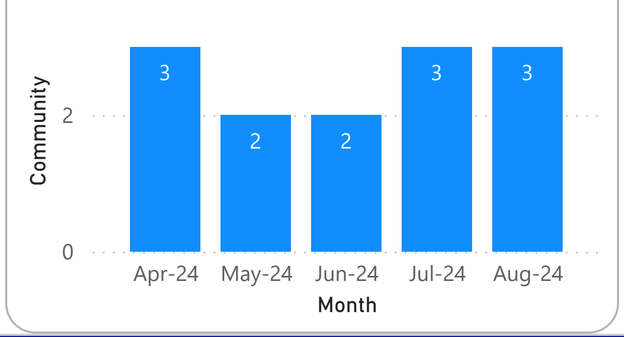
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Further reduction in children overdue follow up care, reduction in over 312 children over the past 3 months

• 100% response rate for formal complaints for 10th consecutive month

• 100% compliance in PALS for 5 months

• Reduction in WNB rate following focused efforts in key specialities

• Reduction in number of patients waiting over 52 weeks for treatment and only 1 patient outstanding treatment over 65 weeks at the end of September

• Slight reduction in patients see within the 4 hour ED standard (85%) compared to previous month however performance remains above previous year and above the national standard

• Improved % recovery for OP and OPROC to 163%

• Sickness rates below 5%

• Staff turn over remain low, now 8%

• Improvement in ED sepsis 1% below target

Areas of Concern

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

• Reduction in % DC and IP elective activity, likely owing to increase in OP and OPROCS activity

• DMO position unchanged despite initial focused efforts to improve, reduction in over all patients waiting however % has not improved to date

• 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

Forward Look (with actions)

• DMO recovery plan presented to executive team in October with updated trajectory in place to improve performance in November

• Focused coding and capturing sessions in place to improve depth of coding

• Reviewing plans in place to achieve 52 weeks for all specialities in March 2025

• Plans in place to maintain improvement in access for children requiring follow up care

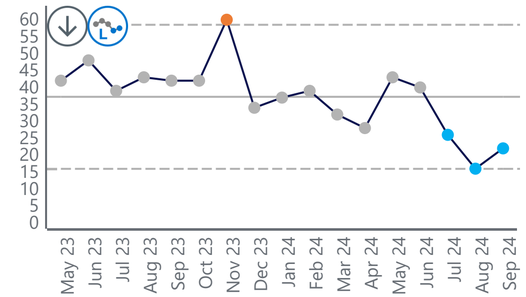
• Continue to embed winter preparedness plans to successful manage increase in demand during the coming months

Integrated Performance Report | October 2024

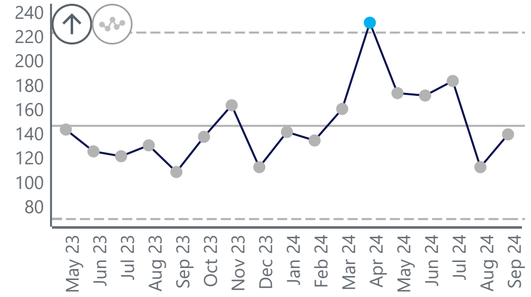
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

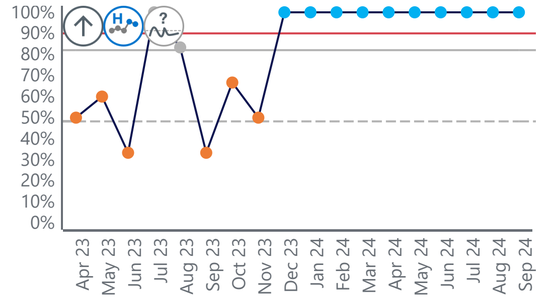
Patient Safety Incidents rated Low Harm & Above



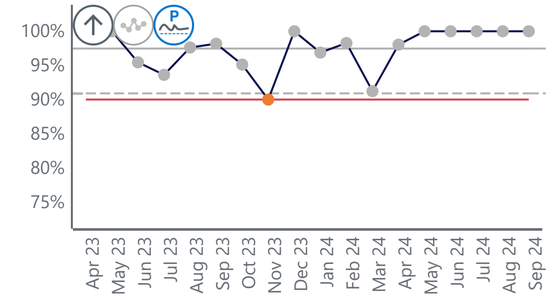
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

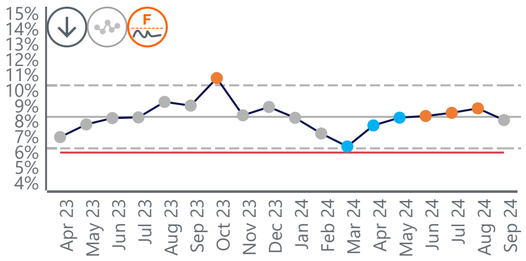


% PALS Resolved within 5 Days

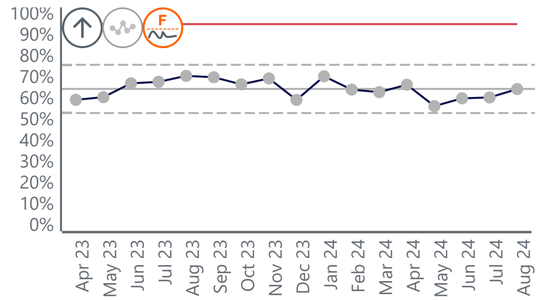


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

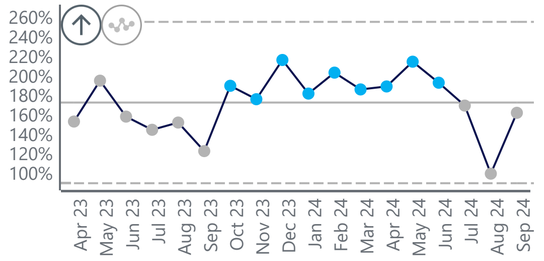


% of Clinical Letters completed within 10 Days

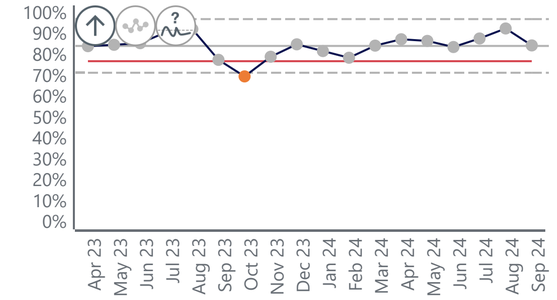


% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

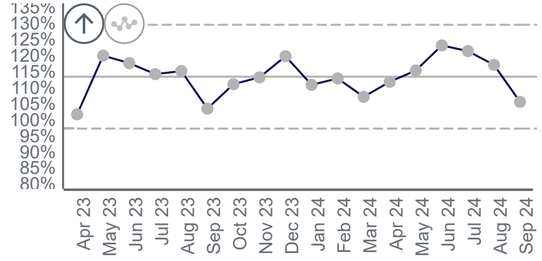


ED: % treated within 4 Hours

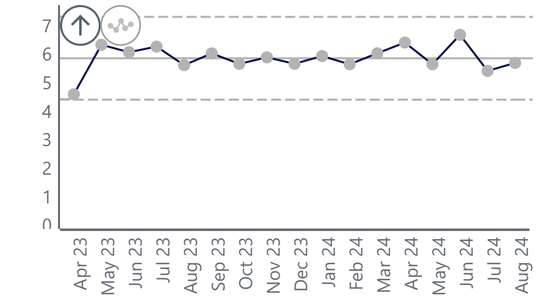


% Recovery for DC & Elec Activity Volume

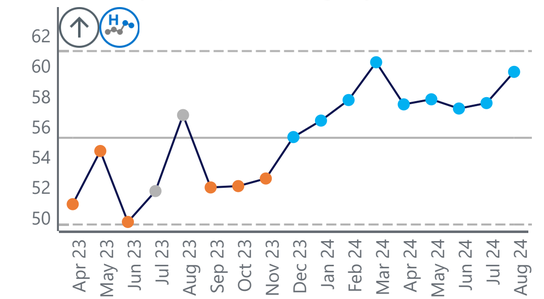
Based on 19/20 baseline



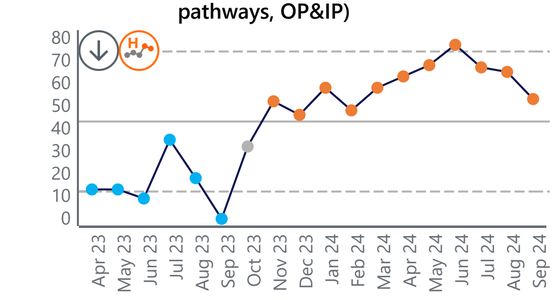
Inpatient Discharges per working day



Day Cases per working day



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

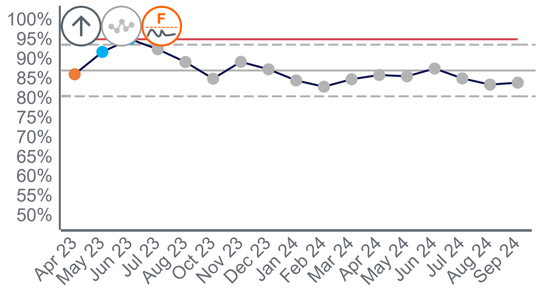


Integrated Performance Report | October 2024

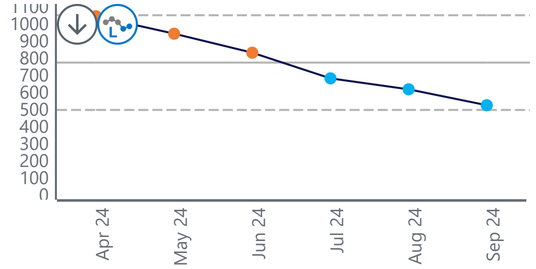
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

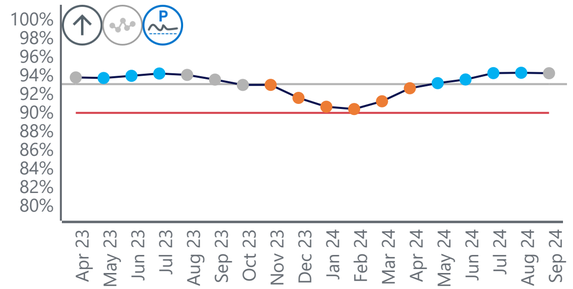
Diagnostics: % Completed Within 6 Weeks of referral



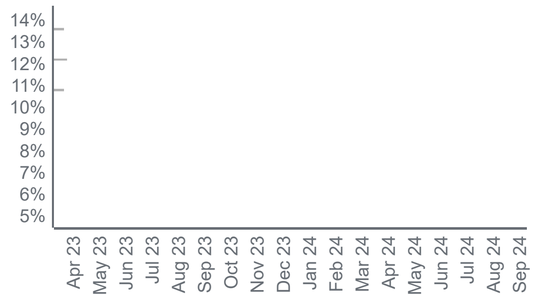
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



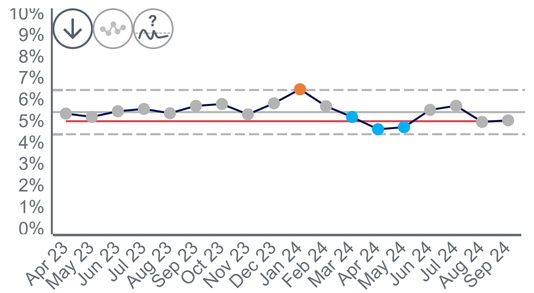
Mandatory Training



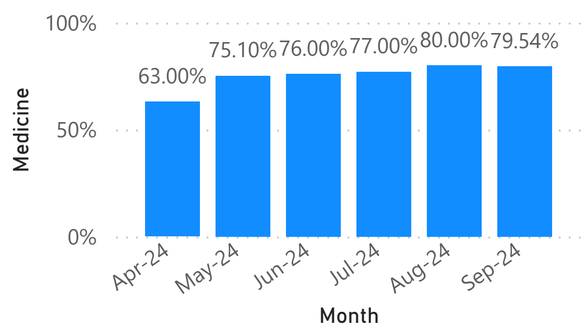
Staff Turnover



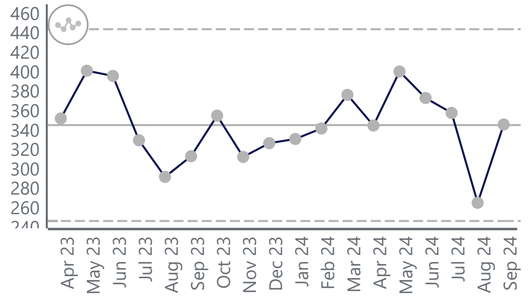
Sickness Absence (Total)



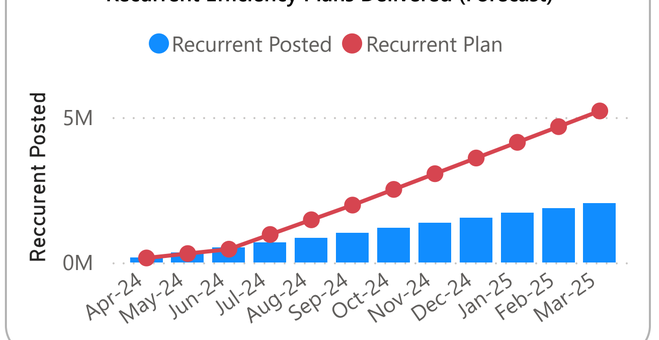
Workforce Stability



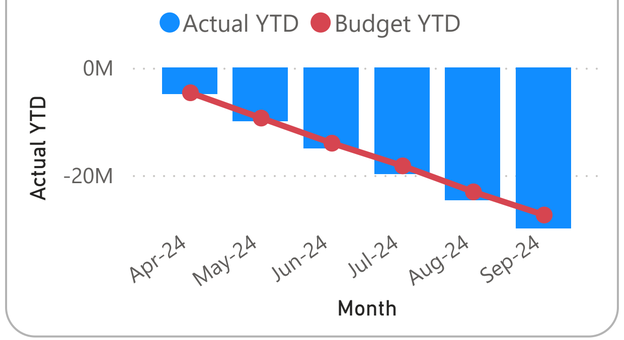
A&E Attendances per ED Consultant WTE



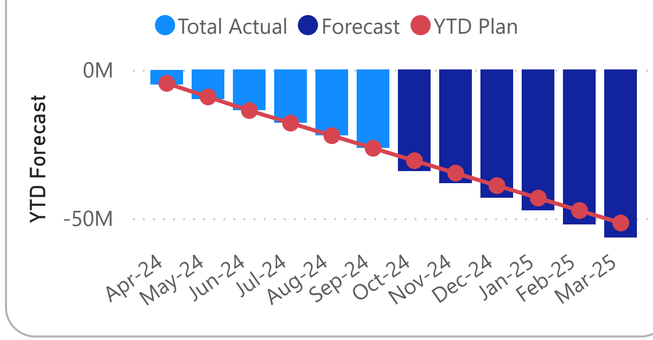
Recurrent Efficiency Plans Delivered (Forecast)



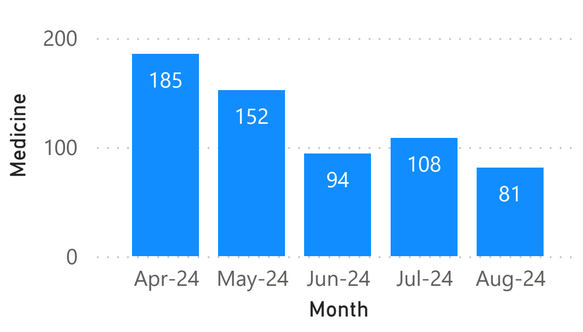
I&E distance from target (cumulative YTD)



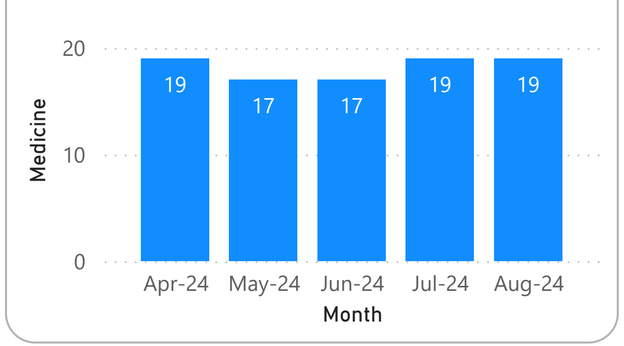
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Continued compliance of 100% with response to PALS and formal complaints.

• Achieved 80% theatre TT utilisation in month which is the highest YTD with some clear improvements in inpatient theatres- Cardiac, Cardiology, Orthopaedics and Neurosurgery

• % recovery for OP NEW & OPROC activity volume increased in month at 128% and consistently remains above plan

• % recovery for DC & ELEC activity 113% in month. Some consistent case mix changes seen in ENT and Paediatric Surgery which is converting a higher volume of patients to DC from IP.

• Increase in Day cases per working day showing statistical significance. Continued focus on productivity through day case theatres.

• Total number of CYP waiting over 52 weeks continues to decrease with a significant decrease in our most challenged specialities- ENT & Dental.

• Although volumes remain significant, overdue FU waits (2 years & over) continue to decrease in month although not yet showing statistical significance. Key improvements seen in Spine, ENT, Paediatric surgery, T & O & Plastics when reviewing cohort required to be seen by March 2025.

• Mandatory training compliance continues to report above target at 94%.

• Staff turnover continues to decrease for 7th consecutive month.

• In year efficiency savings posted at £4.9m (77% of target) with a further £0.8m planned to be posted from Oct/Nov.

Areas of Concern

• Whilst we are seeing an increase in cases through DC theatre via the Productive Theatres Programme we are seeing a decline in TT utilisation due to increased total turnaround time. Team are reviewing approach to reporting metrics to capture improvements/real opportunities.

• Although DM01 compliance showed in month improvement, sustainable improvement is required to achieve 95%.

• WNB rate continues to be above divisional target.

Forward Look (with actions)

• Improvement trajectory to be presented to divisional board in November to improve DM01 compliance.

• Focused review on depth of coding and tariff within Neurosurgery, Cardiac Surgery & Cardiology.

• Modelling underway to review required capacity to achieve 52 weeks wait by March 2025- currently the areas of challenge are ENT & Dental.

• Continued focus on reducing WNB rate via Productive OP programme- to be supported by RPA initiative.

• Plans in progress to ensure mitigations for movement in full year financial forecast (ERF) and delivery of remaining CIP. To include a focus on super specialist surgery initiative within Neurosurgery.

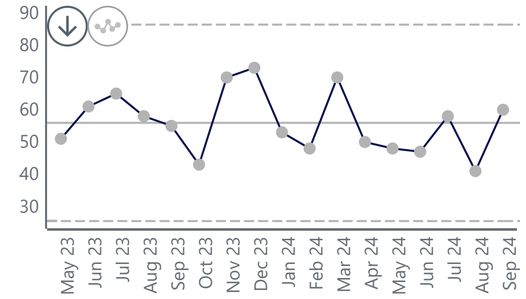
0063

Integrated Performance Report | October 2024

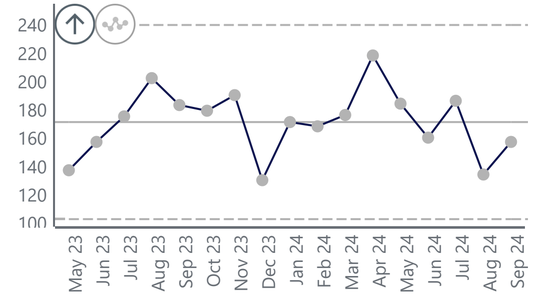
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

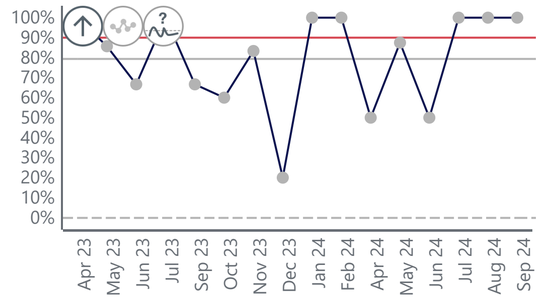
Patient Safety Incidents rated Low Harm & Above



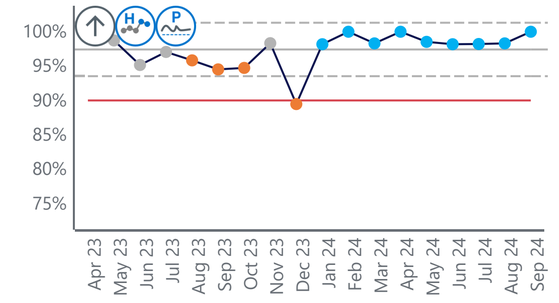
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

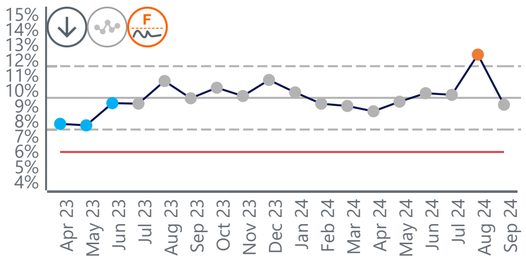


% PALS Resolved within 5 Days

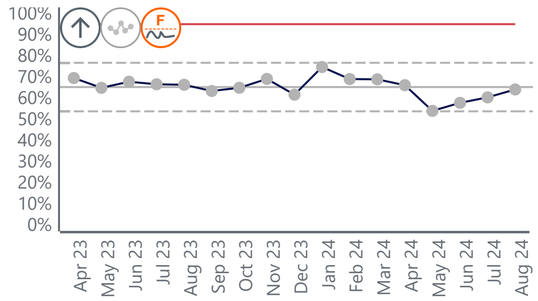


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

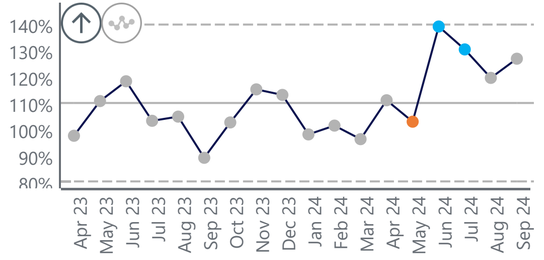


% of Clinical Letters completed within 10 Days



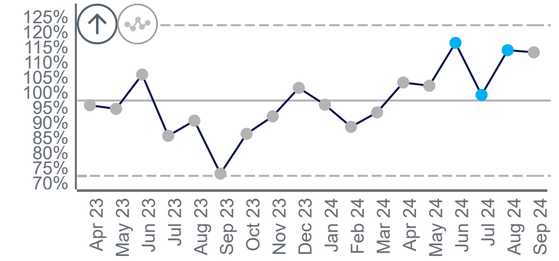
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

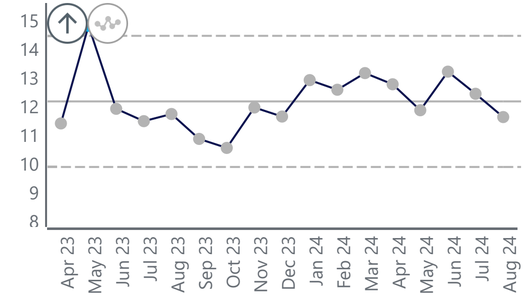


% Recovery for DC & Elec Activity Volume

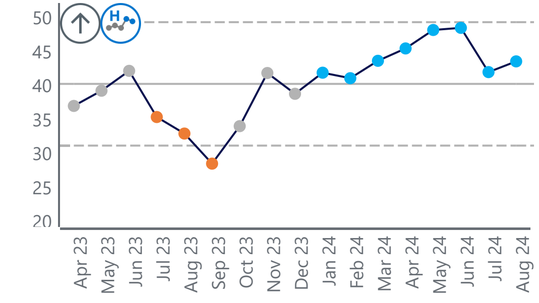
Based on 19/20 baseline



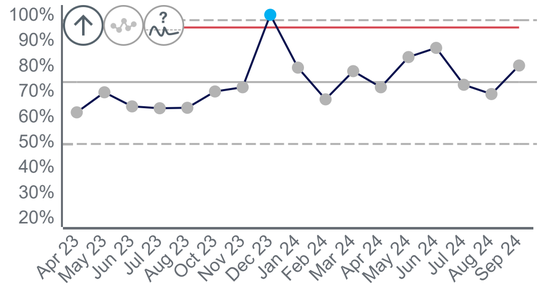
Inpatient Discharges per working day



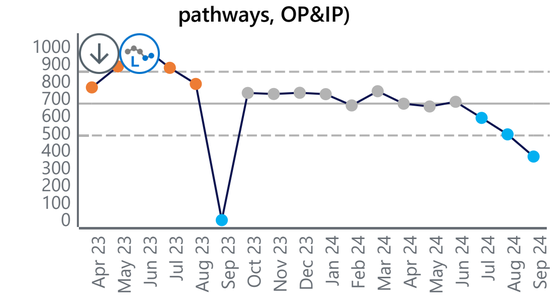
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



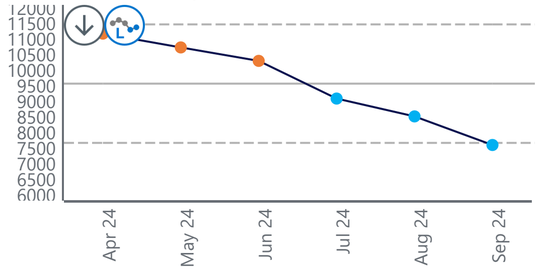
0064

Integrated Performance Report | October 2024

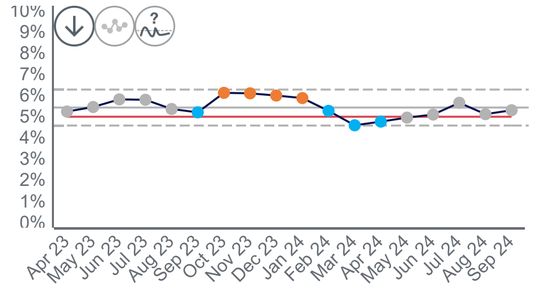
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

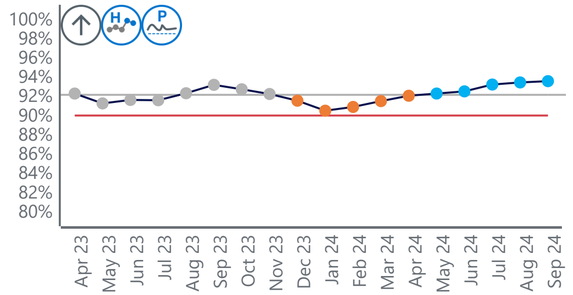
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



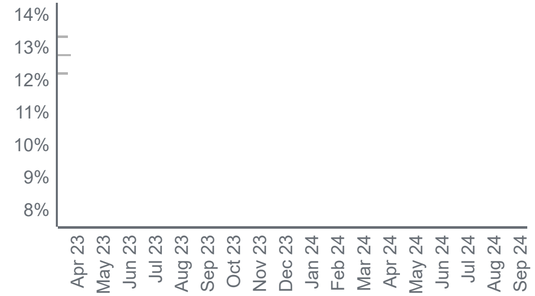
Sickness Absence (Total)



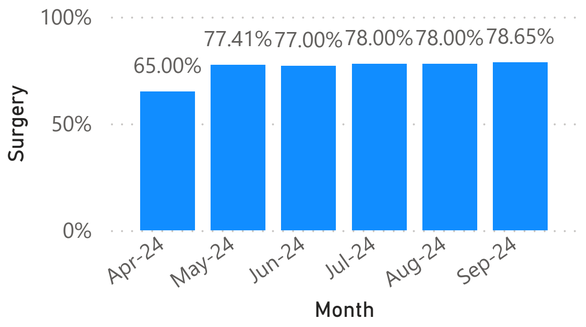
Mandatory Training



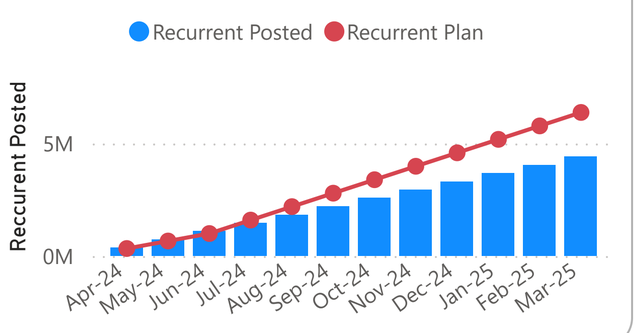
Staff Turnover



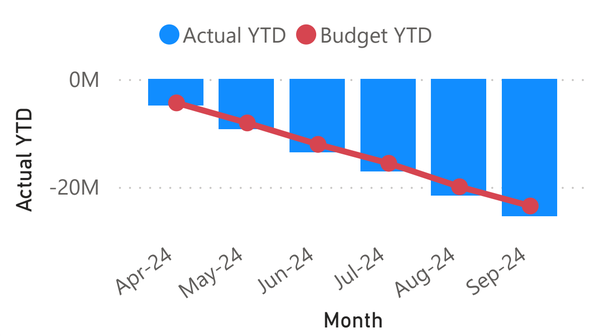
Workforce Stability



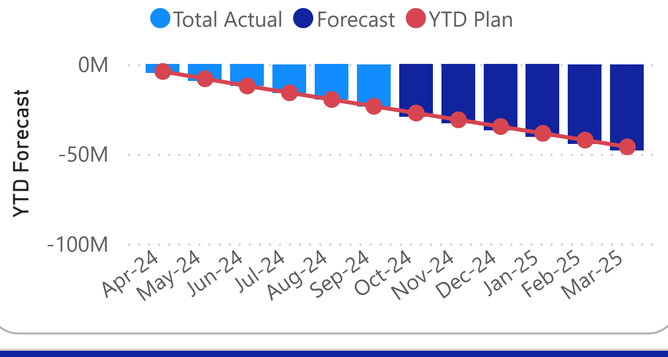
Recurrent Efficiency Plans Delivered (Forecast)



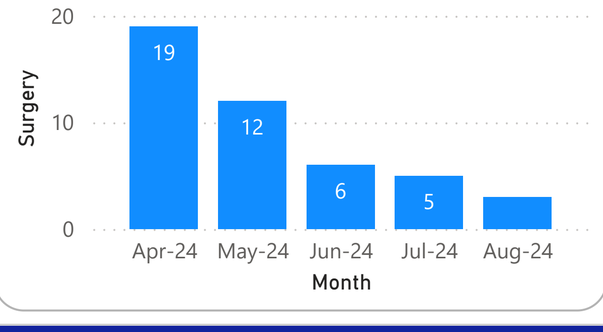
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division



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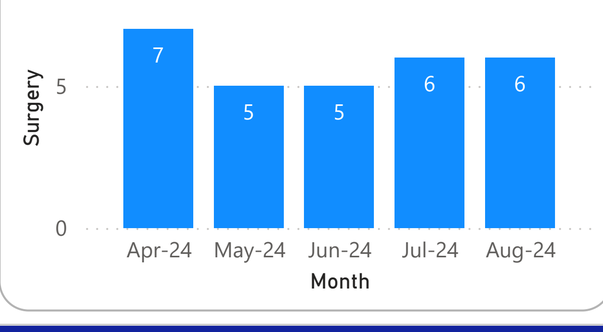


Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

- Continued overachievement of commercial income target – expected to even out by year end.
- 10 commercial studies opened since April (more than double the number opened in 23/24).
- NIHR capital award confirmed and contract received.
- 3rd MRI scanner (NIHR funded) installed and operational.
- Staff turnover remains stable.
- Staff sickness below target.
- Mandatory training remains above target.

Areas of Concern

- Participant recruitment has dropped but number of complex interventional studies has increased.
- Forecast for non-commercial income below target – work underway to identify new opportunities.

Forward Look (with actions)

- Mobile Research Unit delivery date confirmed for 28th Oct.
- Action planning underway for delivering research outside of hospital settings.

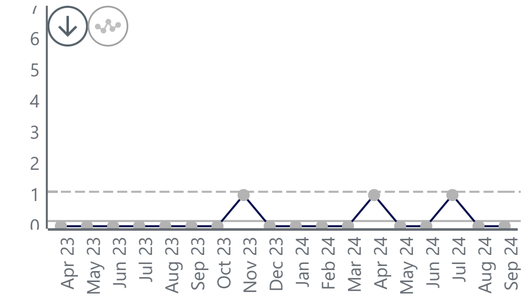
0066

Integrated Performance Report | October 2024

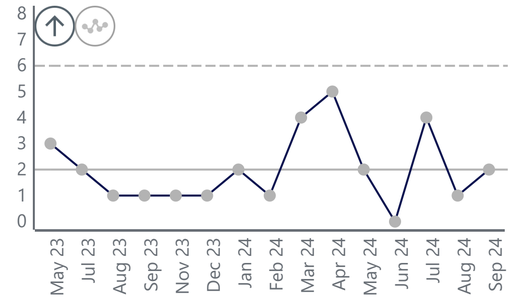
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

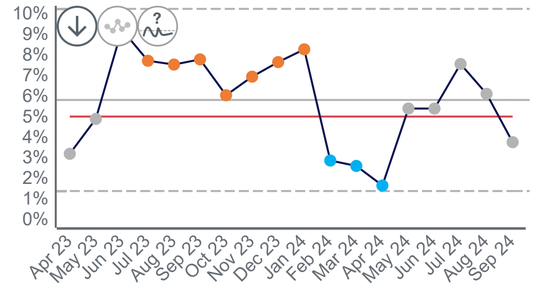


Patient Safety Incidents rated No Harm

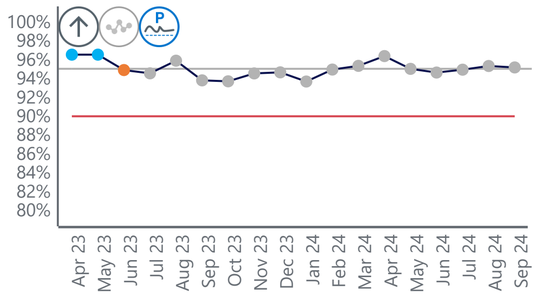


Staff Turnover

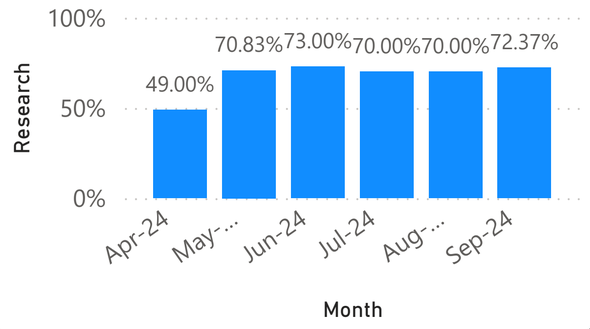
Sickness Absence (Total)



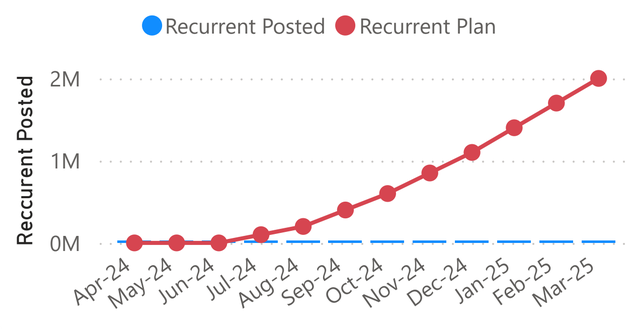
Mandatory Training



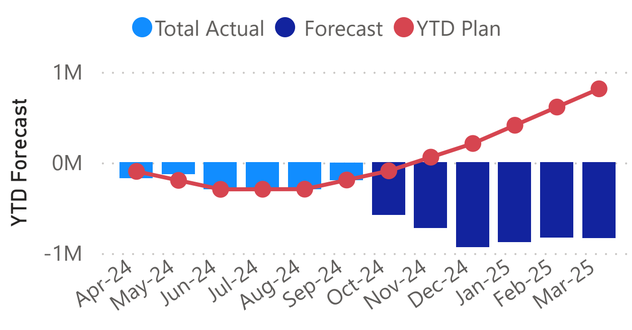
Workforce Stability



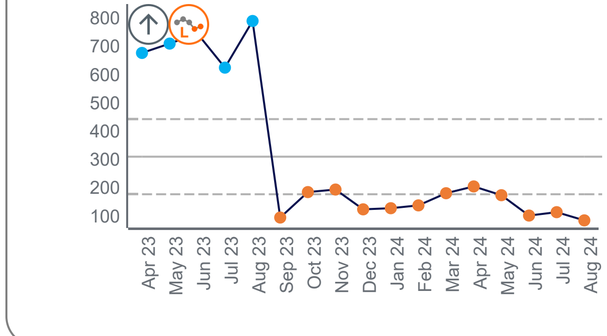
Recurrent Efficiency Plans Delivered (Forecast)



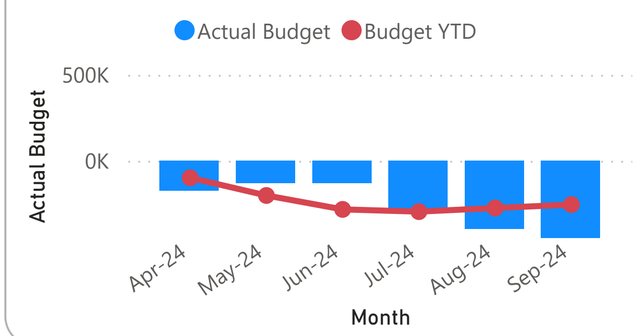
I&E Year End Forecast



Number of Patients Recruited into Research Studies



I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative continues to meet monthly with good engagement from all service areas. Highlights from the meeting held on 30th September are:

- Mandatory training currently at 93%.
- Short term sickness absence is sitting at 1%.
- 84% of CIP identified and/or delivered at M05.
- 96% of risks were in date at 26th September 2024 (4/56 overdue)

Areas of Concern

- Return to work (RTW) completion saw a slight decrease to 71%.
- PDRs for all staff is sitting at 86% against a 90% target.
- PDR compliance for B7 and above remains below target at 67%

Forward Look (with actions)

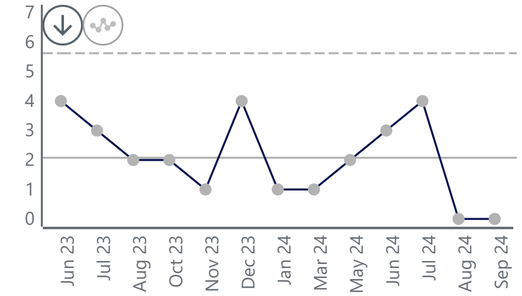
- RTW – weekly reports are being shared with Line Managers to increase understanding of the E-Roster system
- PDRs – HR Advisors are picking up conversations with Managers to ensure completion as priority.
- Continued focus on financial position, system finance and opportunities.

Integrated Performance Report | October 2024

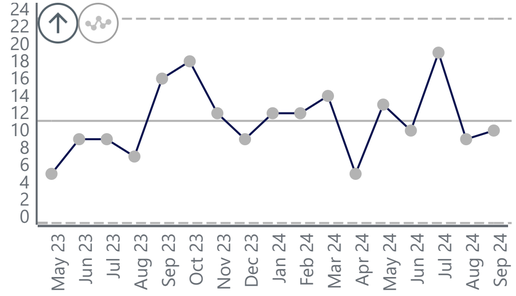
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

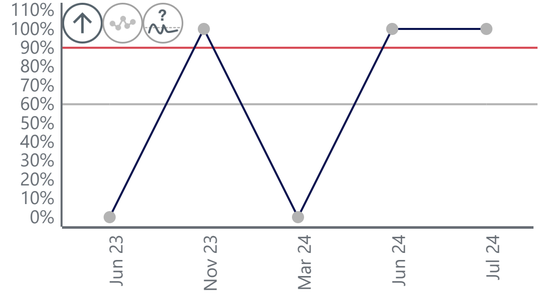
Patient Safety Incidents rated Low Harm & Above



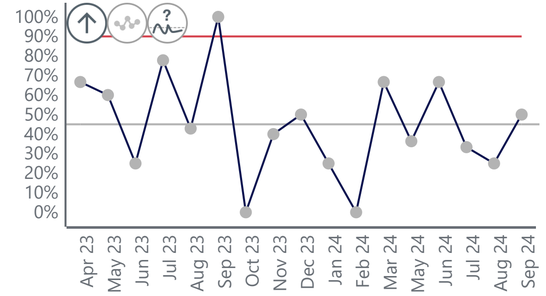
Patient Safety Incidents rated No Harm



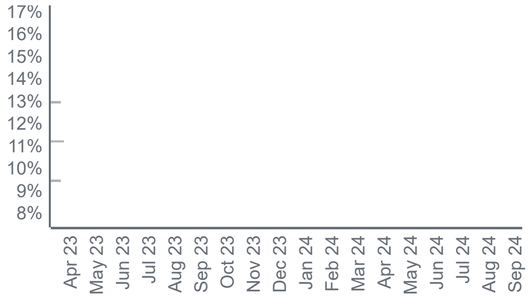
% Complaints Responded to within 25 working days



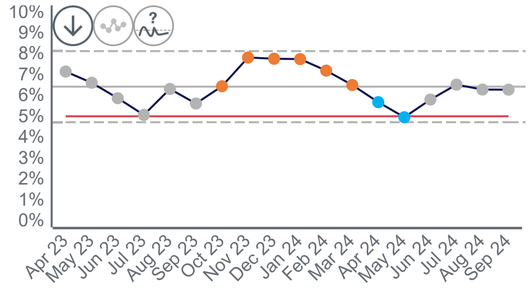
% PALS Resolved within 5 Days



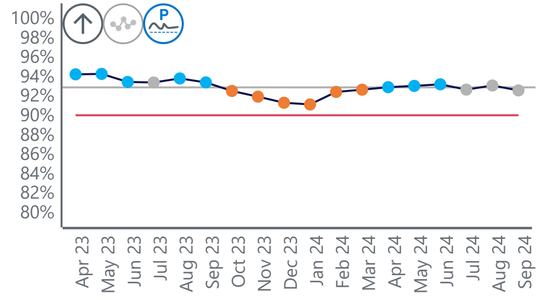
Staff Turnover



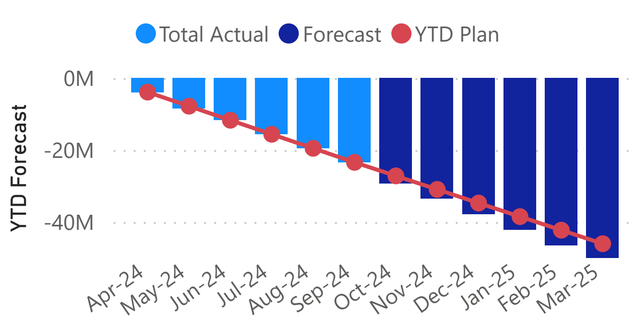
Sickness Absence (Total)



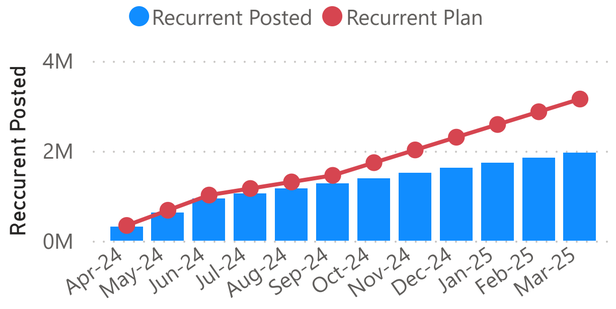
Mandatory Training



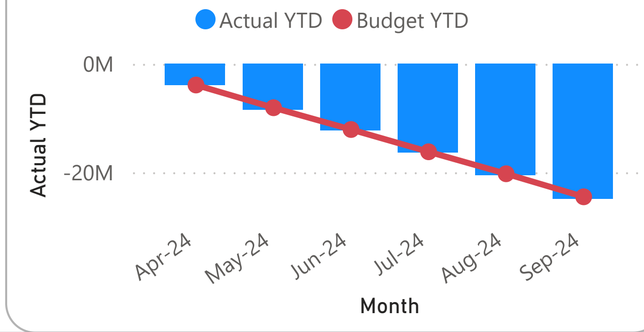
I&E Year End Forecast



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

0070

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

July

	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	108%	-	100%	-	135	15.9	15.88	-1.30	-7.70%	0.00	0%	0.00	0.00%	0.00	0.00%	2.61	0.46%	0.00	0.00%	1	42	0	1	3	100	0	0
HDU	79%	60%	78%	80%	212	39.9	37.81	-3.50	-4.60%	3.33	62%	1.61	2.02%	0.00	0.00%	167.14	6.77%	0.00	0.00%	5	153	0	3	1	100	0	1
ICU	82%	42%	80%	48%	523	31.4	33.55	8.62	5.30%	2.17	52%	0.00	0.00%	0.00	0.00%	222.44	4.67%	5.00	8.06%	8	213	0	1	1	0	0	0
Ward 1cC	86%	86%	79%	87%	564	12.4	12.36	-3.40	-5.80%	0.30	6%	0.00	0.00%	1.00	18.09%	92.97	4.86%	23.23	13.14%	9	111	0	19	12	100	0	0
Ward 1cN	82%	0%	84%	-	231	17.3	17.33	1.22	3.50%	1.43	59%	0.00	0.00%	0.00	0.00%	28.21	2.68%	0.00	0.00%	6	74	0	9	6	100	0	0
Ward 3A	99%	79%	99%	113%	891	9.0	9.31	-4.17	-8.50%	2.23	14%	0.61	1.15%	0.00	0.00%	110.56	6.68%	75.57	17.73%	3	73	0	18	33	87.88	1	0
Ward 3B	97%	107%	96%	-	406	14.7	14.67	-2.32	-5.30%	0.36	7%	0.00	0.00%	0.00	0.00%	106.69	7.52%	19.32	13.02%	10	129	0	9	12	100	1	0
Ward 3C	98%	109%	86%	157%	726	13.0	12.01	-1.13	-1.80%	2.26	23%	0.00	0.00%	0.00	0.00%	110.25	5.57%	5.31	2.23%	5	133	1	7	14	100	1	1
Ward 4A	86%	63%	90%	139%	808	10.7	10.3	-4.58	-6.80%	0.80	14%	0.00	0.00%	0.00	0.00%	110.37	4.86%	18.40	12.10%	7	85	0	5	35	94.29	0	0
Ward 4B	61%	82%	57%	88%	527	15.0	13.98	-4.03	-12.00%	13.16	26%	0.00	0.00%	0.00	0.00%	90.83	7.77%	84.17	7.37%	5	129	0	6	17	82.35	0	0
Ward 4C	92%	88%	97%	95%	722	11.1	11.08	7.18	12.00%	0.40	3%	0.00	0.00%	0.00	0.00%	62.80	3.98%	17.64	5.13%	6	263	1	8	56	98.21	1	1

August

	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	105%	-	100%	-	97	21.6	15.88	-1.30	-8.00%	0.00	0%	0.00	0.00%	0.00	0.00%	3.00	0.53%	0.00	0.00%	1	43	0	1	7	85.71%		
HDU	84%	50%	82%	67%	231	38.1	37.81	-3.74	-5.00%	3.33	62%	0.92	1.16%	0.00	0.00%	98.37	4.01%	0.00	0.00%	5	158	0	3	1	100%		1*
ICU	82%	52%	80%	48%	464	35.8	33.55	8.22	5.00%	2.17	52%	0.00	0.00%	0.00	0.00%	229.16	4.82%	0.00	0.00%	8	221	0	1	2	100%	1	
Ward 1cC	85%	78%	76%	109%	469	14.6	12.36	-3.40	-6.00%	0.30	6%	0.00	0.00%	0.00	0.00%	151.55	7.91%	27.79	17.83%	7	118	1	20	7	100%	1	
Ward 1cN	80%	50%	95%	-	221	18.6	17.33	2.30	6.50%	1.43	59%	1.00	2.99%	0.00	0.00%	31.64	3.09%	0.00	0.00%	7	81	0	9	2	100%		
Ward 3A	95%	63%	93%	100%	583	12.7	9.31	-4.17	-8.50%	2.55	16%	0.00	0.00%	0.00	0.00%	97.69	5.90%	77.19	18.29%	3	76	0	18	29	100%	1	1*
Ward 3B	103%	88%	101%	-	384	15.4	14.67	-1.52	-3.50%	1.28	24%	0.00	0.00%	0.92	21.00%	67.15	4.84%	8.00	5.47%	4	133	0	9	3	100%		
Ward 3C	92%	95%	81%	143%	685	12.9	12.01	0.86	-1.40%	2.26	23%	2.00	3.18%	0.00	0.00%	126.51	6.50%	4.60	1.93%	9	142	0	7	5	100%		
Ward 4A	89%	61%	90%	98%	712	12.1	10.3	-5.82	-9.00%	0.80	28%	0.00	0.00%	0.00	0.00%	89.64	3.96%	0.00	0.00%	6	91	0	5	25	92%		
Ward 4B	64%	87%	60%	105%	539	15.7	13.98	-4.03	-12.00%	13.78	28%	0.00	0.00%	0.77	2.10%	31.36	2.68%	121.51	10.76%	2	131	0	6	2	100%	1	
Ward 4C	88%	68%	91%	79%	514	14.3	11.08	6.26	11.00%	0.40	3%	0.00	0.00%	0.00	0.00%	45.65	2.89%	30.00	8.57%	11	274	0	8	30	100%		1

* HDU and 3A was a combined complaint.

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. The benchmark for CHPPD for the above tables is based data from the model hospital. Those areas highlighted red fall below this benchmark. In July only 1 department is highlighted red with no departments in August below the national benchmark.

Summary

During August all departments had a CHPPD rate above the peer average.

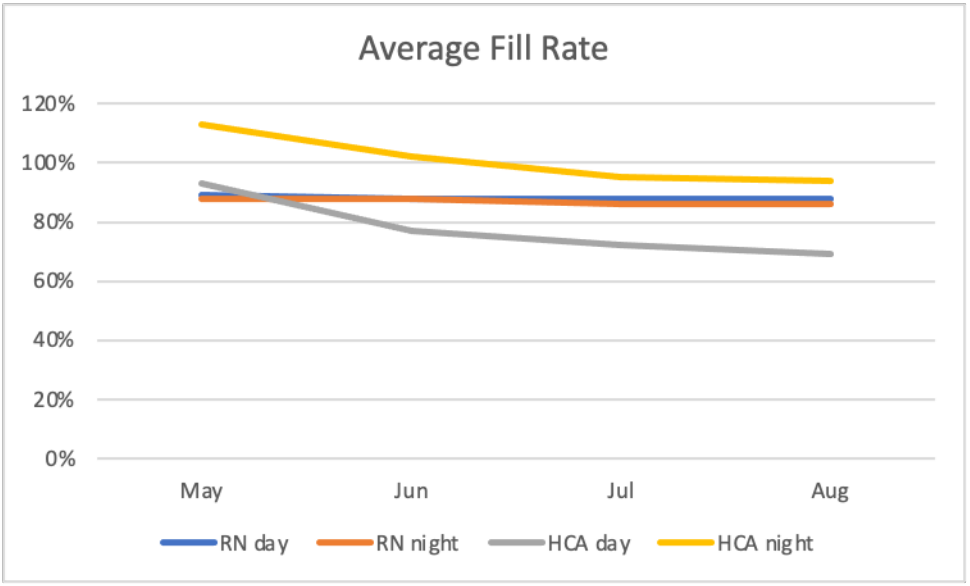
Medicine

1 ward within the Division of Medicine fell below the 80% standard for fill rate for registered nurses. This is 4B, however this is due to the changes in staffing model and therefore not reflective of care hours required. Staffing establishments have been corrected within budget, however, require alignment within the Healthroster to enable the data to be reflective of fill rate.

Surgery

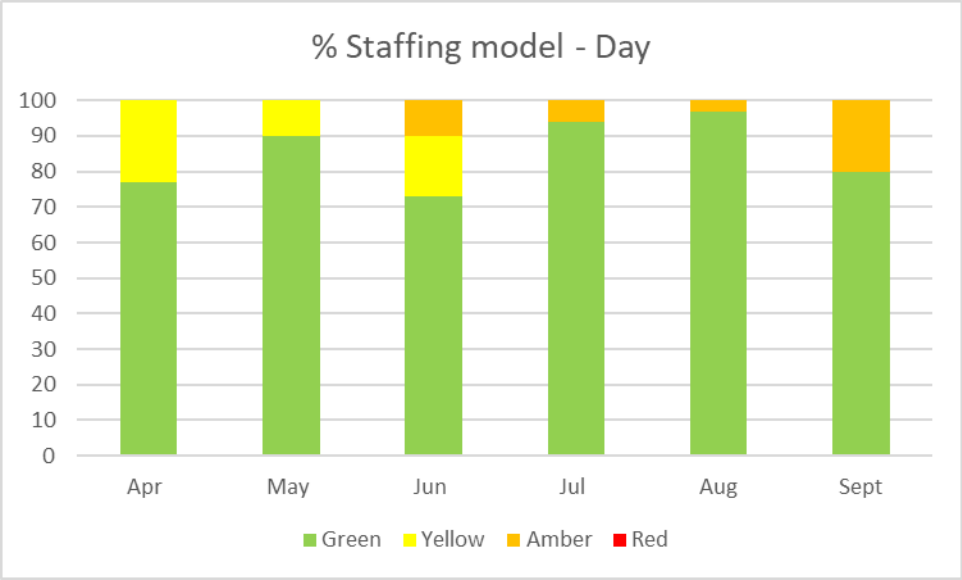
No wards or departments fell below 80% fill rate for registered nurses during July and August.

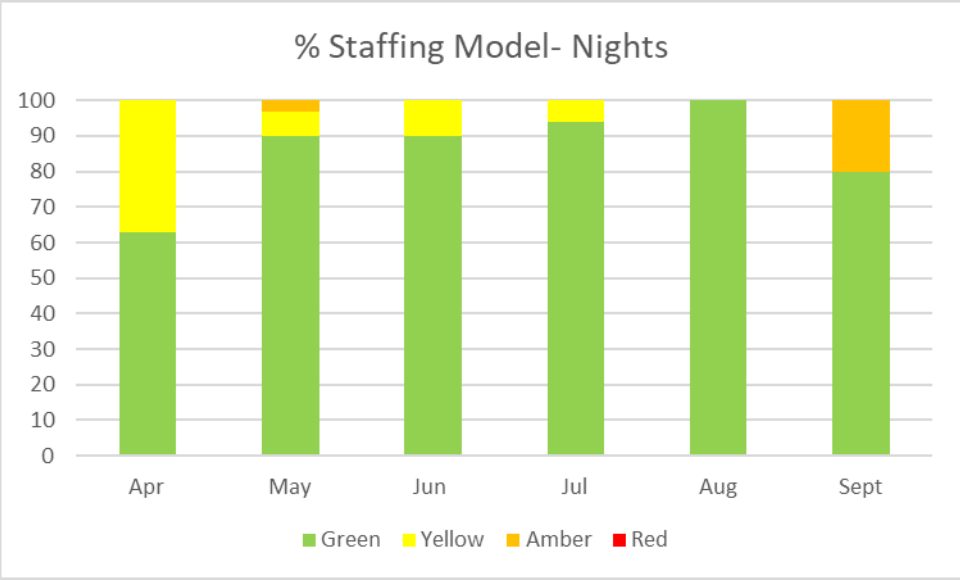
Average fill rates since May 2024 have remained above 85% in all areas for days and nights. There are vacancies within HCA's in the majority of wards and increased 1:1's which impacts on the fill rate reported.



Summary of Staffing models April – September 2024

Staffing RAG data has continued to show improvement with zero red shifts within the wards and departments for this reporting period. September reported an increase in an Amber staffing model from only 5% of shifts in August.





Electronic Roster KPI Report
September Board Paper

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

Summary Narrative

We have seen a consistent improvement over the last 6 months in several of the KPI across the trust which include.

- Bank / Agency Spend has reduced from 13333 to 11462.
- Additional duties continue to show a steady reduction.
- Reduction in the number of rosters changed since approval.

Areas of focus include.

0073

- Annual Leave remains high with 10 out of the 27 areas over the 17% KPI
- Sickness continues to be above the trust target of 5%
- Roster sign -off being undertaken within the correct timeframe (<42 days)

Monthly roster review meetings are now in place across the trust and within each Division and are led by the Heads of Nursing in conjunction with health roster team. Present at these meetings are ward managers and matrons. This meeting has proved successful and ensures that each ward works within a set of Key Performance Indicators which includes the important element of rosters being finalised by managers in a timely manner. In addition, these meetings have been beneficial in highlighting where there are increased numbers of additional shifts as well at the requirement and utilisation of NHSP and agency shifts, The meeting allows the ward managers and matrons to track the range of KPI,s allowing them to focus on improvements in their own areas. Reports are circulated monthly to the ACN and HON to share with their respective teams and take forward any agreed actions.

KPI Description	The minimum no of days notice teams need to be given for shifts to be worked	% of changes made in roster since full approval	The number of contracted hours people owe or are owed (Negative = owed, positive = owed)		The % of shifts filled by temporary staffing	The total number of hours filled by temporary staff	The number of shifts created ontop of the establishment	The % of shifts in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)		<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days (13th August - 15th September)	% 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)	48	26.31%	80.00	531.67	0.00%	0	0	45.00%	9.43%	3.58%	1.53%	12.26%	0.00%	26.98%
Accident & Emergency - Nursing (312201)	42	33.51%	720.00	448.31	12.30%	1351.17	0	18.80%	15.82%	2.01%	0.28%	7.53%	7.13%	34.61%
Burns Unit (315208)	44	18.48%	140.00	126.75	1.06%	22	0	5.25%	13.53%	1.82%	0.00%	0.80%	0.00%	28.93%
Critical Care Ward (313208)	44	17.72%	1200.00	978.65	2.64%	460	0	18.54%	15.56%	2.34%	0.28%	5.15%	4.06%	28.38%
High Dependancy Unit (HDU) (313210)	44	26.67%	640.00	162.25	8.53%	770.5	1	17.27%	14.60%	4.41%	0.43%	4.70%	7.50%	31.13%
Medical Daycase Unit (311314)	45	21.37%	50.00	-15.72	0.82%	8.32	2	16.61%	14.72%	1.14%	0.00%	0.57%	0.00%	16.43%
Outpatients (316503)	37	42.69%	420.00	650.3	13.80%	884.25	23	42.27%	18.17%	0.57%	0.62%	12.07%	2.72%	34.75%
Sunflower House (312310)	19	49.63%	130.00	386.73	26.25%	1033	38	24.08%	18.35%	0.00%	0.64%	10.28%	5.63%	37.61%
Surgical Daycase Unit (315418)	37	50.00%	85.00	-12.5	10.31%	313.25	14	22.55%	21.93%	0.11%	2.58%	3.96%	0.00%	28.57%
Theatres - Cardiac & Cardiology (315405)	44	23.36%	130.00	0	4.48%	34.5	3	1.20%	20.47%	0.33%	6.60%	6.60%	0.00%	33.73%
Theatres - Emergency (315420)	44	26.02%	230.00	15.46	5.47%	117.5	10	2.67%	15.96%	0.00%	0.00%	9.80%	0.00%	25.97%
Theatres - IP Anaesthetics (315423)	44	17.72%	82.00	89.58	1.63%	53.75	7	3.05%	16.34%	0.45%	1.65%	2.73%	6.21%	27.44%
Theatres - IP Porters (315435)	44	32.00%	101.00	14	2.77%	38	0	17.48%	21.20%	0.00%	0.00%	0.83%	0.00%	27.03%
Theatres - IP Recovery (315422)	44	25.73%	103.00	-38.27	7.53%	107.5	1	13.15%	13.57%	0.52%	6.14%	13.00%	0.00%	33.22%
Theatres - IP Scrub (315424)	44	22.43%	128.00	14.25	3.60%	153.5	2	11.32%	22.21%	0.00%	0.00%	7.95%	0.00%	38.66%
Theatres - Ortho & Neuro Scrub (315436)	44	32.76%	37.80	10.5	15.01%	237.75	0	12.04%	16.03%	0.00%	1.06%	15.73%	4.33%	36.21%
Theatres - SDC Anaesthetics (315429)	44	59.05%	58.40	-10.08	37.60%	352.25	3	10.03%	17.11%	0.00%	6.87%	14.02%	18.07%	56.87%
Theatres - SDC Recovery (315430)	44	29.05%	177.30	-2.77	11.61%	144	6	6.02%	26.33%	3.20%	2.04%	7.23%	0.00%	33.52%
Theatres - SDC Scrub (315421)	44	41.72%	532.00	-12.07	10.13%	272.25	12	5.35%	17.38%	0.00%	0.00%	10.09%	0.00%	35.81%
Ward 1C Cardiac (313307)	44	32.50%	361.00	744.2	11.63%	863.75	0	7.21%	14.18%	0.95%	1.38%	9.50%	4.76%	31.96%
Ward 1C Neonatal (313310)	44	43.42%	556.00	631.49	2.62%	130.75	0	17.03%	14.74%	2.32%	0.44%	4.72%	3.93%	31.94%
Ward 3A (315309)	44	22.56%	371.00	228.53	10.32%	781.25	23	8.97%	15.43%	1.86%	1.28%	6.58%	7.38%	32.77%
Ward 3B - Oncology (311208)	41	21.31%	555.00	717.74	6.45%	355.5	50	13.53%	15.11%	0.67%	1.86%	3.93%	4.91%	29.04%
Ward 3C (311313)	44	31.76%	607.00	1614.02	17.08%	1440.5	11	19.78%	15.82%	2.00%	0.33%	6.18%	4.93%	33.54%
Ward 4A (314210)	40	26.43%	624.00	744.52	5.45%	437	26	10.03%	14.55%	2.92%	0.48%	8.68%	4.26%	32.19%
Ward 4B (314211)	39	33.80%	533.00	765.15	11.23%	379.5	9	25.11%	15.28%	2.54%	0.73%	9.25%	5.35%	33.33%
Ward 4C (312207)	41	28.16%	280.00	74.88	7.61%	524.5	8	15.16%	14.98%	3.03%	2.05%	7.50%	3.03%	33.04%
Sep-24	42.2	31.10%	9001.50	9703.2	9.50%	11462.34	314	15.50%	16.95%	1.58%	1.46%	7.57%	3.54%	32.66%
Aug-24	42.2	31.37%	9001.50	9386.6	10.13%	13339.34	339	15.48%	15.84%	1.53%	1.61%	7.31%	3.41%	31.38%
Jul-24	43.1	31.93%	9001.50	8011.5	10.86%	13638.25	326	15.10%	13.31%	1.98%	1.86%	8.58%	3.66%	30.32%
Jun-24	43.3	32.31%	9001.50	8197.9	11.30%	15518.91	425	14.96%	14.16%	1.93%	1.82%	8.17%	3.53%	30.83%
May-24	40.3	28.32%	9001.50	9084.2	10.58%	15592.52	468	14.65%	12.16%	2.69%	1.95%	7.64%	2.90%	29.20%
Apr-24	40	34.90%	9001.50	15075	11.24%	16556.95	421	15.86%	13.52%	3.13%	1.70%	7.19%	2.85%	30.88%
Mar-24	40	37.95%	9001.50	15714	15.80%	20593.58	325	17.47%	20.08%	2.26%	2.02%	7.34%	2.84%	36.23%
Feb-24	38	38.09%	9001.50	25962	15.30%	20805.07	261	19.43%	16.96%	2.67%	2.00%	7.33%	3.35%	34.64%
Jan-24	31	35.00%	9001.00	29114	13.60%	20742	409	21.22%	15.84%	2.08%	2.17%	8.89%	3.48%	34.06%

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th November 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

Alder Hey Children's NHS Foundation Trust

Campus Development Report on the Programme for Delivery

November 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

2024/25 Q3 & Q4:

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

2025/2026 Q3:

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

Springfield Park
This risk has been reduced from a score of 12 to 8 to note progress to conclude this project.

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	

Following continued resource pressure on the Fracture & Dermatology OPD scheme, formal escalation and Executive intervention was applied to mitigate delay to programme. Informal escalation meetings remain in place with Mitie to check, challenge and manage any implications associated with projects in the main hospital building. Progress is noted against projects within this report.

Alder Hey Children's NHS Foundation Trust

Key/High Risks Descriptor

Project	Description	Ref	Score	Status
Springfield Park	Failure to deliver long term vision for park	BAF 3.1	8	Programme continually monitored.
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

		2024												2025												2026+
Project	**Deliverable**	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	
Springfield Park	Phase 1: Main Park																									
	Phase 2: Swale																									
	Phase 3: Park Handover																									
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)																									
	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 being progressed. • Ground Floor shell space design being progressed.		Potential decant costs. Potential budget & programme impact of GF reconfiguration changes.	Agree decant plan ED waiting. Agree shell space design. Agree Services DOV. Equipment & Furniture requirements confirmed and costed. 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: • Tender returns received in excess of budget. • Potential options discussed at 26.09.24 and reported at 28.10.24 Finance, Transformation & Performance Committee.		Fire compliance. Budget.	Proposals to be finalised for discussion at 14.11.24 Executive Director's Meeting, and reported to December '24 Trust Board.

Fracture and Dermatology Outpatients

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Work ongoing in line with programme: • Construction Completion: 20.12.24. (recovery plan in place). • 'Go Live' Jan '25 tbc.		Delay to completion, impact on operational running of the services.	Regular meetings. Close monitoring of critical risks. Confirmation of 'go live' date.

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: • Works to complete the Swale are on target. • Retrospective planning application submitted to LCC on 15.10.24.		Completion of all remaining works.	In agreement with LCC, handover of Springfield Park will be in 3 phases: 1) Main Park Oct 2024; 2) Swale Dec 2024; and 3) Remaining site (Histopathology & surrounding area) Dec 2025.

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
Design layouts completed for the priority major schemes: • Endoscopy Room. • Theatre Staff Rest Facilities. • Day Case Unit reconfiguration works. • Dental OPD reconfiguration works.		Programme, available budget. Mitie PM resources.	Design sign-off. Equipment & Furniture requirements confirmed and costed. Updated costs & programme.

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

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Main Construction: • First fix works commenced 14.10.24. • RIBA Stage 4 Design Sign Off: Workshops with technical and clinical teams scheduled for conclusion early November '24. • Main phase 2 contract to be signed w/c 04.11.24.		Programme, available budget.	Sign off final design. Contract signing. Equipment & Furniture requirements confirmed and costed.

5. Conclusion

Trust Board is requested to receive and acknowledge the update provided as of 7 November 2024.

BOARD OF DIRECTORS

Thursday, 7th November 2024

Paper Title:	**Seasonal Vaccination Update**
Report of:	Chief Nursing, AHP and Experience Officer
Paper Prepared by:	Chief Nursing, AHP and Experience 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

Seasonal Vaccination Update to Trust Board

Staff vaccination

Introduction

Alder Hey Children's NHS Foundation Trust are committed to ensuring that all staff have access to seasonal vaccinations for their health and well-being and to provide a level of resilience in the workforce over the winter period.

This paper provides an update to the Trust board on the seasonal vaccination programme approach for the 2024-25 winter, the most current progress update will be presented at the board meeting.

Background

Winter viruses, such as influenza, cause high levels of absence during the winter months, and well as increasing demand across the NHS.

The single most effective intervention to help protect frontline health and care workers is vaccination with the seasonal influenza vaccination. The Trust approach to vaccination this year is reflected below. The national target for influenza vaccine is 80% of frontline staff.

It has been recommended that frontline NHS staff, along with vulnerable patients are also offered the winter COVID booster, our approach to this is detailed below.

Influenza Vaccine

The vaccination team began this year's programme on 7th October, 2024. The flu clinic runs daily from room 8 on the Mezzanine on the main hospital site. All staff can book an appointment or drop in for a vaccination.

The community teams have several peer vaccinators who have been offering the vaccine across all community sites and at off-site clinics.

The flu vaccination team are also offering reach in services to specific departments, such as PICU and theatres, where staff often find it difficult to leave the departments to attend the flu clinic.

There will be scheduled late evening vaccinations, as well as roving vaccination reaching out to wards and departments.

Staff who have their vaccine elsewhere, such as their local pharmacy or GP practice, are requested to complete a short online form to have their vaccination recorded.

COVID booster

The Trust is currently reviewing the approach to offering the COVID booster. The initial decision has been not to offer this on site for the following reasons:

- The vaccine is a multi-dose vial, with a short usage time once opened

- The vaccine requires additional training, meaning that there is a lack of consistency in the offer to staff as it is vaccinator dependent
- Last year the uptake was 28% of the workforce
- There is very good provision through primary care for staff to access the COVID vaccine in their own communities.

However, the Trust are offering the COVID booster to eligible patients (see below) and as such there may be scope to offer some vaccines on site. Currently staff are encouraged to book a COVID booster through the national booking system.

Patient vaccination
Flu vaccination is recommended across all children aged 2 or 3 on 31 August 2024, children in school years Reception to Year 11, and all children in clinical risk groups aged from 6 months to 18 years. This would cover almost all our in-patient cohort. COVID vaccination is available to patients over the age of 6 months who are in a clinical risk group.

Following additional funding from NHSE NW immunisations team, the pilot patient MMR vaccination programme (led by Rachel Isba and Bea Larru) will expand to cover inpatient 'flu and COVID vaccinations over the winter. This work will be carried out in partnership with the staff vaccination work outlined above, and other vaccination delivery in the trust.

Supplementary approaches such as drop-in clinics e.g. in outpatients and pop-up clinics e.g. in the Atrium, within the Trust are also being explored.

Reporting and monitoring
Weekly staff vaccination figures are provided to the CNO each Tuesday and shared with the wider executive team at the executive team meeting. A review and learning report will be completed at the end of the programme and presented to Trust board.

Recommendation
The Trust board are asked to:

- Note the content of this report

BOARD OF DIRECTORS

Thursday, 7th November 2024

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 23rd October 2024, along with the approved minutes from the 25th September 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:	

Does this relate to a risk? Yes ☐ No ☐

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

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

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

1. Executive Summary

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

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

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

- SQAC 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.

4. Recommendations & proposed next steps

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on Wednesday 25TH September 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)
	Bea Larru	Director of Infection Prevention & Control	(BL)
	Gerald Meehan	Non-Executive Director	(GM)
	Rachael Pennington	Associate Chief Nurse, Surgery Division	(RP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief Peoples Officer	(MS)
	Catherine Wardell	Associate Chief Nurse, Medicine Division	(CW)
In Attendance:			
	Ian Gilbertson	Deputy Chief Digital and Information Officer	(IG)
24/25/125	Julie Grice	Mortality Lead, Consultant in Paediatric Emergency Medicine	(JG)
24/25/128	Susan O'Neil	Deputy Head Neonatal Nursing Liverpool Neonatal Partnership	(SN)
24/25/130	Prof. Rachel Isba	Consultant in Paediatric Public Health Medicine	(RI)
24/25/133	Dan Hawcutt	Director of Research	(DH)
	Rachel Lee	Director of Finance & Development	(RL)
	Hilary Peel	Governor	(HP)
	Jill Preece	Governance Manager	(JP)
	Linda Wain	Corporate Governance & Risk Manager	(LW)
	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)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Clare Ellis	Head of Laboratory Medicine	(CE)
	John Grinnell	Managing Director	(JG)
	Laura Rad	Head of Nursing – Research	(LR)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Paul Sanderson	Chief Pharmacist	(PS)

Welcome and Apologies
The Chair welcomed everyone to the meeting.

24/25/117 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.

24/25/118 Minutes of the Previous Meeting
The Committee members were content to APPROVE the notes of the meeting held on 24th July 2024.

24/25/119 Matters Arising/Review of Action log
The action log was reviewed and updated.

Assurance on Key Risks
24/25/120 *Delivery of Outstanding Care*

Safe
Patient Safety Strategy update
SQAC noted the Patient Safety Strategy update within the meeting pack.

FB referenced the ongoing work undertaken regarding antimicrobial resistance and requested an update to be provided at the October SQAC meeting regarding the new metrics.
Resolved: Antimicrobial Resistance update to be provided at October 2024 SQAC meeting.

GM sought clarity whether there is any identified correlation regarding staffing levels and incidents.
NA stated that within the literature there is, however within Alder Hey staffing model is predominantly Green and fully staffed. CW advised that the Trust safe staffing report does review all staffing incidents on a monthly basis, and colleagues check for any emerging themes.

FB stated that the Trust does review all of the incidents and advised that staffing is not one of the regular themes.

KB questioned if the Trusts noncompliance with NatSIPPs 2, which was launched in January 2023, had any implications and sought clarity regarding timescales when the Trust would be compliant.
RP gave an explanation of the Trust current position, the steps that are needed to become compliant and gave an overview of the development of a real time dashboard which has taken longer than expected. RP stated that she envisaged that this would be completed by the end of 2024.
NA suggested that when NatSSIPs is due to be presented at Patient Safety Strategy Board to include a forward trajectory and overview.
KB agreed this would we welcomed, not only for NatSIPPs, but for all updates.
Resolved: NatSSIPs forward trajectory and overview to be provided to Patient Safety Strategy Board.
FB stated it would be helpful for RP to review and update the next steps narrative statement for NatSSIPs 2 to reflect the current position.
SQAC welcomed a Deep dive update on Antimicrobial Resistance at October SQAC meeting with clarity to be provided regarding the new graphic.
Resolved: SQAC welcomed the progress made in month and welcomed a Deep dive update on Antimicrobial Resistance with a focus on the new metric, including a recap of the work and a forward look at October SQAC meeting.

24/25/121 ED monthly report: MH attendances and ED@its best

CW presented the ED Monthly Report, sharing key highlights.
FB congratulated CW and ED colleagues on the headline metrics and stated that she hoped that the ED retain focus on the continued progress.
FB advised on an error within the report within the PAU conversion to wards admission and requested this be corrected within the report for accuracy/completeness.

GM sought clarity whether SQAC would be provided with a report regarding the 4 missed Sepsis cases.
GM stated that it is extremely interesting to hear that 30% of children and young people were admitted in terms of MH assessments and sought clarity whether there was any particular reason for this.

ABa stated that the report details that 9 of those 11 patients were admitted for overdoses, which is a medical reason for admitting a patient.

NA stated that the Trust is seeing an increase in children streamed to the UTC needing to return to ED and queried whether this had been reviewed.
CW stated that the Head of Nursing is undertaking a review but a theme had been CYP with minor injuries being referred back to ED, which could be attributed to a less experienced junior doctor and ANP workforce.

NA noted the continued challenge with time to medic assessment out of hours and would welcome some further detail within future reports.
NA noted that 40% of PAU attendances result in onward admission to the wards and sought clarity if there was a national benchmark for this. CW would review what the national standard is offline, CW advised that 30% is the aim for the Trust.
ABA acknowledged the ED positive performance, despite ED consultants being under significant pressure with high levels of sickness within ED. ABA sought clarity whether there is a plan for managing this ahead of the winter period to ensure that there are appropriate mitigations.

CW confirmed that the Division are currently discussing this and that they are reviewing different ways of working to ensure that the busiest times are appropriately staffed.
KB alluded to BAF risk 1.2 regarding access and waiting times and requested whether AB could review this risk to ensure that the positive changes had been reflected in BAF Risk 1.2 given the sustained performance of the 4 hour target and significant improvements elsewhere.
FB stated that the BAF risk 1.2 is quite broad and refers to waiting lists for other services and given that the Trust has other challenges with other waiting lists. FB stated that the Trust is making progress regarding dentistry for example, however this is not the case for ASD and ADHD.
AB stated that risk 1.2 is extremely broad and covers different access types. AB confirmed that he could reflect the improvement in ED, albeit AB advised that he is cautious given that it would be over the coming months that the model is going to be tested in terms of sustainability.
AB alluded to the challenge regarding the elective waits and stated that until the Trust could improve the elective access significantly, together with ED, that the Trust could not reduce the risk score.
KB agreed with this and stated that it is more about the specific actions relating to Urgent and Emergency care standards, as some of these actions had been addressed.

AB informed the committee that due to planned building work there are significant challenges regarding the ED waiting room, options are being explored but there is not an ideal option. This will be discussed at the Executive team meeting.
FB sought clarity regarding timescale of building works
AB confirmed that this would be approximately 10-12 months
Resolved: SQAC received and **NOTED** the ED monthly report: MH attendances and ED@its best

24/25/122 Quarterly Infection Prevention Control Report

BL presented the Quarterly Infection Prevention Control Report.
BL stated that the Trust had started to see an increase in C Difficile cases in Quarter 1. BL advised that nationally there had been a significant increase of C Difficile cases across England and advised that there are numerous meetings and investigations to ascertain why this increase is occurring. BL provided a detailed overview of those Children & Young people who would be more susceptible to C Difficile i.e. those patients with gastrointestinal issues, patients with Crohn's disease, children with Irritable Bowel, and oncology patients, BL advised that there had been a substantial number of patients within oncology. BL advised that on review of all of the cases that there had been no lapses in care.

BL advised that the Trust should look to increase the cleaning facilities to ensure the avoidance of transmission through equipment and contaminated services and advised that recommendations would be provided within the next IPC quarterly report with regards to fogging machines to further improve decontamination of surfaces within rooms.

GM requested clarity whether IPC colleagues had reviewed in detail regarding factors outside of the ward, i.e. where food is served, and the general hygiene regarding the whole hospital approach. BL advised that all of the cases had been included as healthcare associated because they had contact with healthcare setting 28 days prior to the onset of infection, however the onset is community onset. BL advised that this is not caused by food eaten but is a bacteria that many people will have in their gut, and it is only when antibiotics are given and the bacteria is killed, that causes the infection.
ABa alluded to healthcare acquired viral infections and a lack of education for parents and visitors and sought clarity how the Trust could resolve this issue.
BL stated that there is a package for families and that there are a number of opportunities to raise awareness for families whilst at the hospital, whilst ensuring that the information provided to Children & Young People is provided is easy and clear to understand.
NA stated that as part of the Patient Experience strategy the Trust does require a digital page for information which would be included in the long term plan, NA agreed to liaise with BL offline regarding an interim solution.

IG stated that this is likely to be included on the patient portal which the Trust is shortly due to go out to tender. IG confirmed that he would follow this up with the team.
FB welcomed an update on C Difficile within next quarterly IPC report and requested BL attendance at the October 2024 SQAC meeting for the discussion regarding Antimicrobial resistance.
Resolved: SQAC received and **NOTED** the Quarterly Infection Prevention Control report.

24/25/123 Safe Waiting List Outcome of Validation work update

AB presented the Safe Waiting List Outcome of Validation work update which detailed an overview of the current position, detailing actions taken to date, and an overview of Governance.

FB stated that the item on governance position should be reported to the Board of Directors, and this would be included in the Chairs highlight report to the Board of Directors.

KB queried whether the Safe Waiting List had really built up over lockdown or whether this had occurred prior to Covid.
AB advised that this was not a lockdown issue, although the lockdown had compounded this, however this had been accumulating for several years. AB stated that people had prioritised new patients and other waiting times and follows up had not had the same transparency or focus.

KB sought clarity on the goals and stated it would be helpful to receive a forward plan to understand the Trust ultimate aim. KB requested clarity regarding timeframes for completion of part 2 and part 3.
AB advised that ultimately the Trust goal is to have 0 high risk patients who are overdue a follow up appointment and that the Trust could have a 6 month overdue tolerance level for those patients who are classed as low risk.

AB recommended quarterly Safe Waiting List updates to be provided to SQAC.
KB queried whether there are any other issues that the Trust is aware of that is building up and may emerge in the future.
AB stated that this was not conscious, and once highlighted it invoked the Safe Waiting list review.
KB alluded to the unacknowledged notifications and sought clarity whether there is a requirement for a review across services.
RP alluded to the follow up aspects and oversight and stated that there are lots of complexities within the system regarding how follows ups are logged and booked and colleagues had not realised the variance on how this is managed.
RP alluded to whether the ACP workforce could be utilised to support reviewing and validating those patients who require a follow up. RP stated that she is happy to liaise with AB offline in this regard.
AB agreed this would be helpful.

ABa stated that this problem has existed for a considerable amount of time. ABa advised that a high number of Alder Hey patients have a set follow up pattern, which is a particular problem with paediatric trusts. ABa stated that the only way that this could be dealt with is to completely redesign how follow up care is delivered and managed in line with the 2030 strategy. ABa stated that 80% of the work undertaken at Alder Hey is within the outpatients' clinics. ABa stated that colleagues need to use the lessons learned from Ophthalmology, as they had reimagined how they deliver outpatient care as a specialty, and that lessons learned through Ophthalmology service should be shared with every specialty.

FB alluded to the psychological impact on patients and families who are waiting on the Safe Waiting List.

Resolved: SQAC received and **NOTED** the Safe Waiting List Outcome of Validation work update and **NOTED** the progress made since July 2024. SQAC supported the proposed governance structure. SQAC agreed to receive Safe Waiting List Quarterly Reports, which would include good news stories regarding how specialities identify good practice.

Caring
Effective

24/25/124 Board Assurance Framework

SQAC received the Board Assurance Framework.
ES stated that the follow up risk issues had been discussed at various forums which would need to be amplified within the next BAF report, whilst addressing the Urgent care risk which is mitigated more thoroughly.

ES alluded to BAF risk 1.1 and advised of a short term issue with regards to an Improvement Notice from CQC regarding Nuclear Medicine, and whilst this is not a safety issue this risk is described as regulatory aspects, and work is ongoing within a 12 week period to address those deficits, with regards to documentation. ES provided assurance that the CQC Inspector had no safety concerns regarding the service.

ES stated that there is some work required to review the niche services where there are very specific regulations, to ensure that services are under regular review, with liaison required with colleagues to understand/agree a process. ES advised that an offline discussion is required with ES/NA & ABa.

ES referenced the additional assurance required regarding the Gender Dysphoria Service. Divisional Director for C&MH had provided a Deep Dive to the Risk Management Forum on 23.9.24, with discussion regarding how some of the principles underlining those risks could apply to other services, with an opportunity to tease out any emerging issues, and services to think about risks in a slightly different way.
ES referred to ADHD medication shortage and the impact this has had. ES advised that she and GM had recently been involved in a Quality Assurance round which provided greater depth regarding understanding the issue and impact, with discussion held with staff, ES & GM which was invaluable. Whilst this risk is well articulated there are opportunities to flesh out actions and mitigations.

ES advised that it is a good mid-year opportunity to have a refresh of the BAF risks and stated that industrial action risk could be removed. ES alluded to the dynamism required within the BAF document when working in a robust manner.
FB stated that dynamism is good and demonstrates that risks are being reviewed, and that the Trust is identifying new risks, and that the Trust is actively enabling risks to be closed or reduced.
FB stated that she is not briefed on the nuclear medicine issue and requested ES to provide FB with an update offline.
ES advised that there is Divisional leadership addressing this risk. ES confirmed that a detailed briefing would be provided to Trust Board.
GM alluded to Risk 1.4 regarding the increased waiting times and sought clarity whether the wording is still relevant, as this details 'reduced support from partner agencies' and whether this is quantifiable, and whether it relates to agency or agencies.
ES stated that this risk is specific to Mental Health Services and had been inserted following the covid pandemic.
LC advised that the support from partner agencies, related to Children Social Care, and the Local Authority arrangements given the Improvement Notices that are in both Local Authorities, but also partner agencies i.e. the third sector having robust commissioning arrangements.
Resolved: SQAC received and **NOTED** the Board Assurance Framework

24/25/125 Quarter 1 Mortality Report

JG presented the Mortality Report
FB welcomed an update regarding the out of hospital cardiac arrests
KB queried whether there is any value regarding providing trend analysis of data over time and whether this would help in future reports.
JG stated that she has a log that details trends. JG confirmed that she is happy to review this and include within future reports.
FB thanked JG for the extremely clear report and stated that it is good to reflect on whether the Trust can learn from trend analysis within the report.
Resolved: SQAC received and **NOTED** the Mortality Report

24/25/126 Gender Development Service quarterly report

SQAC received the first quarterly Gender Development Service quarterly report following the service being mobilised on 2nd April 2024.
FB welcomed future report developing further with outcome data.
KB sought clarity whether the Trust had a target for waiting time from referral to initial assessment standard.
LC advised that there is no national waiting time standard for this service as NHSE had not set one.

Resolved: SQAC received and **NOTED** the Gender Development Service quarterly report for the reporting period of 1st April - 30th June 2024.

24/25/127 Clinical Effectiveness and Outcomes Group Chairs Highlight report

LW presented the Clinical Effectiveness and Outcomes Group Chairs Highlight report from the first to face to face CEOG meeting held on 13th September 2024.

- LW alluded to an ongoing issue with the National Renal Registry due to IT, which had been escalated to the Chief Transformation and Digital Officer.

IG stated that the description of 'IT issue' is not the correct way to describe this issue. IG advised that this mandate was received, and that colleagues quickly identified that the services do not collect this data electronically, therefore there was no means to collect, extract or submit electronically. IG stated that next steps would be to meet with colleagues to enable the data collection forms to be designed, IT could then work on the dashboard and data extraction. IG advised that there is a meeting planned over the coming weeks to address and IG would aim to prioritise and address this as rapidly as possible.

FB sought clarity when IG would be able to provide SQAC with an update

IG stated that within the next week he would write to FB and cc JC confirming timescales, with an update to be provided at October 2024 SQAC.

Resolved IG to provide FB and JC with confirmation of timescales, prior to providing an update on current position at October 2024 SQAC meeting.

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

24/25/128 Liverpool Neonatal Partnership Assurance Report

SN presented the Liverpool Neonatal Partnership Report.

GM alluded to the PSIRF process and sought clarity whether this is generating any information that is feeling different.

SN confirmed that this is making a difference, sighting the after actions reviews that had been completed and the involvement of staff which is multi-disciplinary and is extremely helpful for all involved.

KB advised that she had recently joined the LNP Board as a NED for the LNP and had attended the Board meeting on 23.9.24. SN had provided a tour for KB and KB plans to have a tour of 1C. KB stated that hopefully in the future KB would include necessary information into SN reports.

FB sought clarity whether KB is on the only NED on the LNP Board

KB confirmed this was correct.

Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership Assurance Report

24/25/129 Divisional Update

Division of Surgery – RP presented the Division of Surgery update

- Success in August 2024 related to the Division trialling a new MDT approach with regards to the complex complaints, which is working well with regards to response times.
- Challenges in August 2024 related to ongoing capacity issues on Ward 1C, resulting in delays in step down from PICU, ongoing work is progressing regarding the Business Case to consider expansion of the cardiac service.
- There had been 2 moderate harm incidents reported in August, -1 was a nonclinical incident, and 1 was downgraded following a review.
- 2 patients did not receive antibiotics within 60 minutes, both cases had been reviewed, one patient had been delayed due to clinical assistance required, the other administering of antibiotics had a significant delay. Surgery Divisional colleagues are reviewing this to identify any learning with regards to access issues.

KB referenced the incidents overdue review, and stated that 12 months ago these were high, with a concerted effort to reduce these, however there is an upward trajectory. KB sought clarity whether the learning from those incidents are delayed and therefore the Trust is not making changes as promptly as required.

RP advised that the impact had been during the summer months due to an increase in colleagues being on leave. RP confirmed that every single incident within the Division of Surgery is reviewed on

a daily basis by the Senior Nurse of the day, and that the Ward Managers collectively meet and review the incidents in greater detail and triangulate the learning on a weekly basis. RP stated that the physical closing of the incident on the system is not happening in a timely manner, however the review of the incident and the learning is taking place. RP stated that there is a need to improve the timeliness of administration for closing the incidents.

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

- Successes in August related to the mobilising of the psychological support offer for Children in Southport within 1 week, with support provided to the children and young people, siblings and families who were affected by the Southport incident, the Division are working as part of the recovery process and supporting the wider community, which is an ongoing piece of work.
- The Division celebrated the first birthday event of the Sunflower house, families of the current and former patients were invited to join staff in a garden party celebration.
- Key challenge regarding security issues, given the recent civil unrest and the ability for security to be improved within the premises where Community & MH staff are based, given that the Trust does not own the buildings, with further work required with LSMS in this regard.
- Alder Park development (formally Dewi Jones Unit) - The division are in current discussions regarding the escalation of costs, to ensure this is more affordable as there are economies at scale with regards to moving staff out of the current buildings. LC stated that these premises are not fit for purpose to deliver exemplary service to children and young people.
- Highest incident category related to restrictive intervention, with 34 incidents in August 2024, which related to 2 children and young people within Sunflower House who required restrictive intervention for nasogastric feeding, whilst there is ongoing work to reduce this need, this continues to increase.
- In August 2024 the Division had 3 category 1 pressure ulcers, and 0 category 2, 3 or 4 pressure ulcers. The Division continue to undertake tissue viability audits, and this demonstrates positive compliance.
- Work continues between ICCNT and the UKHSA to support and respond to a recent outbreak of an infectious disease 'Giardia' within a local specialist school, there had been 2 deaths, which were not attributable to Giardia, the Division had been involved with wider work with IPC and colleagues within the Community.

Medicine – CW provided the Divisional update

- Success during August 2024 related to the PAU ED move which had included the relocation of 12 beds to other locations within the Trust.
- There is an ongoing challenge within Haematology and Transfusion labs service which continue to be a high risk of 20. CW advised that although this risk remains at 20 that there is extremely good progress being made with a trajectory that by December 2024 that there would be further staff trained who would participate in the ongoing rota.
- Notable progress in August 2024 regarding the Risk register with no overdue actions or reviews, in addition to progress made in Audit and NICE with non overdue actions.

FB alluded to interventional radiology and sought clarity whether there is likely to be an update regarding timescales.
CW advised that this is a real challenge with regards to recruiting to this post, and that at present CW had no updates to share with regards to timescale.

Research Division - CW presented the Research Divisional update

- There are no concerns to escalate in month
- Challenge in relation to working with the labs team to ensure that the Research Division have cover for processing research samples when the current research labs support goes on maternity leave, progress is being made and despite some challenges, the Division are hopeful to be able to limit the impact to service.
- The Research Division celebrated the news that the Division were successful in an NIHR Capital bid that will see us receive £1.1million for equipment that will advance the type and quality of research that could be provided at Alder Hey.

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

24/25/130 *Well Led*
Responsive

Health Inequalities Report
RI presented the Health Inequality Report.

FB stated that the MMR project is an exemplar project and expressed congratulations on securing funding from the ICB.
RI added she is currently addressing information governance regarding sharing data, and RI hoped that this would be a streamlined system in place in the future.
ABa stated that the adults' trusts are pro vaping and as a paediatric Trust the Trust needs to consider a Trust view as Alder Hey patients should not vape, and Alder Hey should have a different policy regarding vaping compared to adult hospitals.
RI stated that there is no long term data available for vaping for Children and Young people and agreed that the Trust should not expose children to vaping. RI stated that the Smoking and Vapes bill would hopefully change the landscape.
DH stated that as there is no evidence of the impact of vaping, that the Research Division are working with RI and schools programme regarding vaping to obtain the numbers of nicotine dependent children and other information that would help drive the clinical service and also address information gaps.
RI stated that there is no evidence base regarding how to support young person to stop vaping. RI stated that she does not know how mildly, moderate or severely the 11-16 year olds are nicotine dependent. RI state that there is a potential population of 11-16 year olds who are dependent on vaping but are actually not nicotine dependent, however they are dependent on the process of vaping.
RI advised on the added complexities is that one in six confiscated vapes within schools contained spice which is a synthetic cannabinoid, therefore the vaping service may be slightly more complicated.
Resolved: SQAC, received and **NOTED** the Health Inequalities Report

24/25/131 **Ward Accreditation Report**
NA advised that the Ward Accreditation Process had moved to align with the CQC framework, scoring and standards, which is helpful for wards to review the domains for strengths and developments.
NA expressed his disappointment that only 3 Ward Accreditations had taken place this year, and that the reasons outlined within the Ward Accreditation report should not have prevented Ward Accreditations taking place.
NA advised that he would update PB regarding the requirement for development of a Ward Accreditation Plan to ensure that all of the outstanding areas and departments all receive a Ward Accreditation assessment before the end of March 2025. NA advised that there would be an update to SQAC with findings from the Ward Accreditations.

Notwithstanding this year that the 3 Ward Accreditations undertaken this year had performed exceedingly well, with improvements at Ward level, particularly regarding leadership. There had also been some fundamental safety areas that required improvement.

KB requested whether the Ward Accreditation assessment report only contain information in the period, not the position of all assessments, as SQAC receive the Annual report which provides the full position.
NA confirmed that he would update PB regarding this request.
Resolved: SQAC received and **NOTED** the Ward Accreditation Report

24/25/132 **Quality Assurance Rounds Biannual Report**
LW presented the Quality Assurance Rounds (QAR) report for the period of 1st March – 31st August.
LW advised that in January 2024 that the Executive Team and Non-Executive Directors approved the transition to a hybrid QAR approach from April 2024. The Vision 2030 was also aligned to the Brilliant Basics new standardised QAR information pack.
KB stated that it would be helpful to receive a summary of any significant actions agreed at the QAR, LW confirmed that this would be included in future reports.
LW alluded to the Survey that is due to be issued and confirmed that it is only due to be issued to 11 services and to the Non-Executive Directors and Executive Directors, LW sought clarity whether this needed to be shared with any other colleagues.

FB stated it would be useful for Non-Executive Directors to receive the survey, FB stated that she didn't envisage anybody else would need to be included.
RP alluded to the successes, actions and learning through the Quality Assurance Rounds and queried whether this could be triangulated for inclusion within future reports to ensure that it is shared across the organisation and whether good/best practice could be replicated across the organisation.
FB advised that this is included within the actions. FB stated that she would like that this report to be shared with Executive Team and Non-Executive Directors who undertake the Quality Assurance Rounds to share the higher level summary with outcomes following the QARs to ensure all are aware of progress following those recommendations that are made.
FB alluded to a potential discussion with Non-Executive Directors regarding what the Non Executive Directors are getting out of the QARs and being more systematic highlighting good practice etc.

NA suggested a 1 page summary following each of the QAR detailing the successes, challenges and recommendations.
Resolved: NA and LW to agree offline regarding development of a brief QAR overview.
FB stated that after 3 or 4 months it would be helpful to receive an edited highlight report
Resolved SQAC received and **NOTED** the Quality Assurance Rounds Report

24/25/133 Research Quarterly Report

DH presented the Research Quarterly Report, which summaries the Research Divisional update presented to SQAC. DH provided an overview of pressures regarding staffing absence, the workforce model created had been good in flexing to ensure the continued safe delivery of research' the challenges regarding laboratory services; ongoing Work required within the Division to ensure that the investigators are able to access Research Standard Operating Procedures and ensuring there are methods of having data management aligned with the Trust.
FB requested whether SQAC had any questions or feedback regarding how the future report could be enhanced. No feedback or questions were raised.

FB stated that SQAC could see how the capacity is increasing and recognised the good range of studies moving forward. FB acknowledged the ambition within the Division and welcomed an enhanced report in the future.
Resolved: SQAC received and **NOTED** the Research Quarterly Report

24/25/134 Incident Reporting and Management Policy

FB advised that all policies had been significantly scrutinised at other meetings, prior to presenting to SQAC, the Policies had been shared 1 week in advance for review and that the policies would be discussed by exception only should colleagues have any questions. FB stated that this process would be implemented for all future policies received at SQAC.

PW advised in the monitoring section within the policy he is collaborating with JR to ensure that Key performance Indicators that are reported are both recordable within the system and also provide assurance. PW advised that he needs to understand the benchmark, with further scrutiny taking place.

LW stated that within the Incident Reporting and Management Report policy from pages 37-44 from Appendix 1 onwards the documentation refers to Duty of Candour Policy, which required amending to Incident Reporting & Management Policy.

FB stated that given the comments provided the scrutiny prior to presenting to SQAC is not yet at a level as expected.
Resolved: SQAC received, **NOTED** and Ratified the Incident Reporting and Management Policy, subject to the amendments outlined above.

24/25/135 RM47 - Duty of Candour Policy

Resolved: SQAC received, **NOTED** and Ratified RM47 - Duty of Candour Policy

24/25/136 C56 – Parental Nutrition (PN) Policy

LW requested a minor change within the footer of the policy documentation which stated December 2023, this required amending to reflect the depth of change.

KB advised that there are a number of Equality analysis which are missing. KB advised that the reference to ratification at CQSG in 2022 required attention.
Resolved: SQAC received, **NOTED** and Ratified C56 – Parental Nutrition (PN) Policy, subject to the above amendments.

24/25/137 Vaccine Cold Storage Policy – C53
Resolved: SQAC received, **NOTED** and Ratified the Vaccine Cold Storage Policy – C53.

24/25/138 C69 – Chaperone Policy
LC sought clarity whether there is a plan for communication to be provided to Children and Young people and families, to ensure that the children and young people feel empowered to request a chaperone or to decline a chaperone.
LC stated that the policy also needed to be provided in a Children and Young Peoples friendly language
Resolved: NA confirmed he would follow up offline with PB

RP alluded to training and what the chaperones should be trained to look for, and sought clarity whether this training is already available in the Trust or whether this is covered within the Safeguarding training. RP referred to escalation if an individual did have a concern, as this is likely to be HCA level and whether appropriate signposting or escalation may be helpful within the policy.
Resolved: Offline discussion to be held with NA&PB
Resolved: SQAC received, **NOTED** and Ratified C69 – Chaperone Policy, acknowledging the comments above, and the need for any further amendments.

24/25/139 Patient Safety Partner Policy
Resolved: SQAC received, **NOTED** and Ratified the Patient Safety Partner Policy

24/25/140 Any other business - None.

24/25/141 Review the key assurances and highlights to report to the Board.

- SQAC noted the Patient Safety Strategy update. SQAC agreed to receive a detailed update at the October SQAC meeting regarding antimicrobial resistance. SQAC also raised questions regarding NatSIPPs on which SQAC received clarification.
- SQAC received the ED monthly report, ED@ its best update. The positive update was welcomed: SQAC noted the positive statistics regarding time to triage and the overall waiting times. SQAC noted the challenges regarding Sepsis and delivery of antibiotics within 1 hour and sepsis training.
- SQAC noted the month-on-month variations in the paediatric assessment unit statistics with regards to the pathways for those patients, which would be interrogated further.
- SQAC received the Quarterly Infection Prevention Control Report. SQAC noted warning of national challenges regarding C difficile and a good discussion was held regarding healthcare acquired infections, with some suggestions regarding how to raise awareness.
- SQAC received the Safe Waiting List: Outcome of Validation work update, SQAC noted the good progress regarding understanding the data and capacity to address this issue. SQAC approved the governance and reporting arrangements which were proposed, with update to be shared with the Board of Directors.
- SQAC received the Board Assurance Framework with good discussion held. SQAC noted the shift with regards to the risk profile of risk 1.2 Access and identified a couple of developments with regards to risk 1.1.
- SQAC received the Mortality Report, with no significant concerns raised. SQAC would receive a future update regarding out of hospital cardiac arrests which are not unique to Alder Hey and is a potentially worrying national trend.
- SQAC received the first Gender Development Service quarterly report, with positive developments noted.
- SQAC received the Clinical Effectiveness & Outcomes Group Chair's Highlight Report which highlighted a couple of issues that required attention, particularly regarding one of the data sets which we are required to report on nationally and where the Trust requires a solution to be created to enable this.

- SQAC received the Liverpool Neonatal Partnership Integrated Governance Report. SQAC noted that the LNP Board meets regularly, and that K Byrne has joined the LNP Board. SQAC noted that there are challenges regarding recruitment to the Speech & Language Therapy position. Good discussion was held regarding how the PSIRF methodologies are making a difference to how incidents are being follow up.
- SQAC received the Divisional updates and noted the successes and challenges across the divisions.
- SQAC received the Health Inequalities Report, with good discussion held regarding the early success regarding being able to launch a vaccine catch-up Programme for some of our very vulnerable patients and also the proposed launch of the anti-vaping/do not vape service.
- SQAC received the Ward Accreditation Report – N Askew to address issues offline regarding the frequency and vigor of Ward Accreditation across the organisation.
- SQAC received the Quality Assurance Rounds Report. SQAC agreed it would be helpful to supplement this overview of Quality Assurance Round themes and outcomes with examples of good practice, and indications of agreed actions. F Beveridge to share the Quality Assurance Round Report with Non-Executive Directors.
- SQAC received the Research quarterly update which summarised the monthly divisional update and the longer-term overview of the Research Division. SQAC welcomed future Research Quarterly reports containing updates regarding developments and building up on capacity within research and a stronger focus on new studies within the Research Division and progressing with the Research Strategy.
- SQAC received and Ratified the Incident Reporting and Management Policy subject to any minor amendments.
- SQAC received and Ratified RM47 – Duty of Candour Policy subject to any minor amendments.
- SQAC received and Ratified C56 – Parental Nutrition (PN) Policy
- SQAC received and Ratified C53 – Vaccine Cold Storage Policy
- SQAC received and Ratified C69 – Chaperone Policy subject to any minor amendments

SQAC received and Ratified Patient Safety Partner Policy

23/24/148 **Date and Time of Next Meeting:** 23rd October 2024 at 9.30 – 11.30 am via Microsoft teams

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 7th November 2024

Paper Title:	People Plan highlight Report.
Report of:	Chief People Officer
Paper Prepared by:	Kathryn Allsopp, Associate Director of People

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

Does this relate to a risk? Yes ☑ No ☐

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

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

1. Executive Summary

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

2. Workforce Metrics

The monthly workforce metrics are provided in the Integrated Performance Report (IPR). As September workforce information was not available at the date of this writing this report, it is based on September 2024 workforce data.

Key highlights from the workforce metric data:

- **Sickness** - Sickness absence in September was **5.58%** and above Trust Target of 5%. Sickness absence continues to be driven largely by long term sickness absence at 3.33% (target: 3%), with 2.25% being Short Term sickness absence (target:2%). Divisional HR Business Partners continue to support divisions to ensure that there are action plans in place to support all staff absent from work due to sickness.

- **Turnover** - Turnover in September was **11.09%**, against a target of 10%. The position continues to be monitored, with regular reporting continuing. While turnover has seen significant improvement across the past 12 months, there has been a recent error in the IPR report which is being corrected.

- **Personal Development Reviews (PDR's)** - PDR completion has remained below 90%; there are specific concerns with B7+ PDR compliance which were due to be completed by 31st July 2024. PDR completion is being supported across the L&D and HR teams, with data regularly shared with managers for action.

- **Total Workforce WTE** - Total Workforce WTE (whole time equivalent) has become an increasingly prominent metric, both internally and externally. Total workforce includes bank and agency as an WTE, doctors in training working at the Trust, and all staff in post (including maternity leave). In September 2024 actual WTE was **4304**, against a plan of 4339. The plan reduces to 4307.2 WTE in October 2024.

  The workforce efficiencies programme is focused on workforce spend and potential efficiencies for 2024/25, alongside a review of controls and schemes to enable potential future savings (into 2025/26).

3. Staff Survey

The 2024 staff survey has now been circulated and closes on 29th November 2024. Information has also been shared highlighting actions taken because of previous survey feedback, and the importance of the feedback received. Response rates are shared weekly and continue to increase steadily, with **2103 of 4425 colleagues (48%)** having now completed their survey (of note, at the same period in 2023, the response rate was at 47%). The response rate is split out across the clinical divisions and corporate services as below:

Division	% Completed
Academy	68%
Alder Hey in the Park	50%
Capital	59%
Community & Mental Health	58%
Digital	56%
Executive	67%
Facilities	65%

Division	% Completed
Finance	84%
Human Resources	59%
Innovation	52%
Medicine	36%
Nursing & Quality	47%
Research & Development	59%
Strategy	64%
Surgical Care	42%

Marketing & Communications, Medical Services Directorate, Planning and Other all have less than 10 people and therefore aren't able to be reported at this level.

4. Agenda for Change Pay Award

The 5.5% pay award has been paid in October; the introduction of the 8a+ midpoint from 1st April 2024 is being paid in November (backdated). There has been no further update since Royal College of Nursing (RCN) members collectively voted to confirm that they believed this pay award to be sufficient. There are now no industrial action disputes across any professional group outside of GP practices.

5. Conclusion and Next Steps

- Continuation of Divisional HR support to identify appropriate interventions needed, to support thriving teams and improve workforce metrics.
- Focus on workforce spend and potential efficiencies for 2024/25 through the workforce efficiencies workstream.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday , 7th November 2024

Paper Title:	**Highlight report – Equality, Diversity, and Inclusion: NHS EDI Improvement Plan progress update**
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Angela Ditchfield, Head of Equality, Diversity, and Inclusion

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Background Papers and/or supporting information:	NHS England has set targets for Trusts that will support them to in turn provide better support to international staff, improve diversity in senior leadership positions and eliminate bullying, as part of its first equality, diversity, and inclusion (EDI) improvement plan. The plan, published in June 2023 comes as the health service workforce is more diverse now than at any point in its history. The complete document is not included in the paper, but can be found here: https://www.england.nhs.uk/wp-content/uploads/2023/06/B2044_NHS_EDI_WorkforcePlan.pdf The aim of the plan is to improve equality, diversity, and inclusion, and to enhance the sense of belonging for all NHS staff to improve their experience. The plan highlights six high impact actions to address the widely known intersectional impacts of discrimination and bias. **1)** Chief Executives, Chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable **2)** Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity **3)** Develop and implement an improvement plan to eliminate pay gaps

	4) Develop and implement an improvement plan to address health inequalities within the workforce 5) Implement a comprehensive induction, on-boarding, and development programme for internationally recruited staff 6) Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur Alder Hey's current position and planned actions (already underway) that link to these actions is included in the attached appendices. The report also provides an update on the EDI work carried out in September/October 2024 This report also presents the first Alder Hey Anti-Racist statement and the Board is asked to approve this statement. The value of an Anti-Racist Statement is that it sets out our commitment and determination to making Alder Hey a place in which everyone can thrive; it is call to action for all our people to identify, challenge and actively oppose racism, wherever and whenever it is encountered. The statement was written following two staff focus groups and has been co-developed with colleagues and the REACH staff network.
Action/Decision Required:	To note ■ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	
Associated risk (s)	BAF risk 2.3

1. Introduction

The purpose of this paper is to provide the Trust Board with an update on the progress we have made against the six HIAs set out in the NHS EDI Improvement Plan, planned action to support the delivery and further improvements and next steps. It will also provide an update on the key strategic and operational work undertaken, impacting the organisation in relation to Equality, Diversity, and Inclusion (ED&I) during September/October 2024.

2. Background

The Trust is fully committed to advancing equality, diversity, and inclusion. This aligns with our People Strategic priorities and Vision 20230. While progress has been made, we must do more to tackle discrimination, close inequality gaps, and create a true sense of inclusion, and belonging. Through collaboration, accountability, and a relentless focus on equity, we can build a Trust that is fair, compassionate, and welcoming to all. The NHS EDI Improvement Plan was published in June 2023 which sets out 6 high-impact targeted actions to address the prejudice and discrimination that exists through behaviour, policies, practices, and cultures across the whole NHS. These recommendations have been mapped against our existing equality activity to assess gaps and improve standards where we feel there are opportunities to do this**.**

3. Initial success in implementing the plan

The Trust has undertaken a range of activities to support the implementation of the NHS EDI Improvement Plan and the 6 High Impact Actions. We have planned actions which support further progress, see **Appendix 1** for a full summary of progress and planned actions.

High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

- All members of the Trust Board have SMART EDI objectives identified
- Board Assurance Framework updated and monitored
- All staff networks have an executive sponsor
- The Trust Board receive monthly EDI updates
- The Trust Board review the equality data WRES/WDES/GPG/NSS
- A recognised EDI award is part of the inclusive Staff Awards
- Trust Board supporting implementation of NW BAME Assembly Anti Racist Framework

High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

- Continued promotion of Reasonable Adjustment Policy
- We invest in widening participation opportunities to local communities aligning to the NHS Long-Term Plan, offering supported internships, Princes Trust,

NHS apprenticeships programme, graduate programme, employability programmes and work experience
- Launch EDI Plus online access programme that equips staff with information on promoting and supporting equality, diversity, and inclusion
- We are currently working with key stakeholders to review the recruitment processes aligning to the People Strategy, making them more accessible and inclusive
- Work has begun to explore the development of a specific Aspirant Leaders Programme for our ethnic diverse staff
- We have launched of a 'Management Essentials' training programme which focuses on inclusive leadership

High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps.

- We have a new flexible working policy
- We have commenced a Gender Pay Gap Self-Assessment developed by NHS Employers
- We have a well-established Menopause support group
- Currently have onsite childcare provision for staff
- Starting to report on the Ethnicity Pay Gap and currently reviewing the data

High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce.

- Newly established Physical Health and Wellbeing group who provide information, support, and resources to staff
- Several policies support our staff wellbeing whilst at work
- Launched Menopause Support Policy
- Held a 'Wellbeing Week' for staff to enjoy inclusion events, sharing food, yoga, massage
- We offer 'Strong Foundations' leadership training which is for all current and aspiring clinical and non-clinical leaders
- We have a Staff Advice and Liaison (SALs) service available to all staff and learners which is underpinned by the principles of person-centred compassionate care
- SALS PALS wellbeing champions across the trust offering compassionate support, help and guidance to colleagues
- We have several SALS PALS wellbeing champions offer compassionate support, help and guidance to colleagues
- Awarded Navajo LGBTQIA+ Charter Mark

High Impact Action 5: Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.

- We ensure that all internationally recruited staff have clear communications regarding their conditions of employment

- Our recruitment team support them with any queries and are involved in all aspects of the recruitment pathway
- We have developed a career pathway linking to professional development, training and interview support is core to the framework
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- We contact our individual recruits immediately providing them with access to our current recruits who coordinate on-line meetings before they arrive. We provide pastoral support to ensure as smooth a transition as possible and this includes setting up bank accounts, GP registration, Housing, access to local faith services, food shopping for when they arrive, a tour of the hospital and the city for awareness of local amenities. In house support networks such as SALS and mentorship from other international recruits.
- We hold regular meetings with our international nurses and AHPs and act on any feedback
- We have an International Nurses Forum chaired by an international nurse and they meet every month

High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

- We have committed to implement the NW BAME Assembly Anti-Racist Framework
- Bespoke EDI Training secured which will include culture, microaggressions, Anti-Racism etc
- We have signed up to support the Sexual safety in healthcare-organisational charter and we are committed to taking a zero-tolerance approach
- We are developing a new 'Safe and Respectful Behavioural Policy'
- Working in collaboration with Liverpool City Region Race Equality Hub to develop a regional Anti-Racist Toolkit
- Freedom to Speak Up policy and active Guardian who provides ongoing support to all staff, drop-in sessions, signposting, and resources supported by 12 FTSU champions working across the trust. The staff networks also work closely with the FTSU Guardian to support any staff with protected characteristics
- We have just developed an organisational Anti-Racist Statement organisational statement with a range of stakeholders and are awaiting executive approval
- We have established 4 staff networks who are actively making positive changes, supporting staff and the organisational objectives
- We have a Staff Advice and Liaison (SALs) service available to all staff and learners which is underpinned by the principles of person-centred compassionate care

The Trust has undertaken a wide range of activity to progress and implement the EDI Improvement Plan and further actions are planned to ensure we make progress against all six HIAs. See **Appendix** 1 for a full summary of progress and planned actions.

4. Staff Network update

Our staff networks continue to make positive changes to support the workforce, working to enhance the experiences of our staff working at Alder Hey'.

- Our LGBTQIA+ staff network chair Alexandria Bowman won the EDI Champion Staff Award. Alex won the award for her contribution to making our organisation an equal, diverse, and inclusive place to work. This is a great achievement and Alex is always working to support growing an inclusive culture. The network is working on a campaign to introduce personal pronouns to email signatures. They continue to work other regional network chairs to share good practice.
- ACE - Disabilities and Long-Term conditions staff network continue to provide support and guidance to the organisation, recently undertaking PLACE assessments and environmental walkabouts at Baird House and the Alder Centre. The group were recently joined by Sarah Robertson from the Organisational Development/Staff Advice Liaison Service who provided the network with a psychological safety information session. The chair of the network wrote a Blog which was shared with staff during ADHD awareness week. This was welcomed by staff and the network have seen membership grow due to the information Helen shared about her lived experience. They are currently working with communications to develop a proposal for 'Me and My…….' Campaign, sharing staff stories.
- Plans are now in place for Remembrance Day service which will take place on Monday 11th November in the Atrium 10:30am – 11:30am. We will be joined by the local armed forces cadets who will support the event. The staff network has developed a workplan which they are working towards implementing, this includes the developed of a policy to support Alder Hey veterans, Service Leavers, and Military spouse/partners. Some of our staff took part in the Poppy Walk in Sefton Park in October and have also
- The REACH staff network celebrated Black History Month throughout October with events that recognise and celebrate the invaluable contributions of our Black staff in the NHS. We held a Lunch & Learn session which introduced Liverpool's past with a film made by Bea Freeman showing Eric Scott Lynch giving one of his infamous tours of Liverpool, explaining the connection between the city and the international slave trade. We were also joined by Bea Freeman who was on hand to answer questions about the film. Some of our REACH staff network members shared their personal stories throughout the month. On Friday 25th October we had a celebration performance from Afro-Brazilian Samba. This was a vibrant and dynamic dance, deeply rooted in Afro-Brazilian culture, it was a wonderful way to engage children, visiting families, and staff all of whom took part. To end the month, we launched an Inclusive book club open to all staff which aims to create a more inclusive culture by building and enhancing relationships between staff, expanding knowledge and cross-cultural communication/thinking, providing time and space to learn about each other.

5. Liverpool City Region Race Equality Hub Operational Group

Alder Hey recently joined the newly formed Liverpool City Region Race Equality Hub Operational Network. The network has been created to provide a space for open and honest conversations for employers who are interested in increasing equality, Diversity, and Inclusion within their organisations. The network includes representation from several public sector organisations including the Police, Fire Service, as well as the NHS. It is a network to share best practice and work collaboratively to develop resources and initiatives that can support all organisations. Open discussions took place regarding the tragic Southport incident and subsequent riots and the support organisations put in place for their staff. It was evident that many felt uncertain about the support they had provided. We agreed that as a group we will work together to share best practice and collaborate to develop a regional Anti-Racism Tool Kit that will help provide organisations with tools to support staff. Our next meeting is scheduled for December 2024

6. Alder Hey's First Anti-Racism Statement and Commitment

The value of an Anti-Racist Statement is that it sets out our commitment and determination to making Alder Hey a place in which everyone can thrive; it is call to action for all our people to identify, challenge and actively oppose racism, wherever and whenever it is encountered. The Alder Hey statement (see **Appendix 2**) was written following two staff focus groups and has been co-developed with colleagues at all levels of the organisation and the REACH staff network. The final version was agreed after providing staff with opportunities to feedback and contribute to the development of the statement. The Anti-Racism statement and commitment provides a clear message of our intent to become and intentionally anti-racist organisation, supporting our pledge to embedding the high impact actions and implementing the NW BAME Assembly Anti-Racist Framework. An anti-racist statement will have a profound, positive impact on issues of equality, diversity, and inclusion at Alder Hey, contributing to healthy, safe, and effective cultures across all teams and services. The Trust Board is asked to approve the statement for immediate internal and external launch.

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

Appendix 1: Progress against HIA's

High Impact Action	Progress Status	Planned Activity	Key Measure	Success Metric
HIA 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	• All board members have SMART EDI objectives identified • Trust Board support to implement NW BAME Assembly Anti-Racist Framework • Trust Board regularly review equality data to understand the Trust position • Staff stories at Trust Board to facilitate understanding of lived experience • Co-produce of an organisational Anti-Racist statement to show organisational commitment to NW BAME Assembly Anti-Racist Framework • All staff networks have an executive sponsor	• Development of an EDI data dashboard to enable effective reporting against HIA success metrics and collection of EDI data to inform approach • Promote and encourage sharing of protected characteristics to support greater transparency of our diversity • Introduction of Reverse Mentoring Programme	• Every board and executive team member to have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process. • Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025). • The board to review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).	• Annual chair and chief executive appraisals on EDI objectives. Data gathered from Board Assurance Framework
HIA 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation	• Reasonable Adjustments policy in place and promoted • Work had begun to review accessible and inclusive practices which align with People Strategy	• Mandate EDI training for all recruiting managers • Explore more opportunities to widen participation amongst ethnic minority groups • Plan to apply for Disability Confident Leader status	• Year-on-year improvement in representation of senior leadership (Band 8C and above). • HEE National Education and Training Survey (NETS) improvement score metric on quality of training	• Increase in relative likelihood of staff being appointed from shortlisting across all posts. Data collected from WRES/WDES • Improved access to career progression,

and lack of diversity.	• Inclusive leadership is included in the recently launched 'Management Essentials Introduction to EDI' • Widening Participation providing opportunities to local communities, aligning to the NHS Long-Term Plan. Providing opportunities for supported internships, Princes Trust, NHS apprenticeship programmes and graduate management training schemes • Recently launched our EDI Plus online training which includes culture training • Building on the current talent management plan to improve diversity within leadership roles. Work has begun to explore the development of Aspirant Leaders Programme for BME staff	working in partnership with ACE Disability and Long-Term Conditions staff network • Create and implement a talent management plan to improve diversity at senior leadership level • Develop an Inclusive Panel Champions programme to support recruitment panels, training staff to identify any potential biases or discrimination during the interview process	• Increase in diversity in shortlisted candidates	training, and development opportunities. Data collected from NSS • Year-on-year improvement in race and disability representation leading to parity. Data collected from WRES/WDES
HIA3: Develop and implement an improvement plan to eliminate pay gaps.	• Undertaken Gender Pay Gap NHS Employers Self-Assessment	• Produce Ethnicity and Disability Pay Gap report • Develop an action plan based on the	• Implementation of the mend the gap review recommendations for medical staff and development of a plan to	• Year-on-year reductions in the gender, race and disability pay gaps. Data collected from all pay gap reporting

	• Promoting our new flexible working policy and all flexible working options available to our staff • We have completed a self-assessment checklist which was created by NHS Employers which highlights areas of focus • We are currently analysing the Ethnicity data in preparation for the Ethnicity Pay Gap Report • Staff Menopause support group is well established • Current onsite nursery provision for staff	recommendations from the Mend the Gap • Collaboration with key stakeholder groups, such as the staff networks, EDI steering group, and trade union representatives to identify initiatives that will support improving pay gaps	apply those recommendations to senior non-medical workforce (by March 2024). • Analysing of data to understand pay gaps by protected characteristic and put in place an improvement plan. To be tracked and monitored by the board. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. • Implementation of an effective flexible working policy including advertising flexible working options on recruitment campaigns:	
HIA 4: Develop and implement an improvement plan to address health inequalities within the workforce	• ACE Disabilities and Long-Term Conditions staff network support staff, providing information and guidance to managers and staff around reasonable adjustments • Newly established Physical Health and Wellbeing Group who provide information, support, and resources to staff	• Enhancing our approach to Equality Analysis within our workforce and communities • Continue to implement the action plan developed in collaboration with Navajo to enhance staff experiences • Explore the possibility of developing an inclusive holistic needs plan for staff to record their support needs	• Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the NHS health and wellbeing framework • Work in partnership with community organisations, facilitated by ICBs working with NHS Organisations and armed length bodies, such as the NHS Race and Health Observatory. For example, local education and	• Improvement in staff health and wellbeing. Data collected from NSS • Reduction in staff experiencing bullying, abuse, harassment. Data collected from NSS • Improvement in experiences of staff with disabilities and health conditions. Data collected from NSS • Reduction in absenteeism and staff

	• Several of our policies support our staff such as Launch of Menopause Policy • SALS service available to all staff and learners • SALS PALS wellbeing champions offer compassionate support, help and guidance to colleagues • Strong Foundations Leadership training developed for all current and aspiring clinical and non-clinical leaders • Line managers are provided with training to undertake effective wellbeing conversations with their teams • We have held Health and Wellbeing events across the Trust • Awarded Navajo LGBTQIA Charter Mark		voluntary sector partners can support social mobility and improve employment opportunities across healthcare (By April 2025)	turnover. Data collected from sickness and turnover report
HIA5: Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.	• International nurse recruits have very clear communication about their conditions of employment • The recruitment team support them with any queries and are involved in all aspects	• We are offering 20 places on the Florence Nightingale Foundation International Nurses programme • We are looking at developing a robust induction support	• Before they join, ensure international recruits receive clear communication, guidance, and support around their conditions of employment (By March 2024) • Create comprehensive on boarding programmes for	• Sense of belonging for internationally recruited staff. Data collected from NSS • Reduction in instances of bullying and harassment from team/line manager experienced by

	of the recruitment pathway • We have developed a career pathway linking to professional development, training and interview support is core to the framework • We contact our individual recruits immediately providing them with access to our current recruits who coordinate on-line meetings before they arrive. We provide pastoral support to ensure as smooth a transition as possible and this includes setting up bank accounts, GP registration, Housing, access to local faith services, food shopping for when they arrive, a tour of the hospital and the city for awareness of local amenities. In house support networks such as SALS and mentorship from other international recruits • We hold regular meetings with the international nurses	programme for international medical staff • We will introduce information and resources into the "Management Essentials EDI Introduction' for managers to ensure they are supporting their international staff • We are exploring our organisational data related to our international staff to enable us to understand career progression of our international staff and areas we need to concentrate to develop internationally educated leaders • We are developing a working group to design a bespoke leadership development programme that will identify career pathways for our international nurses & AHPs, incorporating leadership development and identifying opportunities for career progression	international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured from, for example, turnover, staff survey results and cohort feedback • Line managers and teams who welcome international recruits must maintain their cultural awareness to create an inclusive team culture that embeds psychological safety • Give international recruits access to the same development opportunities as the wider workforce	(internationally recruited staff). Data collected from NSS

	and AHPs and act on any feedback • We have created an International Nurses Forum chaired by internationals nurses • Launched online EDI Plus training which includes modules on culture			
HIA6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	• Committed to the NW BAME Assembly Anti-Racist Framework • Launched EDI Training which includes, culture, microaggressions etc • We have launched 'Management Essential Introduction to EDI' training which introduces inclusive leadership • We have signed up to support Sexual safety in the healthcare-organisational charter and we are committed to taking a zero-tolerance approach • We have developed a new 'Safe and Respectful Behaviour Policy' • F2SU policy and active guardian who provides ongoing support to all staff, drop-in sessions,	• Working towards NW BAME Assembly Anti-Racist Bronze Status • Launch of the 'Safe and Respectful Behavioural Policy' later this year with a communications • Develop tools to support staff when dealing with discrimination from patients • Work with LCR Race Equality Hub to develop a regional Anti-Racist Toolkit	• Review data by protected characteristics • Review disciplinary and employee relations processes • F2SU policy and active guardian who provides ongoing support to all staff, drop-in sessions, signposting, and resources supported by 12 F2SU champions creating an environment where staff feel that they can speak up and raise concerns • Joined Liverpool City Region Race Equality Hub Operational Group • Provide comprehensive psychological support for all individuals who report that they have been victim of bullying, harassment, discrimination, or violence • Ensure effective policies and processes are in place to support staff effective by	• Year-on-year reduction in discrimination, incidents of bullying and harassment. Data collected from Datix WRES/WDES • 6a. Improvement in staff survey results on bullying/harassment from line managers/teams (NHS Staff Survey) • 6b. Improvement in staff survey results on discrimination from line managers or teams (NHS Staff Survey) • 6c. NETS bullying and harassment score metric (NHS professional groups) •

	signposting, and resources supported by F2SU champions and staff networks • Joined Liverpool City Region Race Equality Hub Operational Group • We have 4 well established staff networks • SALS service available to all staff • We have co-produced an organisational Anti-Racism Statement		domestic violence and sexual violence (DASV)	

Appendix 2: Alder Hey Anti-Racism Statement and commitment

Alder Hey Children's NHS Foundation Trust stands firmly against all forms of racism, discrimination, and inequality. We recognise that racism persists in our society and within healthcare systems, impacting the lives and well-being of our colleagues, patients and their families. We are committed to actively challenging and working together to remove systemic barriers that perpetuate racism and inequity. We believe that every individual, regardless of race, ethnicity, or background, deserves compassionate, high-quality healthcare. We acknowledge the historical and ongoing injustices faced by people from different races, ethnicities and cultural heritages, and we pledge to work tirelessly to address these disparities within our organisation.

Together we will:

- Provide strong leadership from our Trust Board and Executive Team, with everyone working together to support Alder Hey to deliver the changes needed to become actively anti-racist.
- Ensure that inclusivity is central to everything we do, and that our behaviours reflect this and every voice is heard and valued. We will strengthen the voice of our REACH staff network, listening, learning and co-developing actions that will positively impact colleagues.
- Implement anti-racist policies and practices that promote equity and fairness in healthcare delivery. We will work towards effectively implementing the North West BAME Assembly Anti-Racist Framework and the NHS Patient and Carer Race Equality Framework which will support our ambition of becoming an intentionally anti-racist organisation.
- Provide learning opportunities and educate ourselves and our colleagues on the impacts of racism and unconscious bias in healthcare, striving for continuous learning and improvement.
- Advocate for equal opportunities within our workforce, ensuring that all staff have equitable access to opportunities for advancement and professional development. We will implement diverse and inclusive recruitment, succession planning and talent management strategies to strengthen diverse representation at all levels. We will work with the Leadership Faculty Team to develop leadership opportunities for specific staff groups providing and encouraging growth and progression.
- Support our REACH staff network in their positive culture change quality improvement initiatives: Providing an active, purposeful voice and space for the Race, Ethnicity and Cultural Heritage staff network to facilitate constructive challenge to our anti-racist programme of work and to provide a safe space for our colleagues to share ideas, discuss issues and support each other. Listen to the experiences and concerns of our staff from different races, ethnicities, and cultural heritages, patients, their families, taking meaningful action to address their needs.

We recognise that achieving true equity and anti-racism requires sustained effort and collaboration from all members of our community. Together, we are committed to creating a healthcare environment where everyone feels safe, valued and supported. This is not just about leaders recognising and understanding racism. It's about owning responsibility to be proactively anti-racist, both individually and collectively.

We will not achieve change overnight and may not get everything right. However, our commitment as individuals and as an organisation is to be pro-active and striving for change by acting, learning, and improving together.

BOARD OF DIRECTORS

Thursday, 7th November 2024

Paper Title:	**Armed Forces Network Annual Report**
Report of:	**Nathan Askew, Chief Nursing, AHP and Experience Officer**
Paper Prepared by:	Nicola Norris, Armed forces network Chair Peter White, CNIO and Clinical lead

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	As part of the VCHA on going assessment and assurance process the Armed Forces Network are required to provide an annual update to the Trust board. The update provides progress against each of the standards within the Veterans Aware requirements. This report shows good progress against the year one objectives and identifies areas for continued improvement moving into year 2, including widening training across the workforce. The report provides examples of increasing the visibility of the work of the forces within the Trust and through partnerships with local organisations. The next annual review is scheduled for April 2025 with our 3 year assessment planned for April 2026. The board are asked to note the contents of this report and progress of the Armed Forces Network, including achieving Gold status under the Defence Employment Recognition Scheme.
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 ☑

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

Veteran Aware – Year One Review Report (Appendix Two)

Name of organisation	Alder Hey Children's NHS Foundation Trust	
Date submitted to Regional Lead	02/05/2024	
Type of organisation	Specialist Children's Acute, Community and Mental Health Provider	
Region	North West	
Executive Lead – name and role	Nathan Askew, Chief Nurse.	
Name and role of Clinical Champion	Peter White, CNIO	Email address Peter.white@alderhey.nhs.uk
Name and role of Management Champion	Katie Jones, Head of Operational HR	Email address Katie.Jones@alderhey.nhs.uk
Additional Champion/s E.g. Core committee, functional appointments, Trust and/or department ambassadors (Link to Charter)	Nicola Norris – Armed Forces Network Chair Christine Green – Armed Forces Network Deputy Chair	Nicola.norris@alderhey.nhs.uk Christine.Green@alderhey.nhs.uk

Governance arrangements

Confirm governance arrangements and reporting mechanisms for the Veteran Aware work stream in your organisation.

The Trust has an Armed Forces Working Group and adheres to the ToR below.
The Group feed into the EDI Steering Group, reporting to the People and Wellbeing Committee and up to the Board.

VCHA-Working-group-Terms-of-Reference

Veterans accreditation steering

What annual reporting do you have in place for the Veteran Aware work stream? For example: Board level reporting/ Quality Account priorities/ reporting schedule

This is reported into our monthly EDI Steering Group, which reports into the People and Wellbeing Committee and up to the Board.

This short report is an opportunity for your organisation to provide a narrative summary of activities, achievements and challenges since your initial accreditation one year ago, and future aspirations.

The Armed Forces Community Staff Network work that has now been established for 12 months held a stand to promote and celebrate Armed Forces Day and for our staff, children, young people and families to come and learn about the Armed Forces.

This year the Trust recognised Remembrance day by working Merseyside Wing Royal Air Force Air Cadets to hold a service in the atrium.

Standard One – The organisation understands and is compliant with the Armed Forces Covenant

Under the Armed Forces Covenant the Trust has established an Armed Forces Network which developed a TOR's to ensure a network we are compliant.

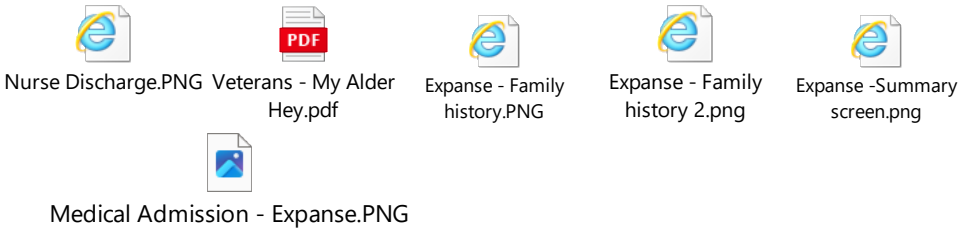
Standard Two – The organisation has a clearly designated veterans and armed forces Champion Dyad

Yes, we have an Armed Force Network with an appointment Chair and Deputy chair. Both Chair and Deputy chair undertook the Service Champion Armed Forces Network training.

Standard Three – The organisation identifies veterans and armed forces community patients to ensure they receive appropriate care

The Trusts EPR (Meditech) was upgraded in September 2023 with features including armed forces status ("Expanse – Family History 1 & 2"), with a specific section for documenting if parents/carers are from the armed forces community and what support via a Likes and Dislikes box ("Expanse – Summary screen") . Training was provided to all staff to highlight that this information could be recorded. The Family History field has a coded option for recording veteran status, which is clearly visible on the Summary screen. There is also the option to document in the Family History field within the medical documentation or the Nursing Discharge. A field is available in the PALS, Compliments and Complaints record since April 2023.

The Trusts Patient Access Policy is currently out for review and reference to the Armed Forces Covenant will be included.



Standard Four – Staff in the organisation are trained and educated in the needs of veterans and the armed forces community

NHS Healthcare for the Armed Forces has been completed by the Clinical Lead. Access to further training will be offered to the Staff Network and the wider workforce in the coming months (see below) and this sits within the Trusts Action Plan
NHS Healthcare for the Armed Forces – elearning for healthcare (e-lfh.org.uk)

Both Chair and Deputy chair undertook the Service Champion Armed Forces Network training.

Standard Five – The organisation has established links to appropriate nearby veterans and Armed Forces support services

The Trust have identified local organisations and hope to establish links with these this year, including:
Veterans HQ https://www.veteranshq.org.uk/support-us/sponsorship-partnerships/
Service leavers Liverpool https://www.serviceleaversliverpool.co.uk/
Royal British Legion – Huyton branch
Royal Air Force Association – Huyton & Roby with Liverpool Branch

Standard Six – The organisation will refer veterans /Armed Forces staff and patients to other services as Appropriate

The Trust has a SOP for any complex referrals (see below). In addition the QR poster below is displayed on Trust screensavers. The link below to the Trusts website will offer details of support/referral organisations.

https://alderhey.nhs.uk/parents-and-patients/other-information/veteran-aware-trust

SOP - Referring a patient to the complex

19-VCHA-Armed-For ces-Community-Supp

Standard Seven – The organisation raises awareness of veterans and armed forces community

As part of the Trusts awareness campaign, the external website and staff intranet will promote the Trusts commitment to being Veteran Aware (see below), including promotion of asking the question regarding armed forces status, signposting to support organisations and to ensuring RTT to those families moving location remains the same, ensuring no disadvantage.

Standard Eight – The organisation supports the UK Armed Forces as an employer

The Trust gained Defence Employment Recognition Scheme Gold in 2024 (Please see link to view ERS Gold award holders Defence Employer Recognition Scheme - GOV.UK).

The Trust have signed the Step into Health pledge – Awaiting a copy of certificate.

All candidates are asked whether they are a member of the armed forces community at application stage and this information is pulled through to TRAC (see below). This information can also be self or centrally recorded with the Electronic Staff Record.

The Trusts Special Leave Policy allows an additional 10 days paid leave for Reservists annual camp (see below).

The Trust has significant commitment to staff health and wellbeing, including a Staff Advice and Liaison Service of which the Deputy Chair is a staff member and is well placed to advise and signpost to external specialist providers.

Special Leave Policy - E14.docx

Step into Health Follow up Summary.n

Recruitment Process.docx

Upon completion of this form, please return it along with any supporting evidence to your Regional Lead

Internal Purposes Only – to be completed by Regional Lead
Date year one review form received from Trust: Click or tap to enter a date.
Date submission sent to steering group: Click or tap to enter a date.

BOARD OF DIRECTORS

Thursday, 7th November 2024

Paper Title:	**Chair's Report from the Audit & Risk Committee meeting on 10 October 2024**
Report of:	**ARC Chair**
Paper Prepared by:	ARC Chair

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☐ Regulation ☐
Action / Decision Required:	To note ☑ To approve ☐
Summary / supporting information	ARC minutes and papers from the meeting that took place on 10 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 ☑

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

Risk Number	Risk Description	Score

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

1. Introduction

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

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

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

- Presentation of risk management within Research & Innovation
- Update on the roll out of Risk Appetite and Tolerances
- Board Assurance Framework
- Update from the Risk Management Forum including the Corporate Risk Register
- Trust Risk Management Report
- Fraud risk assessment
- Quarterly reports on Data Protection Act and Freedom of Information Act delivery and compliance
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Anti-Fraud Services Progress Report
- External Audit Annual Report
- Update on Capital Improvement Action Plan
- Clinical Audit Mid-Year Progress Update
- Verbal update on Compliance with Procurement Act 2023
- Update on the action plans arising from effectiveness reviews of ARC, Internal Audit & External Audit
- Financial Governance Policy (for approval)
- Waiver Activity Report

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

None.

4. Positive highlights of note

As part of considering potential training needs for ARC members, a presentation from the Trust's Finance Team on CIP and budget management has been requested. This will be available to all NEDs.

Significant improvements in the delivery, oversight and reporting of the Clinical Audit Plan for nationally / regionally mandated audits and Trust priority audits in the last 18 months was recognised at the meeting. This was achieved due

to efforts of the Assistant Director of Nursing & Governance, supported by the Central Governance Team, and the introduction of the Clinical Outcomes & Effectiveness Group which is chaired by a clinician.

5. Issues for other committees

For information, the audits included with the 24/25 Internal Audit Plan have been shown in Appendix 1 which will be updated throughout the year as the audits complete. There is no formal reporting from ARC to assurance committees on specific audits; updates are generally provided by the report owner.

6. Recommendations

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

Appendix 1 – 2024/25 Internal Audit Plan

Audit	Assurance Outcome	May be of interest to…
Assurance Framework Opinion		Board
Risk Management Core Controls		Board
Data Security & Protection Toolkit	Substantial – veracity of self-assessment	FTPC
	Moderate – against Data Guardian Standards	
National Cost Collection	Substantial	FTPC
Fit & Proper Persons Requirement	Substantial	Board / CoG
Patient Safety Incident Response Framework (PSIRF)		SQAC
Safeguarding		SQAC
Equality, Diversity & Inclusiveness		People Committee
e-roster		SQAC
Workforce Planning		People Committee
Cyber Assessment Framework		FTPC
Clinical Governance		SQAC

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 20th June 2024**
Meeting Room 20, Alder Hey Children's Hospital

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Ms. E. Kirkpatrick	Assoc. Director of Finance - Commercial, Control and Assurance	(EK)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRO)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mr. D. Spiller	Senior Manager, Ernst & Young	(DS)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Item 24/25/42	Mrs. S. Owen	Deputy Chief People Officer	(SO)
Item 24/25/44	Mr. J. Kelly	Chair of Finance, Transformation & Performance Committee/Non-Executive Director	(JK)
Item 24/25/47	Ms. G. Owens	Principal Digital Risk Consultant, MIAA	(GO)
Apologies:	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)

24/25/38 Introductions and Apologies

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

24/25/39 Declarations of Interest

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

24/25/40 Minutes from the Meeting held on 18th April 2024
Resolved:
The minutes from the meeting held on the 18th of April were agreed as an accurate record of the meeting.

24/25/41 Matters Arising and Action Log

Matters Arising

Action Log

Action 22/23/81.2: *Post Project Assessments/Benefits Realisation Exercises on Projects*

(Conduct a post project assessment/benefits realisation exercise on the new Sunflower and Catkin buildings during Q4 2022/23 or Q1 2023/24 using the developed process. MIAA to review implementation of the assessment and report to the Audit and Risk Committee (ARC) as to whether the recommendation can be closed) – MIAA have reviewed the implementation and it was confirmed that following occupation, the Trust completed a lessons learned exercise, from a construction, clinical and operational aspect on the Catkin and Sunflower buildings. The Trust has also worked with MJM Medical recently to complete the relevant stages of the post project evaluation. **ACTION CLOSED**

Action 23/24/04.2: *MIAA Follow-up Report (Include the outcome of the IT Assets Hardware follow up review conducted by MIAA in October's Follow-up Report)* – An update was circulated outside of June's meeting. **ACTION TO REMAIN OPEN**

Action 23/24/54.2: *Corporate Report (Create four to five codes for longstanding risks to provide rationale as to why a risk is still outstanding)* – Work is ongoing in readiness for the next reporting period. An update will be provided in July. **ACTION TO REMAIN OPEN**

Action 23/24/59.1: *Non-Clinical Claims Report, 2022/23 (Convert previous data into graphs and include this detail in the 2023/24 Non-Clinical Claims Annual Report)* – This report has been deferred to July 2024. **ACTION TO REMAIN OPEN**

Action 23/24/80.1: *External Audit - Additional Fee Proposal (Submit a report to the Council of Governors to advise of the additional fee, once approved)* – The Council of Governors received a report on the additional fee proposal during June's Council of Governors meeting. **ACTION CLOSED**

Action 23/24/97.1: *Risk Tolerance and Appetite (Meetings to be widened to develop a risk appetite and tolerances for advocacy and JG to be invited)* – This item has been included on July's agenda. **ACTION TO REMAIN OPEM**

Action 23/24/103.1: *Internal Audit Follow Up Report (Payroll Review - Further detail on the actions that have taken place to date to implement the recommendations and the forward plan is required before the Committee can approve the extension to September)* – This action has been superseded by MIAA's follow up of these recommendations which confirmed implementation. **ACTION CLOSED**

Action 23/24/05.1: *NHS Employment Check Standard Audit (Arrange for a proactive piece of work to be undertaken by managers to validate and confirm, for the 10% of staff for which we don't hold a reference, if any performance or other concerns have been raised during their employment. Provide an update to ARC in June)* – This action was addressed via a report that was submitted to the Committee in June. **ACTION CLOSED**

Action 23/24/05.2: *NHS Employment Check (Acquire management assessments for individual members of staff who are unable to provide proof of qualifications. Provide an update to ARC in June)* – This action was addressed via a report that was submitted to the Committee in June. **ACTION CLOSED**

Action 24/25/11.1: Review of Internal Audit Effectiveness (Update the Internal Audit Effectiveness Review action plan with IA's responses and submit it to ARC in June for further discussion) – MIAA have provided a response and an updated action plan is included on the agenda. **ACTION CLOSED**

Action 24/25/14.1: *Internal Audit Plan (Split out the days in the IA Plan to distinguish between follow-up and contingency)* – This action has been addressed. **ACTION CLOSED**

Action 24/25/14.2: *Internal Audit Plan, 2024/25 (Meeting to take place to discuss the Terms of Reference for the e-rostering audit/expenditure control audit and to agree the number of days that need to be set aside. An update will be provided via e-mail so that the agreed days can be formally approved)* – MIAA met with the Deputy Director of Finance in May which resulted in Terms of Reference being drafted and the days agreed were approved by the Committee. **ACTION CLOSED**

Action 24/25/14.3: *Internal Audit Plan (Discuss the approach for audit of Clinical Governance (Internal Audit and/or Clinical Audit)* – A meeting took place in May 2024 with the Chair of ARC, MIAA and the Associate Director of Nursing and Governance to discuss the approach for the Clinical Governance audit. A further meeting is to be scheduled to further this discussion. **ACTION TO REMAIN OPEN**

Action 24/25/15.1: *Internal Audit Charter (Advise regarding the IA Strategy that is mentioned in the IA Charter)* – The 'Strategy' referred to in the Charter is an over-arching term and is a combination of the Internal Audit Plan (including a 3 year rolling plan), a supporting Risk Assessment, the Head of Internal Audit Opinion and the Charter. **ACTION CLOSED**

Action 24/25/21.1: *External Audit Planning Report for Y/E 31.3.24 (Discussion to take place once E&Y have reviewed the KPMG model in order to determine the amount of work that will be involved in the IFRS16 assessment and the additional audit fee required)* – A meeting is to be scheduled between E&Y and the Director of Finance and Development.
ACTION TO REMAIN OPEN

Action 24/25/23.1: *Annual Assurance Report – EPRR (Look at whether the data in the 2023/24 Annual EPRR Assurance Report can be framed in a different way to make the report more meaningful from an assurance perspective when it is presented to the Board in May 2024)* – This action has been addressed. **ACTION CLOSED**

Action 24/25/24.1: *Annual Assurance Report 2023/24 and Forward Plan for 2024/25 - Project Assurance (Jo Revill to send an e-mail to Natalie Palin and Kerry Byrne to confirm her approval of Appendix 1 that is included in the 2023/24 Annual Project Assurance Report)* – Jo Revill confirmed her approval of Appendix 1 in the 2023/24 Annual Project Assurance Report. **ACTION CLOSED**

Action 24/25/25.1: *InPhase – Lessons Learnt (Circulate the current status of the various modules and the forward plan for 2024/25)* – A report is to be submitted to the Committee in July 2024. **ACTION TO REMAIN OPEN**

Action 24/25/32.1: *Anti-Fraud, Bribery and Corruption Policy (ARC Chair to advise EK of the amendments to the policy) – This action has been addressed.* **ACTION CLOSED**

24/25/42 NHS Employment Check Standard Audit

The Committee was provided with an additional update of the Pre-employment Checks Audit, specifically relating to residual risks on qualification checks and references. The following key points were highlighted:

- At the beginning of the exercise the Trust was reporting 44% compliance in respect to employment checks relating to qualifications. Compliance increased to 86% in March 2024, but it was agreed to circulate a proforma to managers asking them to confirm that employees hold the relevant qualification and/or equivalent experience to undertake their role. As a result of this action, 401 further data points have been added to ESR records and compliance against this check is currently at 97%. It was confirmed that the team will continue to address the outstanding 3% but it was felt that organisation's level of risk has reduced considerably following the completion of this exercise.
- The Trust also originally reported 49% compliance in respect to employment checks relating to references. Compliance has since increased to 90%. The Committee was advised that since March 2024 over 450 proformas have been issued to managers requesting confirmation that they have no concerns relating to this employment check. This has enabled a further 331 data points to be added to ESR records and compliance against this check is currently at 97%.
- The Committee was advised that there are 3% of colleagues who have no recorded references; 91% of those have been employed for longer than 3 years and 75% of whom have been employed by the Trust for more than 10 years. NHS pre-employment checks standards require references to be sought covering a minimum of 3 years from the current employer, thus the current employment covers this.
- In terms of future assurance, it is felt that the Trust has enough measures in place including new systems, an increased resource within the Recruitment and Employment Services Team which has provided enhanced organisation assurance on current pre-employment recruitment practices. It has also been proposed that an annual audit on pre-employment checks be undertaken to ensure ongoing and future checks remain compliant against the standards.

It was queried as to whether there has been any improvement in the employment checks that hadn't quite achieved full compliance, as per the previous update. It was confirmed that progress is continuing to be made in all areas, with ID and right to work checks verging on 100% compliance. Professional registration is at 100% compliance and an update on DBS checks are being shared with the People and Wellbeing Committee.

The Chair pointed out that the audit hasn't raised any issues and has provided assurance. It was suggested that a deep dive on pre-employment checks take place in six-month's time via the Risk Management Forum.

24/25/42.1 Action: ES/SO

Resolved:
The Audit and Risk Committee (ARC) noted the update relating to the NHS Pre-employment Checks Audit.

24/25/43 Update on the Risk Appetite and Tolerances

Committee members were advised that a report is to be submitted to ARC in July to provide an overview of the definitive position across the main Assurance Committees. A meeting is scheduled to take place on the 24.6.24 with Non-Executive Directors who sit on the Finance, Transformation & Performance Committee as a follow on from the working group session that took place to discuss risk appetite and tolerance.

The outcome of the People and Wellbeing Committee working group was very productive and a number of actions were agreed from an EDI perspective which led to a discussion taking place with the lead NED for Equality, Diversity and Inclusion (EDI), Garth Dallas.

In terms of the Safety and Quality Assurance Committee (SQAC) there is to be a focus on a number of areas, for example, the Trust has been working with the Divisions to test out the application of risk tolerances across the two differentials of quality and safety with the aim to split them accordingly.

It was confirmed that discussions are ongoing in relation to the Futures Committee and the risks that appertain to research and innovation. It was agreed that a meeting would take place arranged for KB, ES, JRO, Adam Bateman, John Chester and Shalni Aurora to further the discussion.

24/25/43.1 Action: ES/KMC

The Chair queried as to whether there should be a risk appetite/tolerance for advocacy. It was reported that a wider conversation is going to take place about which Assurance Committee the overarching 2030 strategy programmes should be aligned to. The Trust is also looking at resetting the 2030 governance principles for its Assurance Committees therefore it was felt that advocacy could be addressed via this route.

Resolved:
ARC noted the verbal update provided on risk appetite and tolerances.

24/25/44 Ernst and Young (E&Y) External Audit Year End Report on the Trust's Accounts for 2023/24

The Committee received the External Audit Results Report for year ended the 31st of March 2024. Apologies were offered to the Committee for the late submission of the report. It was confirmed that the audit is on the verge of completion but there is an area that the auditors are reviewing in relation to accounting for capital expenditure.

It was noted the following changes had been agreed as part of the audit process;

- Materiality updated to £8.21m based on a percentage of operating expenditure
- Update to exit package and pay multiple note, following audit review, in line with best practice/guidance received

Outstanding Matters (Appendix B) – It was reported that the majority of the items relating to the completion of the audit procedures, as detailed in Appendix B, have either been addressed or are in the process of being finalised.

It was also noted that the following areas were still outstanding in terms of audit completion;

- **IFRS 16 PFI Implementation**: E&Y are currently awaiting for a report from the specialist it has engaged, who has queries outstanding with management relating to an error from the previous financial year.
- **Capital additions** –Reference was made to page 11 of the report (*inappropriate capitalisation of expenditure)*. E&Y are questioning cases of capital expenditure that were recognised as additions in 23/24, querying the timing of recognising the capital additions. Discussions are ongoing with management in this regard and extending audit testing may be required.

Of the sample selected for capital additions testing;

- Management have identified £1.4m of capital expenditure that they believe has been incorrectly capitalised before the 31.3.24 and are proposing to amend.
- E&Y have identified £3.6m of expenditure where there is a difference of opinion between the Trust and E&Y over accounting treatment, which is likely to remain as an unadjusted difference. The Committee was advised that this matter relates to the evidence of valuation on capital assets for construction schemes. It was reported that the Trust made a payment to the PFI for a contract variation for a scheme that is underway but not yet completed, therefore from an accounting perspective the Trust treated this as a purchase as the PFI is not an asset. Alder Hey committed to this liability as a contractual liability and felt this should be capitalised. E&Y determined this should be a pre-payment. Alder Hey noted they were not proposing to adjust for this difference, as it is a difference of opinion on accounting treatment, and it purely moves the balance
- It was noted the remaining balances in query were subject to further discussion and an update would be circulated following conclusion of queries raised with regards to any further adjustments required. The main additional items under discussion were;
    - £2.8m that relates to the Gender Service scheme building and the Police building scheme which are due to be completed week commencing the 24.6.24.

In terms of the work that has taken place to review capital expenditure, E&Y have concluded that the arrangements that have been reported throughout the year are satisfactory and will not impact the VFM, although commentary may be included on the control points.

- **Patient care activity income** – it was noted that a query had been raised around the classification of patient care income. The Trust were reviewing whether to update the accounts for this difference, but noted it would have no impact on the results reported

  Plant and Equipment (PPE)Presentation and Disclosure*:* Procedures continue in this area therefore an update will be provided upon conclusion.

- ***Value for Money (VFM)*** – E&Y have completed their planned VFM procedures and have no matters to report by exception in the auditor's report. E&Y plan to issue the VFM commentary by the end of July as part of issuing the Auditor's Annual Report.

Annual Report and Annual Governance Statement – E&Y have reviewed the Annual Governance Statement and can confirm it is consistent with other information that they were aware of from its audit of the financial statements. It was confirmed that there are no other matters to report. E&Y confirmed that there aren't any wider reporting issues noted that will lead to the consideration of exercising wider powers in the public interest.

As part of the work on capital additions it was noted that improvements need to be made in terms of valuation techniques. The Chair felt that given the challenges that have been experienced the Committee will require formal assurance that there are plans in place to strengthen building valuations, taking into account the complexity of the capital programme and the present NHS funding regime. It was reported that sub groups have been established, the Finance, Transformation and Performance Committee has capital as a standalone risk and therefore has a greater line of sight, and work is taking place to strengthen the teams' knowledge of this specialist area.

The Chair referred to the two high rated observations that relate to capitalised payroll and capital expenditure and asked for a formal response to be submitted to the Committee in the next three months which includes a recommendation to address each observation.

24/25/44.1 Action: RL/EK

A discussion on risk took place in light of the audit queries raised and it was felt that it is important that the Trust endeavours to address the issues relating to capital ahead of next year (2024/25). It was pointed out that organisation should take the opportunity to reflect and look at the support that the Finance Team requires to address such complexity. It was also suggested having earlier debate on capital opportunities when they arise in order to understand the detail and particularly to understand the potential accounting impacts as well as the commercial benefits so that similar challenges as outlined above are not experienced at future year ends

The Chair referred to introducing a proactive approach to assessing capital opportunities and felt that it would beneficial to set some criteria based on previous ones, for example, the point that the Executive can accept capital opportunities and when Assurance Committee approval is required.

24/25/44.2 Action: RL

John Kelly pointed out that capital is a key risk for the Finance, Transformation and Performance Committee (FTPC) and one of the areas that hasn't been addressed to date is timing. It was confirmed that action will take place to include timing as part of the risk and oversight for capital.

24/25/44.3 Action: RL

The Committee was advised that a lot of work is taking place via a follow-up investment review and it was felt that it would be beneficial for the FTPC to receive the detail relating to the outcome of this work.

24/25/44.4 Action: RL

Letter of Representations

Resolved:

The Letter of Representations was not submitted to the Committee as the audit has not been concluded as of the 20.6.24.

Trust's Annual Report and Accounts - 2023/24

The Committee received the Trust's Annual Report for 2023/24 which was prepared in accordance with the NHS Foundation Trust Annual Reporting Manual, and the Annual Accounts for the same period. An overview of both reports was provided to the Committee. The Chair thanked all those involved in compiling the reports and circulating them in a timely manner ahead of the meeting.

The Chair felt that the Annual Report was outstanding and drew specific attention to the sections relating to the organisation's Volunteers, the Academy and the Charity. It was queried as to whether the KPI for Play has been removed from the Integrated Performance Report. The Committee was advised that the Experience workstream is reframing some of the Play metrics therefore this may be a product of the transition.

Reference was made to the Medical Director's pension related benefit detailed in the Remuneration Report and it was queried as to whether the Trust has explained this in a way

that makes it understandable for the reader. A discussion ensued and it was agreed that the figures in the table won't change from a compliance perspective but further work will take place in association with NHS Pensions to see if there is alternative way in which to present this information to provide further clarity/clearer narrative.

24/25/44.5 Action: RL

Resolved:
ARC received and approved the Annual Report and Accounts for 2023/24.

Understanding how the Audit and Risk Committee Gains Assurance from Management

The Committee received a copy of the response letter that was sent to E&Y in this regard. It was reported that information is compiled as part of the audit process to provide E&Y with an overview of the risk assessment of fraud/error on the accounts and how the Trust manages risk generally.

Resolved:
ARC noted the Chair's letter to E&Y that provided an understanding of how the Committee gain assurance from management.

24/25/45 Final Head of Internal Audit Opinion, 2023/24

The Committee received the final Head of Internal Audit Opinion for 2023/24. The overall opinion for the period from the 1.4.23 to the 31.3.24 provides Substantial Assurance that "*there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently*".

It was confirmed that there have been no changes to the Opinion since it was last submitted in its draft format in April. Detail will be provided via the Progress Report in terms of one audit which has been updated.

Resolved:
ARC received and noted the content of the Head of Internal Audit Opinion for 2023/24.

24/25/46 Response to the Internal Audit Effectiveness Review

An in-depth discussion took place on the 19.6.24 regarding MIAA's response to the recommendations made following a review of Internal Audit's effectiveness. It has been agreed to slightly amend the responses and include the updated action plan in the report that provides detail on the progress that is being made against actions arising from the ARC self-assessment, and effectiveness reviews of Internal and External Audit.

The Chair asked that a meeting be scheduled in September to address the recommendations in the action plan appertaining to ARC/Execs.

24/25/46.1 Action: KMC on behalf of KB/ES/RL

Resolved:
ARC noted MIAA's response to the Internal Audit Effectiveness Review.

24/25/47 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on

the progress that has been made during the period
from April 2024 to June 2024. The following points were highlighted:

- Two reviews have been finalised in this reporting period;
  - Cyber Assessment Framework (CAF) – Substantial Assurance (2023/24 review). The objective was to complete a baseline/gap analysis review of current Trust controls and processes against two of the Principles of the CAF; (C) - detecting cyber security and (D) - minimising the impact of cyber security incidents events. It was reported that there were four recommendations made (*two medium risks and two low risks*) in respect to Principle C of which management have provided a comprehensive response to.

    A response was provided to a query that was raised by the Chair regarding the scope of category C versus category D. The Committee was advised that there isn't a requirement for the Trust to report externally on the CAF but it is felt that it is good practice to conduct a review.

  - Data Security Protection Toolkit (DSPT) – Substantial Assurance (2023/24 review) (Veracity of self-assessment) and Moderate Assurance (National Data Guardian Standards). It was reported that the Trust achieved an overall risk classification of 'Substantial' assurance in the veracity of the Trust's self-assessment and 'Moderate' assurance in the National Data Guardian Standards using the NHS England defined approach to assessment of the in-scope assertions. Of the 10 National Data Guardian Standards nine were substantial, with Accountable Suppliers being moderate assurance hence the overall moderate assurance level for the National Data Guardian Standards.

    The Chair pointed out that the Committee doesn't receive the results of the DSPT review as it would publish the organisation's weaknesses to the wider world. Taking this into account, it has been agreed that MIAA will circulate details of any issues that arose as a result of the review, via e-mail to enable Committee members to make an informed decision as to whether follow up or further assurance is required.

24/25/47.1 **Action: KS**

Reference was made to the amount of sensitive topics that the Committee has discussed during the last twelve months and it was felt that going forward an approach needs to be agreed for these items in terms how and when the Committee addresses them.

24/25/47.2 **Action: KB/ES**

- The Fit and Proper Persons (2024/25 review) fieldwork is currently in progress.

The Committee's attention was drawn to the Internal Audit Plan for 2024/25 and the agreement that had been made on a previous occasion to incorporate an additional 35 days in the plan. It was confirmed that two thirds of the additional days will be set aside to undertake a review on ICB Expenditure Control and e-rostering which will leave a slot for another review. A conversation took place about the benefits of conducting a review on risk management, which it was reported may take place as part of an external advisory piece, and workforce planning. Following discussion, it was agreed that a workforce planning review should be conducted in 2024 and a risk management review be undertaken in early 2025.

It was pointed out that an element of the ICB Expenditure Control review will address workforce controls and pay, therefore it was felt that it would be beneficial to have a conversation outside of the meeting about the scope of this review.

24/25/47.3 Action: KS/RL/MS

A discussion took place about bringing the two pieces of work together, and given the financial rules around the management of the budget in the NHS it was felt that it would also be useful to determine the Trust's optimal, adequate and minimal staffing levels and attitude to risk in order to have a proactive response to workforce as a whole going forward.

The Chair acknowledged the element of workforce planning that relates to the 2030 Strategy and the skills that will be required in terms of the future workforce. The Chair asked that the Chief People Officer, Melissa Swindell, be made aware of the forthcoming workforce review as soon as possible.

24/25/47.3 Action: ES

Reference was made to the of the national review and update of Internal Audit Standards and it was confirmed that there was nothing contentious to report to date. A briefing paper will be submitted to the Committee once this area of work has been finalised.

24/25/47.4 Action: KS

Resolved:
ARC noted the content of the Internal Audit Progress Report.

24/25/48 Internal Audit Follow Up Report

The Committee received an update on the latest position regarding the most recent phase of follow-ups and the progress that has been made between April and June 2024. The following points were highlighted:

- Of the 15 recommendations which have fallen due in this reporting period, 12 have been confirmed as implemented, and recommendations relating to the Safety Standards for Invasive Procedures, EPRR and On Call Payments reviews remain partially implemented with approvals requested from ARC for extensions.

A discussion took place about the partially implemented recommendations and the requests for an extension relating to On Call Payments and EPRR, which the Committee approved due to extenuating factors. In terms of the request for an extension relating to Safety Standards for Invasive Procedures it was felt that further information is required to understand the reasons for the significant length of the extension requested and to determine whether anything can be done in the meantime to reduce the risk. The Chair agreed to write to the Medical Director, Alfie Bass, to request further details. It was confirmed that the Committee will revisit this matter during July's meeting.

Post meeting update: KB sought the view of MIAA in relation to the mitigations in place in the meantime which MIAA confirmed were reasonable. Committee Members then agreed to the extension by email with the requirement that MIAA check in with the recommendation owner to confirm that progress remains on track.

The Chair raised a number of questions that MIAA agreed to respond to outside of the meeting; **1.** Has the three-hour training course in EPRR been reviewed? **2.** Confirm the

amount of sample testing that has been undertaken in payroll. **3**. Confirm that the practice of saving documents on local drives has now ceased.

24/25/48.2 Action: KS

Post meeting note: KS confirmed that 1, the three-hour EPPR course was reviewed, 2. 10 leavers and 10 payroll changes were sampled and 3. the practice of saving to local drives has ceased.

Resolved:
ARC received and noted the content of the Internal Audit Follow Up Report.

24/25/49 Clinical Audit Annual Report for 2023/24

The Committee received the Clinical Audit Annual Report for the period from the 1st of April 2023 to the 31st March 2024. Attention was drawn to the following key points:

- The Trust was unable to provide a full submission of data sets for three national audits. One incomplete submission was as a result of a cyber-attack which was experienced nationally which prevented submission of data, and two were due to a lack of capacity within teams. The Trust has undertaken a piece of benchmarking work to look at outstanding audits and it is apparent that the data collection points are becoming larger and more complicated which is having an impact.
- Following a review of clinical audit approval and oversight processes for clinical audit meetings across all clinical divisions a proposal for the formation of a Clinical Effectiveness and Outcomes Group (CEOG) was agreed by SQAC in March 2023 and came into effect in August 2023. There are a number of arenas where the organisation shares the outputs but this tends to be done in silos therefore work will be conducted over the next twelve months to address this issue.
- *Clinical Audit Training* - A clinical audit awareness session was held on the 23.10.23 during Allied Health Professionals' Day, and the Trust is holding its first ever Audit Master Class on the 24.6.24 with a wide range of delegates attending.
- The Governance Team has increased its collaborative and oversight work with the Divisions, are focussing on streamlining the re-audit (follow up) process, registering appropriate audits, and generally being proactive. Weekly and monthly internal meetings are taking place and the Team will continue to work with the Divisions to hold them to account, whilst focussing on the quality improvement aspect that comes from audits via the Brilliant Basics lens.
- *Activity in 2023/24* – The Trust submitted a compliant submission of 83% for National Clinical Audits and 83% for National Confidential Enquiries, which it was eligible to participate in during the 1.4.23 and the 31.3.24.
- *Trust Priority Audits* – There were thirteen Trust Priority Audits on the Audit Plan for 2023/24 of which four audits were included due to NHS Quality Contract requirements. It is recognised that the organisation is undertaking a number of audits which are specifically requested by various services/departments therefore work is taking place to ensure these audits are included in the Audit Plan for 2024/25.

The Chair felt that there has been a huge step change in clinical audit during the last eighteen months and drew attention to the importance of ensuring the Trust is compliant with audits in 2024/25. It was pointed out that the next key piece is to provide assurance of embedded learning.

The Chair advised that a model is to be implemented that will enable the Divisions and CEOG to monitor and approve Divisional Audits, therefore ARC will only receive an update on specific findings that require the Committee's attention. The Chair acknowledged the work that has been undertaken by the Associate Director of Nursing and Governance and the Governance Team to help the Trust achieve its current position.

A number of questions were raised and responded to about **1.** How do audits help the Trust meet the needs of children and young people? **2.** How do you ensure that audits undertaken are beneficial to the organisation? **3.** Does the audit process provide data/assurance in terms of how the Trust is working as a system?

The Chair referred to the questions raised and pointed out that this is the next stage of the process for the Trust.

Resolved:
ARC received and approved the Clinical Audit Annual Report for 2023/24

24/25/50 **Third Party Assurance – ELFS Payroll Service**
Resolved:
This item has been deferred to July's meeting as further detail is required in the report cover sheet.

24/25/51 **Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 - Non-Clinical Claims Assurance Report.**
Resolved:
This item has been deferred to July's meeting as the report was not available.

24/25/52 **Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 - Clinical Claims Assurance Report.**
Resolved:
This item has been deferred to July's meeting due to the extensive agenda.

24/25/53 **Audit and Risk Committee Annual Report for 2023/24**
Resolved:
The Committee received and approved the Audit and Risk Committee Annual Report for 2023/24.

24/25/54 **Committee Annual Reports for 2023/24**

The Audit and Risk Committee received and approved the 2023/24 Annual Reports for the:

- Resources and Business Development Committee (now Finance, Transformation and Performance Committee).
- Safety and Quality Assurance Committee.
- People and Wellbeing Committee (now People Committee).
- Research and Innovation Committee (now Futures Committee).

The Chair pointed out that there were a number of principal devolutions in the first section of the People and Wellbeing Committee Annual Report and it was queried as to whether a bullet point relating to workforce planning should be included too. It was agreed to look into this matter.

24/25/54.1 Action: JP

Received and approved.
ARC received and approved the Assurance Committee Annual Reports for 2023/24.

24/25/55 Waiver Activity Report; Q3/Q4.

The Committee received the tender and quotation waivers report for Q3&Q4 2023/24. It was pointed out that the new format of the report has flagged a high number of retrospective purchase orders therefore work is being undertaken with the Procurement Team to try and resolve this issue. The Trust has also requested detail on the average waiver for other trusts across Health Procurement Liverpool (HPL) for benchmarking purposes. The Chair felt that it would be useful to benchmark retrospective purchase orders too.

It was reported that Alder Hey is going to conduct a retrospective look of purchase orders jointly with HPL. The Trust also receives a data set of retrospective orders which is circulated with management accounts information and addressed via Divisional performance sessions when particular trends occur. The Chair felt that it would be helpful to understand the key findings of the joint work with HPL especially in terms of the large amount of waivers that are generated.

24/25/55.1 Action: RL

The Chair asked that a description of the key controls be included in the covering paper for the Waiver Activity Report going forward.

24/25/55.2 Action: RJ/EK

Resolved:
ARC received the Waiver Activity Report for Q3 and Q4, 2023/24.

24/25/56 Update on progress against actions from the Audit and Risk Committee Self-Assessment

The Committee was provided with an update on the current state of the actions from the ARC self-assessment. It was reported that information relating to the Internal and External Audit Effectiveness Exercise has been included in the report. From a timetable perspective a review of the Anti-Fraud Service has been scheduled for 2024 and an update on the outcome will be shared with the Committee during October's meeting. A full assessment of ARC will take place between January and April 2025.

Resolved:
The Committee noted the satisfactory progress that has been made in implementing the actions from the ARC Self-Assessment and the Effectiveness Review of Internal Audit.

24/25/57 Gifts and Hospitality

The Committee received the 2023/24 Gifts and Hospitality Register that was extracted from Civica. It was reported that the Trust has improved immensely in respect to the declaration of interests and staff are more aware of what gifts and hospitality can be accepted. The organisation is continuing to share communications Trust wide on gifts and hospitality.

Resolved:

ARC received the Gifts and Hospitality Register for 2023/24.

24/25/58 Any Other Business

Attention was drawn to the updated committee cover reports and it was pointed out that Strong Foundations is no longer included as a strategic objective. The Committee was advised that Strong Foundations has been retained as a heading on Board agendas and it was suggested reinstating this on Committee cover reports.

24/25/58.1 Action: JP

24/25/59 Meeting Review

The Chair thanked everybody for their contributions and patience during what was a very busy meeting due to the extensive agenda. It was confirmed that the Committee is clear on the plan for finalising the external audit year-end report on the Trust's Accounts for 2023/24 and in the event of any changes an update will be circulated accordingly.

The Committee was informed that during July's meeting ARC will receive an update on the risk management process within the Community and Mental Health Division along with the Chief Information Officer's quarterly update on Data Protection and Freedom of Information.

The Managing Director of the Trust, John Grinnell, thanked all those concerned for their pragmatism and flexibility in terms of the delay in finalising the 2023/24 external audit year-end report and praised the professionalism of both teams.

Date and Time of the Next Meeting: Thursday 11th of July 2024, 3:00pm-5:00pm, via Teams.

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 11th July 2024**
via Teams

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mr A Bateman	Chief Operating Officer	(AB)
	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
	Ms. L. Wain	Corporate Governance and Risk Manager	(LW)
Item 23/24/64	Ms. M. Swindell	Chief People Officer	(MS)
Item 23/24/65	Ms. L. Cooper	Director of Community and Mental Health Division	(LC)
Item 24/25/72	Ms. M. Perrigo	Clinical Legal Service Manager	(MP)
Item 23/24/73	Mr. P. White	Chief Nursing Information Officer	(PW)
Observing:	Mr. R. Tabb	Governor	(RT)
Apologies:	Ms. E. Kirkpatrick	Assoc. Director of Finance - Commercial, Control and Assurance	(EK)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRO)

24/25/60 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received. The Committee was advised that Trust Governor, Rob Tabb, would be joining to observe the meeting.

24/25/61 Declarations of Interest

There were none to declare.

24/25/62 Minutes from the Meeting held on 20th June 2024
Resolved:
The minutes from the meeting held on the 20th of June will be approved during October's meeting.

24/25/63 Matters Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

Action 23/24/04.2: *MIAA Follow-up Report (Include the outcome of the IT Assets Hardware follow up review conducted by MIAA in October's Follow-up Report)* – The document relating to the outcome of the IT Assets Hardware Follow-up Review will be issued outside of the meeting. **ACTION CLOSED**

Action 23/24/22.01: *Acorn partnership update (Include an item on October's agenda item to discuss how ARC can receive assurance on innovation activities and risks)* – This item has been included on the agenda. **ACTION CLOSED**

Action 23/24/54.2: *Corporate Risk Register (Create four to five codes for longstanding risks to provide rationale as to why a risk is still outstanding)* – This action is to be discussed outside of the meeting. **ACTION TO REMAIN OPEN**

Action 23/24/59.1: *Non-Clinical Claims Report, 2022/23 (Convert previous data into graphs and include this detail in the 2023/24 Non-Clinical Claims Annual Report)* – The Chair is to contact the Chief People Officer, Melissa Swindell to advise about the trends and graphs the Committee would like to see in the Non-Clinical Claims Report. **ACTION TO REMAIN OPEN**

Action 23/24/97.1 : *Risk Tolerance and Appetite (Meetings to be widened to develop a risk appetite and tolerances for advocacy and JG to be invited)* – Conversation to take place between JP and JG to discuss as to whether advocacy should be separate from reputation. **ACTION TO REMAIN OPEN**

Action 23/24/98.1: *Board Assurance Framework (Liaise with the Chief People Officer the concerns as to number of gaps in assurance and minimal actions recorded to mitigate BAF risks 2.1, 2.2 and 2.3 and ask that this be reviewed)* – It was confirmed that the controls, gaps and actions have been updated for these risks. **ACTION CLOSED**

Action 24/25/10.1: *2023/24 Annual Report on Risk Management (Conversation to take place with the Chief People Officer and the Director of the Academy to escalate the Committee's request for Risk Management Training Programme to be included on the list of mandatory training)* – The Chair agreed to discuss this action with JRO outside of the meeting. **ACTION TO REMAIN OPEN**

Action 24/25/14.3: *Internal Audit Plan, 2024/25 (Discuss the approach for the Clinical Governance audit (Internal Audit and/or Clinical Audit)* – An update will be provided in October as a further meeting is to take place. **ACTION TO REMAIN OPEN**

Action 24/25/21.1: *External Audit Planning Report for Year-ended 31.3.24 (Discussion to take place once E&Y have reviewed the KPMG model in order to determine the amount of work that will be involved in the IFRS16 assessment and the additional audit fee required)* – A meeting will take place w/c 15.7.24 and an update on the outcome will be circulated to the Committee via e-mail. **ACTION TO REMAIN OPEN**

Action 24/25/25.1: *InPhase – Lessons Learnt (Circulate the current status of the incident risk feedback modules and the forward plan for 2024/25)* – This item has been included on the agenda. **ACTION CLOSED**

Action 24/25/25.2: InPhase – *Lessons Learnt (Provide the Committee with a forward plan detailing what is required to progress Phase 2 of the InPhase programme (list all modules,*

provide an overview of what needs to be delivered, the resources required and the costs) – This item has been included on the agenda. **ACTION CLOSED**

Action 24/25/27.1: *Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Data Quality (decision to be made about the reporting process into Assurance Committees for Data Quality. Provide an update in July 2024)* – An update has been provided and included in the action log. **ACTION CLOSED**

Action 24/25/28.2: *Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Cyber Security (Review the new legislation re on line safety to see if it will impact the Trust. Provide an update in July 2024)* – An update has been provided and included in the action log. **ACTION CLOSED**

Action 24/25/29.1: *Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Data Protection (advise of the number of people involved in classifying exemptions)* – An update has been provided and included in the action log. **ACTION CLOSED**

24/25/64 Non-Clinical Claims Report for 2023/24

The Audit and Risk Committee (ARC) received a summary of non-clinical claims received During the 1st April 2023 to the 31st March 2024, with a comparison of claims received during the same period in 2022/23. Attention was drawn to the following key points:

- There was a total of 22 claims in 2023/24 which is a significant increase from 4 claims in 2022/23. 6 of the total claims related to assault on staff by a single patient, and 6 needlestick claims were received in 2023/24. It was reported that there has been an increase in needlestick injuries in 2023/24 (*up from zero the previous year*).
- There are a number of recommendations in the report detailing how the Health and Safety (H&S) team are proposing to work with the Facilities team to ensure needlestick injuries are reduced. It was reported that Weightmans are providing the Trust with paralegal support to manage these claims.
- Discussions have taken place about clinical and non-clinical claims being amalgamated for efficiency purposes and to save costs. It has been agreed that as of the 1.9.24 non-clinical claims will be managed by the Clinical Legal team. this will align the Trust with other organisations in terms of having them managed in one place rather than separately. It was confirmed that the H&S Team will still play a role in this process in terms of taking responsibility for investigating claims relating to slips, trips, and falls, etc.

The Chair queried the process for overseeing the implementation of the lessons that have been learnt when the Trust admits liability. It was reported that the H&S Committee reports into the People Committee to provide oversight and assurance that actions are taking place for respective issues. It was confirmed that the H&S Committee will receive the Non-Clinical Claims Report during July's meeting.

The Chair referred to the increase in needlestick injuries and asked as to whether there has been a change in procedure, etc. that has caused this increase. The Committee was advised that there has been an inconsistency in the management of teams on a practical level therefore work is being undertaken on standardisation, operational management and holding managers to account. It was confirmed that the H&S team are in the process of liaising with the Domestic Management team regarding this matter.

It was queried as to whether there had been any further needlestick injuries between April 2024 and July 2024. The Chief People Officer, Melissa Swindell, agreed to look into this matter and provide an update.

24/25/64.1 Action: MS

Resolved:
The Committee received and noted the Non-Clinical Claims report for 2023/24.

24/25/65 Update on the Risk Management Process within the Community and Mental Health Services (CAMHS) Division

The Committee received an overview of the risk management process within the CAMHS Division. A number of slides were shared that provided information on the following areas:

- Priorities for 2023/24.
- Good governance meeting structure.
- Risks in the CAMHS Division.
- Board Assurance Framework risks for the Gender Service.
- Board Assurance Framework risk for ADHD.
- Board Assurance Framework risk for CAMHS.
- Corporate Risks 15+.
- Gender Service (North West) risks.
- Priorities for 2024/25;
  - Review and update Gender Service (North West) risks as the service becomes embedded in the Division and new risks emerge.
  - Amend the Division's governance training to include information on risk appetite.
  - Review the frequency of the Division's risk review meetings to potentially increase to 3 or 4 meetings per month to ensure a quicker review of any new, escalating or closed risks.
  - Develop a rota to ensure all risks in the Division are subject to a detailed review at least twice a year.
  - Develop the InPhase reports for risks at Divisional level.
  - Increase the information on risks on the Division's Governance SharePoint page to support risk managers and provide further information on Divisional risks to staff in the Division who do not routinely access the InPhase risk module.

Lisa Cooper (LC) responded to a number of questions that were raised about the issues being experienced in terms of registering the Warrington location with CQC, and how the Trust is making sure that staff who work off site are part of the Alder Hey culture.

It was pointed out that during Divisional performance reviews a theme has been highlighted by heads of services relating to data and digital systems for colleagues who are having to work in an agile way. It was queried as to whether there is a broader risk in terms of the quality and effectiveness of electronic systems and data in community. It was confirmed that risks relating to digital and data have been incorporated in the risk register.

The Chair advised the Committee that the CAMHS Division have three/four risks that will be discussed during the Risk Management Forum that may need to be included on the risk register as Trust wide risks.

It was queried as to whether the risk register reflects the workforce risk in terms of 1. The pressures being experienced by teams, and 2. Whether the workforce will be able to meet the scale of transformation to meet the needs of CYP in the future. It was reported that the Division is mindful of how it supports its workforce, as well as each layer of management in order to help them develop and grow. LC informed the Committee that reflection will take place on the culture across the Division, and wider system working. Attention was drawn to the ADHD team who are working under immense pressure due to a shortage of ADHD medication.

The Chair drew attention to two key risks that concern her that relate to the Gender Service; culture, and staff feeling that they belong. It was pointed out that the Cass review recommended that staff shouldn't work full time in the service. The Chair queried as to whether there are any staff working full time in the new service and if so, is there a forward plan to reduce that. It was confirmed that all 32 members of staff work full time on a rotational basis. Within their job description is a requirement that they return at some point to work either in CAMHS or Occupational Therapy for a day on a weekly basis. The Committee was advised that Hilary Cass's view was more about staff going back into local services to develop them because at some point the Gender Service will be part of a core offer in CYP paediatric services.

The Chair asked as to whether the Trust has been approached by pressure groups. It was confirmed that the Trust hasn't been approached since the new Gender Service went live. The service is a tertiary service therefore the Trust is maintaining its stance of non-engagement/collaboration with such groups.

It was queried as to whether staff have received pressure from patients following the Government's recent announcement about prohibiting the use of puberty blockers. The Committee was advised that the service is seeing patients from the open caseload who aren't receiving puberty blocker treatment, with the exception of two patients who are under the care of Leeds. As the service commences to care for patients from the national list there will be clear guidelines advising that proposed interventions will be based on evidence and that puberty blockers will not be an option.

The Chair thanked LC for the presentation which it was felt was informative and provided assurance.

Resolved:
ARC noted the update on the risk management process within the CAMHS Division.

24/25/66 Risk Appetite and Tolerances

An update was provided on the current position and forward plan to finalise the risk appetite and risk tolerance work within the organisation.

The Committee was informed of the exercise that was undertaken to re-profile the Trust's current risks against the eleven risk categories linked to appetite which provoked some thoughtful and insightful discussions around the degree of risk the Trust is willing to accept, and more practically when applying the tolerances how this may change the Trust's risk profile. The discussions at various committees acknowledged both the changes to the NHS landscape and Alder Hey's strategic outlook since the risk appetite levels were initially proposed in 2021, which has resulted in a number of suggested changes. It was reported that there was acceptance of the proposed tolerance levels across the majority of the eleven

categories from each of the Assurance Committees with a number of caveats, as detailed in the report.

Discussions are yet to take place with the Futures Committee as part of the exercise. A meeting is in the process of being scheduled and will likely take place in Q3 or Q4, 2024/25.

The Committee was asked to share its views on 1. Whether the content of the report feels appropriate, 2. The level of stratification that the Committee would like to see, and 3. Whether the risk tolerance and appetite will be usefully applied going forward. It was pointed out that the feedback received, in particular, from the Associate Chief Operating Officers (ACOOS) is that they are engaged with this piece of work.

The Chair felt that the exercise was really useful, and the report is succinct. In terms of implementation, it was pointed out that once the organisation starts to roll out its risk appetite and tolerances there will be a change in the numbers of risks reported with the potential for closed risks to be re-opened due to a difference in tolerances. It was felt that a discussion may need to take place to determine the speed at which this is rolled out.

A discussion took place about the restrictions the new risk appetite and tolerances might bring in terms of investment decisions; future workforce needs, thinking creatively, etc. It was pointed out that the Trust's risk appetite and tolerances is there as a framework and not to stop decisions being made that are outside of the risk appetite. It's about acknowledging that when a decision sits outside of tolerance levels and doing it in a recognised way.

A query was raised about whether advocacy sits within reputational risks. It was agreed to have a discussion regarding this matter outside of the meeting, as per action 23/24/97.1
Action: JG/JP

A number of questions were raised and responded to about whether the risk appetite and tolerances align with Vision 2030 in terms of what the Trust is trying to achieve, and how the organisation is going to factor its ambitions and external constraints into its appetite.

Non-Executive Director, Jo Revill drew attention to the importance of staff understanding risk appetite and tolerances, and pointed out that the Trust is in a volatile environment where decisions being taken will be outside of the appetite boundaries. With regard to reputational risk, it was felt that there is a deeper conversation to be had in terms of framing/describing reputational as it is quite complex.

The Chair informed the Committee that approximately 80% of risk appetite and tolerances has been determined and the vast majority of the work has been addressed, subject to a small number of amendments ahead of Trust Board. It was felt that the discussion during the meeting was very useful and highlighted that risk is never static.

The Director of Corporate Affairs, Erica Saunders, paid tribute to the Governance Manager, Jill Preece for driving this outstanding piece of work.

Resolved:
The Committee received and noted the latest position with regards to implementing risk appetite and tolerances throughout the Trust.

24/25/67 Board Assurance Framework

The Committee received the Board Assurance Framework (BAF) report for May 2024. The following points were highlighted:

- There are three risks that are in the process of being included on the BAF; ADHD, Gender Service, and the financial environment. It was reported that further work is required on the financial risk in terms of including information on the pressures, gaps, and additional controls.
- An overarching piece of work will be undertaken on risk tolerance post September's Trust Board to determine what it will mean for the BAF going forward.

The Chair referred to the issues that the Trust has been experiencing over a number of years in relation to corroded pipes, sky lights, water temperatures, and requested an update on these risks. The Chief Operating, Adam Bateman, gave an overview of the recent actions that have been agreed/implemented which provided assurance to the Committee that work is taking place to resolve these risks. It was reported that the plans for each of these risks are being monitored by the Finance, Transformation, and Performance Committee (FTPC).

Resolved:
The Committee noted the content of the BAF report for May 2024.

24/25/68 Risk Management Forum (RMF) Update including the Corporate Risk Register (CRR) and minutes from the last meeting.

The Committee was provided with an overview of the key points and areas of concern that were discussed during the RMF meeting that took place on the 26.6.24.

Corporate Risk Register

The Committee received the CRR for the reporting period from the 1.6.24 to the 30.6.24. The following points were raised:

- Over the previous 6-month timeframe (1.1.24-30.6.24) there has been a static trend in three areas; high risks with increase in risk score, high risks with no agreed action plan, and actions past expected date of completion.
- There is an improving picture of; risks overdue review, and high risks with a decrease in score.
- There is an increasing trend in the number of high risks with a static score, and a number of high risks reported on the CRR during three separate periods.
- As of the 31.6.24 there were 37 risks incorporated on the CRR. It was reported that a review of the categories has been undertaken by the Corporate Governance team to ensure correct alignment of current CRR risks to risk category. Following this exercise, it was concluded that staff may require further support in correctly articulating their risks and subsequent alignment to the correct risk category which in turn will potentially alter the Trust's risk profile.

The Chair referred to the review of risk categories (in relation to whether risks are categorised by their impact or cause) and advised that an approach needs to be agreed before any wholesale changes are made. Following a discussion it was agreed to have a conversation outside of the meeting about the classification of risk and circulate an update

via e-mail. The Chair asked for changes to risk classification to be deferred until further notice.

24/25/68.1 Action: KB/ES/JR

Corporate Risk 226

Risk 226 was presented by the Division of Surgery at the RMF in June and was discussed at length. This risk relates to discrepancies in admission accounts which are having a detrimental impact on Trust income. There are limited patient safety concerns at present but the Division feels that it is unable to mitigate what is potentially a Trust wide risk.

The Committee was advised that following migration to Meditech Expanse a risk has been identified that when patients have different 'account numbers', for different types of visits, these cannot be merged and prevent an entire history being accessed in one place within the record. The different accounts for patients for 'pre-admission' versus 'admission', if incorrectly selected, cannot be merged and the wrong account can be used for the wrong visit. This poses an issue in terms of income as costing may be inaccurate due to the inability to see a complete overview for the patient. The additional safety risk is that it's not possible to view a patient's clinical history if this is not within the account number accessed or the visit could be logged on the wrong account visit number which is then not easily rectified and has implications for the accurate planned visit.

There has been a focus on training, and a large workshop took place w/c 1.7.24 which helped reach out to Pathway Co-ordinators, ward staff and administration staff to try and resolve the processes that have been flagged as a training issue. As a result of the workshop it has been agreed to monitor the support provided to staff. Following the submission of a request to Meditech asking for assistance, a specialist in registration is currently looking to see if there is a process that will help mitigate the Trust's issue that the Digital team can support.

The Chair pointed out that there are two proposals in the report; 1. Staff support and 2. A system wide fix, and it was queried as to whether conversations have been undertaken to see if any of the issues can be resolved internally. It was reported that discussions have taken place in terms of a system solution that will mitigate the risks. The Trust is also exploring the possibility of having a visual prompt for staff to ensure they are accessing the appropriate account type when opening patient records, and a process that will merge records back together.

It was queried as to whether assurance can be provided to confirm that the Trust hasn't lost any income as a result of this issue. The Committee was advised that the Clinical Coding team, Validation team and the Theatre Digital team are undertaking a check of patient accounts but until this work has been completed full assurance can't be provided. It was reported that the FTPC will be receiving a broader coding position update in two weeks' time and a request was made that an update on the validation work be included within the wider update.

24/25/68.2 Action: PW

For noting

The Chair summarised the actions that need to take place to support the mitigation of this risk; 1.Pursue a system fix, 2. In the interim raise awareness of the risk to help minimise the input of additional errors, 3. Undertake a review of past records to ensure nothing has been overlooked.

Kath Stott informed the Committee that MIAA has a Clinical Coding team who train colleagues around the country and offered the team's support to the Trust.

Following a discussion, it was agreed to incorporate clinical coding in the Internal Audit Plan Forward View.

24/25/68.3 Action: KS

For noting

The Chair advised that it has been agreed to invite the owners of risks that have been ranked as 25 to attend ARC to provide an update/presentation, going forward.

An update was requested on the risk relating to Haematology. It was reported that this risk relates to laboratory on call cover during the night and the ability to carry out urgent clinical work around transfusion. It is a high risk which has been really challenging and has put pressure on staff, but the Trust hasn't had to divert any major traumas, for example. If that was the case the consequence would be in line with a score of 25.

The Committee was advised that the Trust has been able to secure the rota during the last month due to implementing a number of mitigations, therefore it is felt that the risk should be reviewed with the view to reducing the score. It was reported that a number of requests have been made of the team to review the risk score but all to no avail, therefore it is necessary to discuss this matter with the Director of Medicine.

It was suggested that there is a debate to be had about the process for the de-escalation of risks and the ways in which it can be done. The Chair pointed out that the risk gained visibility and mitigation took place therefore it is the right time in which to have a conversation with the team about reducing the score of this risk.

Resolved:

ARC noted the RMF update, CRR and the approved RMF minutes from the meeting held on the 21.5.24.

24/25/69 Trust Risk Management Report

The Trust Risk Management report was submitted to provide the Committee with the opportunity to scrutinise the effectiveness of risk management across the Trust for the reporting period for the 1.6.24 to the 30.6.24. The assurance presented in this report is a direct reflection of the evidence available on the electronic risk management system (InPhase) at the time of reporting. The following key points were highlighted:

- There are 269 risks on the Trust Risk Register for the reporting period, a slight increase compared to the previous reporting (266).
- There are 29 risks overdue a review compared to 23 in the last reporting period. Risk overdue reminders remain in place and this position will continue to be monitored.
- There are 35 risks without an ongoing/agreed action plan compared to 23 in the last reporting period. This remains an area of focus to ensure risks have appropriate treatment plans in place to reduce the likelihood and impact of the risk being realised.
- *Risks with Overdue Actions* - 40.5% of the total actions are overdue. This is a slight increase compared to the last reporting period of 39%. It was confirmed that a meeting is scheduled for w/c 15.7.24 to review overdue actions with the Divisions.

- A meeting is planned in July 2024 to further explore report enhancements with continued support from the Data Analytics Team.
- The Committee was advised of the improving trend of open long-standing high-moderate risks, and the open long-standing high-moderate risks with reduced scores, as detailed in Appendix 1 of the report.

The Chair felt that there some good analysis in the report along with data from InPhase included in the charts and tables. It was pointed out that there will be a need to review the Trust Risk Management Report once the Trust rolls out its risk tolerances as all risks regardless of their score will be outside the organisation's risk tolerance.

Attention was drawn to the graphics of the bullseye in the report which it's felt is not big enough and when expanded the reader is unable to see the narrative. It was agreed to look into this matter.

24/25/69.1 Action: LW

A discussion took place about overdue actions, particularly in the Division of Medicine, CAMHS Division, and Corporate services and a question was raised about the reason behind the delay in completing actions. It was reported that a meeting has been arranged with the Divisional Governance Leads to try and understand what is preventing the timely completion of actions.

Resolved:
The Committee noted the content and level of assurance provided in the Trust's Risk Management report.

24/25/70 Chief Transformation & Digital Officer (CTDO) Quarterly Updates for Data Protection and Freedom of Information

The Committee received and noted the CIO's quarterly report which provided an update on compliance with the Data Protection Act and Freedom of Information (FoI) Act.

The Chair advised that a request has been made for an analysis of the nature of the FoI requests to be included in the next quarterly report to help highlight trends or arising themes.

24/25/70.1 Action: KW

The Chair also pointed out that the Trust is receiving a number of complex requests therefore it has been agreed to look at whether there is a process for agreeing an extension on a 20-day deadline to give the Trust enough time to respond appropriately to complex cases. It was reported that the clock can be stopped but it has to be with the agreement of the requester.

As ARC is ultimately responsible for FoI Act requests, it has been agreed that the company who is responding on behalf of the Trust to Gender Service related FoI Act requests will share its statistics with the Committee. It was reported that the Trust has received between 6 and 10 FoIA requests in this area to date.

Resolved:
The Committee received the CTDOs quarterly updates report for Data Protection Act and Freedom of Information Act compliance.

24/25/71 Third Party Assurance – ELFS Payroll Service
Resolved:

The Committee receive and noted ELFs Payroll Audit report for 2023/24.

24/25/72 Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Clinical Claims

The Committee was provided with an overview of the 2023/24 Clinical Claims Annual Assurance Report/Forward Plan for 2024/25. The following key points were highlighted:

- 14 new clinical claims were reported to NHS Resolution (NHSR) in 2023/24, this is a slight increase to the 13 clinical claims reported to NHSR in 2022/23. Of the 14 new clinical claims reported to NHSR, 11 were Letters of Claim and 3 were Inquest Funding.
- The Division of Surgery received the highest number of new claims in 2023/24, with 11 new clinical claims.
- The 2 highest new clinical claim themes in 2023/24 were failures/delays in treatment/procedures and clinical assessments, including diagnostics tests and assessments.
- Themes from claims are incorporated into the Trust's aggregated risk report on a six-monthly basis to enable them to be viewed alongside incidents and complaints.
- At the end of Q4, the Trust had 78 clinical claims open with NHSR, 16 of those were potentially for high value damages of over a £1m. 9 of the 16 high value clinical claims have a current estimated financial year of settlement date as 2024/25.
- In 2023/24 a total of 18 clinical claims were closed. Of those, 8 were closed with no damages paid and 10 were settled with damages paid.
- In terms of looking forward, regular training sessions on clinical claims will continue to be provided for Trust staff every six months, and work will continue to embed learning from clinical claims across the Divisions.
- The Governance team and IT teams are working in collaboration to improve the claims modules on InPhase.
- It was reported that the Trust is required to review and update its Clinical Claims and Litigation Policy along with the Non-clinical Claims Policy in 2024/25.

The Chair asked for information to be included in the report on the total value involved in the 78 claims that are open with NHSR. It was pointed out that the Committee receives this report on an annual basis during April and it is this type of detail that the external auditors require as part of the annual audit. In addition to this it was felt that it would be beneficial to include a trend analysis to compare the number and values of claims over the last five years and to determine as to whether there is an improvement/decline. It was agreed to include this information in the report and circulate it to the Committee outside of the meeting.

24/25/72.1 Action: MP

The Committee was advised that joint work will take place to enable the Clinical Legal team to produce an annual report that covers both non-clinical and clinical claims that will provide ARC and other Assurance Committees with respective data from a risk/exposure position. Thanks were offered to Michelle Perrigo and the team for the work they conduct as it can be very complex, have huge sensitivities, and take a long time before a case is closed.

Resolved:
The Committee received and noted the content of the Annual Clinical Claims Assurance Report for 2023/24 and Forward Plan for 2024/25.

24/25/73 InPhase – Forward Plan

The Committee received a report that provided an overview of Phase 2 implementation for the continued development and support of the InPhase Risk and Incident Management system. It was reported that Phase 1 of the project went live in May 2023 and was a shared procurement with Liverpool Heart and Chest Hospital (LHCH). Lessons learnt from the implementation were shared with ARC in April 2024. The following key points were highlighted:

- Reporting and dashboard functionality has improved as a result of the previous implementations, but the Trust would like to undertake further work.
- The Trust is looking to develop outstanding modules from Phase 1 as there are several that aren't fully utilised.
- *Proposal for Phase 2* – The progress of Phase 2 will be dependent on an InPhase developer role being created. It was reported that the need for a dedicated development resource has been identified as an essential component to long-term development and success of the system. The Trust has been working closely with several other trusts, particularly King's College who have a robust team in place and offered assistance. As a result of this the Trust has a job description which has been submitted to HR and is awaiting sign off by Finance as funding has been secured for a twelve month period.
- To deliver an effective solution the Senior Responsible Officer (SRO) providing executive oversight for Phase 2 will be jointly held by the Trust's Chief Nursing Officer and Chief Transformation and Digital Officer. The asset ownership of the entire InPhase system is held by the Associate Director of Nursing and Governance.
- Module leads have been highlighted as subject matter experts and will be responsible for the output of the data.

The Chair highlighted the importance of progressing Phase 2 but advised that time needs to be set aside to establish the programme to ensure implementation is more streamlined than Phase 1. It was acknowledged that there is a significant reliance on the new developer role and it was queried as to whether the Trust will encounter restrictions from the ICB in terms of this non-clinical recruitment. It was reported that this role will be reviewed by the Executive Vacancy Control Panel who will discuss the benefits of this role and the longer term risk of funding it before validating this post.

A question was raised about whether the Trust has undertaken any staff satisfaction surveys as part of the Phase 1 implementation. It was confirmed that a survey has taken place as part of the closure of Phase 1 and the feedback received was really positive. It was felt that it would be beneficial to target governance teams, module leaders and core users to gain an understanding of the impact that this development has had.

24/25/73.1 Action: PW

The Chair brought the agenda item to a close and asked that a more detailed project plan be submitted to the Committee in October/January.

24/25/73.2 Action: PW

Resolved:
The Committee received and noted the InPhase progress report.

24/25/74 Assurance on Futures Activities and Risks including; Update on Shareholders Register.

The Chair advised that the Committee hasn't received formal assurance on innovation activities since 2019, other than updates on the implementation of actions following the outcome of the commissioned KPMG report. Fundamentally innovation is run differently now but attention was drawn to the importance of developing a risk appetite and tolerance for innovation and the work of the Futures Committee, and relooking at ways in which risks are articulated whilst recognising the difference of a commercial environment versus a governance environment. Once the Futures Committee has had time to evolve, ARC will seek formal assurance on a regular basis. It was confirmed that a meeting is to be scheduled to discuss this area of work. (See action 24/25.43.1)

Shareholders Register

The Committee received an update on the status of Alder Hey's company shareholdings. The report sets out the current status of company shareholdings with any changes made since the last report in May 2024. The Director of Finance and Development, Rachel Lea provided a detailed position statement on each of the remaining three companies under the ACORN partnership.

A discussion took place about ensuring that new ventures and the setting up of companies are done in a robust way, taking into account the learning from the ACORN Partnership. Attention was drawn to the importance of having a clear exit strategy for partnerships and being cautious about who the Trust partners with.

It was queried as to whether the administration of directors has been addressed. It was confirmed that the latest company confirmation statement was filed at the end of June 2024.

Resolved:
The Committee:

- Noted the update on Futures activities and risks.
- Noted the update and content of the Shareholders Register.

24/25/75 Update on Action Plan for Property Valuations

The external audit report on the 2023/24 annual accounts, included a recommendation in relation to the valuation and reporting of capital expenditure. In response to this, a Capital Improvement Plan has been developed with actions to be implemented over the coming months in readiness for the 2024/25 year end and to avoid similar issues arising. It was reported that the action plan has been shared with Ernst and Young (E&Y) as part of the management's response to the audit findings.

The Committee was advised that this exercise provided the Trust with an opportunity to review other areas to ensure the plan captures everything that needs to be addressed in terms of capital. There are eleven actions in the plan, and all are on track. Implementation dates have been incorporated in the plan and a number of actions have been completed as far back as April 2024.

Reference was made to action 2 '*ensure contractor valuations are booked in to take place on or as close to the 31st of March for all building schemes to record as accurate a position as possible. Ensure this is reflective of actual works completed and not used as a contract*

management tool'. The Chair felt that conscious consideration needs to be given to this action in terms of what it means for the Trust's year end accounts. It was also queried as to whether a further action should be included in the plan about confirming how the Trust accounts for a capital scheme at the time the potential scheme is considered. It was reported that this action can be incorporated in the plan.

The Chair pointed out that during the 2023/24 external audit there were differences of opinions therefore it was felt that the Trust may have to change its assumptions of how it deals with particular areas in the future.

A discussion took place on action 7 *'for all capital bids, agree and implement a SOP which outlines a criteria and process before the bid is submitted'*. It was reported that the Trust does have a process in place for submitting bids, but it doesn't address the urgency when there is zero time. The SOP will focus on this element of urgency when having to submit a bid quickly along with timeframes in terms of spending funding in a way that the Trust has planned.

Resolved:
The Committee noted the update on the action plan for property valuations.

24/25/76 Conflicts of Interest Policy

The Committee received version 4 of the Conflicts of Interest Policy for approval purposes. It was felt that the policy was very comprehensive, but a challenge was raised relating to item 10.6, third bullet point, page 13 *(Loyalty interests should be declared by staff involved in decision making where they: are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners).* It was reported that the policy indicates that if the organisation finds that a staff member is closely related to somebody who recruited them it may adversely impact their employment with the Trust. The Chair felt that the person involved in the recruitment who is an existing employee should also be disciplined.

It was reported that work is taking place on the compilation of a stand-alone employment policy which is to be submitted to the People Committee in the next quarter. In the meantime, the Conflicts of Interest Policy has been updated to incorporate loyalty interests to ensure the Trust is covered from a risk perspective.

Resolved:
The Committee approved the Conflicts of Interest Policy (v4).

24/25/77 Any Other Business

Internal Audit Follow Up Report (June's meeting)

Reference was made to the request for a significant length of extension relating to an outstanding action from the internal audit of Safety standards for Invasive Procedures. It was reported that the Chair sought the view of MIAA in relation to the interim mitigations in place which MIAA confirmed were reasonable.

For noting
Following this, Committee Members agreed to the extension via e-mail with the caveat that MIAA liaise with the recommendation owner on a regular basis to confirm that progress remains on track.

24/25/78 Meeting Review and Forward Look to the Next Meeting

The Chair thanked everybody for their contributions during the meeting. It was felt that the Committee had a number of quality discussions particularly about the Gender Service and risk appetite.

Date and Time of the Next Meeting: Thursday 10th October June 2024, 2:00pm-5:00pm, Room 20.

Alder Hey Children's NHS
NHS Foundation Trust

Finance, Transformation and Performance Committee
Confirmed Minutes of the meeting held on Monday 30th September 2024 at 13:00, Via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Dame Jo Williams	Non-Executive Director	(JW)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Managing Director / CFO	(JG)
	Rachel Lea	Deputy Director of Finance	(RL)
In attendance:			
	Nathan Askew	Chief Nurse	(NA)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Ian Gilbertson	Associate Chief Digital and Information Officer	
	Jane Halloran	Acting Deputy Development Director	(JH)
	Emily Kirkpatrick	Deputy Director of Finance	(EK)
	Andy McColl	Deputy Director of Finance	(AMC)
	Natalie Palin	Associate Director Transformation	(NP)
	Jill Preece	Governance Manager	(JP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	
	Gary Wadeson	Associate Finance Director, Income	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:	Katie Tootill		
	Peter Barnes		

24/25/88 Apologies

Apologies were noted from:

Kate Warriner	Chief Digital and Information Officer	(KW)

24/25/89 Minutes from the meeting held 22nd August 2024

The minutes were approved as a true and accurate record.

24/25/90 Matters Arising and Action log

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

RL noted further work being completed on WTE, RL referred to methodology provided through NHSE. MS noted this was all so a priority at a recent Cheshire and Merseyside HR Directors meeting. Extra data on WTE had been included in the M5 Finance report. FTPC noted it would take time to work through anomies and how to extract going forward.

24/25/91 Declarations of Interest

There were no declarations of interest.

24/25/92 Top 5 Risks

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

M5: In line with plan.

System wide PWC checklist continues, report to be circulated in November. Current £63m gap waiting to hear on conclusion. Alder Hey is on plan to meet £3.3m surplus.

Industrial Action funding has been approved, amounts to be confirmed.

Pay Awards have been approved, payments split between October and November. Gaps in funding have been highlighted to ICB.

2. **Capital Programme (RAG HIGH)**
   To be presented under agenda item.

3. **Efficiency Programme (RAG HIGH)**
   Included in Finance report, continue working towards closing the gap.

4. **Benefits realisation, governance and prioritisation of change programme to 2030 (RAG MEDIUM)**
   NP gave a presentation on the Benefits Realisation review, noting the purpose is to assess whether the expected benefits have been achieved. 64% of the programme has been completed with 4 business cases due to be completed in September.

   AMc went through the financial slides noting the upward trajectory from last year, to remain financially sustainable focus is to continue on long term recurrent high value savings.

   FTPC went through a number of positives from the programme noting this needed to link in with moving forward with a narrative to communicate with staff where we are and what is else is required.

   NP highlighted key recommendations and learning from the year.

5. **The campus & Park developments (RAG MEDIUM)**
   To be presented under the agenda item.

24/25/93 **Finance Report**

Month 5 Financial Position

£0.4m deficit in August (M5), and £3.4m deficit year to date which is off plan due to industrial action (£0.2m).

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

CIP in month on plan, supported by technical adjustment. Focus continues on red schemes.

Capital £3.4 overspent year to date in relation to audit payments from last year. Full delivery is expected.

DJW CAMHS supporting other divisions is this likely to continue. RL noted it's not ideal and will continue to be reviewed going forward. EK highlighted CAMHS continue to try to close the gaps on vacancies.
Action: RL to discuss further at the October FTPC.

Current pack states we will overachieve on forecast, this is an error and correct report will be circulated after the meeting.
Action: COMPLETED.

Resolved:

FTPC received and noted the M5 Finance report.

24/25/94 **5 Year Capital Plan**

RL presented slides on the 5 year plan highlighting 24/25 is the final year of allocation.

A slide on 5 year capital requirement was presented. Total for the next 5 years is around £69m with £4m supported from charity.

Further work is to be completed on priority order. Cases are to be presented to ICB and NHSE on CDEL gaps. A further updated will be presented at the October FTPC before updating Trust Board, November 2024.
Action: RL

DJW asked if there had been any details on the ICB estates plan. RL said she there is a draft version and will circulate with FTPC.
Action: RL

24/25/95 **Month 5 Integrated Performance Report**

AB highlighted:
Due to meet no patients waiting over 65 weeks for treatment.

ED Good performance at 84%.

Challenges continue in neurodiversity pathway. None NHS capacity to be used to support waiting lists.

Follow up care continue to reduce waiting times patients waiting over 2 years. Patients are triaged within the first 100 weeks after being seen.

SA metric on Virtual Ward is positive. AB part of the winter plan, will circulate report presented at a separate meeting.
Action: AB

Resolved:
FTPC received and noted the M5 Integrated Performance report.

24/25/96 **PWC Checklist**

A paper had been included in the pack. RL presented slides noting there had been no surprises within the findings. Main areas of concern included; efficiency programme and pay and control.

Resolved:
FTPC received the PWC Checklist.

24/25/97 **Liverpool Neonatal Partnership**
Resolved:
AB highlighted the impact on the emergency department and the waiting area.

24/25/98 **Campus update**

JH highlighted 3 main risks; Fractional Dermatology, Outpatients and the Elective Hub.

A workshop is scheduled for the elective hub on Thursday, it's a clinical team, with the full design team and it's hoped that the architects who did all the early works on

this scheme will get us back on track and give a real focus and drive to make up time on the elective hub.

Sprinkler system within the car park continues to be reviewed to ensure cost effective. JG noted the discussion on this at Executive Committee, costs are looking at around £1m. As this isn't an option the team continue to review.

Resolved:
FTPC received an update on the Campus.

24/25/99 **Digital Futures Strategy**

IG highlighted:

- Collaboration continues with 5 adult Trusts to converge their electronic patient records.
- supported the deployment of allocate in pre OP support and remote questionnaires as well as supporting the deployment of the external advice application. This enables clinical teams to record activity when given advice and guidance to other care providers, something which we've not done before.
- Optimization of progression really well, and recently we've had a number of high priority solutions delivered by Meditech, which has mainly improved their fare on management and booking and scheduling components of the system and then the system enhancements have also been supported by quality rounds which we've established follow.
- Build relationships with services and identify quick fixes or training issues.
- Data team is currently under review also looking into the replacement of our data warehouse.

Resolved:
An update on 2030 Programme had been received under Top 5 risks.

24/25/100 **Procurement update**

Resolved:
A deep dive was presented on stock across Alder Hey. Following discussion it was agreed further feedback would be required before moving forward.

24/25/101 **PFI report**

Chris Gildea highlighted:

- 4% over the monthly contractual target for energy and 9% over for annual, we've gone back to Project Co over this just to make sure that we're working to the correct baseline considering new energy intensive kit that's come online.
- The decoration piece is going to be mobilised looking at areas and bringing the place up to a standard that we expect.
- Skylights are going to be complete in October.
- Mite have recruited an interim account director who is now in post.

A discussion was held in relation to the breach of the PFI contract. The Chair noted a meeting with their senior managers may be needed.

Resolved:
FTPC noted PFI report and progress to date.

24/25/102 **Board Assurance Framework**

ES highlighted:

- Follow up is now more acute, we're looking at it from a patient safety perspective, there is a productivity issue as well.

- Financial environment risk, which is obviously very fully populated with things we talked about today.

Resolved:
FTPC noted risks within the Board Assurance Framework.

24/25/103 Any Other Business
SA asked for further details on the Data-ware house. IG said a business case is under review and will be presented at Capital Management review next week.

24/25/104 Review of Meeting
The Chair highlighted the discussion around the benefit realisation programme.

Date and Time of Next Meeting: Monday 28th October at 1pm, Innovation Park, Room 2/3 Edge Lane.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 7th November 2024

Paper Title:	**Board Assurance Framework (BAF) Report September 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 September 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 9th October 2024

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x2
1.2 AB	Children and young people waiting beyond the national standard to access planned care and urgent care	FT&P / SQAC	**4x5**	3x3
1.3 AB	Building and infrastructure defects that could affect quality and provision of services	FT&P	4x3	2x3
1.4 LC	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	FT&P / SQAC	**3x5**	3x3
1.5 LC	Lack of visibility at Board level across the Gender Service	Trust Board	4x2	4x1
1.6 LC	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board	**4x4**	4x2
STRATIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	People Cttee	3x4	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Cttee	3x3	2x2
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	People Cttee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	FT&P	4x3	3x2
3.2 KW	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	FT&P	**5x3**	4x2
3.4 JG	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 September 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  Risk 1.1 has been reviewed and continues to be monitored through SQAC.

- ***Lack of visibility at Board level across the Gender Service (LC).***
  Detailed review of this BAF risk to take place on 08 October 2024 with Clinical Lead. Additional wording and measures to be included.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC). NEW***
  Gradually improving picture. A meeting with NHSE and some other large children's providers is being scheduled to share practice, impact and response. Ongoing clinical actions to ensure safety of children already prescribed medicine. Commencing of medication still on hold until the supply is stable.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in September maintains above the national standard of 78%, achieving 84.5%.

  There has been a continued decline in DM01 performance, reducing from 82.3% in August to 80.7% in September. Nationally, the target remains to achieve 95% by March 2025, however Cheshire & Merseyside ICB have challenged Trusts to achieve this by December 2024. Areas which remain a challenge are sleep studies and medical scope. There is a trajectory for sleep studies to be DM01 compliant by the end of October.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. The trust had two patients waiting longer than 78 weeks in September, both were treated in month. The number of patients waiting over 65 weeks at end of September was 2; one due to patient choice and one due to last minute cancellation, both of which have an October plan. The Trust is now focused on sustaining zero patients above 65 weeks and reducing the number of patients waiting over 52 weeks.

- ***Building and infrastructure defects that could affect quality and provision of services (AB).***
  Project Co. have advised of the 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 is received.

  meeting are ongoing regarding the internal AH staff pipe works.

  Leak incidents have reduced over the last three years.

  Out-of-range water temperatures continue to be monitored and local mitigations are in place such as filters on water outlets. Booster pumps installed on the hot water system have proved effective and this will now be discussed as to introduce to cold water.

  Joint water safety workshops continue. 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 completion is due to be completed this month with handover expected October 21st.

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

Green roof final works completion expected December 2024.

- ***Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (LC).***
  Risk reviewed and actions updated. BAF risk remains the same due to issues with national MHDS which remain unresolved. NHS England aware and national review ongoing.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***
  Risk and actions reviewed, and addressed through 24/26 people plan. No change to score.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).***
  Risk reviewed and all actions reviewed and updated. No change to risk rating.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risks reviewed. New EDI training launched in September, Gaps and actions reviewed no change to score.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk reviewed - no change to score. Agreed 3 phase handover with LCC:
  Main Park - Oct 2024
  Swale - Dec 2024
  Remaining Site (where Histopathology is currently located) - Dec 2025

- ***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).***
  Findings of 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, the potential risk of compromising the long-term

strategic vision in favour of immediate financial gains remains a critical area of focus. Continued alignment and strategic oversight are necessary to safeguard the broader goals of Vision 2030.

The risk score this month has therefore remained unchanged.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (JG).***
  Risk reviewed along with actions and controls. No changes to risk score given external environment and financial risk within the C&M system. Internally in year forecast remains on track to deliver in line with plan with ongoing additional controls to overachieve to support the wider system position. A 5-year capital plan was presented at FTPC in September to be presented at Board November with significant risk on future years, ongoing discussions with ICB on CDEL allocations.

- ***System working to deliver 2030 Strategy (DJ).***
  Controls and risk reviewed; no change to score in month. Actions updated reflecting trust board Oct 24/CMAST.

- ***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).***
  Actions updated - outline business case for investment zone funding submitted and under review. Futures business case actions underway. Commercial research income forecast remains ahead of target.

- ***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, controls remain adequate and score static. A number of priority developments have now been delivered in AlderCare including improved Booking and Scheduling module. Senior Team redesign underway and first post is out to recruitment. Cyber Manager starting in post on 14th October and Cyber Assurance Framework assessment to commence in the same month. National monies now available for Cyber and AH will be submitting a bid for tools that will improve security and cyber posture.

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

There are currently 22 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
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
2290	A child may be harmed in the process of holding them to complete an intervention anywhere in the Trust ***(NEW)***	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 ***(NEW)***	4x4	Business Support		Sept 2024	Sept 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2606	Children at risk of a decline in clinical condition requiring Emergency Department attendance and/or Hospital admission ***(NEW)***	3x5	Community		Apr 2022	Sept 2024
2623	Then there is no access to CT scans for the entire trust. the trust is unable to provide CT scans for all patients, including major trauma patients, deterioration inpatients, elective patients, forensic patients and ED attendances.	5x3	Medicine		Apr 2022	Mar 2024
2704	Potential reduction in ultrasound service provision ***(NEW)***	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
151	Expanse Referral Process	5x3	Business Support	4.2	May 2024	May 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
212	Reduced staffing in Plaster Room	3x5	Community	2.1	May 2024	July 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)						
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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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 ***(NEW)***	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
212	Reduced staffing in Plaster Room	3x5	Community	1.1	May 2024	July 2024
2.2 Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (3x3=9)						
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1	Feb 2023	*Apr 2023
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.1	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.1	Dec 2023	Dec 2023
2.3 Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (4x3=12)						
	None					

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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)						
151	Expanse Referral Process	5x3	Business Support	1.2	16 May 2024	May 2024

* risk movement data not available pre-move to InPhase

6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

Erica Saunders
Director of Corporate Affairs

Inability to deliver safe and high quality services	
Risk Number	Strategic Objectives
1.1	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	Safety & Quality Assurance Committee

Description
Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

Oct 2024	
Control Description	Control Assurance Internal
The Trust has a quality improvement programme 'Brilliant Basics', where quality improvement is at the heart of everything we do and provides staff with the skills, knowledge and confidence to learn, lead and deliver in an improvement style.	Formal and informal training and coaching available to support departments to make positive changes. Outcomes shared through the SharePoint site and reported to board bi-annually against agreed plan.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I).	Annual QIA assurance report
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes.
The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Patient safety meeting actions monitored through CQSG, learning bulletin produced and learning from RCA's shared at the meeting
Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
The STAT education and training program is in place in theatre to improve safety awareness and culture	monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC

Gaps in Controls / Assurance
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis 2. Robust 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	October 2024	
		Due Date	Action Update
Alder Care (Expanse)	8. The risks to quality and safety need to be monitored during the period of stabilisation	30/11/2024	Command and control in place through the deployment which includes the monitoring of quality and safety data,.
Delivery of 2030 Vision	6. The programme will need to articulate resources required against impact of no additional resources being available. The experience focus underpins all other parts of the vision and key to the delivery of the overall strategy	31/01/2024	Resource requirement and impact assessment currently under development.
Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	1. Continue to monitor KPI's at SQAC and within divisional governance structures.	31/03/2025	There has been improvement in administrations times which continue to be monitored through SQAC to embed improved performance.
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	
Medication Errors and Near Misses	3. Proactive programme of work in place to reduce medication errors	31/03/2025	Dashboard in place with insight into the causes of medication errors and a proactive reduction plan monitored through Patient Safety board.
New CQC Assessment Framework	5. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2025	Key executive and corporate staff have undergone training in the new process and will continue to work with the CQC whilst change over date is pending
New Models of Care	7. Clinical leaders will need to be appointed to oversee the process and provide challenge on the principles of the strategy	31/03/2025	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

Capacity and Demand modelling undertaken during March 2023 shows that a small number of specialties have a long term challenge relating to waiting times for planned care, and risk to achieve the national standard of eliminating waits >65 weeks by March 2024. Our challenged specialties include ENT, Dental, Spinal Surgery, ASD/ADHD and CAMHS. In addition, unprecedented demand for urgent care has increased the wait for clinical assessment and reduced the percentage of patients treated within 4 hours. These factors combine to create a risk that waiting times for elective and urgent care will exceed national standards, with potential detriment to experience and outcomes for Children, Young People and their families.

Oct 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	October 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

0171

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

Oct 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 FT&P 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	October 2024	
		Due Date	Action Update
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	30/11/2024	Reports continue to be received from Project Co on the current status. These reports will continue until a permanent solution is agreed. I have extended the date range for completion. A board to board meeting was held on the 5th June where option where discussed with Exec reps.

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

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

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

Description

There has been a significant increase in demand for Specialist Mental Health Services at Alder Hey following the COVID-19 pandemic which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours. This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.

Oct 2024	
Control Description	Control Assurance Internal
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)
Business case for investment submitted to Liverpool and Sefton Place and approved. This is is now being fully implemented.	Business case (attached)
Weekly performance monitoring in place for operational teams which includes: • Weekly Tuesday/Wednesday meeting with PCOs • Divisional Waiting Times Meeting each Thursday • Trust Access to Care Delivery Group each Friday This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required.	Monthly assurance processes include: • Monthly contract statements • Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Weekly allocation meetings
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software

Gaps in Controls / Assurance

1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to legacy waiting times and recruitment issues as a result of national workforce shortages.

Action	Description	October 2024	
		Due Date	Action Update
Continued workforce planning	Continued workforce planning including: - introduction of new roles - continued representation at C&M workforce meetings - review of all job descriptions and person spec to ensure consistency and ability to progress - development of preceptorship/development pathway	31/12/2024	
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting	31/10/2024	
Introduction of PIFU discharge pathway	Introduction of PIFU discharge pathway - ongoing	31/12/2024	email sent 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 aresponse
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/12/2024	
Proceed with changes to CAMHS internal waiting times measures	Proceed with changes to CAMHS internal waiting times measures including: SOP/Pathway to be created Training plan for clinical and admin staff to be created and rolled out Data and reporting	31/10/2024	

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

CQC Domains	Linked Risks	Owner
Safe Responsive		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
8	4	Trust Board

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

Oct 2024	
Control Description	Control Assurance Internal
Dedicated communications lead and communications plan in place to manage internal and external communications and media.	Internal and external communications plan
Monthly Operational and governance meeting to be in place to review service delivery and escalate key issues to Division and Trust Board.	Divisional governance meeting minutes
All identified risks within the Gender Service are reflected on the risk register. Appropriate controls and actions are in place and are reviewed on a fortnightly basis with Gender Service Senior Leadership Team.	risks on InPhase being managed closely

Gaps in Controls / Assurance
o Extensive media attention o Risk of involvement with a range of legal proceedings o Unknown changes or asks to the service

Action	Description	October 2024	
		Due Date	Action Update
Escalation of Key Issues to Divisional Integrated Governance Meeting	Key Issues to be reported to Divisional Integrated Governance Meeting on a monthly basis.	25/06/2025	
North Programme Delivery Board	Reports and issues to go back to monthly North Programme Delivery Board, chaired by CEO of Alder Hey NHS Foundation Trust and/or Director of Operations, Manchester Foundation Trust.	31/12/2024	

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

CQC Domains	Linked Risks	Owner
Effective Safe Responsive		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	4	Trust Board

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

Oct 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	October 2024	
		Due Date	Action Update
Risk 236 - Action 1	Engagement with suppliers to increase knowledge and seek support.	31/10/2024	
Risk 236 - Action 2	Increase capacity to the prescription rota to cover the additional work.	01/11/2024	The rota has been reviewed in an attempt to increase capacity to the prescription rota - further work needs to be done to review all professions who are contributing to the rota as some are also contributing to other rotas that equally need resourcing. Ongoing to ensure this rota is as effective as it can be.
Action 9	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative	30/09/2024	
Risk 236 - Action 5	Two additional telephone lines ordered and awaiting installation to support the increased demand	01/11/2024	Installation complete - log in error so awaiting fix for this
Risk 236 - Action 6	Plan for a “Super Saturday” with clinical teams and Pharmacy	01/11/2024	Planning continues - agreed with OPD that rooms can be made available and HCA staff can be provided to do measurements and support the clinic. Discussion with Pharmacy re whether open OP Pharmacy or issue FP10 prescriptions or invite families in batches over the week following the Saturday clinic to collect their prescription. Additional hours offered to Psychiatrist and ADHD NMP's - rota to be built.
Risk 236 - Action 7	Plan for Psychiatry support to increase number of complex assessment conclusions using voluntary additional hours	01/11/2024	Additional hours offered to Psychiatrists - names being gathered and a separate rota to be created. Cohorts of children and young people ready for MTD to be complied.
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	

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	
Risk Number	Strategic Objectives
2.1	Support our People

CQC Domains	Linked Risks	Owner
▪ Safe ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	People Committee

Description
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation. 3. Not developing inclusive recruitment and talent management practices to improve workforce diversity

Oct 2024	
Control Description	Control Assurance Internal
Monthly Ops Board monitoring	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
People Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Apprenticeship Strategy implemented	Annual update to PAWC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PAWC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
PDR and appraisal process in place	Monthly reporting to Board and PAWC
Nursing Workforce Report	Reports to PAWC, SQC and Board
Nurse Retention Lead	Bi-monthly reports to PAWC
Recruitment Strategy currently in development	progress to be reported PAWC
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance
1. Not meeting compliance target in relation to some mandatory training topics 2. Sickness absence levels higher than target 3. Lack of workforce planning across the organisation 4. Lack of robust talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity across the organisation

Action	Description	October 2024	
		Due Date	Action Update
1. Not meeting compliance target in relation to some mandatory training topics	Process in place to monitor take up of training by topic; subject matter experts engaged in the process Overall Mandatory training is above 90% and achieving trust target however it is recognised that some key and important topics are less than 90%. A newly appointed Head of L&D has a full action plan in place to increase compliance across the organisation and this is supported by the Academy Director. Gill Foden Head of L&D is the owner of this action.	31/03/2024	Mandatory training activity is monitored by Education Governance Committee as a standard agenda item. As at May 24 overall trust compliance was 93.00%. Areas of concern are highlighted, discussed and supported with subject experts. The current area under review is SEPSIS.
2. Sickness absence levels higher than Trust Target	The sickness Target has been reduced for 2024 to 5% and the start of the year has commenced with sickness absence being below target. Ongoing interventions remain in place to support the management of sickness, however until the absence has had a sustained reduction it will continue to monitored as a risk impacting on this overall BAF risk.	31/03/2025	
3. Future Workforce	3. Review of skill mix, talent and succession planning across the organisation against full demographic analysis. Annual operational plans are in place, Establishment control in place.	31/03/2025	Establishment control project close to completion before commencing the wider workforce planning project
4. Lack of Robust talent and succession planning	The next stages of the People Plan and key deliverables for 24/25 were presented to Trust board on 6th June 2024 and the plan approved. The plan requires key strategic areas of focus, one of those three areas is the development plans for Future workforce. Succession and Talent management is a workstream that sits beneath this strategic initiative. HR, OD and Academy will work together to review skill mix, talent and succession planning, prioritising those areas were there is the most need over the next 12 months.	11/06/2024	
5. Lack of a robust Trust wide Recruitment Strategy	The next stage of the people Plan 24/25 there is a key work stream related to the Future Workforce, which addresses accessible and diversified recruitment and the Trust recruitment strategy. This action is addressed through the 24/25 People Plan.	31/03/2025	Action linked to Trust's People Plan and delivery will be dependent on resource within HR team being increased. A Business Case has been shared with Exec Team - outcome awaited.
6. Lack of inclusive practises to increase diversity across the organisation	Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030. EDI is central to all elements of the people plan with particular focus on learning, recruitment, development, and retention in 2024/25 - with operational leads assigned to each area. A comprehensive EDI plan is in place, which is aligned to the NHS England high impact changes.	31/03/2025	

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	
Risk Number	Strategic Objectives
2.2	Support our People

CQC Domains	Linked Risks	Owner
▪ Caring ▪ Safe ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	People Committee

Description
Failure to set up the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision.

Oct 2024	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports Bi-monthly reporting to PAWC
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on Trust Intranet and accessible for staff
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2023 Staff Survey Report - main report, divisional reports and team level reports
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Thriving Leadership Programme	Strategy implementation as part of the People Plan
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at People and Wellbeing Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC bi-monthly
Regular Schwartz Rounds in place	Steering Group established
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to PAWC
Alignment of staff safety and patient safety work via developing safety culture training and developing Restorative Just & Learning culture strategy	Patient Safety Board minutes
Monthly Thriving Teams MDT established comprising all corporate support functions who work with teams. Chaired by Associate Director of Organisational Development and enables shared thinking about teams in need of support and joint working where indicated.	

Gaps in Controls / Assurance
- lack of embedded safety culture across the organisation - lack of understanding about a just and restorative culture approach - lack of consistent compassionate leadership - Inconsistent application of Trust values and behavioural framework - insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas - insufficient OD resource available to fully address all culture tensions and challenges when they arise

Action	Description	October 2024	
		Due Date	Action Update
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards.	30/09/2024	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 supporting culture work	Culture strategy to be developed and to include review of governance framework and reporting processes for culture work including via Patient Safety Strategy Board and People and Wellbeing Committee.	23/12/2024	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 focussed review and development and Operational Leaders programme.NHSE Board level leadership competencies published with full appraisal process to follow in autumn 2024. All leader competencies to be developed based on same principles with reference to NHSE line manager competencies and other published leadership competencies.	30/10/2024	Strong Foundations review complete. Clinical Leaders programme scoping underway with listening sessions with all clinical leads to take place between July and Sept 2024. Scoping also underway to develop Operational Leaders programme. Thriving Leaders Framework to include these components and to be supported as part of Vision 2030 programme support with relevant people invited to attend and become part of development team.
Values and behavioural framework review, update and implementation	Current values and associated behavioural framework to be reviewed in dialogue with segmented groups of staff to develop updated values and underpinning framework. Both to be embedded across the organisation with support from Brilliant Basics.	31/03/2025	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).

Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	
Risk Number	Strategic Objectives
2.3	Support our People

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	4	People Committee

Description
- Failure to have a diverse and inclusive workforce which represents the local population. - Failure to take steps to become an inclusive work place where all staff feel their contribution as an individual is recognised and valued. - Failure to provide equal opportunities for career development and growth. - Non-compliance with the public sector equality duties

Oct 2024	
Control Description	Control Assurance Internal
Establishment of 4 x Staff Networks	All networks have appointed chairs, supported by Head of EDI. members of EDI Steering Group and report bi-monthly
Education and Training in EDI	Mandaotry EDI Training for all staff. current compl;iance above Trust target of 90%.
Head of EDI (0.6wte) in post. joint post with Clatterbridge Cancer Centre.	
Actions taken in response to Gender Pay Gap	
PAWC Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via 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	September 2024	
		Due Date	Action Update
1. Multi-factoral issues spanning training and education	Education and training programme launched. Conversations underway to implement EDI training as mandatory	13/12/2024	
2. Sufficient EDI resources to support the EDI agenda	Business case for additional resource to be developed.	08/11/2024	
3. Cultural awareness and understanding	Programme of awareness in train including establishment of Staff Networks, devoted sessions at 'Ask the Execs'. Regular commutations, atrium events, celebrations and awareness raising emails issued to all staff.	31/03/2025	

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

CQC Domains	Linked Risks	Owner
Responsive		Rachel Lea

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

Description
The Alder Hey long term vision for the Alder Hey Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale and in partnership with the local community and other key stakeholders as a legacy for future generations

Oct 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	October 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
15	8	Finance, Transformation & Performance Committee

Description
Risk of failure to: - translate the 2030 Vision into operational plans and systematically execute. - deliver on the strategic ambitions to make a difference to CYP impacting on the delivery of the NHS Long Term Plan and Trust's reputation.

Oct 2024	
Control Description	Control Assurance Internal
Collaborating in Communities is a key theme in the 2030 Change Programme: assurance received through Strategy Leadership Group and Strategy Board	
2030 Vision: Alder Hey strategy refresh - Q4 23/24 - delivery of brochure and final comms collateral	Council of Governors strategy session (full overview) (Jan 2023) Strategy 2030 - Approved at Trust Board (March 2023) Strategy 2030 wider Staff Launch (May 2023)
CYP System update report to Strategy Board, incorporating partnership assurance periodically throughout the year.	Building upon Growing Great Partnerships report
Operational Plan incorporates Vision 2030 deliverables (2024/25)	Operational Plan
Executive Portfolios all incorporate elements of Vision 2030 delivery	
SRO Group established	
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	

Gaps in Controls / Assurance
1. Completion of 2030 Vision communication collateral 2. 2030 delivery programme and plan in development 3. Failure to develop capacity for delivery 4. Failure to build capacity and skills within our workforce to deliver the 'new' aspects' of the 2030 Strategy 5. Failure to deprioritise to enable requisite focus on areas of need and transformational change 6. Risk of 'mission creep' associated to the Strategy

Action	Description	October 2024	
		Due Date	Action Update
2. 2030 delivery programme and plan	Trust Board signed off 23/24 multi-year April 2024. Delivery scope and plans developed for all strategic goals, required at a subject level.	31/03/2025	
3. Developing skills and capacity to deliver the Strategy 2030 (24/25)	This task has started across the individual workstreams, but given the shift that 2030 this will be continued task. New skills and capacity has been secured through the appointment of a Public Health Consultant (Started - May 24). New customer service capabilities are being developed through the roll out of customer service training in health care (April 24). The Managers Essential training which has started deliver provides a further opportunity to equip leaders/managers across Alder Hey, to support there teams to thrive (April 24).	12/12/2024	
4. Sharp focus at Strategy Board on core mission		12/12/2023	
5. Focus on transformational change	Oversight through Strategic Leadership Group and Strategy	12/12/2023	
Understand the impact of organizing ourselves around the needs of and the impact on income.	As part of vision 2030 we are seeking to meet the needs of CYP, this includes working and thinking different. Our current working approaches have often been designed to support the organisation and the opportunity to secure income for activity; that allows us to delivery world class specialised care. There are however examples emerging that indicate that whilst a change will be positive to CYP it could potential impact on received income. A balance between doing the right thing / or the better financial return. Work to be undertaken with costing team, transformation and divisional colleagues.	28/05/2024	

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

Description
Failure to meet NHSI/E targets. Inability to invest in the capital programme.

Oct 2024	
Control Description	Control Assurance Internal
Organisation-wide financial plan.	Monitored through IPR and the monthly financial report that is shared with FT&P and Trust Board.
NHSi financial regime, regulatory and ICS system.	- Specific Reports submitted monthly and annually as part of business plan process.(i.e annual plan reviewed by FT&P) - Attendance at ICB DoF Group
Financial systems, budgetary control and financial reporting processes.	Daily activity tracker to support divisional Performance management of activity delivery -@ Full electronic access to budgets &@ specialty Performance results -@ Finance reports shared with each division/@department monthly -@ Financial in-month and forecast position reported through SDG, Exec team, FT&P, and trust Board -@ Financial recovery plans reported through SDG and FT&P -@ Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend. Updated 5 year capital plan shared with FT&P and Trust Board.
Divisional performance discussed at FT&P with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting through FT&P with divisional leads ('3 at the Top')
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / FT&P and SDG for the relevant transformation schemes.
FT&P deep dive into any areas or departments that are off track with regards to performance and high financial risk area	FT&P Agendas, Reports & Minutes
Financial Review Panel Meetings	Any area/division that is off plan is expected to attend a financial review panel meeting with DOF with action plan detailing mitigation to bring back into budget.
Financial Improvement - SDG Meetings - Oversight of Plan delivery	Minutes from SDG

Gaps in Controls / Assurance
1. Changing financial regime and uncertainty regarding income allocations and overall financial position of Trust. 2. Long Term tariff arrangements for complex children shows underfunding of c£3m for Alder Hey 3. Devolved specialised commissioning and uncertainty impact to specialist trusts 4. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme 5. Funding models not aligned to 2030 creating a shortfall. 6. Deliverability of high risk recurrent CIP programme 7. Increasing inflationary pressures outside of AH control 8. Divisional budget positions are not achieved due to emerging cost pressures and impact of Industrial Action.

Action	Description	October 2024	
		Due Date	Action Update
Changing financial regime	1. Continued annual Regular reporting to strategic execs and assurance to FTP and Trust Board	31/03/2025	
Delivery of 5 year programme	4. Five Year capital plan	31/03/2025	23/24 Capital plan submitted in final plan. Due to changes in CDEL limits for the future years, further work is ongoing on the next 3 years including a review with each capital lead. This work will be complete and presented to executive team early June and reported back through 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. Ongoing monitoring of efficiency schemes through Sustainability Delivery Group. Assigned finance lead to all transformation efficiency schemes. Benefits realisaiton approach for all transformational schemes to ensure financial saving captured. Weekly updates to strategic execs on the status of the efficiency programme. Assurance report into FTP and one of the top areas of focus for the committee.	31/03/2025	
Inflationary pressures	7. Monitor closely impact of inflation increases working with HPL to obtain data on supplier increases and inflation avoidance through negotiations.	31/03/2025	
Shortfall against Long Term Financial Plan	5. Long Term Financial Plan to be updated for latest position and to take us to 2030 as part of financial strategy.	30/09/2024	Annual planning process complete and bridge completed by division. However further delays to the completion of the LTFM and the productivity work has resulted in this not being completed in the time-frame initially set. This will form part of the 2030 financial strategy to be completed in Q2.
Underfunding of Long Term tariff arrangements for complex children	2. Regular reporting to strategic execs and assurance to FTP and Trust Board. Use of SLR and PLICS to understand tariff shortfall and reasons and then build case for discussion with commissioners.	31/03/2025	

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

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

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

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

Oct 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	October 2024	
		Due Date	Action Update
3. Partner Engagement	Complete partner engagement	01/10/2024	
4. Horizon Scanning	4. Horizon scanning	01/10/2024	Systematic horizon scanning update built into quarterly 'Growing Great Partnerships' board report
Capacity and capability to deploy Vision 2030 at Place(s)	Assessment of central team capacity along with a 24/25+plan to address gaps to be undertaken with MD & CSPO in December 23. Linked with COO and divisions for wider capacity and capability across clinical teams. Capacity and capability for Place especially for Get me Well is needed both in partnerships/strategy team and clinically	01/10/2024	
Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	01/10/2024	Conversations with NHSE and colleagues within Greater Manchester and South Cumbria continue to support a North West Children's Strategy for delegation of services.
System Developments	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	30/09/2024	Now have agreement for a Children's Board under the Cheshire & Mersey ICS which will include a children's health network. This will include key stakeholders from across the region with the ability to influence and transform children's services. It will act as a Forum for sharing information across the system to help us keep abreast of the changing landscape.

Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.		
Risk Number	Strategic Objectives	
4.1	Pioneering Breakthroughs	
CQC Domains	Linked Risks	Owner
Well-Led		John Chester

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	6	Futures Committee

Description
Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships - which would delay new discoveries. Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities. Risk of exposure to ethical challenges and national and international reputational risks.

Oct 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	October 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.

Oct 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	October 2024	
		Due Date	Action Update
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2025	
3. Alder Care	Implementation of Alder Care Optimisation Programme	30/08/2024	Programme to commence Nov 2023
Cyber Assurance Framework	This has replaced the action around Cyber Essentials +. The Trust are partway through completing the Cyber Assurance Framework, Part C and D were completed in 23/24 and Part A is scheduled to be completed before the end of 2024. For 25/26, Cyber will now become a key part of the Data Protection and Security Toolkit which is completed annually and assurance will be sought through this assessment. Results of the next annual DSPT will be received in July 25.	31/07/2025	
Experienced Resources	Assess workforce and develop options appraisal for impacted services	14/05/2024	