BOARD OF DIRECTORS PUBLIC MEETING
Thursday 6th February 2025, commencing at 9:00am
Lecture Theatre 4, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00pm-9:15pm)							
1.	**24/25/294**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/295**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/296**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **9th January 2025.**	**D**	Read enclosure
4.	**24/25/297**	**9:19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**24/25/298**	**9:20 (10 mins)**	**Chair's/Chief Executive's Update.**	Chair/ J. Grinnell	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**24/25/299**	**9:30 (15 mins)**	**System Alignment and Partnerships.**	J. Grinnell/ D. Jones	To receive an update on the current position.	**N**	Presentation
7.	**24/25/300**	**9:45 (10 mins)**	**Vision 2030 Strategy deployment update; including:** • **Transformation Programme update.**	K. Warriner /N. Palin	To receive an update on the deployment of Vision 2030, and the Transformation Programme.	**A**	Read report
Operational Issues							
8.	**24/25/301**	**9:55 (10 mins)**	**2025/26 Annual Planning Update.**	A. Bateman	To receive an update on the current position.	**N**	Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
9.	**24/25/302**	**10:05 (40 mins)**	**Evidence of Our Performance:** • **Flash Report, M10.** • **Integrated Performance Report for M9, 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
10.	**24/25/303**	**10:45 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Unrivalled Experience							
11.	**24/25/304**	**10:55 (30 mins)**	**Neurodiversity Transformation Plan.**	L. Cooper	To receive the transformation plan for Neurodiversity.	**A**	Presentation
12.	**24/25/305**	**11:25 (5 mins)**	**Network Approach for the Gender Service – Briefing.**	J. Grinnell	To receive a briefing on the network approach for the Gender service.	**A**	Read enclosure
13.	**24/25/306**	**11:30 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 22.1.25.** - **Approved minutes from the meeting held on the 18.12.24.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 18.12.24.	**A**	Read enclosures
Collaborating in Communities							
14.	**24/25/307**	**11:35**	**Liverpool Neonatal Partnership Board: - Chair's Highlight Report**	A. Bass	To receive an update on the LNP Board meeting that took place on the 20.1.25.	**A**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
		(5 mins)	**from the meeting held on the 20.1.25**				
Supporting our People							
15.	**24/25/308**	**11:40 (10 mins)**	**People Plan Highlight Report, including:** • **Staff Survey update.**	M. Swindell	To receive an update on KPIs and actions.	**A**	Read report
16.	**24/25/309**	**11:50 (5 mins)**	**People Committee:** - **Chair's Highlight Report from the meeting held on the 15.1.25.** - **Approved minutes from the meeting held on the 13.11.24.**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 13.11.24.	**A**	Read enclosures
17.	**24/25/310**	**11:55 (10 mins)**	**Freedom To Speak Up Update.**	K. Turner	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
18.	**24/25/311**	**12:05 (5 mins)**	**Update to Corporate Governance Manual (Standing Orders, Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD)**	R. Lea	To receive an update on the amendments to the Corporate Governance Manual.	**N**	Read report
19.	**24/25/312**	**12:10 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 16.1.25.** - **Approved minutes from the meeting held on the 10.10.24.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 10.10.24.	**A**	Read enclosures
20.	**24/25/313**	**12:15 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's Highlight Report**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 16.12.24, and to receive an update on the top key risks for	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			from the meeting held on the 27.1.25. - **Approved minutes from the meeting held on the 16.12.24.** - **2024/25 Top Key Risks, (M9).**		2024/25.		
21.	**24/25/314**	**12:20 (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							
22.	**24/25/315**	**12:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
23.	**24/25/316**	**12:29 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Lunch (12:30pm-1:00pm)							
Date and Time of Next Meeting: Thursday, 6th March 2025, 11:00am, LT4, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in January 2025: • 422: DS1 Form (land at Alder Road). • 423: Deed of Variation (south side of Alder Lane)

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M9, 2024/25	R. Lea
2025/26 Priorities and Operational Planning Guidance	D. Jones

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 9th January 2025 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 Nursing, AHP and Experience Officer	(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	Chief Executive Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. R. Lea	Chief Finance Officer	(RL)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
	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)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/270	Ms. M. Ashe	Policy Lead and Advisor to the CEO	(MA)
Apologies:	Dr. U. Dass	Director of Medicine	(UD)
	Ms. B. Pettorini	Director of Surgery	(BP)

Patient and Staff Story

The Chair welcomed Sienna and her mum, Katie, Dr. Anna Simmons (*Clinical Psychologist*), and Lucy Bray (*Professor of Child Health Literacy at Edge Hill*), who had been invited to attend January's Board to present their story on how ISupport standards were introduced for children undergoing clinical procedures at Alder Hey.

Katie provided an overview of her experience explaining that when she was younger she felt disconnected from her care due to the lack of communication by her medical team, and was very distressed when being treated as she did not know what was happening. Doctors had advised her parents that Katie was too young to remember the procedures, but this was incorrect as it has impacted her life immensely. Katie is unable to attend hospital appointments by herself and drew attention to the importance of supporting nurses when having to deal with very distressed children. Katie became involved with the work that Lucy was doing to support children attending hospital and now supports the core team.

Lucy shared a number of slides that explained the purpose of the ISupport rights-based standards for children undergoing clinical procedures. ISupport was initiated by Katie and has only recently been implemented. This was a huge piece of work in which consultation took place with professionals, parents and children. Over the last twenty years work has taken place on the Clinical Holding Policy, and this is ongoing. The Trust has been listening to children's voices via the Young People's Forum and is involved with the 'Putting Children First'

campaign in partnership with the University of Liverpool. Alder Hey is working hard to ensure each child has the best experience but there are some children who are still having experiences like Katie described. The team are looking to roll out the ISupport toolkit to all Trust staff and have engaged with departments to show how it is being used to help patients. The team is in the process of auditing the use of the toolkit with respective teams, and it was reported that more departments have shown an interest in becoming involved following the launch of ISupport.

Anna informed the Board that the launch of ISupport took place in November, and it was Sienna's idea to attach the standards to a pen for staff. ISupport lanyards have also been introduced which Sienna is using.

Sienna advised that she has been a patient at Alder Hey for the majority of her life due to having complex needs. Prior to the introduction of ISupport, Sienna explained that attending appointments was really hard as doctors didn't always listen to her and didn't explain what was going to happen which made her feel frightened. Since working with Anna, Sienna has been building trust with her team of doctors via the use of a range of things: Play Specialists, getting to know the things that she likes, using safe spaces to help with relaxation, prep sheets, and making sure medical staff know that she likes to be spoken to during appointments. Sienna informed the Board that she now feels confident enough to voice her thoughts and decided to help with the ISupport launch as all children should have a voice.

Sienna's mum commented that ISupport has given Sienna a voice, she is listened to now and her medical team are starting to see her as a person. Anna informed the Board that she has seen the positive impact ISupport has had on appointments for all. Sienna's mum offered thanks to Anna and her team for helping Sienna.

The Chair thanked everyone for attending Board and sharing their experiences. It was felt that the team is undertaking some remarkable work that will support many children who have to attend Alder Hey for clinical procedures. The Chair pointed out that the Board has listened to Sienna's and Katie's story in terms of their experiences and confirmed that learning will be taken from this.

24/25/266 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.

24/25/267 Minutes of the previous meeting held on 5th December 2024.
Resolved:
The minutes from the meeting held on the 5.12.24 were agreed as an accurate record of the meeting.

24/25/268 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

There were no actions to discuss.

24/25/269 Chair's and CEO's Update

The Trust received positive feedback from families in respect to the celebrations that took place across the hospital in December. On behalf of the Board, the Chief Executive offered thanks to all those involved in making Alder Hey a magical place over the festive period.

The Board was advised of the incredible pressures being experienced by the wider health system. The Trust is trying to be as proactive as possible and is running a Cheshire and Merseyside (C&M) 'Gold System' for paediatrics to support the wider system. There is a focus on achieving the end of year position, with numerous discussions and briefings taking place across the North West which is dominating the external environment. Reference was made to January's agenda which provides time in which to discuss the organisation's financial position as it heads toward the end of 2024/25. It was reported that the Trust is also focussing on developing its annual plan for 2025/26. The centre's direction of travel for the NHS has just been published and there is a real sense of the money driving the thinking for the next year with lots of positives in terms of elective recovery. It will be necessary to focus on the financial projections for 2025/26, but it is also important to remain optimistic and progress the organisation's plans through what is expected to be a very difficult time.

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

24/25/270 Emerging Government Guidance and Policies

The Board received a presentation from the Trust's Policy Lead and Advisor to the CEO, Melissa Ashe, on emerging government policies and guidance. A number of slides were shared that provided information on the following areas:

- Children's Wellbeing and Schools Bill.
- Proposals to regulate NHS managers.
- English Devolution White Paper.
- New 10 Year Health Plan.
- Emerging Priorities and operational planning guidance;
  - Reforming elective care for patients.

Attention was drawn to the slide relating to proposals to regulate NHS managers. The Board was advised that there is a broad set of options in this consultation, from a disbarring process to a full-scale statutory regulation that matches doctors and nurses. It was reported that there will be a significant cost to the system to establish this process, and there is a debate to be had about the scope of something like this. Erica Saunders advised that one of the options is to include Board members, Non-Executive Directors (NEDs) in the first instance, but this will be complex in terms of having a regulated system that is parallel to other professions. There is usually an entry qualification which could be problematic when establishing this for NEDs. It was pointed out that NHS England is in the process of developing a management development framework and potentially a code of practice.

Reference was made to the Thirlwall Inquiry, and it was reported that the author of the Code of Conduct for NHS Managers (2002), Ken Jarrold, gave evidence at the Inquiry on the 6.1.25. Ken Jarrold shared his thoughts on the failure to implement recommendations from various Inquiries and was in favour of a Code of Conduct

for all NHS employees which would apply to all and not define standards along professional lines. Taking into account the way this was framed it was felt that a specific recommendation might be made by Rt. Hon Lady Justice Thirlwall.

It was felt that the Trust should continue to focus on this area through its work on values and behaviours with an emphasis on culture and what it means for the organisation, ensuring people feel free to speak up safely. A discussion took place and suggestions were made about investing in managers to prepare them for forthcoming changes, and looking at culture in a way that people take responsibility for their own actions and are held to account.

Erica Saunders suggested that she and Melissa Swindell take responsibility for compiling an organisational response to the NHSE consultation which closes in February.

A further conversation took place about the opportunities of the wider footprint in relation to the English Devolution White Paper, and the key elements of the emerging priorities and operational planning guidance.

The Chair thanked Melissa Ashe for providing detail on the emerging guidance and policies.

Resolved:
The Board noted the update on emerging government guidance and policies.

24/25/271 Cheshire and Merseyside Financial Position Update

The Board was provided with an update on the latest C&M financial position as at the end of November 2024, including system efficiency plans, workforce and an update on the forecast for the full financial year. The following key points were highlighted:

- The C&M system is reporting a deficit of £229.4m at the end of November which is £67.3m adverse to the plan agreed at the start of the year and also £18.9m worse than the recovery trajectory submitted at the end of August.
- CIP plans are behind plan by £22.4m at Month 8, with only 53% of the full year plan delivered to date.
- Forecast for the year highlights a further deterioration in the risk adjusted forecast to £222m deficit largely due to the residual gap in funding for the pay award, overall, a £72m variance to the £150m deficit plan set.
- Workforce numbers have increased over the last three months at nearly 1000 WTE over plan YTD, with a significant reduction of 1,468 required to achieve the workforce plan target by the end of March 2025. It is felt that this target is unachievable given all the critical incidents over the winter period.
- At the end of November, Alder Hey is reporting in line with its financial plan, except for the impact of the pay award funding gap (£0.6m). Delivery of efficiency savings is slightly ahead of plan, however 10% is still categorised as high risk which is in line with the system average but continues to be monitored and challenged weekly to ensure schemes are delivered and does not create a risk to the overall financial forecast for the year. The Trust is on the ICB's radar in terms of workforce numbers with additional questions being asked of the organisation.

- Whilst the overall position across the C&M system is showing challenge and deterioration there is still an expectation by NHSE that the system will achieve its plan by the end of the financial year.

Resolved:
The Board noted the C&M System wide update.

24/25/272 Collaborate for Children and Young People: Partnerships Update

The Board was advised that the emerging planning priorities align strongly with the Trust's Vision and 2030 Strategy. It was felt that the emerging guidance and operational changes across C&M will propel the Children's Alliance to undertake work in collaboration on elective services. A number of slides were shared that provided the following information:

- C&M (CYP Alliance);
  - Accelerate elective recovery further and faster.
  - ICB discussions;
    - Address RTT waiting times.
    - Meeting scheduled for w/c 13.1.25.
    - Alder Hey's leadership is paramount for CYP.
- Liverpool City Region;
  - Developing Office for Public Service Innovation (OPSI) relationship - Link with Neighbourhood model.
  - Innovation Zone – Artificial intelligence/digital.
  - Exec to Exec meetings have been scheduled between Alder Hey and Liverpool City Council to progress the Neighbourhood Model.
- Liverpool;
  - Advancing partnership working across health and with city partners.
  - ToR are in the process of being compiled to determine how the Trust will work in partnership with the various providers.
  - There is to be a focus on relationships in order to work together as a city.

Resolved:
The Board noted the partnerships update.

24/25/273 Evidence of Our Performance

Flash Report, M9

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

- There was one serious incident reported in December 2024.
- There has been a slight reduction in the Trust's FFT scores due to a decrease in patients being treated in ED within the four hour target.
- Revolutionising Care;
  - ED: 81.1% patients treated within 4 hours.
  - RTT: There are 256 patients waiting over 52 weeks for treatment. This is the 6th consecutive month with a reduction for RTT.
  - Elective Recovery is at 115% in December.
  - Diagnostic performance is at 95.8% in December.

- Finance/People: The Trust remains focussed on finances/headcount and is looking at the use of technology to modernise some the organisation's support services and administration functions.

A slide was shared that provided a summary of winter demand and performance. Attention was drawn to the following points:

- *ED Performance*;
  - Performance in December returned to above the national standard for treating patients within 4 hours.
  - *Type 1 ED Ranking* – The Trust's Emergency Department has been ranked as the 2nd best nationally. It was noted that ranking is determined by Trust Type 1 ED performance from the 1.4.24 to the 30.11.24.
  - The Trust's performance is similar to the previous year between October and December which is positive as the organisation has six fewer beds in 2024.
  - There was a slight increase in RSV positive cases *(574 between October and December 2024 in comparison to 561 between October and December 2023).*
- Paediatric Intensive Care Unit (PICU);
  - The demand on critical care has increased but the teams have addressed the pressures for which thanks were offered.
- Theatres;
  - Seven elective sessions were cancelled between October and December 2024 due to there being no beds available in PICU. It was reported that the Trust's aim is to have 0 cancellations.

Adam Bateman pointed out that when presenting a macro view it doesn't capture the day to day pressures and effort required to ensure continuity of services for patients. The Chair felt that the information shared was a true reflection of the hard work that has taken place.

Integrated Performance Report for M8, 2023/24

The Board received the Integrated Performance Report (IPR) for Month 8. An update was provided on the following areas of the IPR:

Outstanding Care and Experience – Safe and Caring

- 87% of formal complaints were responded to within 25 working days.
- There was 1 never event recorded which will be investigated via a PSII. This related to a Grade 3 pressure ulcer in a patient with complex needs (*this is the first pressure ulcer case reported in 900 days*).
- Overall compliance in responding to PALS concerns has decreased to 80%.
- The number of patients being admitted to PICU from HDU has increased.
- As at the 31.12.24, the Trust had commissioned two PSIIs. One related to a retained instrument which has been completed with findings and learnings presented to the Patient Safety Board and SQAC in December. The second relates to a wrong site injection and is still under investigation with an expected completion date of March 2025.

- There has been an increase in an amber staffing model (50%) being reported in November driven by higher acuity, increased capacity across the wards and some seasonal sickness.
- November has seen higher usage of bank spend and is attributed to additional winter beds, increased capacity and acuity. The influx of new starters is to be reflected in the numbers from December and therefore the organisation should start to see a reduction in bank usage.

Martha's Rule Update

The Board was advised that the pilot went live on the 9.12.24 on Ward 3C and Ward 4A. Tabletop holders with QR codes have been installed in all bed spaces on both wards and extensive trials have been undertaken on the use of WhatsApp with CYP, their families and staff to enable the chatbot process to be refined. To date one family has activated Martha's Rule. The response team attended within a ten-minute timeframe, and it was found that the matter related to a communication issue between the treating teams and family rather than a clinical deterioration. The response team spent thirty minutes with the patient and their family and escalated the situation to the nurse in charge and the medical team. Following discussion a Multi-Disciplinary Team (MDT) meeting was arranged to clarify the patient's treatment options and to hear the family's voice.

It was reported that the pilot was successful therefore Martha's Rule is to be rolled out across Ward 3C and Ward 4A from the 20.1.25 following completion of training, with plans for all areas to go live across the Trust by the beginning of March 2025. Alder Hey is hosting the C&M Collaborative celebration event at the end of March which will mark the end of the first phase pilot site. The Trust is awaiting further details in terms of stage 2 for Martha's Rule.

Revolutionising care

- The largest cross Divisional challenge relates to follow-up care. Huge progress has been made in the Community and Mental Health Division but overall, a lot of support is required to reduce overdue follow-ups. It was reported that work is being undertaken to resolve the situation digitally, via a transformation programme, and clinical validation but it was pointed out that it will take at least twelve months in which to solve this issue in a sustainable way.

Support our People

- There has been an increase in sickness absence to 6.2% *(and not 6.9% as detailed in the flash report)* due to seasonal ailments. It was confirmed that the Trust is monitoring sickness absence across the organisation and is encouraging staff to have the flu vaccine.
- Total Workforce (WTE) remains a challenging plan and was exceeded in both October and November 2024. A report has been submitted to the ICB, and a large number of measures have been implemented to try and resolve this issue. The second round of MARS (Mutually Agreed Resignation Scheme) was also launched w/c 6.1.25.

A discussion took place about the challenges of the workforce WTE plan and the actions taking place to support the reduction. It was agreed that a systematic methodology needs to be established to bring all aspects of the plan together; MARS, spans of control, reset points and communications for staff and the system.

24/25/273.1 Action: MS

Pioneering Breakthroughs

- *Investment Zone Business Case* – The Trust has been preparing a £4 bid to the Liverpool City Region Combined Authority (LCRCA) to support new activity around job creation and economic benefits from an innovation perspective. It was reported that a review of the investment business case took place on the 12.12.24 by an external panel of experts with a positive outcome and Alder Hey is now through to the final stage of the process in terms of approval from an internal panel within the LCRCA. The internal panel is scheduled to meet late January/early February which in effect will provide the Trust with a final decision. The organisation is cautiously optimistic that it will be successful with this bid. Funds will be available in April following sign off in March by the LCR. A further update will be provided during April's Board.

Collaborating in communities

- Discussions will take place with the respective people in the context of the elective guidance now that it has got real emphasis on how to address priorities within access. It was pointed out that the Trust has been very clear with regard to supporting learning difficulties and disabilities in CYP to make sure that patients are being seen appropriately whilst ensuring that the organisation is not creating or misunderstanding inequalities and access to people with backgrounds from different areas of deprivation. It was felt that this is an opportunity for the Trust to start to systemize the organisation's lens and metrics on this area of performance.
- Collaborating for CYP is now an area where the Trust has to provide assurance on its contractual obligations around policies and prevention, of which it is meeting. Assurance is provided via the Safety and Quality Assurance Committee (SQAC).

Financial Sustainability: Well Led

- The Trust reported a £0.5m deficit in M8, which is off plan by £0.6m YTD, due to the pay award impact. M8 has been a challenging month in terms of activity and costs. This has been mitigated by bringing forward the release of future benefits into the position.
- It was reported that the pressures in M8 have continued into M9 therefore work is being undertaken with the Divisions to gain further understanding of this issue and determine what it means for the organisation's year end position.

Community and Mental Health Division

- Challenges relating to the national shortage of ADHD medication continue, therefore the Trust has agreed to purchase medication for a cohort of 400 high risk patients and courier it to them. This comes with an increased risk but this process will cease once medication shortages have been resolved.

A request was made for an update on the Neurodiversity Transformation Plan. It was agreed to submit a report to the Board in February.

24/25/273.2 Action: LC

Division of Medicine

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

Division of Surgery

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

The Chair queried as to whether the Trust has started to generate funds through the use of the new MRI scanner. It was reported that the scanner is being used for research/innovation and to scan patients. Conversations and negotiations have also commenced with customers, but the phasing of income is behind time. Following discussion, it was agreed to review this matter and provide an update.

24/25/273.3 Action: RL

Resolved:
The Board:

- Noted the Flash Report for M9.
- Noted the content of the IPR for Month 8.

24/25/274 Tuberculosis Positive Case Update

The Board received a report that outlined the Trust's response to a confirmed Tuberculosis (TB) case in a rotational Trainee Doctor. Information was shared on the support that was provided to the affected individual, the track and trace approach that was undertaken by the Trust, and the clinical criteria for screening staff and patients impacted by this incident. Attention was drawn to the following points:

- Following notification of a positive test for pulmonary TB in a rotational Trainee Doctor the Trust engaged with the UK Health Security Agency (UKHSA) and commenced a track and trace approach.
- At the outset the Trust was informed that it was a low-risk incident. To date there has been no additional activity, however the screening process remains underway.
- The incident was managed as a local business continuity response and learning from the incident will follow. During the internal incident the Tactical Command team worked alongside UKSHA, Warrington and St. Helens who were the lead employer for the Trainee Doctor, the ICB, internal colleagues, the Communications team and Human Resources to ensure the appropriate measures were taken and all parties were updated.
- The Board was advised that the individual is well and no longer on rotation with Alder Hey, however support has been offered by the Trust if required.
- It was reported that there was a delay in the Trust being notified of the incident formally from the respective occupational health provider and the original track and trace process. An external review has commenced to ensure learning is identified from the incident. It was felt that this matter should be formally lodged with occupation health from a contractual perspective. It was agreed to look into this matter further.

24/25/274.1 Action: MS

Resolved:
The Board noted the recommendations and proposed steps as detailed in the report.

24/25/275 Organ Donation Annual Report, 2023/24

The Board received the 2023/24 Organ Donation Annual Report. Thanks were offered to the new team who have transformed organ donation at the Trust during the last 18 months. The following points were highlighted:

- The Trust referred 57 patients to NHS Blood and Transplant (NHSBT) during 2023/24; 27 of these were considered potential organ donors. It was confirmed that there were no occasions where potential organ donors were not referred.
- *Performance* – It was reported that conversations with families have been transformed and as a result of this there has been no missed donation opportunities.
- The Trust had 3 deceased solid organ donors resulting in 8 patients receiving a transplant.
- Once the new national guidance has been published in January the Trust will update its Organ Donation Policy accordingly.
- The team are liaising with the Bereavement team to commission a piece of artwork in collaboration with the Charity and families.

Resolved:
The Board received and noted the Organ Donation Annual Report for 2023/24.

24/25/276 Mortality Report, Q2

The Board received the Mortality Report for Q2. The following points were highlighted:

- The Medical Examiner (ME) process is now embedded. It was reported that 64 of the Trust's paediatric deaths have been scrutinised by the ME team with no issues raised.
- There were no avoidable deaths as a consequence of Alder Hey's care during Q2.
- *HMRG Primary Reviews within 4 months standard* - The percentage of cases being reviewed within the 4-month internal target has improved (85% in Q2) and an extra meeting has been scheduled in January to clear the backlog.
- A section has been included on Neonates in the Mortality Report. It was acknowledged that this is the first iteration, but it was felt that further work is required to include meaningful information/data, trends and benchmarking.

The Chair queried as to whether families are receiving support with the repatriation of their loved ones. A suggestion was made about contacting Great Ormand Street Hospital (GOSH) who deal with this at national level to see if they can offer any advice on a solution. It was agreed to look into this matter further.

24/25/276.1 Action: ABASS

Reference was made to the proposed new law to legalise assisted dying for over-18s. It was felt that this will raise a lot of concerns for young people and attention was drawn to the importance of determining what this will mean for the Trust. It was agreed to flag this to the Children's Health Alliance (CHA).

24/25/276.2 Action: DJ

Resolved:

The Board noted the Mortality Report for Q2

24/25/277 Learning from Patient Safety Incidents

The Board was provided with a summary of activity and system-wide learning following the transition to the Patient Safety Incident Response Framework (PSIRF) for Q3 2024/25 and next steps. It was noted that this is an iterative process as the organisation continues to transition and embed PSIRF. Attention was drawn to the following points:

- The report has evolved based on feedback and provides additional background information particularly in respect to serious investigations.
- It has been agreed to submit the Learning from Patient Safety Incidents report to the Trust Board on a quarterly basis. The team will continue to develop the report via the use of data and context.
- In November 2024 the Trust recruited 55 Patient Safety Partners (PSPs) following an active recruitment campaign supported by the organisation's Children and Young Person's Forum. An estimated start date of February 2025 is planned with the development of a bespoke programme
- Mersey Internal Audit Agency (MIAA) are currently undertaking an internal audit into the Trust's PSIRF arrangements to evaluate the operating effectiveness of controls and level of consistency in place for the management, recording, monitoring, and reporting of incidents following the adoption of PSIRF. The audit is due to be completed in January 2025 and the findings will be presented to the Audit and Risk Committee (ARC) in Q1 2025/26 and the Board in due course.

The Chair of ARC advised the Board that MIAA are undertaking the same piece of work for each trust in the C&M region. The outcome of the audit should provide benchmarking insight, if this is not the case Kerry Byrne offered to liaise with MIAA regarding this matter following completion of the audit.

Resolved:
The Board noted the Q3 Learning from Patient Safety Incidents update.

24/25/278 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 20.11.24 were submitted to the Board for information and assurance purposes.

During December's meeting there was a focus on Divisional updates and anti-microbial resistance. The committee noted the pressures being experienced in the Emergency Department and received an update on safeguarding training and C-diff. infections in Oncology.

Resolved:
The Board noted the approved minutes from the meeting held on the 20.11.24.

24/25/279 LNP Board – Chair's Report to Trust Board

The Board received a report from the Co-Chair of the LNP Board that provided an overview of the partnership and the activities that have taken place to date. Attention was drawn to the following points:

- It was reported that November's meeting was really positive, and it has been agreed that the LNP Board will revert back to monthly meetings as there is less than a year before the new Neonatal Unit opens.
- The LNP has developed a clear structure to deliver the new model of neonatal care for Liverpool. This is underpinned by a comprehensive project plan that will be delivered via six distinct workstreams with associated subgroups to ensure that all the necessary tasks have been identified and completed in the timeframes agreed.
- The Board was advised that the LNP has developed a thorough training schedule for all staff groups moving into the new unit, which includes weekly simulation sessions.
- The build timeframes and costings will be very much dependent upon the decisions made in relation to water safe requirements. A proposal is being explored but it was pointed out that in the event this route is taken there could be a three-month delay. This matter is moving at significant pace, and further updates will be shared at the earliest opportunity. A discussion took place regarding this issue from a financial and delay perspective. The Board was informed that this matter is high risk, and the organisation has an obligation to ensure the unit is safe for patients.
- A piece of work has been undertaken to confirm that the demand is consistent with the 22 cots that will transfer to the new unit once it is built, and it was found to be consistent with what has been agreed with the commissioners. This work aligned with the beds that will be decommissioned on the present Neonatal Ward and Ward 1C once the new unit is open. A discussion is scheduled for January's Operational Board to look at possible opportunities for these beds. It was pointed out that a transparent process will be required when deciding on the future use of these beds.
- A report has been compiled outlining a proposal for governance, policy and leadership arrangements. This document will be presented during the next Exec to Exec meeting with the Liverpool Women's Hospital (LWH) for discussion purposes. An update on the outcome will be submitted to the Trust Board in March.

24/25/279.1 **Action: ABASS**

Resolved:
The Board noted the LNP Board Chair's report.

24/25/280 People Plan Highlight Report

The Board received a detailed report on the progress that has been made against the core workstreams of the People Programme. Attention was drawn to the following points:

- During November's Trust Board, the networks presented their 'asks' to the Board in terms of support and actions. It was confirmed that the organisation is working with the network leads to support these actions
- The Trust has received six expressions of interest from medical colleagues for the Aspiring Chief Medical Officer programme that is being facilitated by the NW Leadership Academy.

Staff survey

A number of slides were shared to provide the headlines of the 2024 Staff Survey and discuss the initial data received. It was reported that the Trust has improved against each of its People Promises and Themes, especially in 'we are safe and healthy and we work flexibly'. It was reported that the official Staff Survey data will be available towards the end of February but in the meantime the People Committee will digest the initial data and discuss it further.

A conversation took place about appraisals, autonomy and control, trends/themes and the following actions were agreed:

24/25/280.1 Action: MS

- Look at the possibility of making it mandatory for PDRs to take place in person rather than virtually.
- Look at the correlation between positive feedback from staff following their appraisal and managers who manage large numbers of staff.
- Review the cultural element of the Trust's plan via an autonomous culture lens taking into account that this area needs performance at the heart of it.
- Use trends to display changes to enable staff to look back and compare data.
- Look at the trends/themes of feedback from staff on lower bands in the organisation.

A suggestion was made about preparing a comms piece to highlight the positive outcome of the 2024 Staff Survey and presenting it to various forums to raise awareness.

The Chair pointed out that there is a lot to do once the final results are available but felt that the Trust has advanced immensely in the last eight years.

Resolved:
The Board received the People Plan Highlight Report and noted the update on the outcome of the 2024 Staff Survey.

24/25/281 EAO Inquest 9th/10th December - Summary of Coroner's Findings and Residual Actions for the Trust

The Chair asked the Board to pause and reflect ahead of the briefing and advised that what happened to Eleanor Aldred-Owen has had a huge impact in so many ways not least to the grief and heartache of her family and those involved in what happened. On behalf of the Board, the Chair offered condolences and a sincere apology in relation to Eleanor's death.

The CEO, John Grinnell, recognised that it needs to be a profound moment for Alder Hey as the Trust didn't do well enough for Eleanor and her family, and confirmed that the Trust is committed to learning from this. It was confirmed that the Trust has sent a full apology and admission to Eleanor's parents.

The Board was provided with a briefing on the outcome of the inquest into the death of Eleanor following elective cranio-facial surgery at Alder Hey, including a summary of the coroner's findings and the current status of actions that the Trust is taking to address the issues identified.

The Chief Medical Officer (CMO), Alfie Bass, informed the Board of the profound effect attending the inquest had on the family and the visible effect it had on staff members who gave evidence.

An overview of the actions that have taken place to date was provided and attention was drawn to the action plan that has been established following the incident. It was pointed out that reflection has taken place on how the Trust manages deterioration broadly across the hospital. The following points were highlighted:

- The Trust now has a 24-hour, 7-day, response team in place, and two very senior nurses in post that cover Alder Hey.
- The organisation is in the process of implementing Martha's Rule with plans for all areas to go live across Alder Hey by the beginning of March 2025.
- The Neonatal Intensive Care Unit has funded 24-hour, 7-day, middle grade consultant cover. Cardiology consultant in-house cover has also been established.
- Work is being undertaken with General Paediatrics on a new model of acute delivery. An Away Day is taking place to consider this and agree a number of principles.
- A Discharge Policy has been established for recovery.
- It was pointed out there is still work to do; training assessments for staff along with an educational piece Trust wide, a review of processes in place for monitoring and escalating patients, look at integrating observations into EPRs, review the existing emergency airway cover, new model to be agreed for the Paediatric Assessment Unit (PAU) that is opening in 2025, enact policy changes, deliver a safety culture change via cultural human factors training, look at having a measure that applies to deterioration to drive cultural change.

The Chair thanked Alfie Bass for his leadership and Erica Saunders for her support at the Inquest. It was felt that the follow up is immense and the actions are being driven forward with great passion by the CMO and CNO.

Resolved:
The Board noted the contents of the briefing and confirmed its support to further the actions being taken in response to Eleanor's parents' comments and the coroner's conclusion.

24/25/282 Finance, Transformation and Performance Committee (FTPC)

The approved minutes from the meeting held on the 2.12.24 were submitted to the Board for information and assurance purposes.

During December's meeting there was a focus on operational performance, financial performance, and the cash position ahead of review by the ICB. The chair of the FTPC, John Kelly, highlighted his concerns about forecast accuracy and drew attention to the importance of compiling a paper detailing the use of the organisation's cash to replace medical equipment in the new financial year as there is no alternative resolution to address this risk.

2024/25 Top Key Risks (M8)

The Board was advised of the latest position of the 2024/25 FTPC key risks.

Resolved:
The Board noted the approved minutes from the meeting held on the 2.12.24 and the update on the FTPC's top key risks in M8.

24/25/281 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:

- BAF risk 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)* – It was confirmed that the score for risk 4.2 has increased in month.

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

24/25/282 Any Other Business

It was reported that the improvement notice for Nuclear Medicine has been lifted.

24/25/283 Review of the Meeting

The Chair thanked everyone for their contributions and openness during the meeting.

Date and Time of Next Meeting: Thursday 6.2.25 at 9:00, 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 February 2025							
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	Feb-25	**27.9.24** - This item will be included on November's Board agenda. **3.10.24** - This action has been deferred to December as further work is required before an update can be submitted to the Board. **28.11.24** - This action has been deferred to January. **3.12.24** - A report on the resolution of the sprinkler system in the Under-Croft car park will be submitted to the Board in February following approval of the proposal by the FTPC. **31.1.25** - An update will be provided in February. **ACTION TO REMAIN OPEN**
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	
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	Feb-25	**3.12.24** - A workshop is taking place at the end of January to discuss site planning opportunities. An update will be provided in February. **ACTION TO REMAIN OPEN**
Actions for March 2025							
9.1.25	24/25/273.1	Integrated Performance Report	*Support Our People* - Establish a systematic methodology to bring all aspects of the Workforce WTE plan together; including MARS, spans of control, reset points and communications for staff and the system.	M. Swindell	6.3.25	On track Mar-25	
9.1.25	24/25/273.3	Integrated Performance Report	Review the generation of income for the new MRI scanner and provide an update to the Board.	R. Lea	6.3.25	On track Mar-25	
9.1.25	24/25/274.1	Tuberculosis Positive Case Update	Formally lodge the Trust's concerns with the respective occupational health provider about the delay in being notified of the positive TB case.	M. Swindell	6.3.25	On track Mar-25	
9.1.25	24/25/274.1	Mortality Report, Q2	Contact GOSH to see if they can offer advice to help the Trust support families with the repatriation of their loved ones.	A. Bass	6.3.25	On track Mar-25	
9.1.25	24/25/274.1	Mortality Report, Q2	It was felt that the proposed new law to legalise assisted dying for over-18s will raise concerns for young people and attention was drawn to the importance of determining what this will mean for the Trust. It was agreed to flag this to the Children's Health Alliance (CHA).	D. Jones	6.3.25	On track Mar-25	

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

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
9.1.25	24/25/279.1	LNP Board – Chair's Report to Trust Board	*LNP* - Provide an update on the on the outcome of the proposal for governance, policy and leadership arrangements once it has been discussed at the next Exec to Exec meeting with the Liverpool Women's Hospital (LWH).	A. Bass	6.3.25	On track Mar-25	
9.1.25	24/25/280.1	2024 Staff Survey	•Look at the possibility of making it mandatory for PDRs to take place in person rather than virtually. •Look at the correlation between positive feedback from staff following their appraisal and managers who manage large numbers of staff. •Review the cultural element of the Trust's plan via an autonomous culture lens taking into account that this area needs performance at the heart of it. •Use trends to display changes to enable staff to look back and compare data. •Look at the trends/themes of feedback from staff on lower bands in the organisation.	M. Swindell	6.3.25	On track Mar-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	
7.11.24	24/25/214.2	Integrated Performance Report	Invite the family of a patient who were supported by the Wellbeing Hub, to a future Board meeting to share their story.	D. Jones/ K. McKeown	6.2.24	Sep-25	**31.1.25** - The family advised that February is too soon for them to attend Board to share their story. Contact will be made with the family again in six month's time. **ACTION TO REMAIN OPEN**

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
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	Closed	**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. **3.1.25** - An update will be provided in February. **31.1.25** - It was confirmed that work is ongoing to address this risk. **ACTION CLOSED**
7.11.24	24/25/219.1	Staff Story (EDI)/ Equality Act	Discuss the recommendations made by the Chairs of the staff networks and provide feedback on the outcome following discussion by the Exec team - (It was suggested that the big items be discussed; recruitment, promotion, management training, but in terms of the smaller asks it was felt that these should be responded to point by point with a mini action plan underpinning this work.	M. Swindell	9.1.25	Closed	**7.1.25** - Work is taking place with the network leads to support the recommendations made by the Chairs of the staff networks. An update on progress will be provided in February 2025. **31.1.25** - Regular updates on this action are provided in the People Plan update which is submitted to the Board on a monthly basis. **ACTION CLOSED**
5.12.24	24/25/244.1	Integrated Performance Report for M7, 2023/24	Submit a briefing to the Board on the network approach for the Gender Service.	L. Cooper	6.2.24	Closed	**31.1.25** - This item has been included on February's Board agenda. **ACTION CLOSED**
9.1.25	24/25/273.2	Integrated Performance Report	*Community and Mental Health Divisio* n - Provide an update on the Neurodiversity Transformation Plan in February.	L. Cooper	6.2.25	Closed	**31.1.25** - This item has been included on February's Board agenda. **ACTION CLOSED**

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	**2030 Transformation Programme Update** Period: December 2024 – January 2025
Report of:	**Natalie Palin,** Director of Transformation **Kate Warriner,** Chief Digital and Transformation Officer
Paper Prepared by:	**Natalie Palin,** Director of Transformation

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

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
3.2	Strategy Deployment	12

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

1. Executive Summary

This report outlines Alder Hey's current Vision 2030 transformation programme, focusing on the delivery of strategic priorities, oversight of benefits and milestones, and the transition to the next phase. The forthcoming phase will be driven by four cross-cutting collaboratives, designed to align with strategic goals, targeting savings of approximately £10 million in 2025/26 while contributing to sustained year-on-year financial transformation, whilst assessing the opportunity in the long-term.

2. Status Current Programme

The current programme remains firmly aligned with Vision 2030's strategic priorities, with rigorous oversight of milestones and benefits to ensure delivery against objectives. For areas identified as at risk, targeted reviews are underway with SROs to evaluate challenges, refocus efforts, and assess their integration into the next phase of the transformation programme.

Table 1: Programme Status and Milestones

Strategic Goal	Key Updates	Status – Milestones	Current Benefit Position
CYPF Engagement and Experience	• Realignment of milestones underway – in the context of the next phase 25/26+. ✓ Martha's Rule –successful piloted in Dec 24, with further roll out across clinical areas Qt4. 4.	On Track – 80% completion	**Driver measure**: 89% of families would recommend the Trust (below target for the past four months). Improvements in data collection and expanded language options were implemented to boost response rates and representation. Monitoring continue.
Supporting Our People	✓ Metrics have consistently met targets. • Delayed milestone benefit in the launch of Staff Thriving	On track – 85% completed / on track.	✓ Strong progress across all benefit metrics.
Futures Programme	✓ £4.5 m Investment Zone Bid at final stage ✓ Liverpool selected as NIHR Commercial Research Development Centre, with Alder Hey as Paediatric Hub ✓ Lyrebird Ambient AI – deployment in progress • Futures is currently undergoing extensive replanning and benefit measure review. • The Discovery Pillar is behind schedule • The commercialisation strategy has not generated significant new investment yet • A more ambitious discovery and AI strategy is in development	59% - completed 5 milestones at risks. Futures pillars most challenging are discovery and people.	YTD 3/4 benefits exceeding / on track ✓ **Driver measure:** Exceeding target number of colleagues benefitting from Futures masterclasses and workshops. ✓ **Benefit:** Number of Chief Investigation exceeding target (55) – YTD 58 ✓ Seed Funding awarded to 22 colleagues – supporting capacity and capability building – exceeding target

Collaborating for CYP	• Delayed milestones in Greener Alder Hey due to resource gaps. • Social value metrics under review. • Improve Life Chances Summit – 7th March (Key milestone)	60% Completed (9) 40% at risk off track	Jan 25 – social value driver measures off track (£147k YTD / Target £400k) currently under review.
Revolution Care	• Continued milestone delivery across workstreams. • Patient Portal procurement decision expected January.	On track (70% completed on track)	• Significant progress; across most of the programme. • Expected delays to Patient Portal, with anticipated benefits to be scheduled for 25/26.

3. The Next Phase of Vision 2030

The December 24 Strategy Board provided support and direction, shaping the next phase of Vision 2030. The Board's endorsement of a continued strategic toward **preventive and neighbourhood care** underscores a unified commitment to addressing the evolving needs of children, young people (CYP), and their families. This direction reaffirms the focus on delivering meaningful, sustainable transformation aligned with both organisational and system-wide imperatives.

The next phase of Vision 2030 will embrace a **collaborative delivery model**, to accelerate transformation, and address cross-organisational challenges and opportunities. This approach is essential to:

- **Empower clinical-led change**: Engaging teams closest to care delivery to drive high-impact, locally informed solutions.

- **Foster system-wide integration**: Advancing preventive and neighbourhood-based care models to deliver equitable and accessible services.

- **Embed long-term sustainability**: Aligning operations to improve outcomes, build resilience, and enhance resource efficiency.

The transformational benefits will be aligned to the Trusts agreed benefit realisation framework, which is anchored by the NHS Quadruple Aim framework (*Experience, Outcomes, Sustainability*). The transformation programme currently in development will focus on:

- **Improving outcomes for CYP and families** through tailored, needs-driven care models that prioritise prevention and accessibility.

- **Enhancing workforce well-being and satisfaction** by aligning skills and resources to organisational and patient needs.

- **Delivering financial efficiencies**, targeting £10 million in savings for 2025/26, alongside year-on-year efficiencies enabled by innovative practices

and optimised resource allocation.

- **Improving system efficiency and experience**, leveraging digital tools, AI, and integrated care pathways to enhance operational performance.

The next phase will be **Experience-Led and Needs-Driven**, transforming experiences for CYP, families, and our people. It represents a long-term strategic commitment, underpinned by:

- **New Models of Care**: Prioritising prevention, neighbourhood-based delivery, and person-centred care pathways that reflect population needs.

- **Technology and Innovation**: Leveraging digital tools and AI to drive smarter decision-making, enhance personalisation, and improve operational efficiency.

- **Optimising and Aligning Skills to Needs**: Ensuring workforce capabilities are strategically deployed to meet organisational priorities and service demands.

How: Four cross cutting collaboratives

As the Vision 2030 transformation programme evolves, achieving its ambitious objectives requires a delivery model capable of addressing complexity, driving system-wide integration, and fostering innovation. To realise the programme's potential, the next phase will be delivered through **four cross-cutting collaboratives**, each aligned to strategic priorities and designed to unlock opportunities across organisational boundaries.

The collaborative model builds on the principles of **experience-led and needs-driven transformation**, ensuring that every initiative prioritises outcomes for children, young people, families (CYPF), and our workforce. By bringing together expertise, resources, and leadership from across divisions, the collaboratives will:

- Enable the Trust to respond flexibly to emerging challenges and opportunities.
- Create alignment across clinical and operational areas to drive consistent progress.
- Leverage shared accountability, with **Executive Sponsors** providing strategic oversight and unblocking barriers to delivery.

This structure is not just about operational efficiency it is about **changing the way we work**, embedding collaboration, innovation, and resilience at every level of the organisation. To make this happen, we have brought together dedicated change resources from Transformation, Digital, HR /OD, Corporate Nursing, Finance, and Futures, ensuring teams have the right expertise and support to deliver meaningful change at scale.

The **collaboratives** are key to achieving **Vision 2030's** ambitions. Their focus areas are still being refined to make sure they align with **organisational priorities, strategic goals, and opportunities to drive financial sustainability**, all while delivering real, long-term value.

The emerging focus areas for the collaboratives are outlined below and are currently being refined and developed to ensure alignment with organisational priorities, strategic goals, and opportunities to unlock financial efficiencies and deliver long-term value.

Table 2: Collaborative Model Overview

Collaborative	Key Focus Areas	Hosting Division	Executive Sponsor
Neighbourhood Preventative Care Models (*Revolutionise Care*)	- Deliver prevention-focused care closer to home. - Reduce inequalities and improve access. - Develop virtual care and streamlined outpatient pathways.	Community and Mental Health	Chief Nurse, Chief Medical Officer and Chief Operating Officer
Acute, Diagnostics & Urgent Care (*Revolutionise Care*)	- Enhance efficiency and responsiveness in acute care. - Develop rapid diagnostics and to reduce hospital visits.	Medicine	
Centres of Excellence and Reimagined Elective Care (*Revolutionise Care*)	- Expand Centres of Excellence for world-class care. - Leverage digital tools and AI for personalised medicine. - Reform elective care pathways.	Surgery	
Fit for the Future (Working Title)	- Modernise support services to align with strategic goals and clinical collaborative. - Strengthen workforce leadership. - Optimise workforce planning - Leverage digital tools and AI to improve experiences. - Simplify governance and reduce bureaucracy to enable agile decision-making.	Cross-Cutting (All of AH)	

4. Conclusion

The Vision 2030 programme demonstrates Alder Hey's unwavering commitment to transforming care and experiences for CYPF and its workforce. Anchored in the NHS Quadruple Aim framework, the next phase prioritises meaningful and sustainable outcomes through a collaborative, **experience-led, and needs-driven approach**.

The establishment of four cross-cutting collaboratives will act as a cornerstone for driving clinical-led change, fostering system-wide integration, and delivering operational resilience. These collaboratives are positioned to unlock financial efficiencies, enable innovation, and embed cultural alignment, ensuring the Trust remains agile and future-focused in delivering its strategic priorities.

5. Recommendations

The Trust Board is asked to:

1. **Note** the progress made in delivering the current Vision 2030 programme, including the realignment of milestones and transition planning to BAU.
2. **Note** the establishment of four cross-cutting collaboratives to deliver the next phase of Vision 2030, aligned with strategic priorities.

6. Next Steps

Action	Timeline
a) Develop Transformation Blueprint, plans and benefit cases	February 2025
b) Transition Current Programme (BAU / Close / Integrate)	March 2025
c) Annual Plan and Transformation Programme – presentation Trust Board	March 2025

Flash Report January 2025

Performance is subject to change

Alder Hey Children's NHS Foundation Trust

0	0	92.6%	2
Severe/Fatal Incidents/Never Events	Number of Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections

78.4%	310	116%	97.3%
ED: %Treated within 4 Hours	Number of RTT Patients waiting >52weeks	Elective Recovery Volume vs 19/20	Diagnostic Performance

TBC	9.85%	81%	6.17%
Estimated Workforce Plan	Staff Turnover	%PDRs Completed	% Sickness

VISION 2030

HIGHLIGHT

- No severe incidents, Never Events or PSII's
- Diagnostics achieved 95% performance for 3rd consecutive month
- 4 hour Emergency Department target achieved

UPDATE — Financial Sustainability

- M10 position was £1.7m surplus and £0.6m surplus ytd which was off plan due to pay award. £0.2m of benefits that were assumed for future months were used to achieve this position.
- Forecast to be finalised, but likely to show £3.3m surplus for the year, however risk adjusted forecast remains at £2.2m following another challenging month.

CHALLENGES

- Sickness above target and WTE anticipated to be above plan, although position to follow once determined.
- x2 C.Diff hopsital onset healthcare associated infections

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: January 2025

VISION 2030

Our Journey To 2030

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

OUR ASPIRATION
To be world-leading

Get me well

Personalise my care

The Needs of Children, Young People and Families

Improve my life chances

Bring me the future

Outstanding care and experience

Collaborate for children & young people

Revolutionise care

Support our people

Pioneering breakthroughs

respect | excellence | innovation | together | openness

Contents

VISION 2030

Our Journey To 2030

IPR Summary

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

Variation	Assurance: Achieving Target	Assurance: Inconsistently Achieving Target	Assurance: Not Achieving Target
Special Cause - Improvement	Liquidity, Mandatory Training and Level 1 patient safety training are consistently achieving target with an improving trend	Incidents of harm, Severe/Fatal incidents, Complaints/PALs resolved, RTT 52 weeks, ERF Value and DC Recovery are inconsistently achieving target with an improving trend	Diagnostics, Staff Turnover, PDRs completed, Medical Appraisal and IHAs are not consistently achieving target but demonstrating an improving trend
Common Cause	Cancer and MRSA are achieving targets with common cause variation.	Incidents no harm, F&F, Sepsis, ED 4hr, WNB Rate, C.Diff, Sickness (Total and risks within review date are inconsistently achieving target and are yet to evidence statistical improvement	Theatre Utilisation, Long Term Sickness and Medical Appraisal are not achieving targets and currently not demonstrating statistical improvement
Special Cause - Concern	Category 3 & 4 Pressure Ulcers	F&F Emergency Department are inconsistently achieving target but demonstrating declining trend	

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

- 61.2% of measured metrics have achieved target in the month of December 2024.

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

- We are consistently passing 18.4%* of our metrics.
- We are achieving 65.3% of our metrics inconsistently.
- We are not achieving the target for 16.3% of our metrics, 0 are showing special cause of concern.

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

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

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

•Improved compliance in ED for antibiotic administration for sepsis: 94%
•93% compliance with PALS responded to within 5 working days demonstrating a timely response. Oversight of corporate PALS reviewed to increase support and ultimately timely response to families

Areas of Concern:

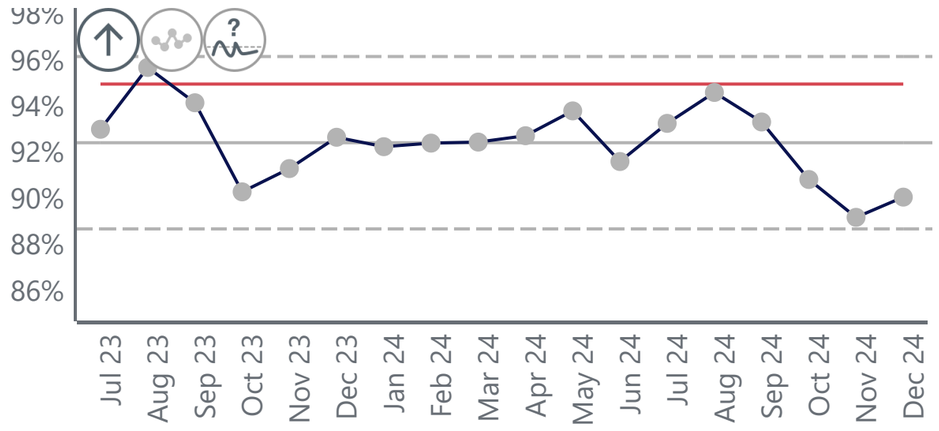
• Device related Category 3 pressure ulcer reported; investigated and then reviewed by PSIRI panel. Duty of Candour undertaken
• Trend over 3 months of reduced compliance below 90% for antibiotic administration for sepsis in inpatients

Forward Look (with actions)

• Divisional review of inpatient antibiotic administration for sepsis

F&F Test - % Recommend the Trust

Target: Statutory



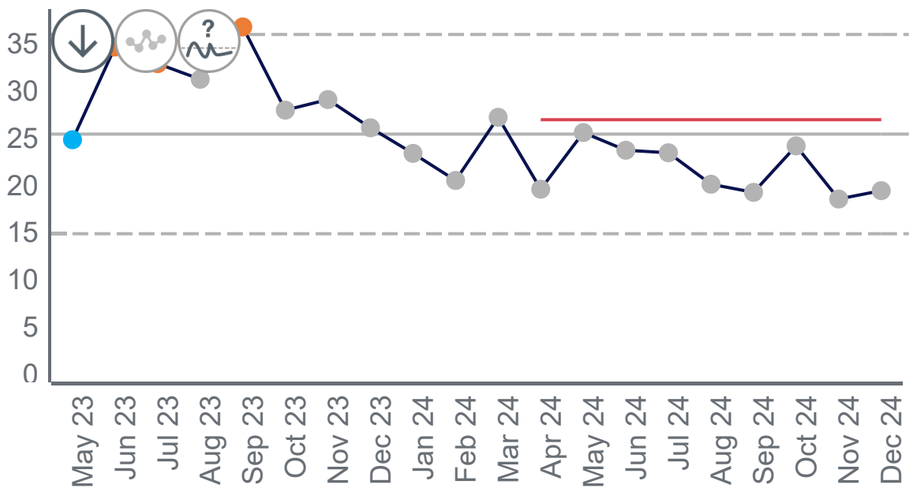
Technical Analysis:

89% of families would recommend the Trust from those who completed the FFT; review of the changes made in the FFT process in the New Year and impact of changes

Actions:

89% of families who completed the FFT would recommend the Trust. Quality Ward Round scheduled to review changes in FFT process

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



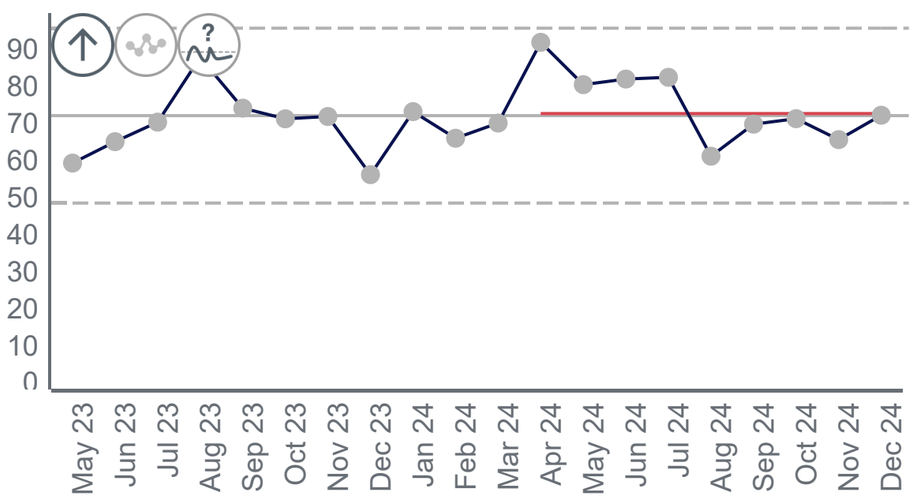
Technical Analysis:

Common cause variation has been observed with performance of 19 incidents of harm per 1,000 bed days, with a monthly average of 25 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:

Reduction of incidents resulting in harm in December

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



Technical Analysis:

Common cause variation observed with 72 incidents of no harm per 1000 bed days, with a monthly average of 72. This includes 38 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:

Reporting trend demonstrates continued positive culture of reporting no harm and near miss incidents; near miss incidents which are deemed a Good Catch are nominated to the weekly Patients Safety Meeting and celebrated and learning disseminated

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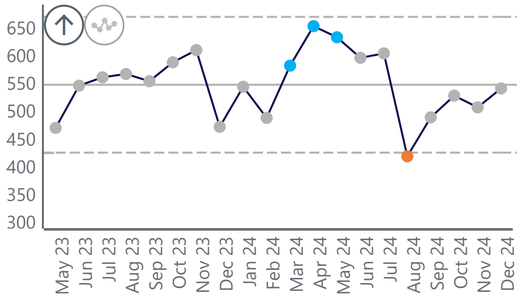
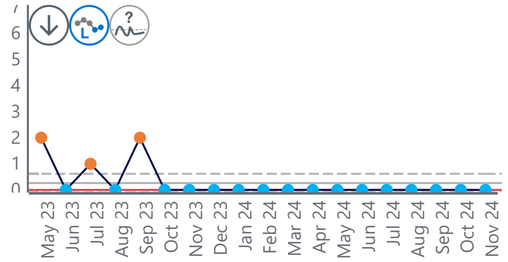
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



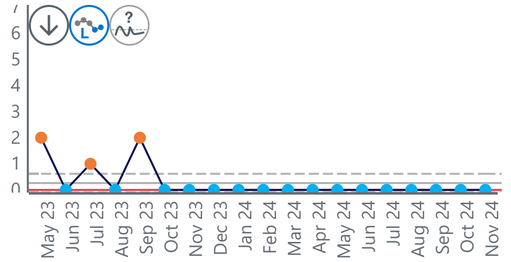
Severe or Fatal Incidents – Physical only

Target: Internal

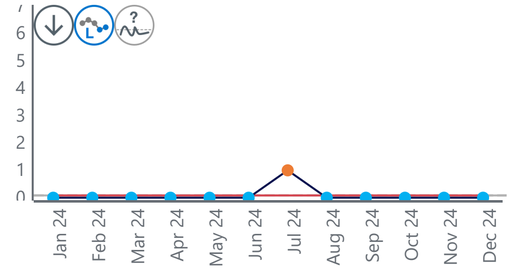


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

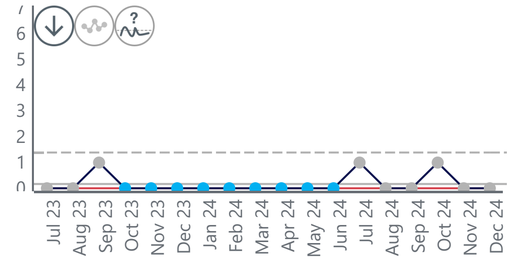


Number of PSIIs (Patient safety incident investigation) undertaken



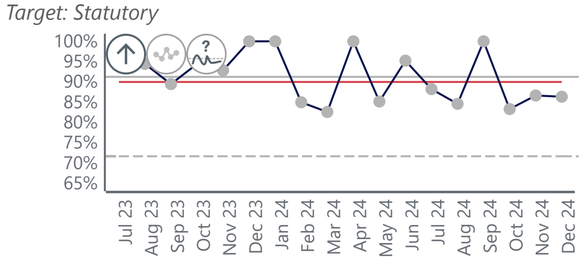
Number of Never Events

Target: Internal



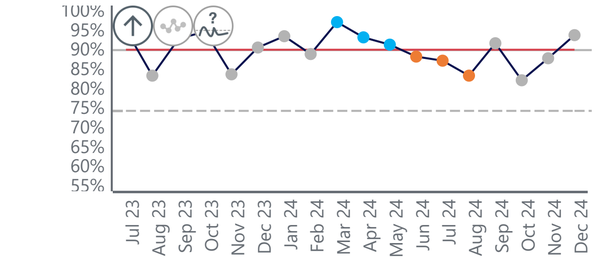
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

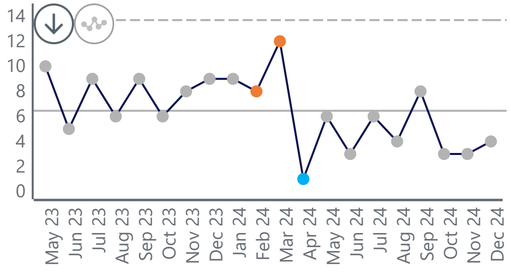


Sepsis % Patients receiving antibiotic within 60 mins for ED

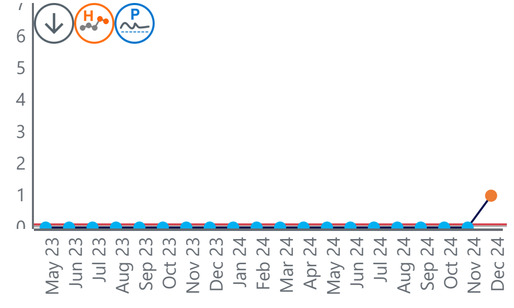
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

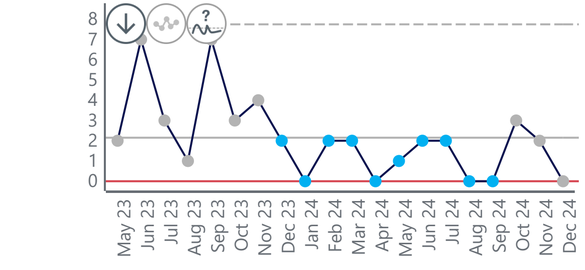


Pressure Ulcers Category 3 and 4

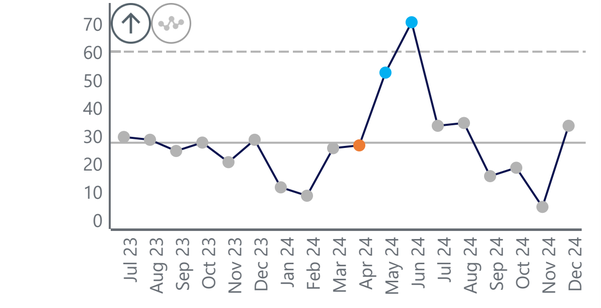


Pressure Ulcers Category 2

Target: Internal

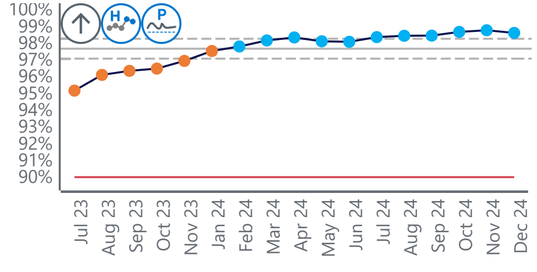


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



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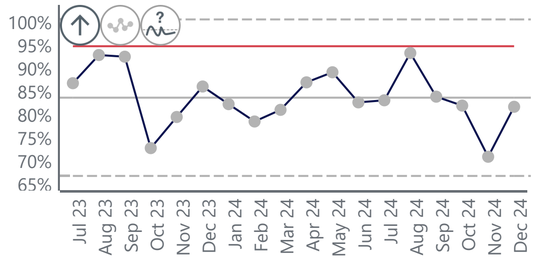
Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

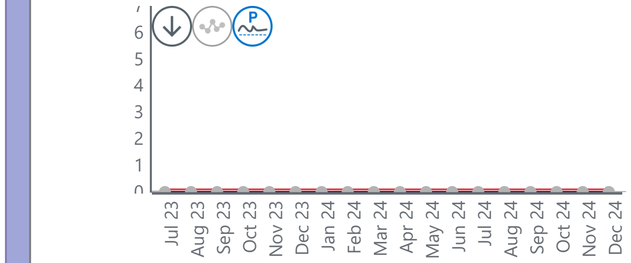
F&F ED - % Recommend the Trust

Target: Internal



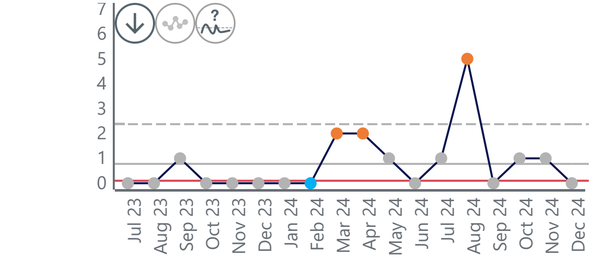
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



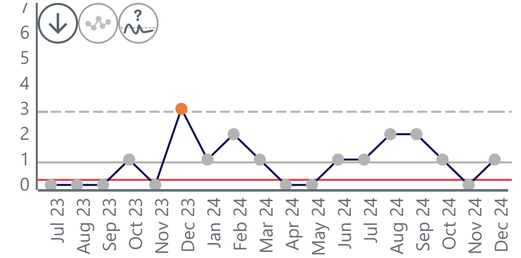
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



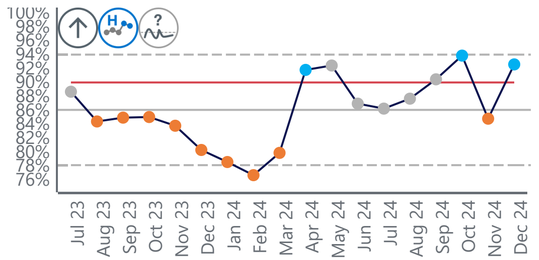
Hospital Acquired Organisms - MSSA

Target: Internal



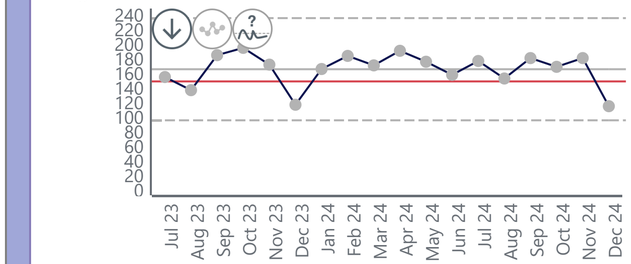
% PALS Resolved within 5 Days

Target: Internal



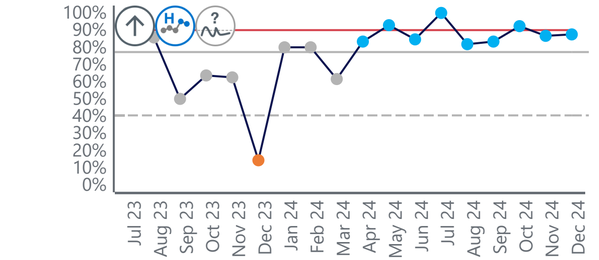
Number of PALs contacts

Target: Internal



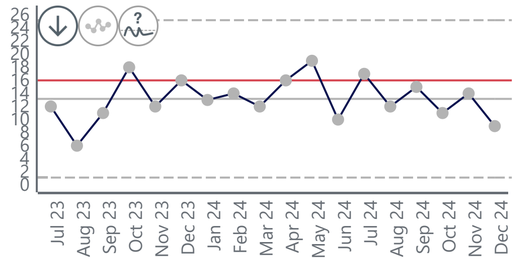
% Complaints Responded to within 25 working days

Target: Internal

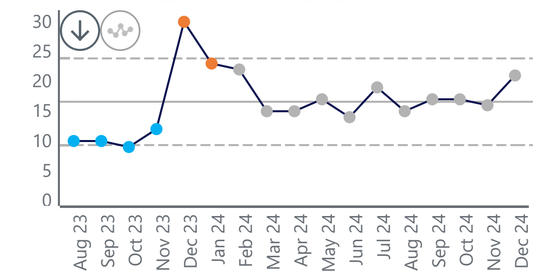


Number of formal complaints received

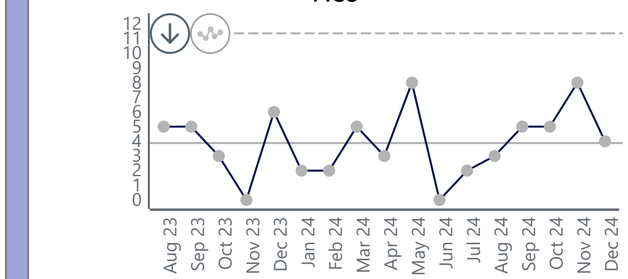
Target: Internal



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



Number of patients deteriorating from HDU admitted to PICU



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:

• The trust continues to exceed the target of 107% DC & EL achieved in 2019/20, reaching 115% in December. Year-to-date performance remains at DC - 104%, EL - 94%, OPN & OPROC – 103%. • Maintained 95% DMO1 compliance for a second month • Maintained no patients waiting over 52 weeks in CAMHS and Community Paediatrics

Areas of Concern:

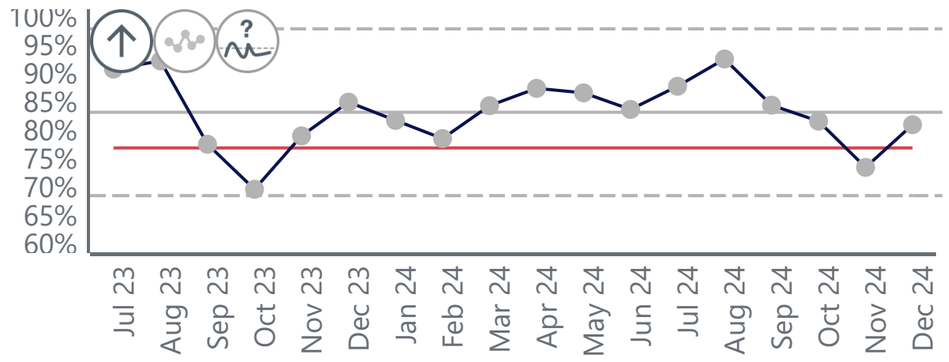
WNB rate continues to be above trust target and increased from 9% to 10% in month.

Forward Look (with actions)

• Further reduction to overdue FU >2 years however the current run rate doesn't achieve target. High impact actions being taken e.g. 500 text messages being sent to FU list on 20th January. • Touch time utilisation was at 78%. There were 55 patient cancellations on the day of surgery, which is the highest month YTD. A working group has been established to address patient cancellations, focusing on WNB, those who did not want the procedure or deemed themselves unfit for it.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

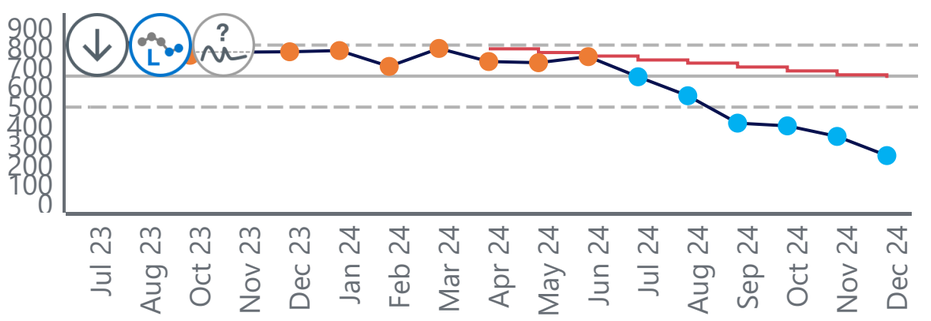
Trust achieved the national target (>77%) in December-24. Common cause variation has been observed with performance of 81.1%, an increase from Nov-24 (73.6%). Dec-24 performance is -4% compared to Dec-23 (85.1%). Dec-24 seen an 162 fewer attendances compared to Dec-23 however Dec-24 had +1.5% greater ratio of Resus and Very Urgent patients (n=44). 2024/2025 performance to date is 83.9%

Actions:

Performance monitored weekly through Care Group Leadership/Winter Planning Meetings. Key actions: • Launch of Clinically Ready to Proceed • Managing the impact of waiting area move • Maximising use of primary care streaming within the UTC • Testing and roll out of new escalation plans

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

Target: Internal 24/25



Technical Analysis:

Demonstrating special cause variation of improving nature with number of patients waiting > 52 weeks at 254 for Dec 2024 against a trajectory of 651. Further decrease from Nov 2024 position of 352 and the 6th consecutive month with a reduction. Top 3 services with waiters >52 weeks: Dentistry (n= 145), Neurology (n=45) & ENT (n=14). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

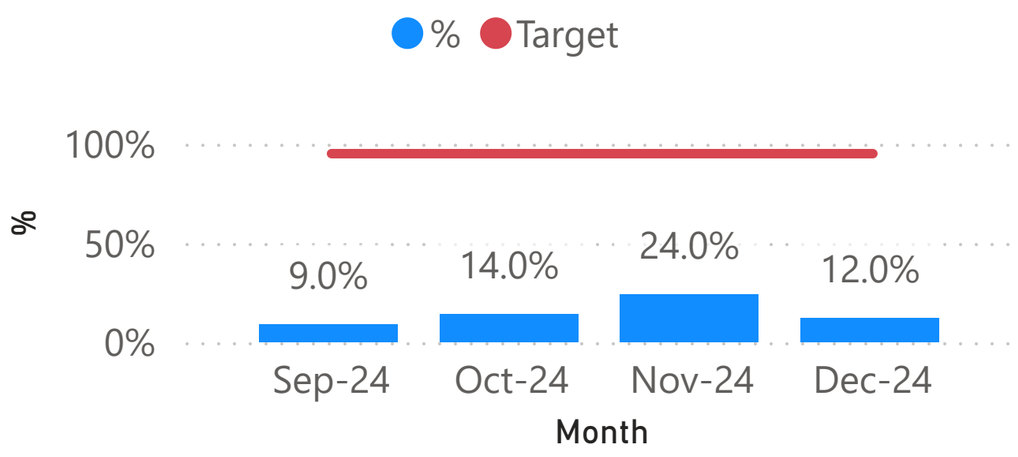
Actions:

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

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:

Performance at the end of December is 12% against a target of 95% which is a reduction from performance of 24% in November 2024. Insufficient data to assess previous years if any seasonality impact on performance.

Actions:

Focus remains on longest waiting children and young people therefore % of young people receiving an outcome within 65 weeks of assessment remains low as expected. Transformation programme work continues to reduce longest waiting times.
Metrics under review to ensure sufficient oversight is provided on waiting time performance position for ASD and ADHD

Integrated Performance Report | January 2025

NHS
Alder Hey Children's
NHS Foundation Trust

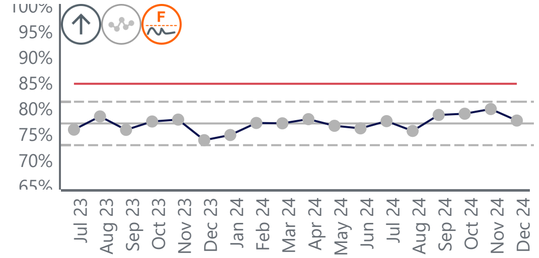
Revolutionise Care - Effective & Responsive - Watch Metrics

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

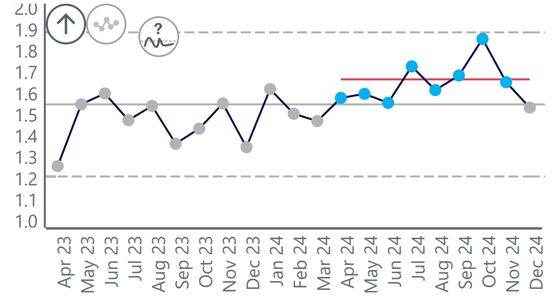
Target: Internal

Theatre Utilisation (Capped Touch Time)

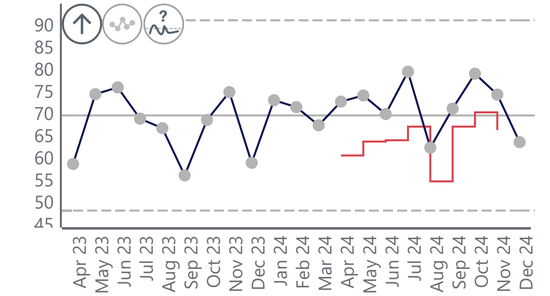
Target: Internal



Elective admissions (IP & DC) per clinical WTE

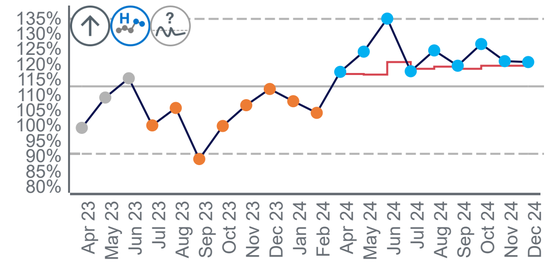


Outpatient attendances per Consultant WTE



% Recovery for Daycase Discharges

Based on 19/20 baseline

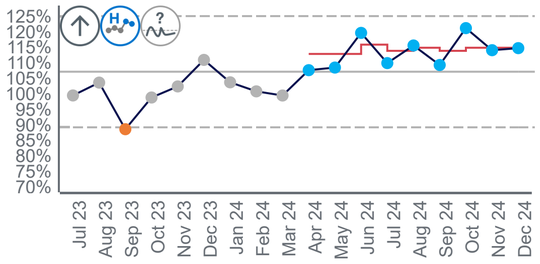


% Recovery for Elective Discharges

Based on 19/20 baseline

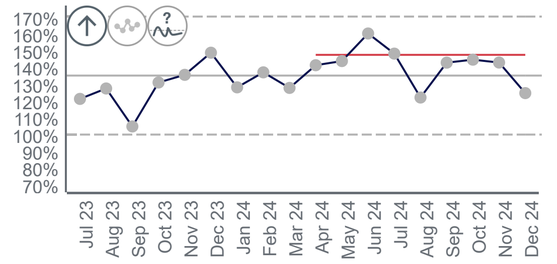
% Recovery for DC & Elec Activity Volume

Based on 19/20 baseline



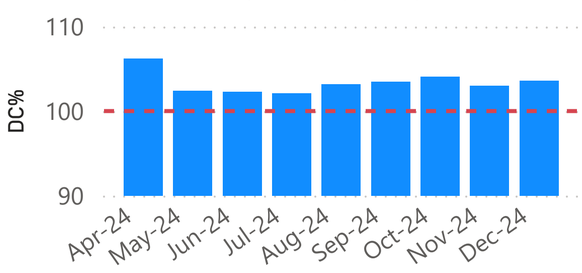
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline



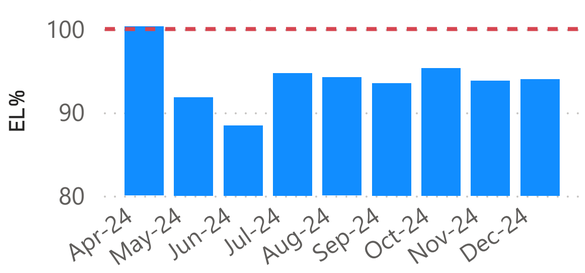
Daycase Activity vs Plan (YTD Position)

SLAM Performance (Volume)



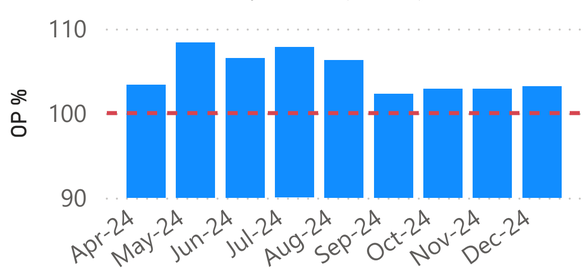
Elective Activity vs Plan (YTD Position)

SLAM Performance (Volume)

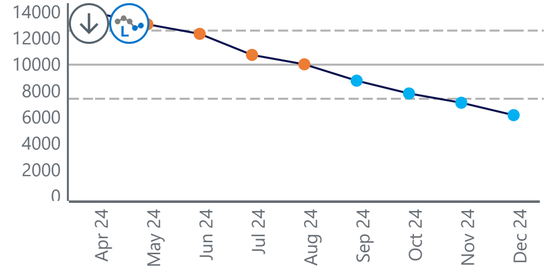


OP New & OPPROC Activity vs Plan (YTD Position)

SLAM Performance (Volume)



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



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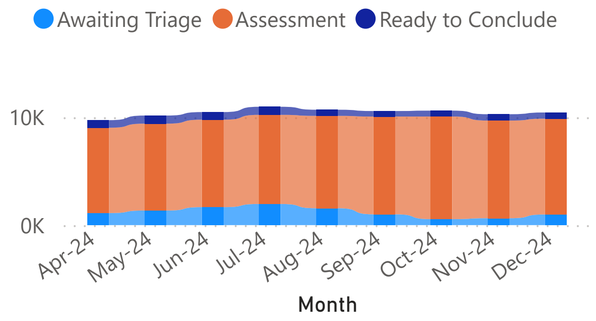
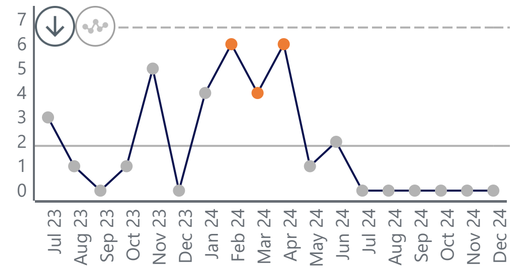
Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

ADHD/ASD Diagnosis Status

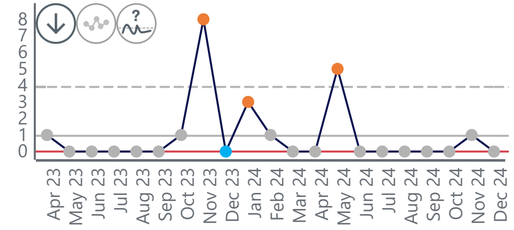


CAMHS: Number of children & young people waiting >52weeks



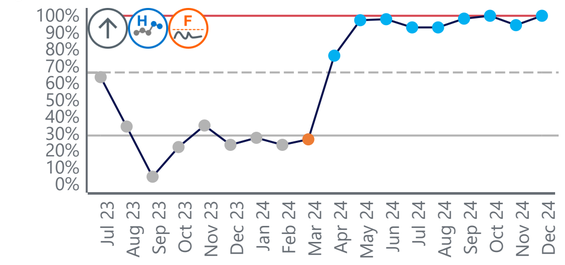
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



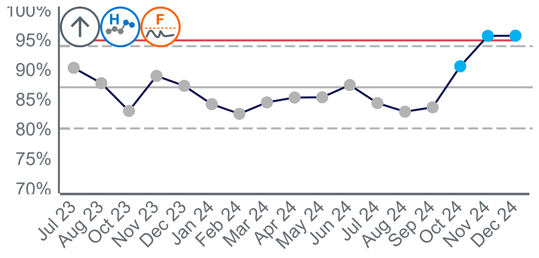
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



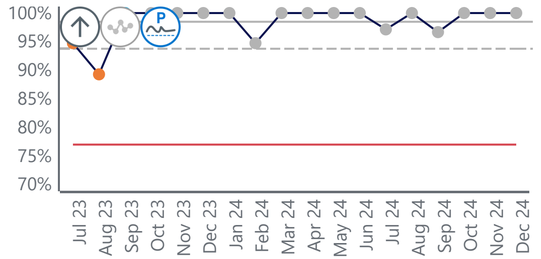
Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory



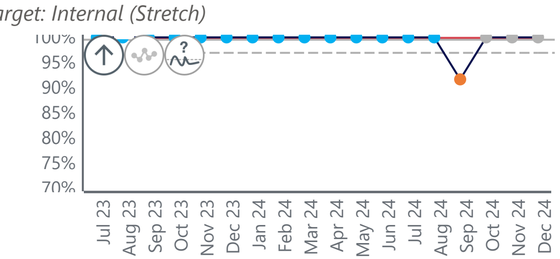
Cancer: Faster Diagnosis within 28 days

Target: Statutory



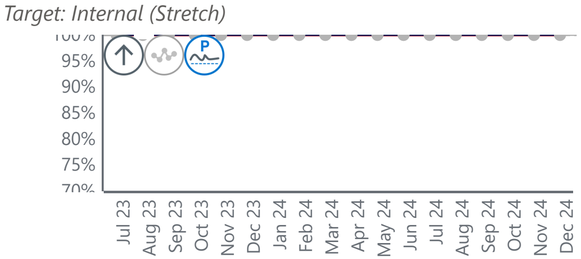
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)



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

Target: Internal (Stretch)



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

• Mandatory training completion remains over 90%

Areas of Concern:

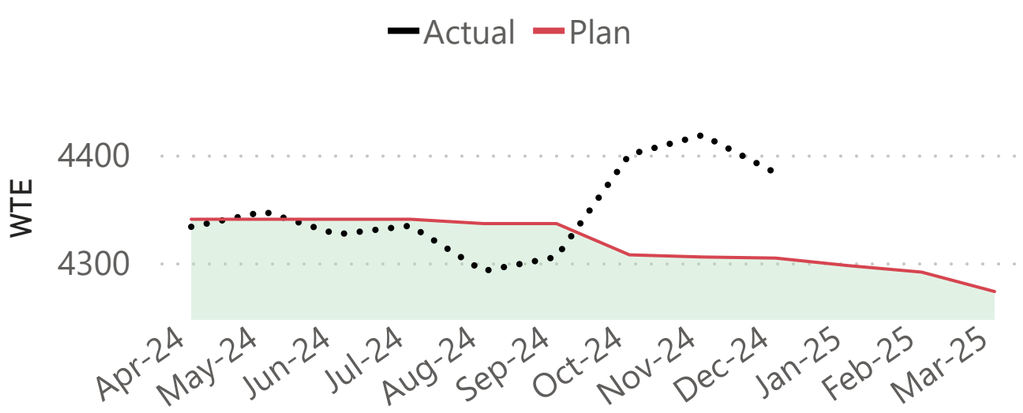
• Sickness absence levels are high, especially in long term absence, mirroring the high levels of December 2023.
• Though total workforce (WTE) reduced in month, following a reduction in both bank and agency spend, the plan to the end of March remains challenging.

Forward Look (with actions)

• Looking at total workforce (WTE), both long- and shorter-term actions are in place to support a reduction in WTE, with additional actions focused on non-clinical and corporate roles.
• PDR % Completion is increasing to 82%; B7+ PDRs have now achieved 88%. Work to support PDR completion continues, alongside a full review ahead of the 2025/26 PDR process.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

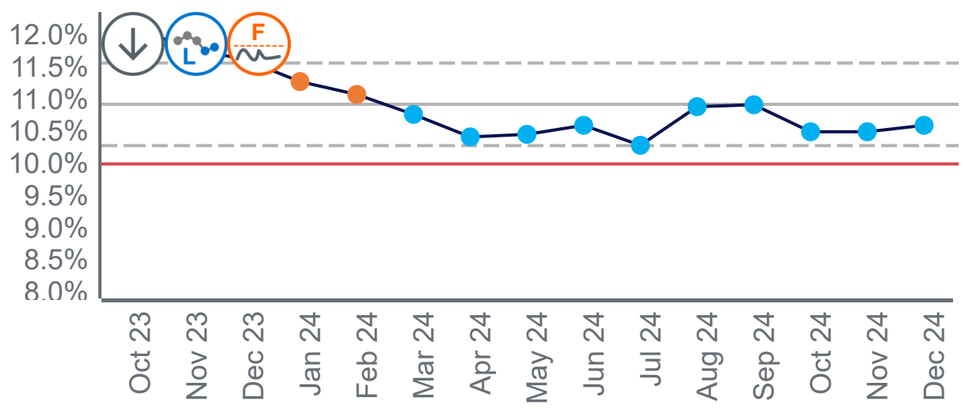
Total workforce for the end of Deceber 2024 was 79.69 WTE above plan. Actual WTE was 4383 against a plan of 4303. 24/25 year end plan is set at 4273.4 WTE.

Actions:

Positive change has been seen in month, with a reduction in bank and agency spend. Additional measures have been implemented to support a reduction in WTE, with additional actions focused on non-clinical and corporate roles.

Staff Turnover

Target: Internal



Technical Analysis:

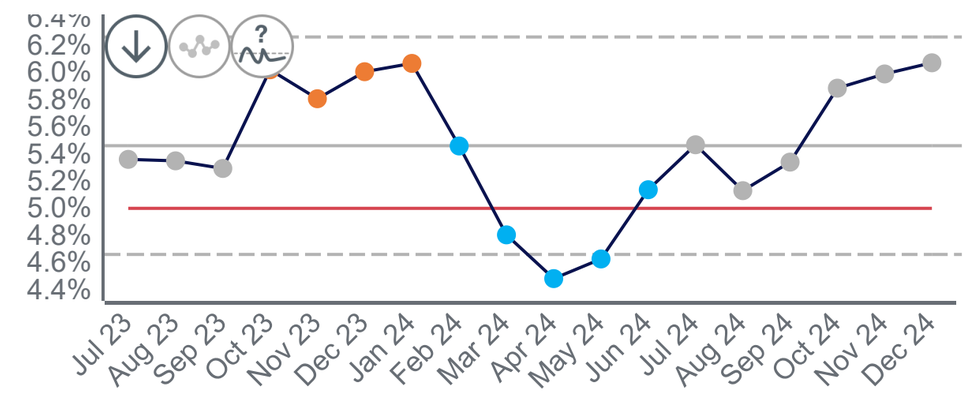
Staff Turnover is demonstrating special cause variation of improving nature with performance of 10.6% in December 2024

Actions:

While staff turnover is reporting above the 10% target, it remains between 10-11%.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in December 2024 is 6% which is above the 5% target. Slight increase from November 2024 at 5.9%. December 2024 performance comprises STS at 2.14% and LTS at 3.82%. Still demonstrating common cause variation, 6th consecutive month above the target in 24/25.

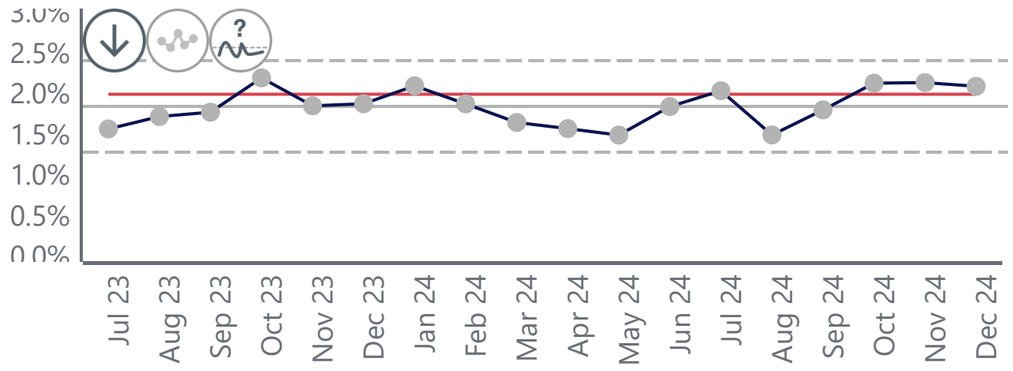
Actions:

Sickness absence has remained high and similar to absence levels during this period last year. Additional case and trend reviews are being held, with focus continuing on supporting sickness absence, specifically long-term absence.

Supporting Our People - Watch Metrics

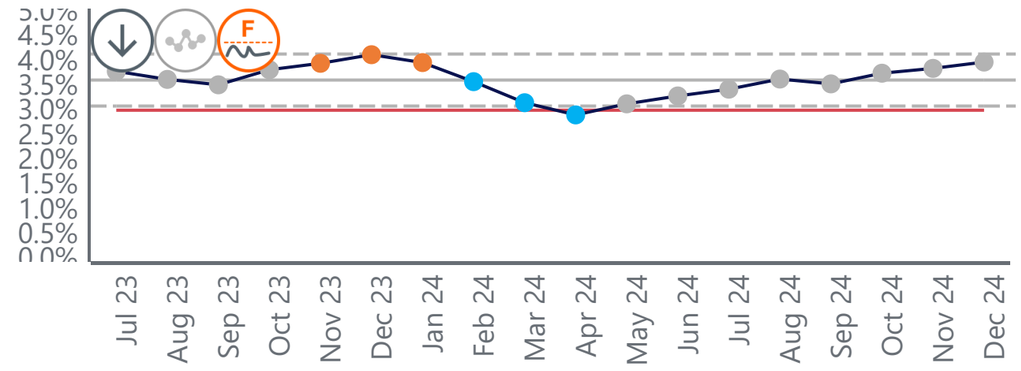
Short Term Sickness

Target: Internal



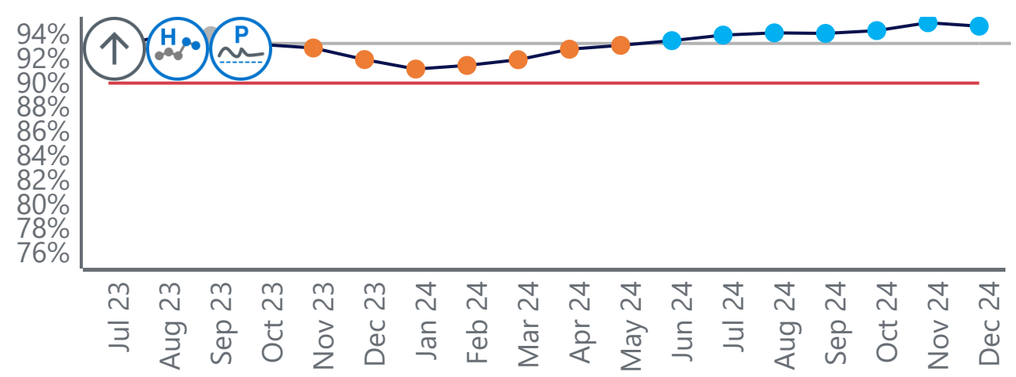
Long Term Sickness

Target: Internal



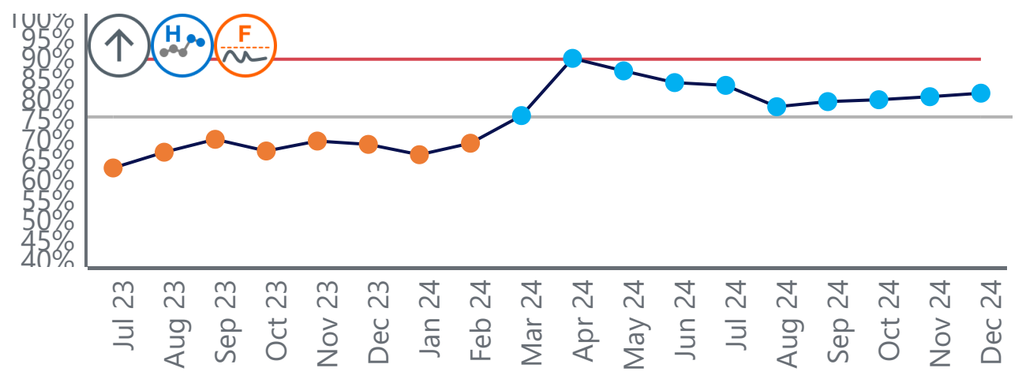
Mandatory Training

Target: Internal



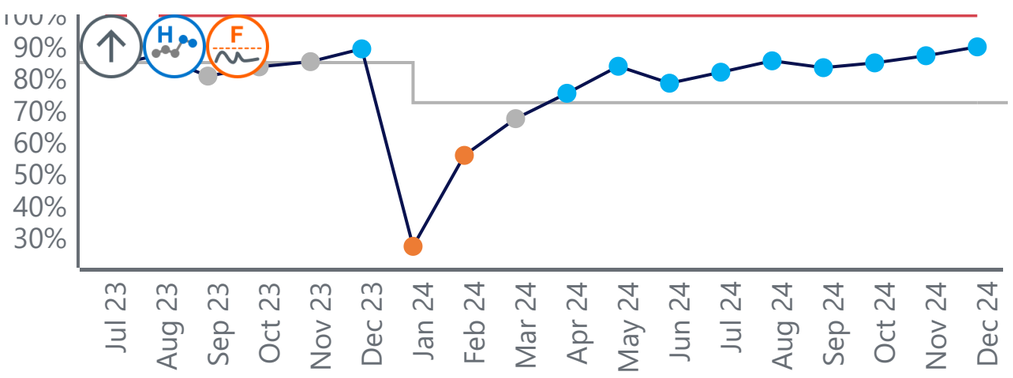
% PDRs Completed (Rolling 12 Months)

Target: Internal

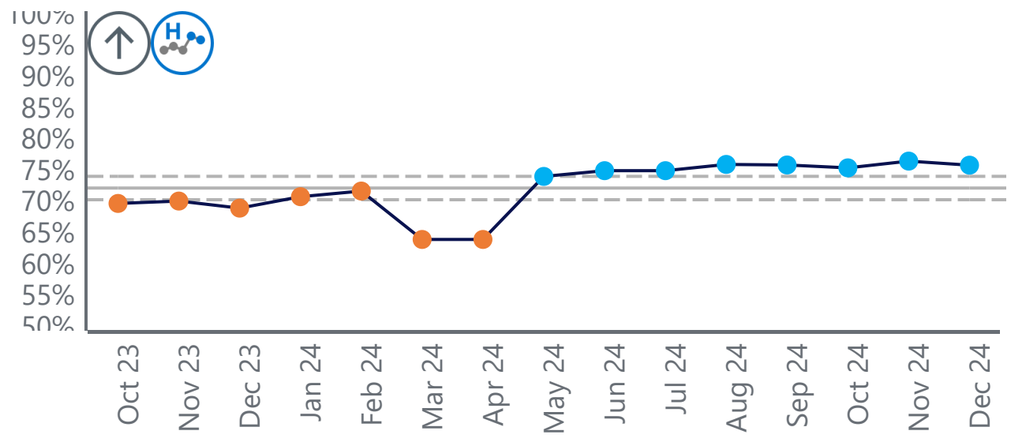


Medical Appraisal

Target: Internal



Workforce Stability



Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

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

Highlights:

• Paediatric Open Innovation Zone application to Combined Authority for £4.1m over 4 years has progressed through external panel and will be reviewed by internal panel in Feb 2025
• Commercial income for Research remains ahead of target offsetting underachievement against 3rd MRI business case targets
• Internal research funding call live – closes on 20th Jan

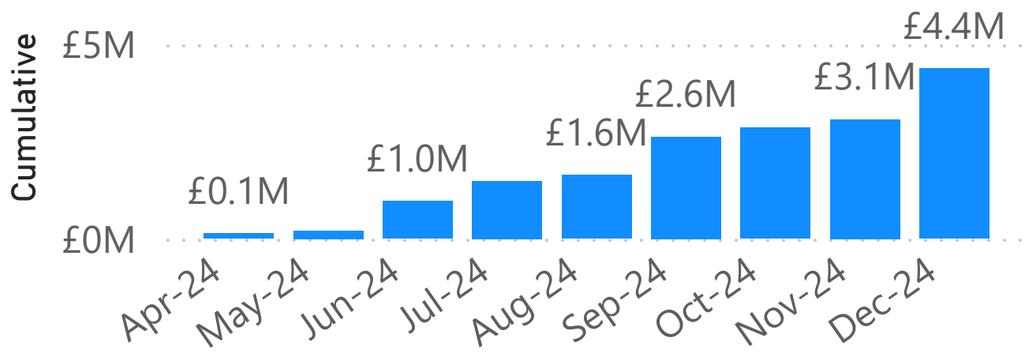
Areas of Concern:

• 3rd MRI scanner not yet fully operational and activity pipeline not established. Risk added to risk register. Income target offset for 24/25 by overachievement in commercial income.

Forward Look (with actions)

• Comms plans underway to identify clinical leadership for Futures • Joint working between Futures and AH Charity – paper being developed for 3-year approach to charitable spend across Futures disciplines to be reviewed at Feb Charitable Spend Committee • External workshops hosted by Lyvalabs to review approach to driving forward innovation and developing effective partnerships planned for 16th Jan and 6th Feb • Visits from Birmingham Women's and Children's Hospital and GOSH planned for Jan

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



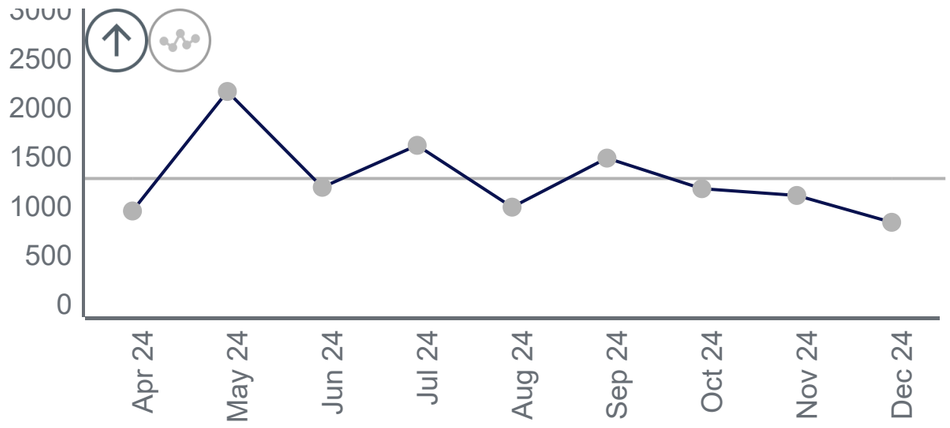
Technical Analysis:

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

Actions:

Forecasting underway for 25/26 commercial and non-commercial income

Manual hours saved through automation solutions - Monthly

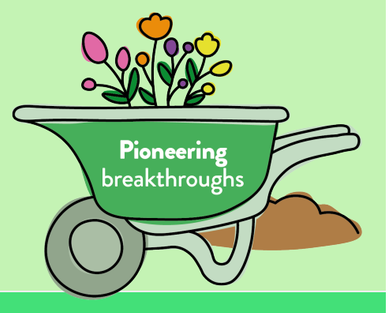


Technical Analysis:

This relates to fully implemented RPA solutions.

Actions:

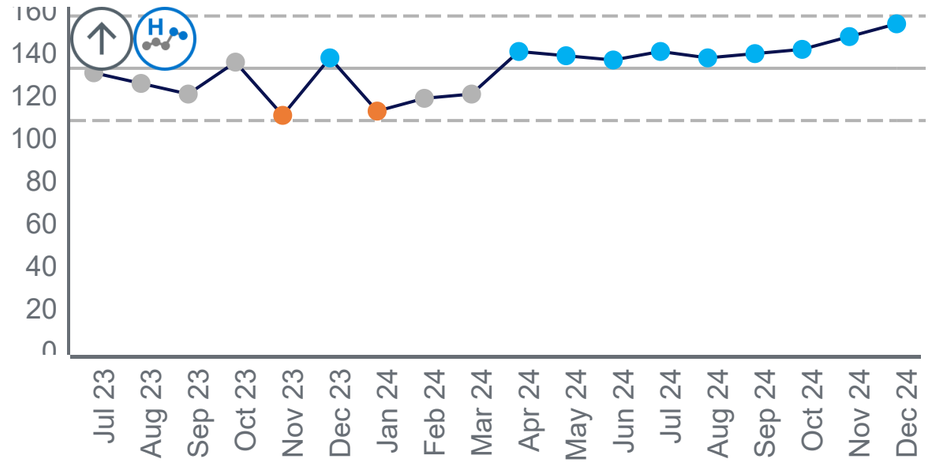
Delays in access to data being addressed



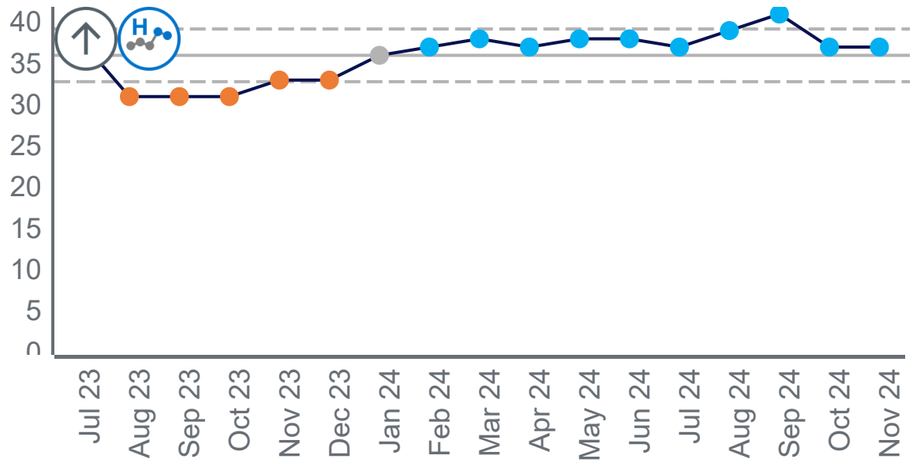
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

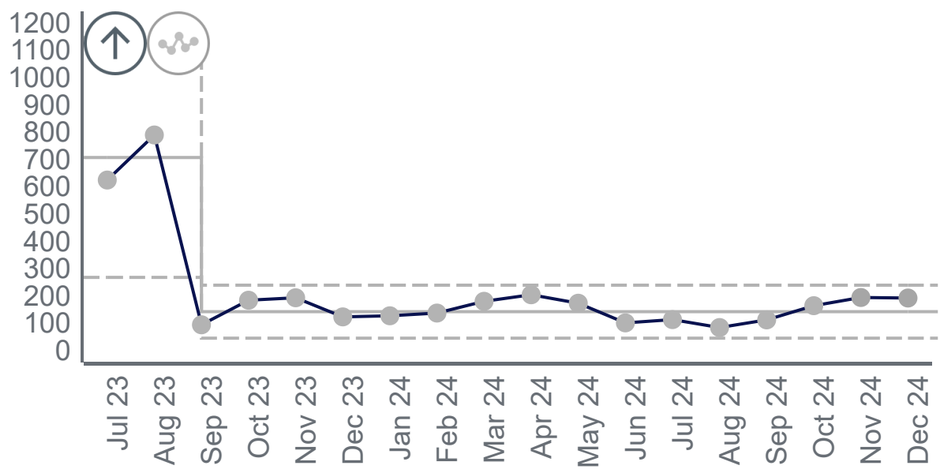
Number of Active (Open) Studies - Academic



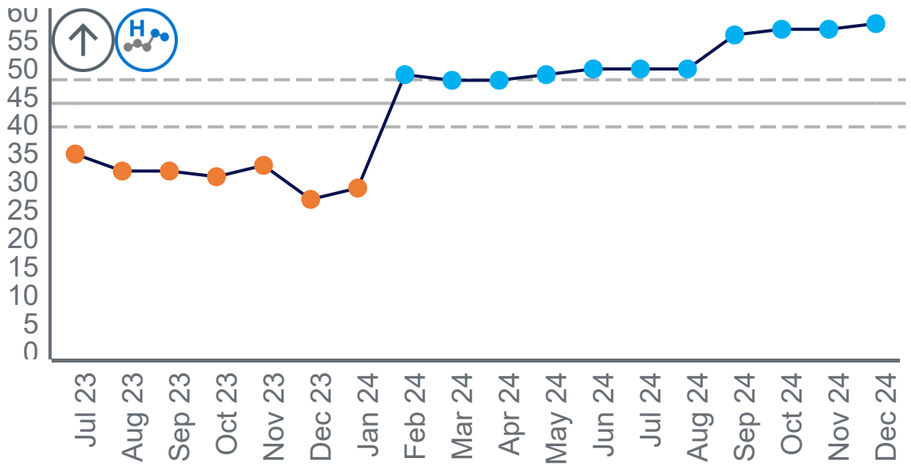
Number of Active (Open) Studies - Commercial

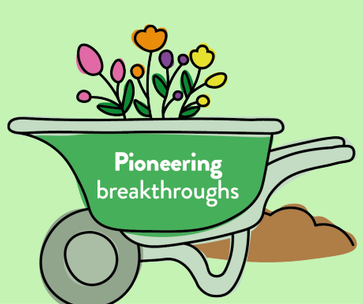


Number of Patients Recruited into Research Studies



Number of Chief Investigator led studies





Collaborate for CYP

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

Highlights:

• Health Inequalities and Prevention: NHSE-funded vaccination pilot delivered more than 200 vaccines. In the US (led by Boston Children's Hospital) a collection of journal articles are under consideration at "Pediatrics" (which is the journal of the American Academy of Pediatrics) which would be published (if passed by the peer review) under the title "Global Scholarly Collaboration in Pediatric Health Equity".
• Wellbeing Hub: 30 referrals at 31/12/2024 (nb one referral can equate to multiple social prescriptions). Formal relationship established with Parent Champions supporting Community Paeds SEND Team.

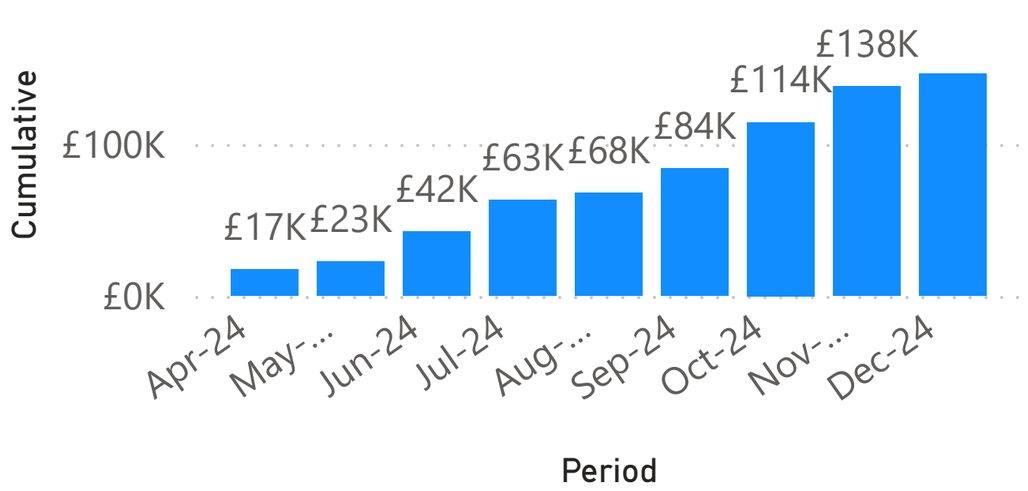
Areas of Concern:

• Interconnections and crossovers of all workstreams, particularly Advocacy workstream

Forward Look (with actions)

• Respiratory next specialty to go live with the Wellbeing Hub • January drop-in clinics being promoted on social media channels • ICB-funded vaping service will see first patients in January 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.

Actions:

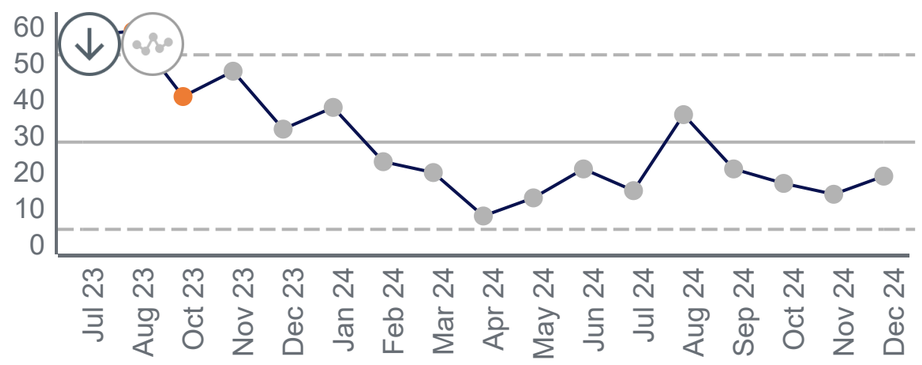
Actions: December activity consisted of future planning, contacting range of primary schools to consider what a programme could look like and consider methods for engagement.

Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

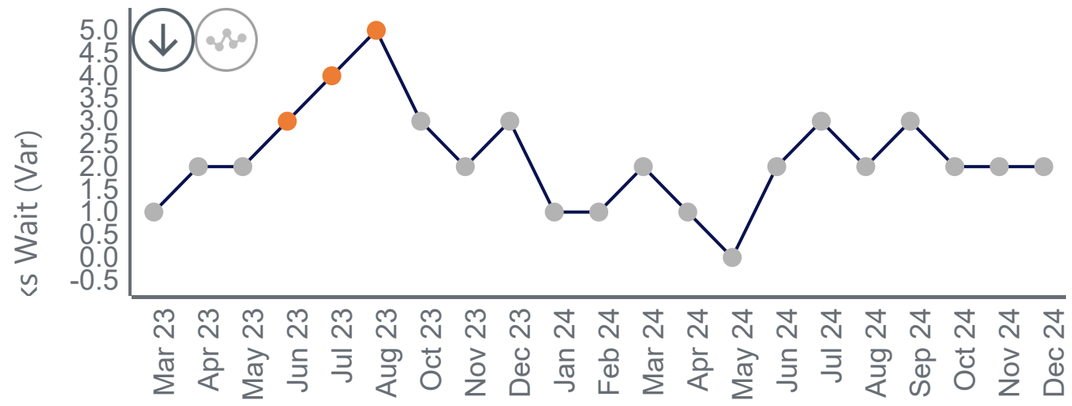
Oral Health: Number of children <10 years old waiting >52wks for tooth extraction

Sept-23 Unavailable

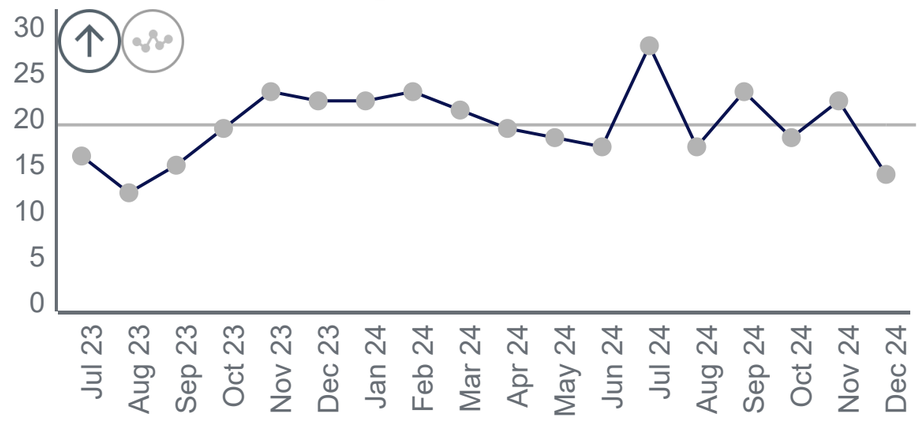


Median Waiting Time (RTT) - LD Waiters Variance (Wks) to Non-LD

Sept-23 Unavailable



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



Collaborate for children & young people

Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

Off plan by £0.8m YTD, due to pay award. Divisional forecasts have deteriorated by a further £2m compared to M8 due to challenges within surgery and income. Forecasting to achieve £3.3m surplus, with a risk adjusted forecast to the ICB of £2.2m (off plan by pay award). CIP was above plan in M9, £17.9m CIP has been transacted in year, with £2m in progress/opportunity.
Capital broadly on plan YTD however forecast is ranging from -£0.9m underspend to £2.9m overspend against budget, following decisions to progress with AlderPark second floor, second CT and bring forward £1.3m of urgent medical equipment spend from 25/26.

Areas of Concern:

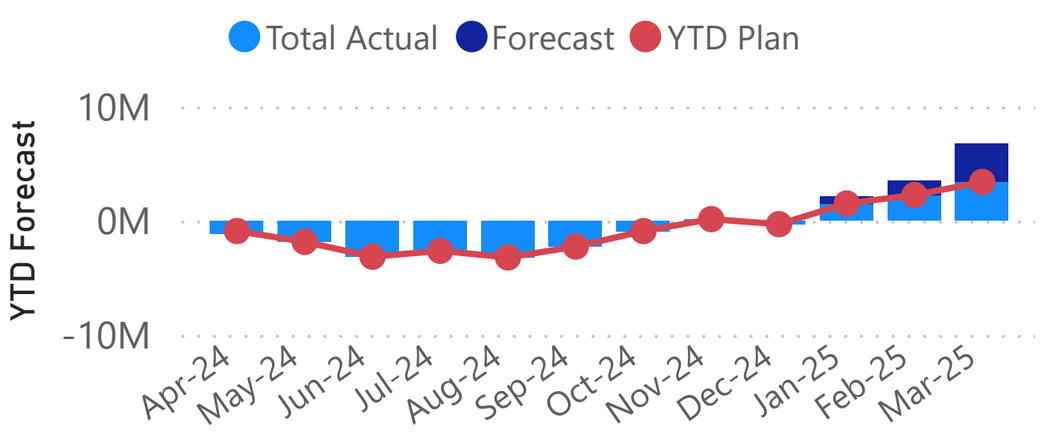
Recurrent CIP pressure of £6.5m not yet transacted. Divisional forecasts highlight significant financial and operational challenges with Surgery's forecast deteriorating by £1m since M8. SDG meetings continue to focus on 4 key priorities (Workforce, Drugs, Coding and Activity). The capital allocation in year is tight, and will be carefully managed over final quarter.

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, which is being managed through Executive weekly meetings.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

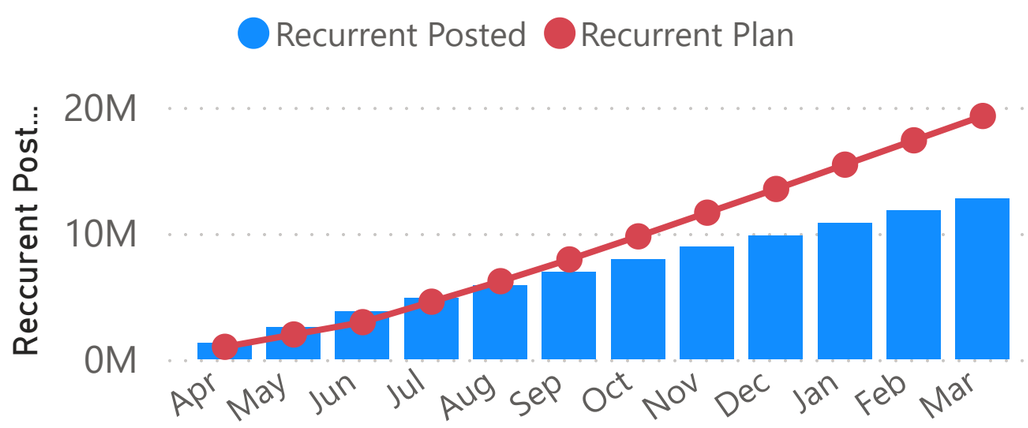
Current plan is £3.3m surplus (£1.2m pay award risk) however, M9 forecast continues to highlight significant challenge. Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

Actions:

Tighter grip and control of non-pay discretionary spend. Non-clinical posts recruitment on hold. Continue to monitor efficiency schemes in progress and cost control for arising pressures to be managed through SDG meeting and divisional deep dives. SDG meetings continue to focus on 4 key priorities (Workforce, Drugs, Coding and Activity) with a view to deliver savings and achieve the full year forecast. Executive considering any additional controls required.

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

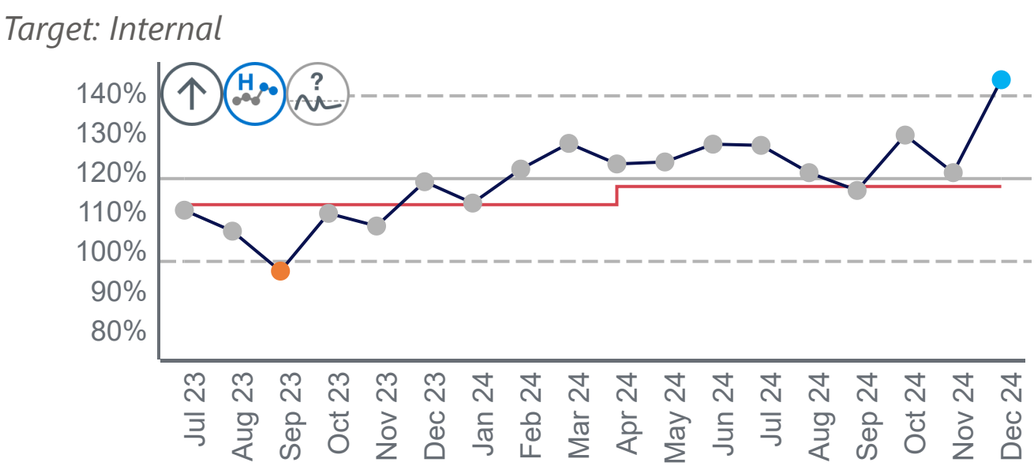
In year CIP identified and in progress is £19m whilst recurrent CIP is £14.7m

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:

December performance estimated at 143%.

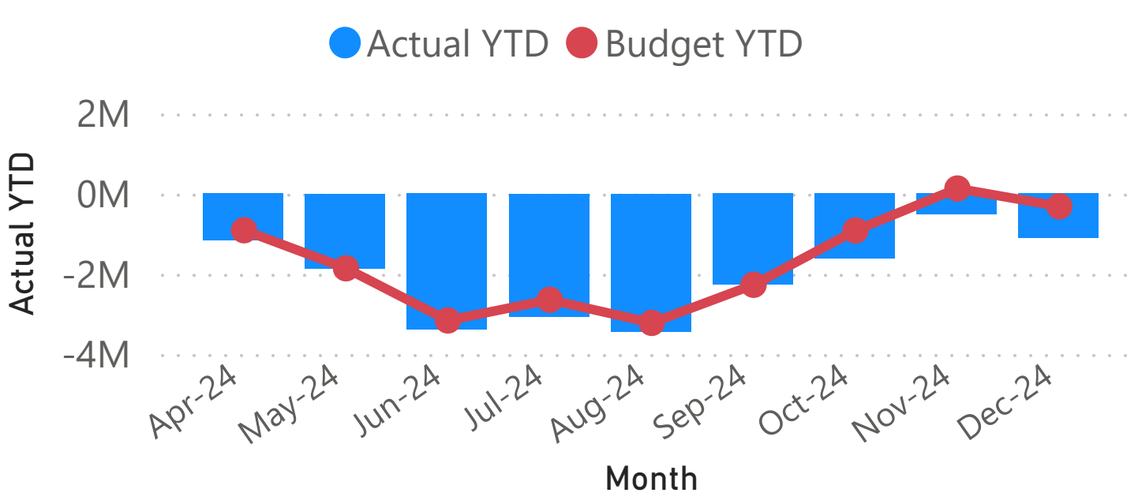
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

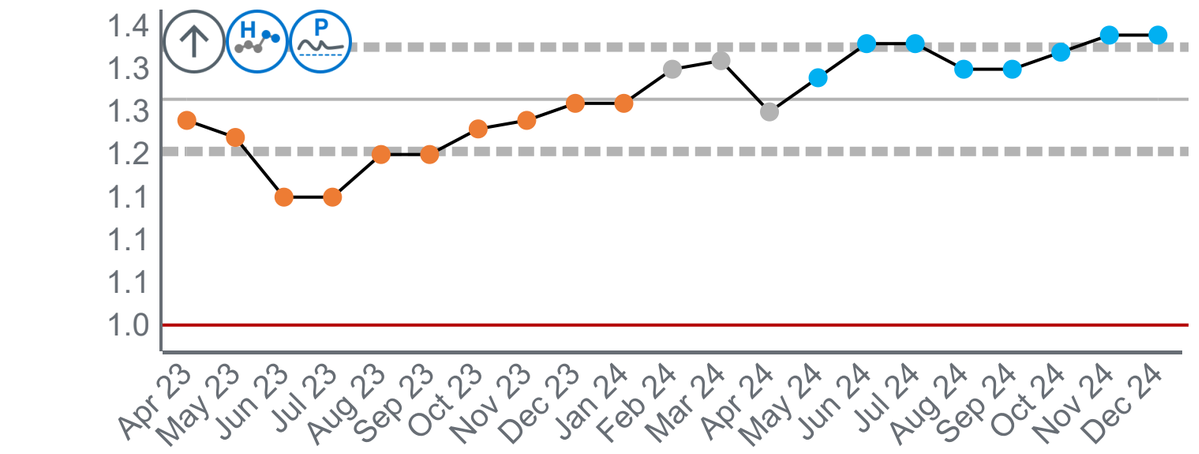
I&E distance from target (cumulative YTD)

Target: Internal

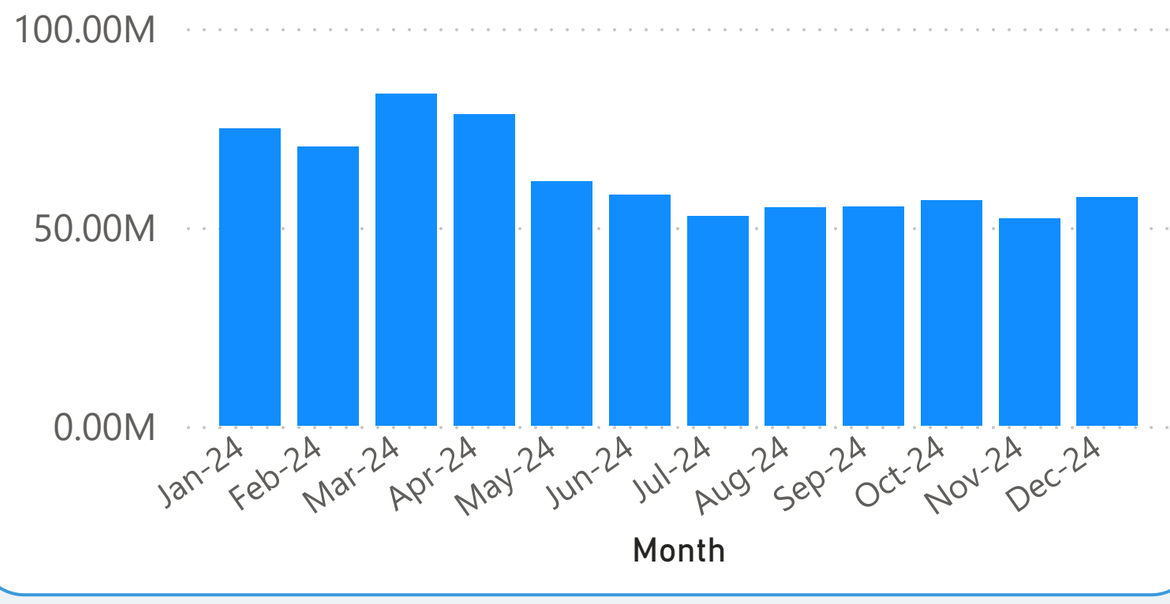


Liquidity

Target: Internal



Cash In Bank



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Positive engagement with teams at risk oversight meetings

Deep dive into long standing high moderate risks (score 12+ on register for >12 months) undertaken at RMF December 24.

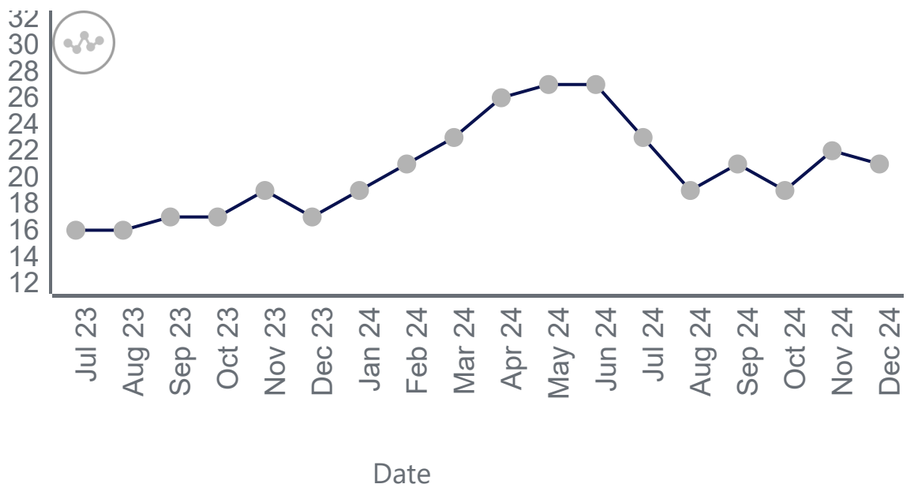
Areas of Concern:

Decembers Education Governance Committee not quorate so proposal for risk management training not approved-held over into January '25 meeting Watch Metric: 16.7% of high risks (4/24) with actions past expected date of completion –escalated to risk owners

Forward Look (with actions)

• Meeting with NEDs/Director Futures Committee to set risk appetite tolerances (Jan 25) • Meeting with C&MH Division to test out use of risk appetite across division with feedback into RMF Feb 25 • Introduction to risk management training to be undertaken with Innovation Team

Number of High Risks (scored 15 and above)



Technical Analysis:

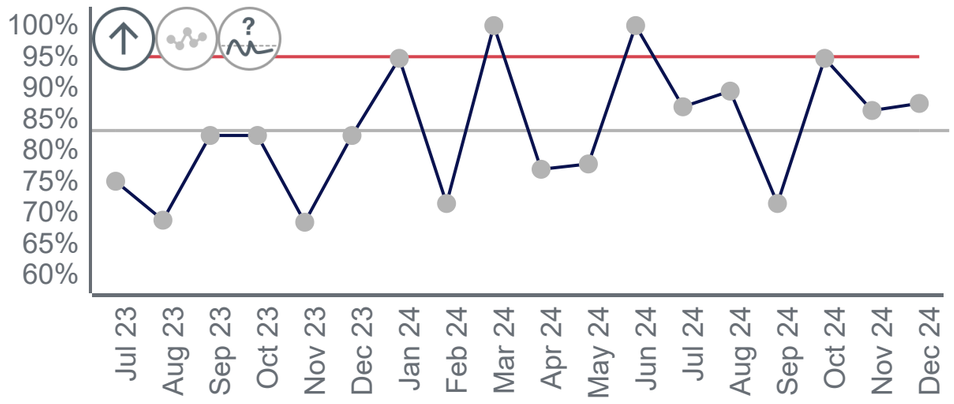
24 high risks on risk register as of end of December 24

Actions:

24 high risks on risk register as of end December 2024: an increase of 2 from the previous reporting period. Risks themed as follows: Quality safety-11, Workforce (sustainability)- 7 risks, Compliance & regulatory –4 risks, Reputation – 1 risk and Financial (investment) 1 risk.

% of High Risks within review date

Target: Internal



Technical Analysis:

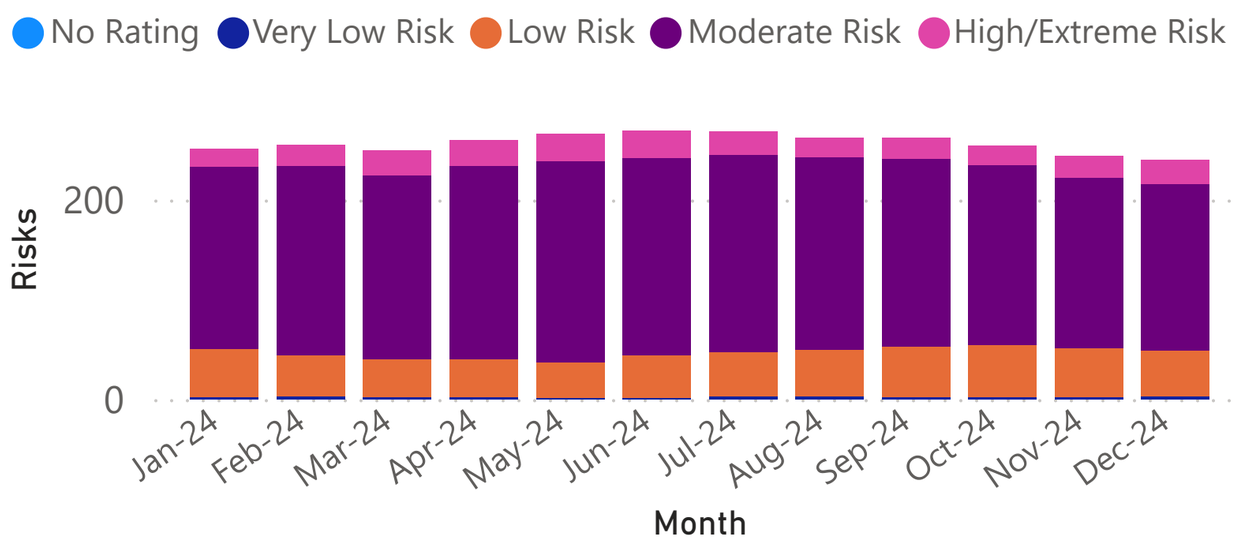
Common cause variation observed with performance of 87.5% in December for risks within expected review date

Actions:

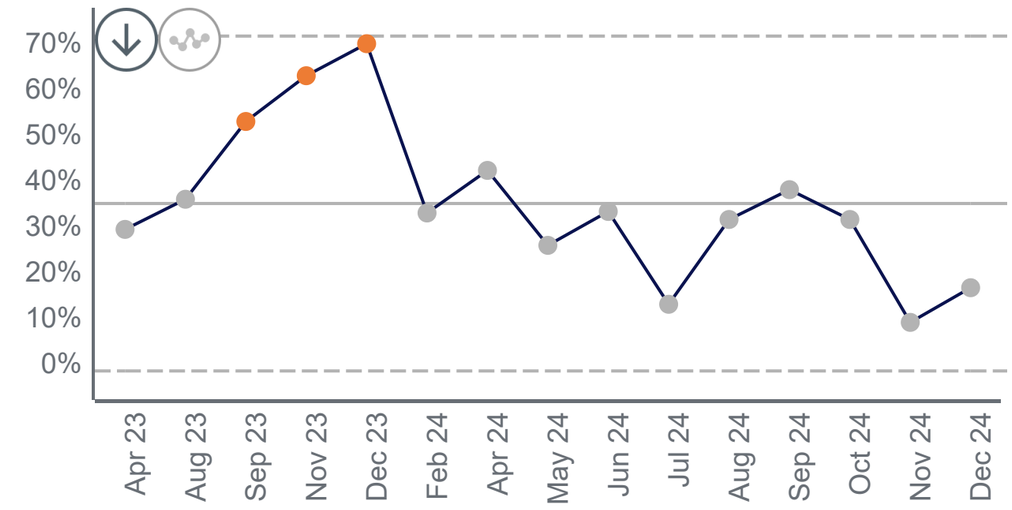
87.5% (21/24) risks within expected review date. Overdue risks have been escalated to risk owner/manager for immediate review and update.

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 patient waiting over 52 weeks in Mental Health Services or Community Paediatrics

• Sustained reduction in follow up appointments more than 2 years overdue and on track to have Zero by 31 March 2025

• Continued improvement in PDR rates for Band 7+ (95%)

• Staff Survey final response rate was 70%

• Was not brought rate showing some sustained improvement (third month) at 11%

• Initial Health Assessments continue to sustain improved level of compliance for seventh consecutive month with 94% completed within 20 days of referral to Alder Hey

Areas of Concern

• Waiting time to complete ASD and ADHD assessment

• Sickness absence rates remain at 7% with specific areas of concern

• Waiting times for routine Eating Disorder referrals are back up to required levels but with enhanced monitoring to ensure improvement is sustained.

• CAMHS paired outcome scores remain below expected levels

• In CAMHS, whilst waiting time to first appointment is improving (65% within 6 weeks) the overall waiting time to treatment is still just over 60% within 18 weeks

• Continued ADHD medication shortages impacting on children and families accessing treatment but also on diagnostic capacity

Forward Look (with actions)

• Planned OPD development day in February 2025

• Focussed intervention support for Sunflower House to address increased sickness absence, rise in incidents

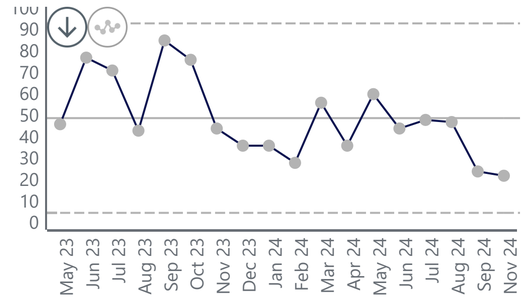
• Continued work to address the gaps in reporting via MHSDS and to communicate with teams the importance of recording outcome scores to demonstrate impact of intervention

• Procurement of additional external capacity for ADHD assessments to conclude in December with contract awarded early January 2025

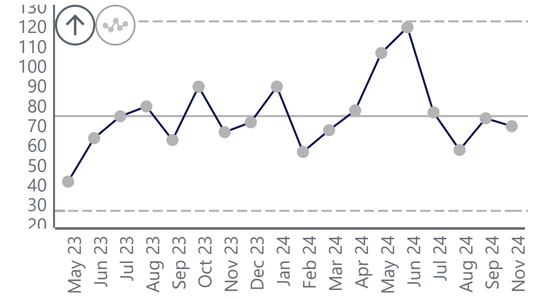
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

Patient Safety Incidents rated Low Harm & Above

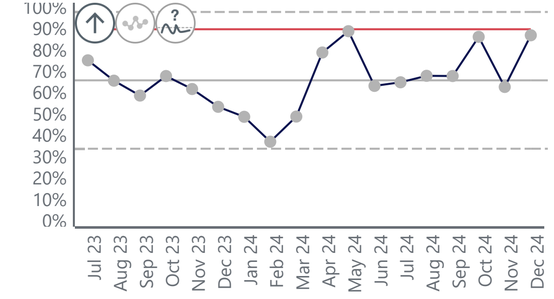


Patient Safety Incidents rated No Harm



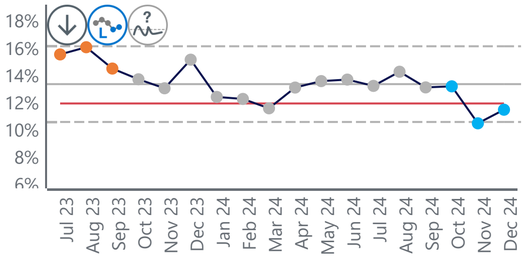
% Complaints Responded to within 25 working days

% PALS Resolved within 5 Days

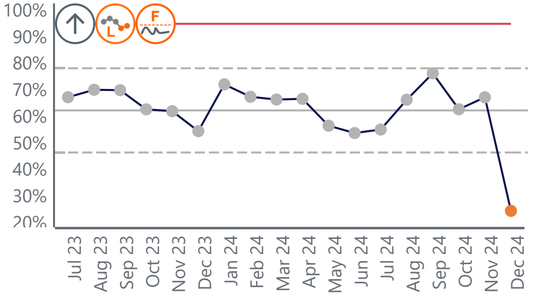


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

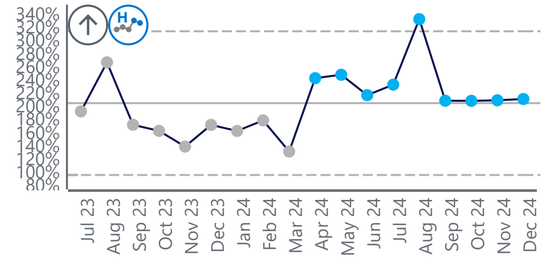


% of Clinical Letters completed within 10 Days

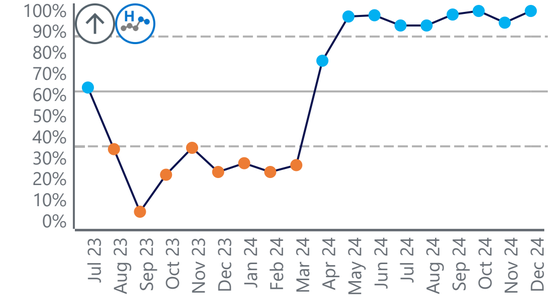


% Recovery for OP New & OPPROC Activity Volume

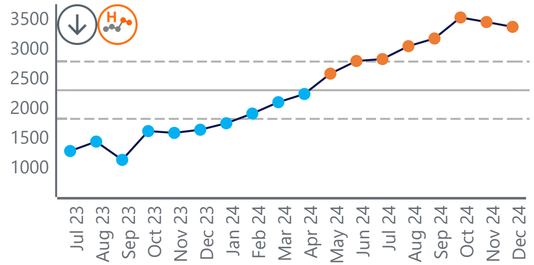
Based on 19/20 baseline



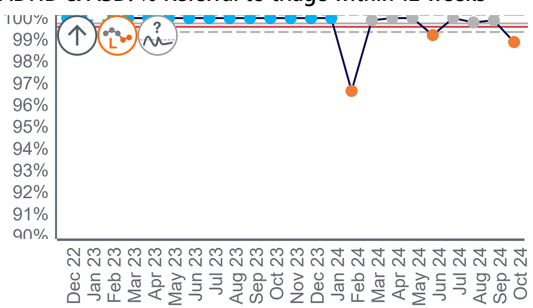
IHA: % complete within 20 days of referral to Alder Hey



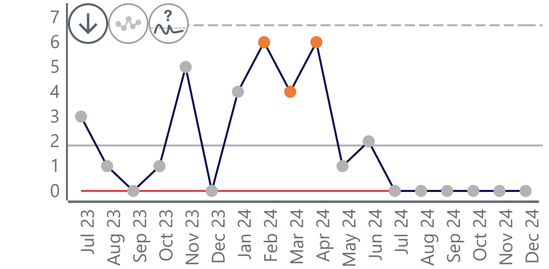
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



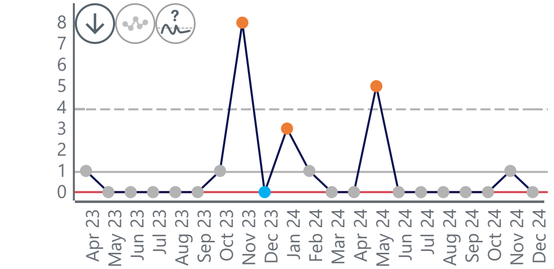
ADHD & ASD: % Referral to triage within 12 weeks



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



Number of Paediatric Community Patients waiting >52 weeks



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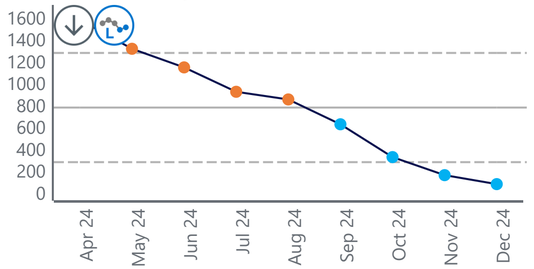
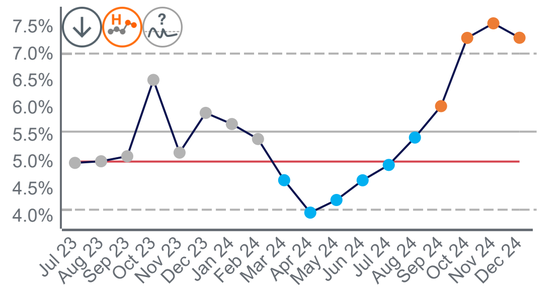
Divisional Performance Summary - Community & Mental Health

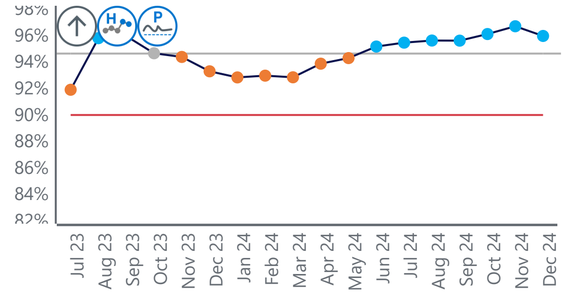
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



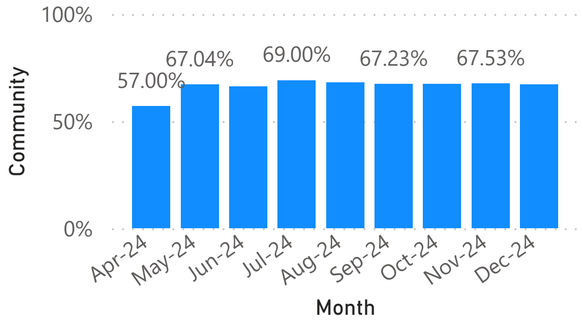
Sickness Absence (Total)



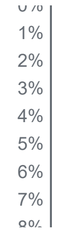
Mandatory Training



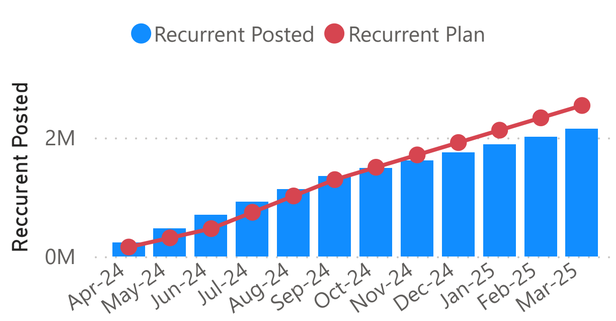
Workforce Stability



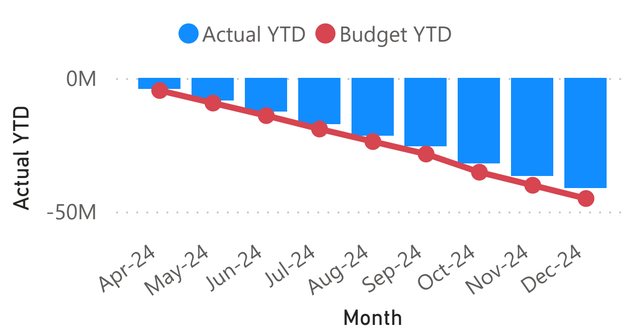
Staff Turnover



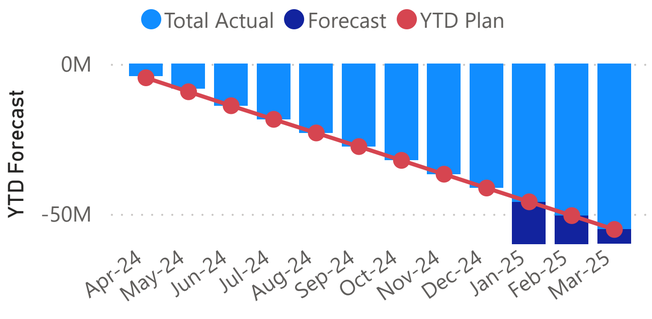
Recurrent Efficiency Plans Delivered (Forecast)



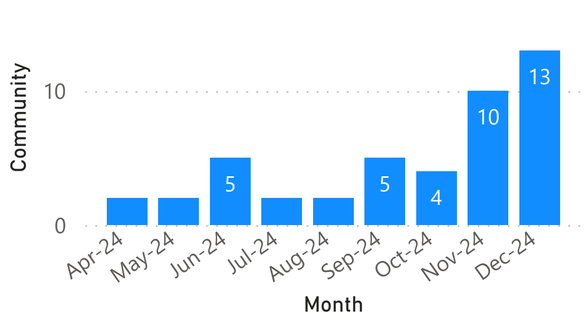
I&E distance from target (cumulative YTD)



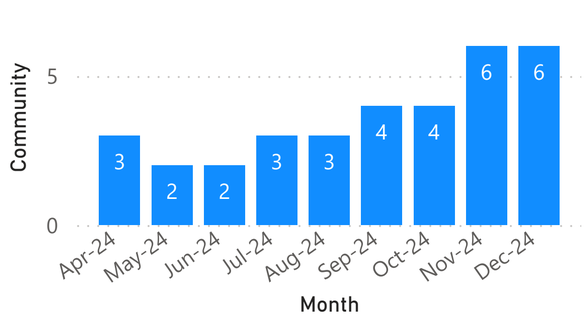
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• DM01 target maintained 95% compliance for the second consecutive month

• Sepsis compliance within ED

• Improvement in compliance with national standards for ED 4hour target, December saw 81% of children treated within 4 hours

• Continued reduction in children waiting over 52 weeks for treatment; however, primary area of concern being neurology for March 2025 target

• Continued reduction in children waiting over 2 years for follow up care

• 100% response rate for formal complaints for over 12 months

• 100% compliance in PALS for the month

• Maintained high performance in mandatory training compliance

Areas of Concern

• Decrease in the number of clinic letters signed within target period, a number of team are piloting Lyerbird to improve the letter writing and sign off process within the trust
• Increase sickness absence noted with worsening short notice sickness
• Despite achieving operational CIP targets within year and matching the CIP posted for 2023/24 a challenge remains in delivering the transformational CIP allocation
• Acute bed capacity challenges remained during the first week weeks in December, associated with increase demand and peak RSV surge
• Reduction in activity against plans for Elective activity, plans in place to increase for January and Feb
• Challenges month for all ED measures including increased in medium time to triage and increase number of children waiting over 12 hours within the department
• Challenging financial position, owing to reduction in forecast income anticipated and increase in non-pay spend, resulted in worsening end of year forecast position

Forward Look (with actions)

• Continued heightened monitoring and actions associated with DMO1 recovery plan to ensure 95% compliance is maintained

• Implementation plan in place to re-locate the ED waiting area into radiology / the atrium owing to the NICU/ acute floor build

• Maintained focus on winter pressures and initiatives in place to maintain safe access and flow during periods of increased demand

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

• Action plan in place for Haematology and Transfusion laboratory services with plans in place to increase rota resilience again from January 2025

• Neurology service transformation continues with focus on high impact actions associated with addressing safety concerns

• Pharmacy sprint group in established to improve cost pressures associated with drug spend

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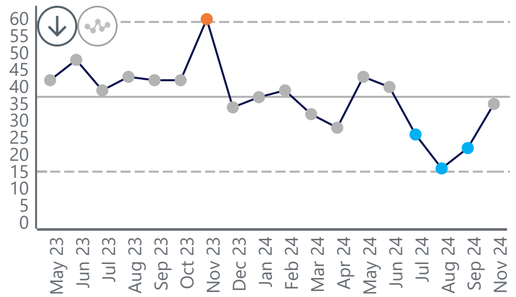
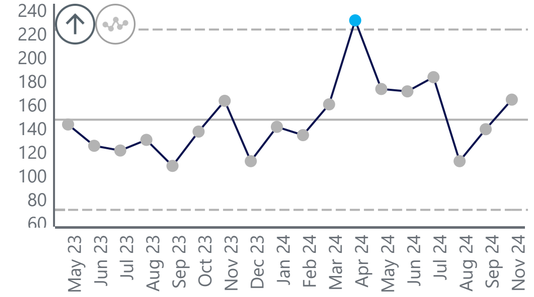
Divisional Performance Summary - Medicine

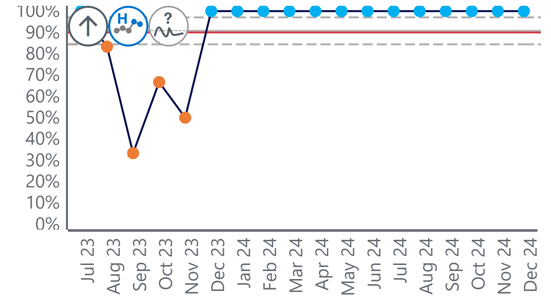
Patient Safety Incidents rated Low Harm & Above



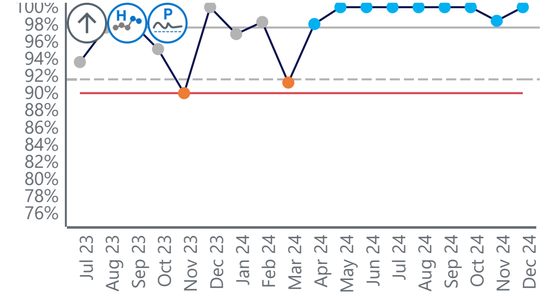
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

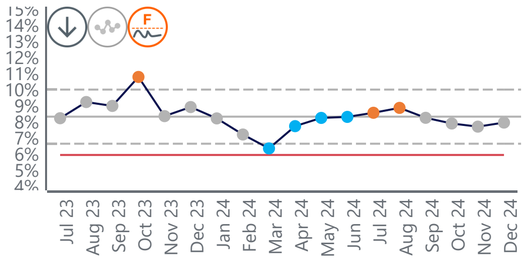


% PALS Resolved within 5 Days

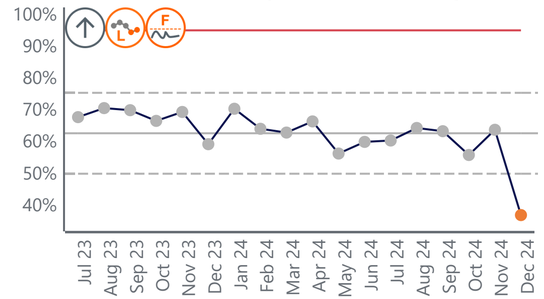


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

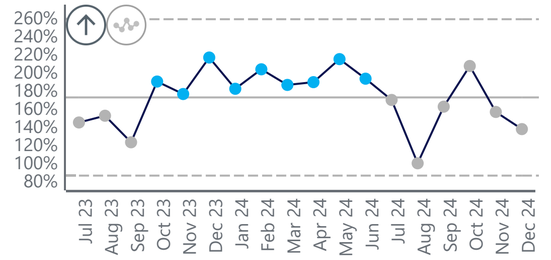


% of Clinical Letters completed within 10 Days

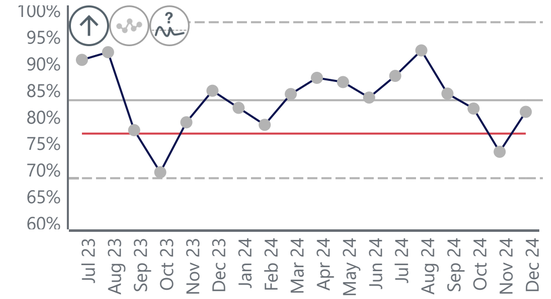


% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

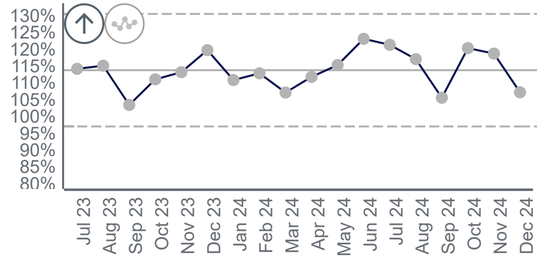


ED: % treated within 4 Hours

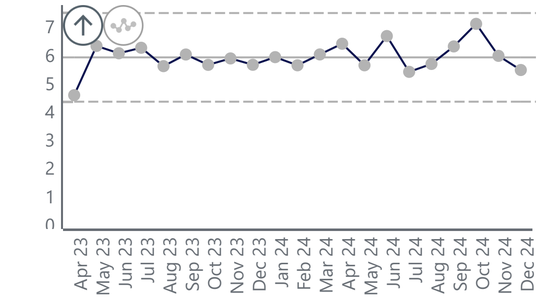


% Recovery for DC & Elec Activity Volume

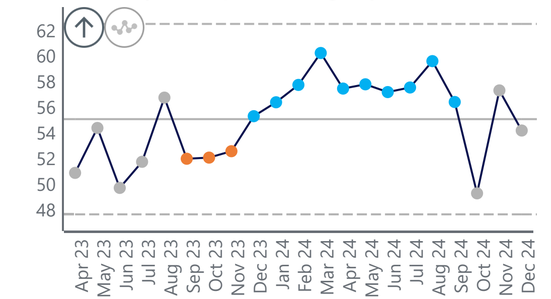
Based on 19/20 baseline



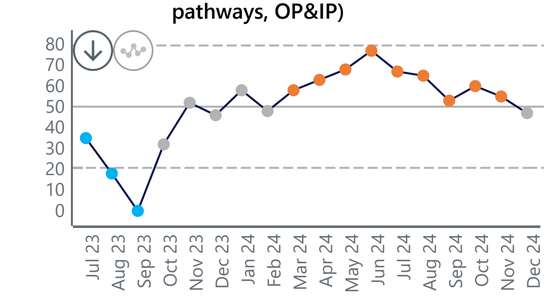
Inpatient Discharges per working day



Day Cases per working day



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



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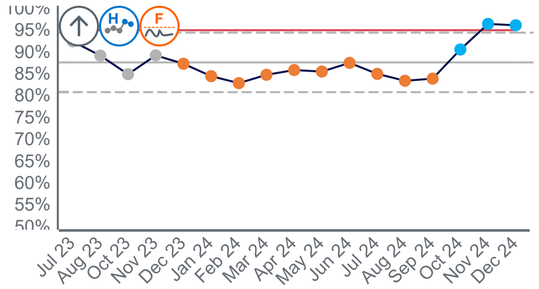
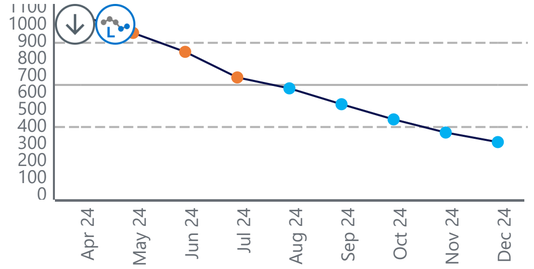
Divisional Performance Summary - Medicine

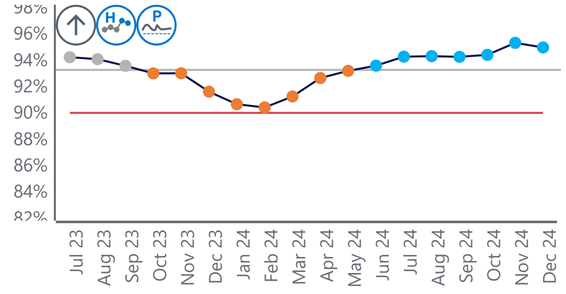
Diagnostics: % Completed Within 6 Weeks of referral



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

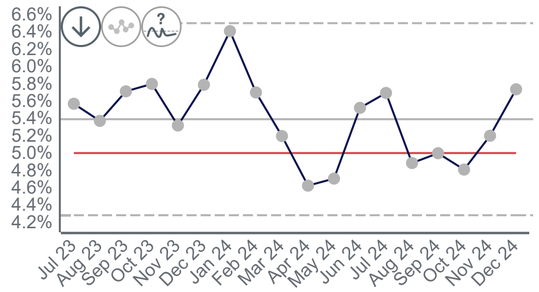


Mandatory Training

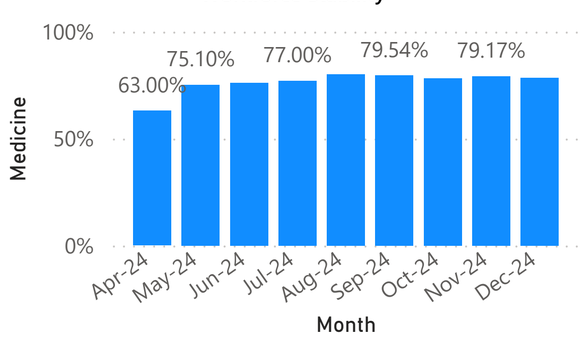


Staff Turnover

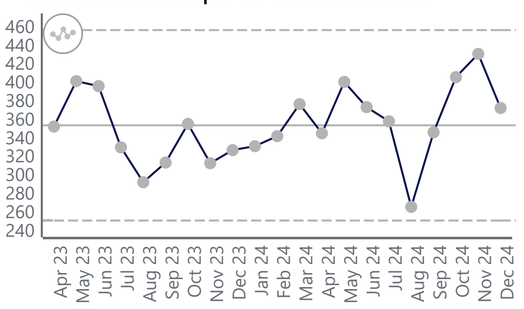
Sickness Absence (Total)



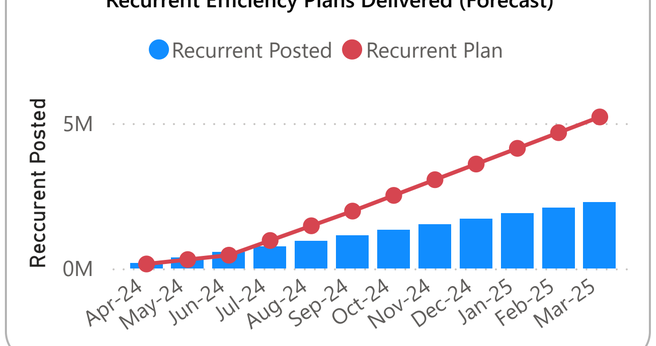
Workforce Stability



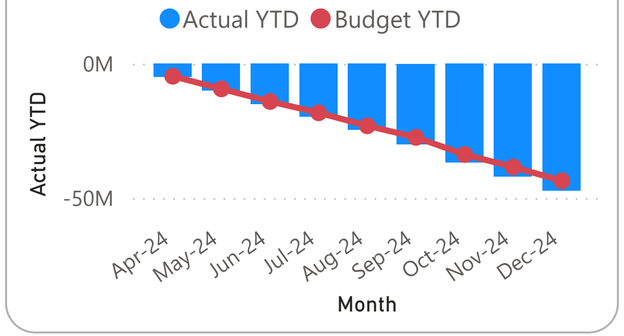
A&E Attendances per ED Consultant WTE



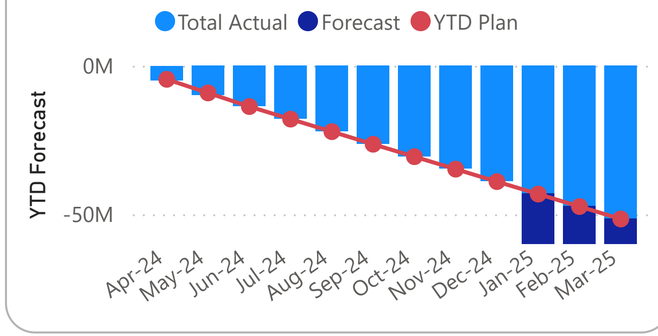
Recurrent Efficiency Plans Delivered (Forecast)



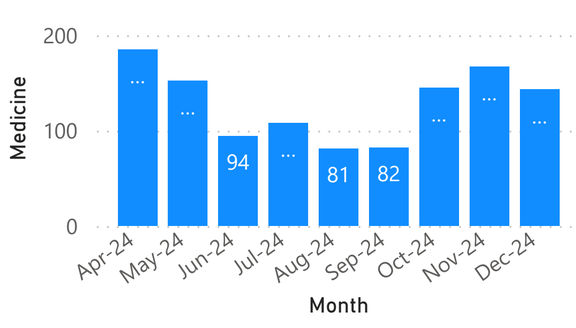
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division



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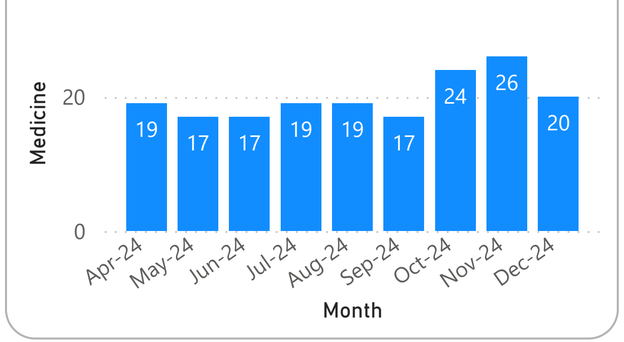

Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

- 100% compliance with response rates to PALS and formal complaints
- 123% recovery volume for DC & IP activity
- Continued increase in number of day case procedures per working day
- Continued significant reduction in number of CYP waiting over 52 weeks for treatment
- 110% recovery volume for OPN and OPROC
- Mandatory training compliance remains well above trust target
- Posted 100% recurrent delivery of £6.4m CIP target

Areas of Concern

- WNB rate increase slightly in month and still above trust target
- Volume of FU patients overdue by 2 years by March 25 continues to decrease however still a significant volume
- Sickness absence rates increased in month however no themes and all LTS cases being managed appropriately

Forward Look (with actions)

- Re-consider approach to WNB improvement within collaboratives for 25/26. Improvement projects underway in a couple of areas with the highest WNB rate but requires increased support. Pilot currently underway in Gynaecology to reduce their WNB rates which is showing success so far and learning will be shared post pilot evaluation.
- Continued focus on overdue FU backlog- 3 key areas have targeted support: ENT, Audiology & Cardiology.

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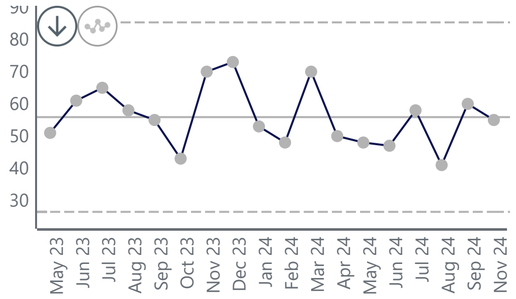
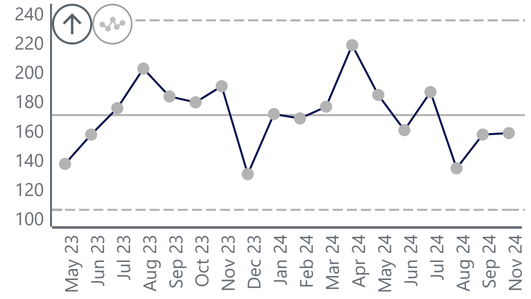
Divisional Performance Summary - Surgery

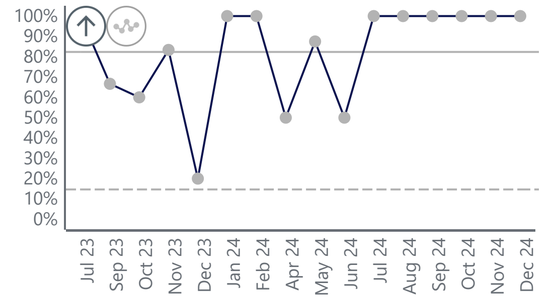
Patient Safety Incidents rated Low Harm & Above



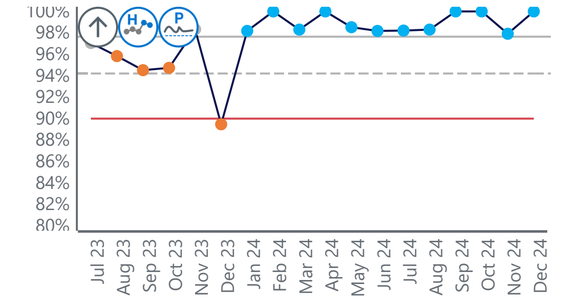
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

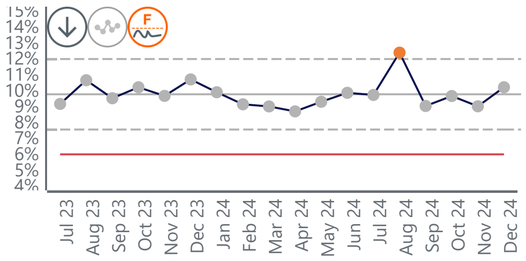


% PALS Resolved within 5 Days

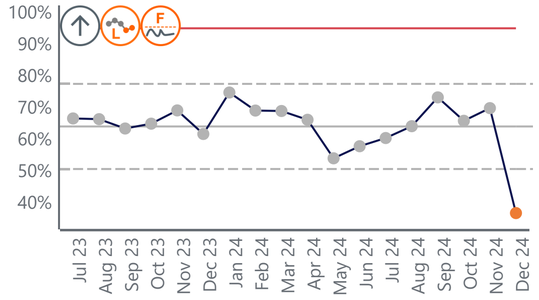


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

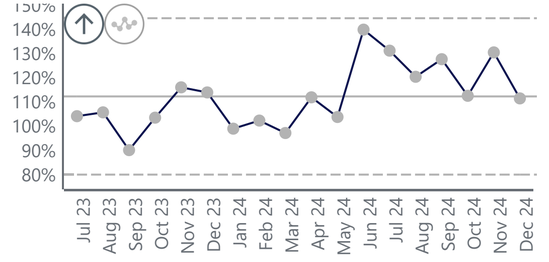


% of Clinical Letters completed within 10 Days



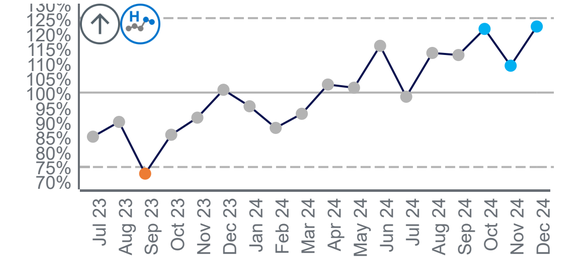
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

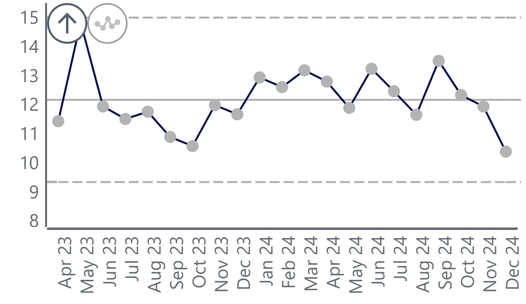


% Recovery for DC & Elec Activity Volume

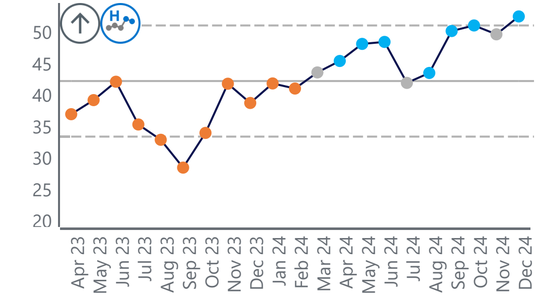
Based on 19/20 baseline



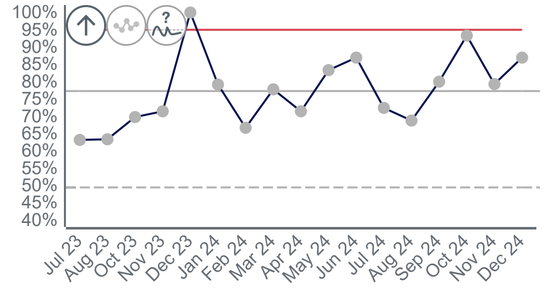
Inpatient Discharges per working day



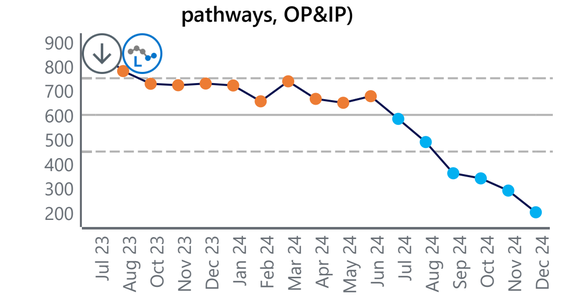
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



NHS
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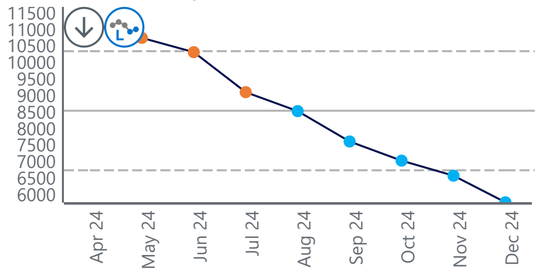
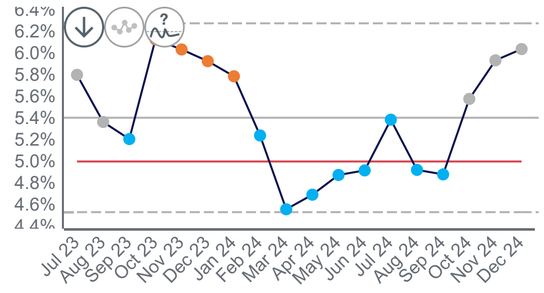
NHS Foundation Trust

Divisional Performance Summary - Surgery

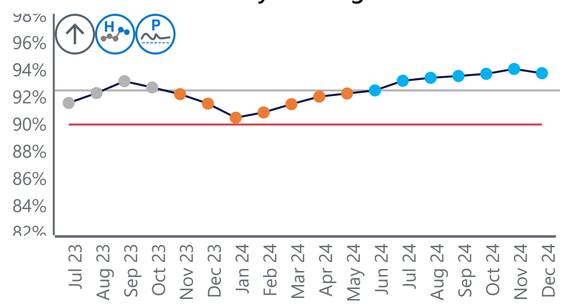
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



Sickness Absence (Total)

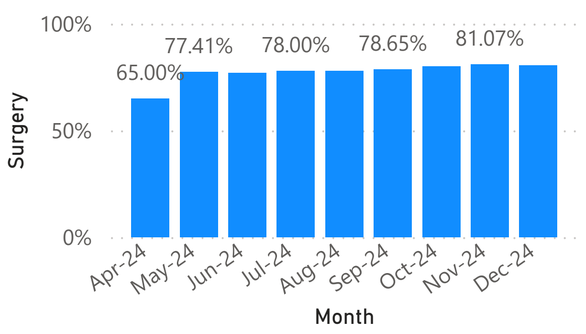


Mandatory Training

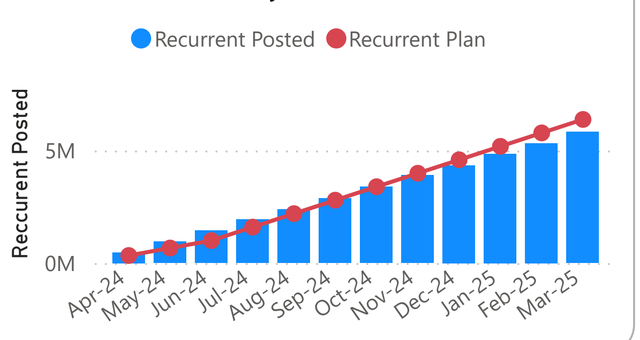


Staff Turnover

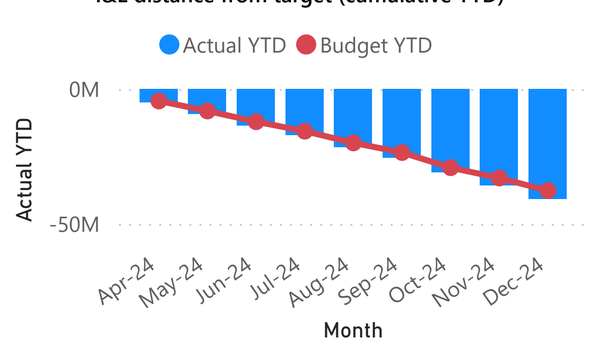
Workforce Stability



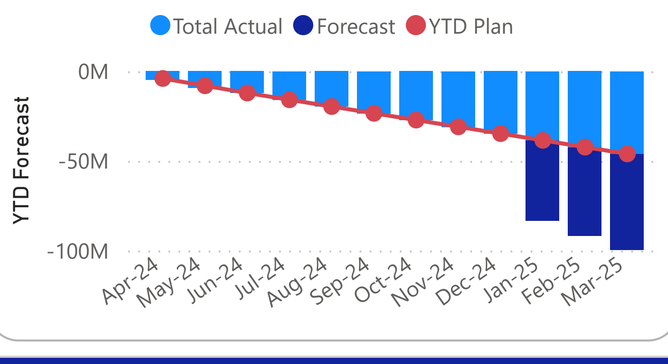
Recurrent Efficiency Plans Delivered (Forecast)



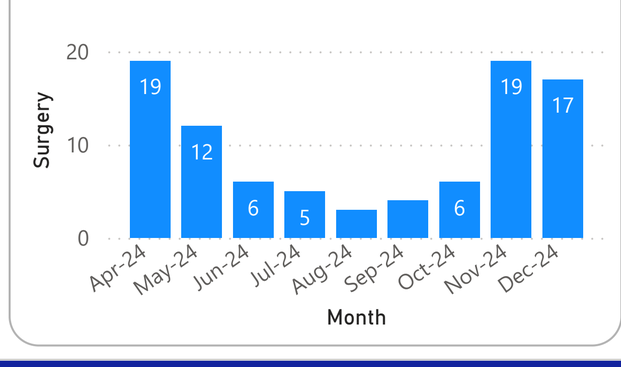
I&E distance from target (cumulative YTD)



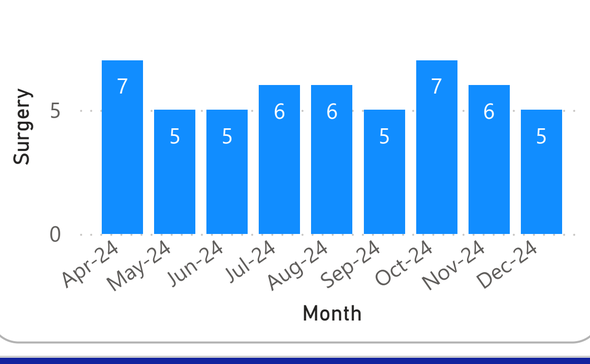
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• HR metrics remain positive with sickness absence well below target and mandatory training above target

• B7+ PDRs 100% complete

• Commercial research income ahead of target offsetting the underachievement against the 3rd MRI scanner (NIHR funded) business case targets

• Internal research funding call (supported by AH Charity, Research Capability Funding and Commercial Capacity Building funds) open to applications – closes 20th Jan 2025

Areas of Concern

• 3rd MRI scanner not yet fully operational and activity pipeline not established. Risk added to risk register. Income target offset for 24/25 by overachievement in commercial income

Forward Look (with actions)

• Review of MRI business case underway

• Panel convened for review of internal funding applications - decisions expected in Feb

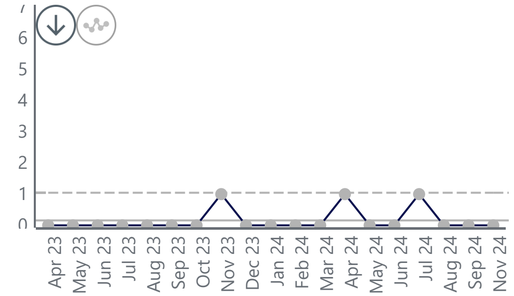
• Visits from Birmingham Women's and Children's Hospital and GOSH planned for Jan

Integrated Performance Report | January 2025

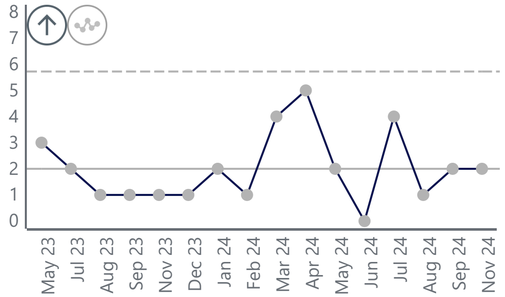
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

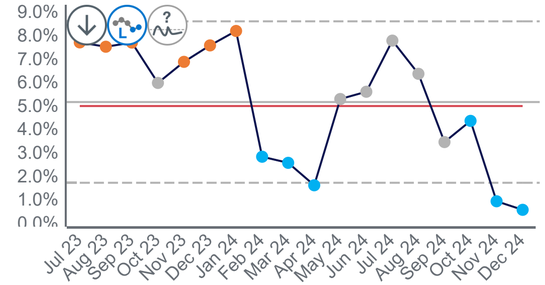


Patient Safety Incidents rated No Harm

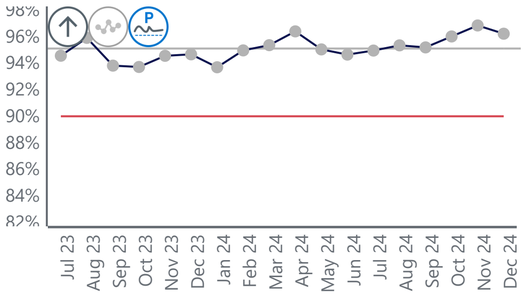


Staff Turnover

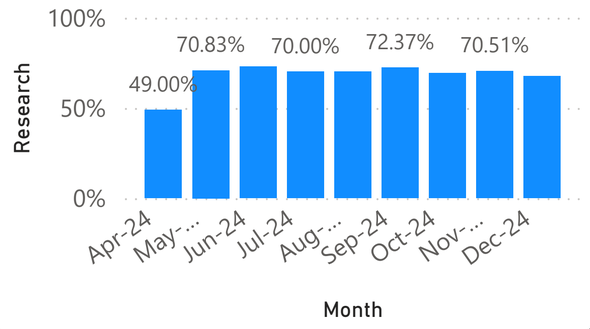
Sickness Absence (Total)



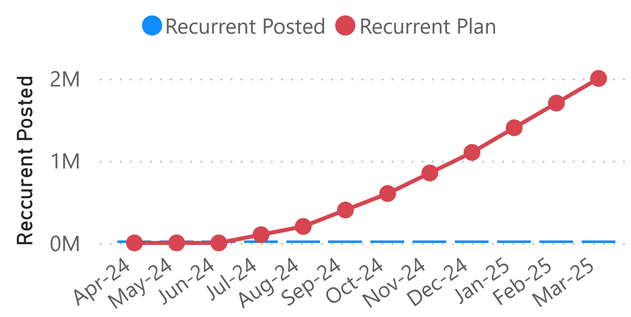
Mandatory Training



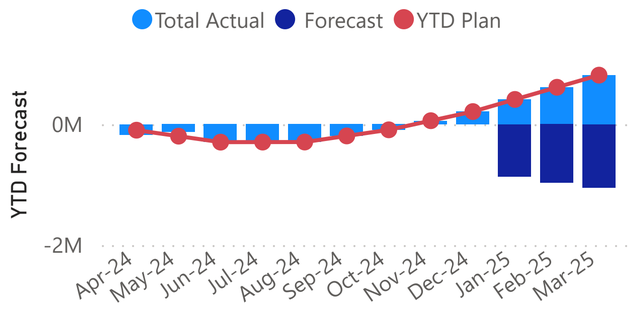
Workforce Stability



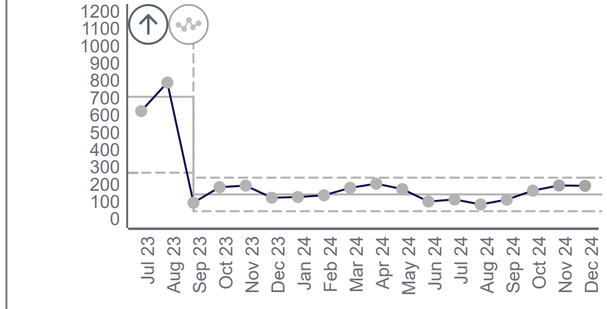
Recurrent Efficiency Plans Delivered (Forecast)



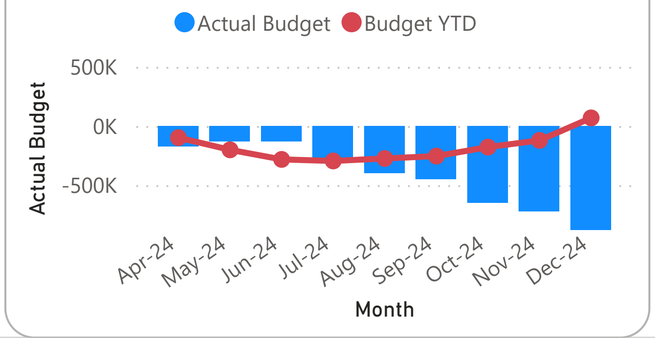
I&E Year End Forecast



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 met on 13th January 2025. Highlights from the December data include:

- Mandatory training remains stable at 94%.
- Short term sickness absence remains within Trust target at 2%.
- Proportion of BAME staff in workforce is currently sitting at 7%.
- Long term sickness has remained at 5% from the previous month.
- 94% of CIP already identified and/or delivered at M08.
- Income ahead of plan at M09 and YTD.

Areas of Concern

- PDRs for all staff is currently sitting at 82%.
- Overall sickness remains above Trust target at 6.8%
- Policy compliance is an area of concern with fifteen policies overdue within Corporate Services.
- Risk management compliance saw an improved position with 5/53 risks overdue review (91% in date).

Forward Look (with actions)

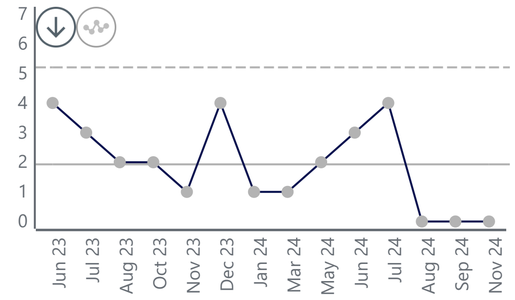
- Continued focus on financial position, system finance and internal controls/opportunities.
- Risk owners asked to ensure all overdue risks are reviewed as a priority.
- Call to action for Policy owners to update outstanding documentation and submit through the appropriate governance channels.

Integrated Performance Report | January 2025

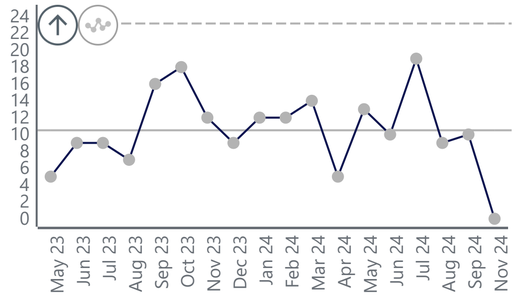
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

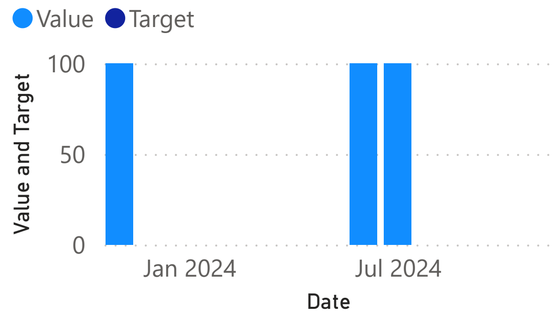
Patient Safety Incidents rated Low Harm & Above



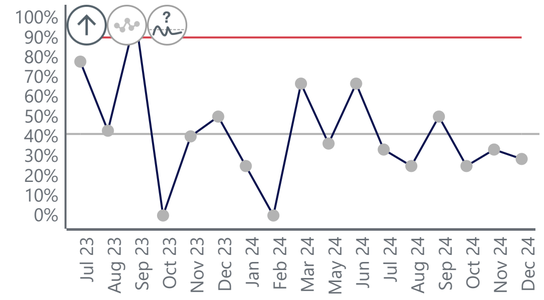
Patient Safety Incidents rated No Harm



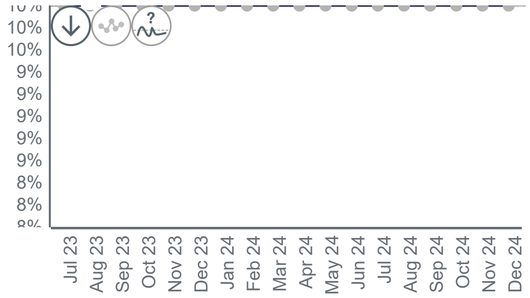
% Complaints Responded to within 25 working days



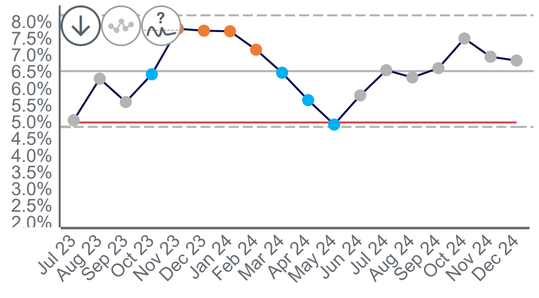
% PALS Resolved within 5 Days



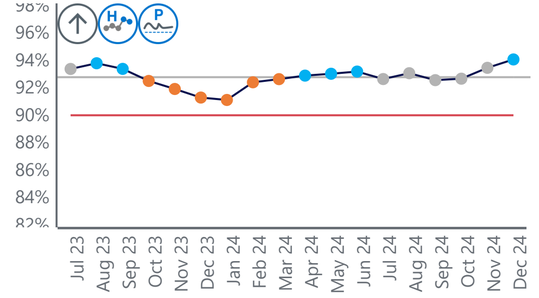
Staff Turnover



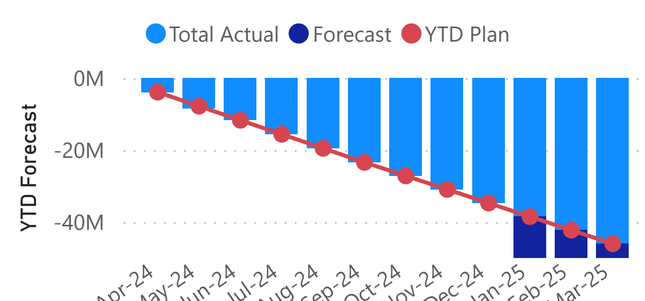
Sickness Absence (Total)



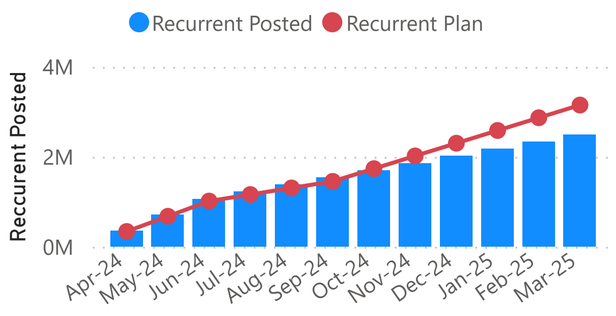
Mandatory Training



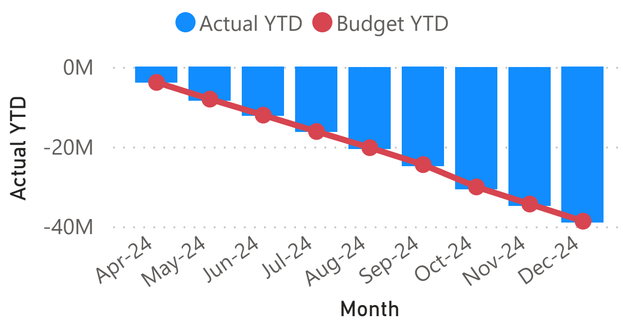
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

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

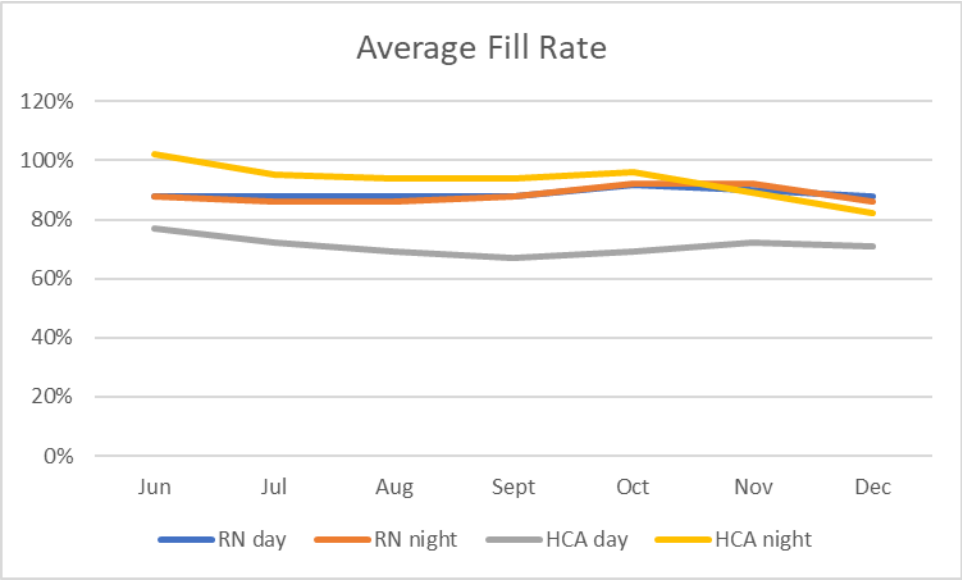
	Day		Night		Patients	CHPPD	National benchmark	Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate	Oct-24	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%	-	97%	-	95	21.6	13.56	16.84	-5.00%	1.00	0%	0.00	0.00%	0.00	0.00%	4.92	0.90%	2.00	6.45%	0	47	0	1	2	100%	1	0
HDU	80%	45%	78%	58%	317	25.9	27.35	75.67	-2.00%	7.99	67%	0.92	1.19%	0.00	0.00%	235.39	9.83%	0.00	0.00%	9	184	0	3	2	100%	0	0
ICU	89%	97%	91%	42%	484	37.6	27.35	161.87	3.00%	6.08	51%	1.53	0.98%	0.00	0.00%	298.53	6.13%	0.00	0.00%	16	253	0	1	2	100%	2	0
Ward 1cC	92%	76%	88%	64%	617	11.5	12.41	58.43	-8.00%	5.33	6%	0.00	0.00%	0.00	0.00%	146.21	7.43%	19.87	12.75%	2	140	2	28	90	80.00%	1	0
Ward 1cN	89%	0%	98%	-	243	17.7	15.09	35.21	-9.00%	2.63	70%	0.00	0.00%	0.00	0.00%	86.32	7.26%	0.00	0.00%	1	90	0	9	1	100%	0	0
Ward 3A	95%	69%	96%	123%	766	10.1	10.17	49.23	-16.00%	15.98	19%	0.00	0.00%	0.00	0.00%	134.97	7.87%	54.26	13.44%	3	90	0	19	26	100.00%	1	0
Ward 3B	91%	85%	89%	-	333	15.9	10	43.95	2.00%	5.28	7%	0.00	0.00%	0.00	0.00%	81.07	6.06%	2.76	1.81%	3	145	0	9	2	100%	0	0
Ward 3C	93%	68%	82%	71%	766	10.5	8.65	62.65	-4.00%	11.47	25%	0.00	0.00%	0.00	0.00%	120.76	6.00%	4.68	1.89%	5	163	0	7	10	80.00%	1	0
Ward 4A	84%	46%	83%	124%	707	11.3	10.25	67.53	-2.00%	8.51	44%	0.00	0.00%	0.00	0.00%	213.47	10.01%	54.60	36.80%	6	112	0	5	15	93%	1	0
Ward 4B	62%	82%	62%	100%	670	12.2	11.92	33.67	-7.00%	50.01	28%	0.00	0.00%	0.00	0.00%	76.00	6.77%	79.53	7.14%	6	148	1	9	2	100%	0	0
Ward 4C	83%	70%	81%	73%	581	11.7	11.8	57.68	1.00%	11.69	5%	0.00	0.00%	0.00	0.00%	98.65	5.65%	10.83	3.14%	4	301	0	9	12	90.00%	2	0

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Fill rates are produced by setting out the planned number of hours required for Registered Nurses (RN) across days and nights and the same for Health Care Assistants (HCA) for a full month period and is captured daily. The electronic roster produces the percentage fill for the month and accurately reflects the hours worked against the planned number. The percentage fill rates include any hours worked by bank staff. The benchmark for CHPPD for the above tables is based on October 2024 data, which is the latest information available from the model hospital. There are two areas highlighted red which fall below this reported benchmark.

Summary

Only one area is reported as falling below the 80% benchmark, however data for ward 4B is not a true representation as the model has been realigned. The health roster has been realigned to reflect this, there is however a delay as the changes could only take effect for those rota's that had not been approved.

There are vacancies within HCA's in all wards with the exception of the burns unit which impacts on the fill rate reported, in addition an increase in those requiring 1:1 care particularly overnight is reported in wards 3A, 4B, and 4A.

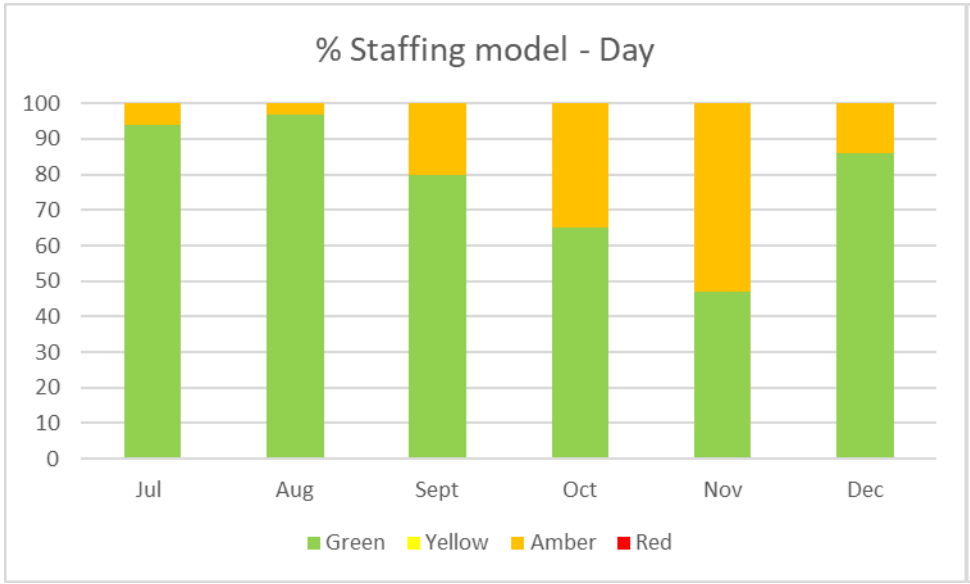


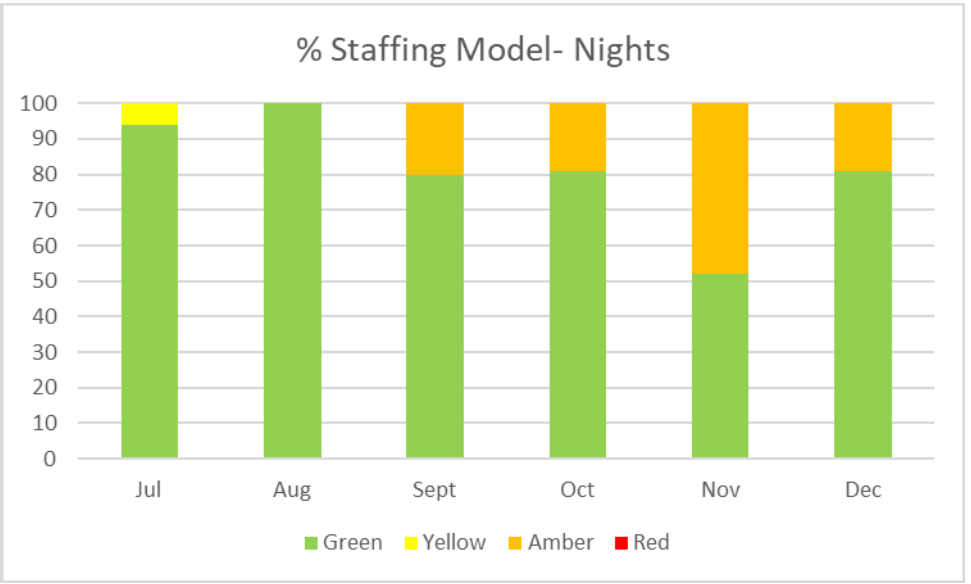
Nursing and care staff average fill rate December 2024	
Day and Night average fill rate	
Registered (%)	**Care Staff**
87% ↓	**77%** ↓

The overall improved position in relation to fill rates across day and nights continues with a slight reduction reported in December. There are vacancies within HCAs across the trust which impacts on the fill rate reported in some areas.

Summary of Staffing models July – December 2024

December reported an improved position with less days/nights with an amber staffing model, this in part is due to capacity on the wards during the Christmas period. There were no red reported staffing days in 2024.
To Note only Red, Amber, and Green staffing status is now reported via the staffing template.





NHSP Bank Spend December 2024

Temporary staffing is monitored closely with weekly oversight from Workforce Efficiencies group attended and represented by senior staff from various disciplines including nursing. This group developed trust and divisional dashboards to support the monitoring of bank and agency use across all areas and has oversight from executives. Weekly monitoring of bank and agency occurs in each division as well as daily oversight from Safe Staffing Chair and Senior Clinical Site Practitioner out of hours. We have seen a reduction in Registered Nurse Bank spend in December and a significant decrease compared to December 2023.To note all new starters from October are now reflected in the numbers.
Unregistered Nurse Bank has also reduced in the month of December despite the number of substantive vacancies within the trust. Recruitment for HCA is in progress.

Registered Nurse Bank Spend

YOY Comparison for Dec-2024

WTE

54.2 !
72.3

% Total Fill

84.7% ✓
80.0%

% Bank Fill

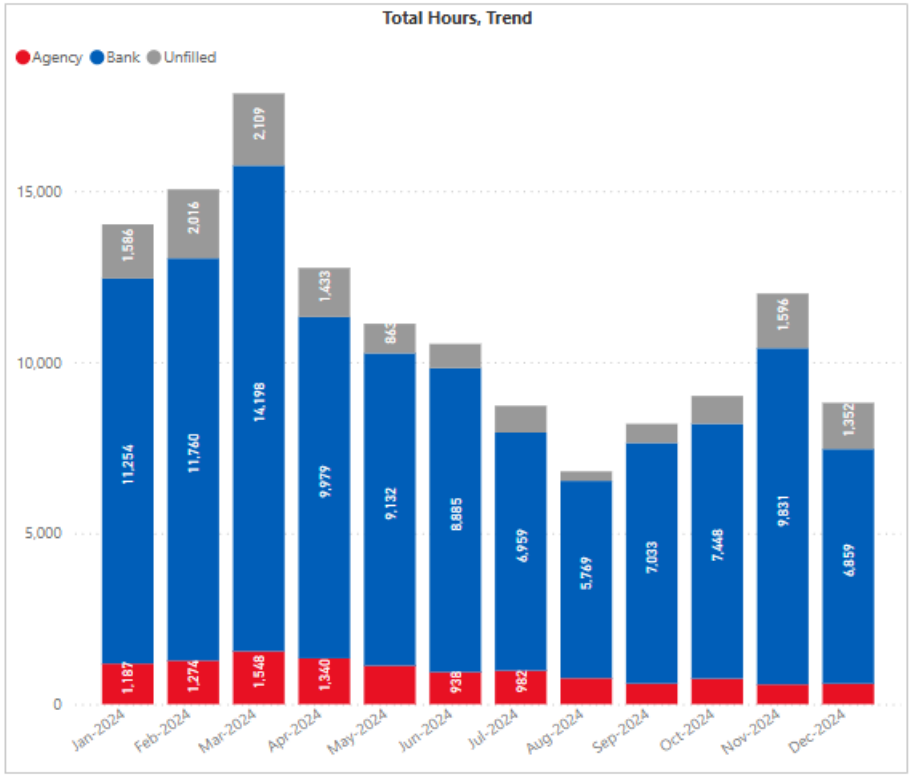
77.8% ✓
72.5%

% Agency Fill

6.8% ✓
7.5%

% Unfilled

15.3% ✓
20.0%



Demand: in Dec-2024 totalled 8,811 hours (889 shifts), a change of -26.6% on Nov-2024

Bank: in Dec-2024 totalled 6,859 hours (698 shifts), a change of -30.2% on Nov-2024

Unfilled: in Dec-2024 totalled 1,352 hours (129 shifts), a change of -15.3% on Nov-2024

Agency: in Dec-2024 totalled 601 hours (62 shifts), a change of 4.0% on Nov-2024

Unregistered Nurse Bank Spend

YOY Comparison for Dec-2024

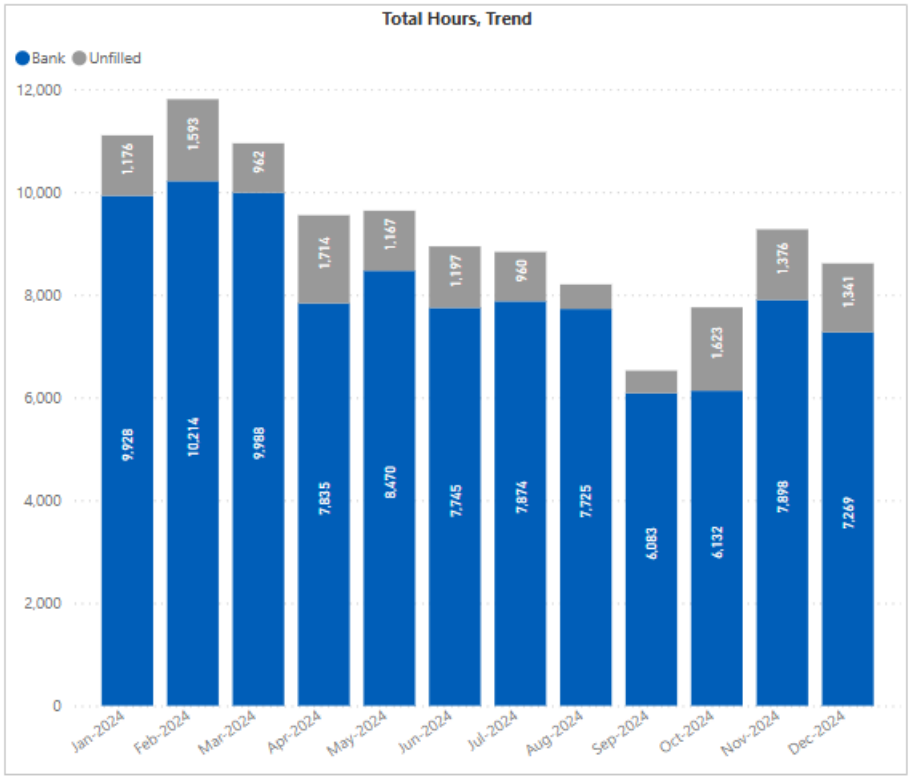
WTE
53.0 !
71.9

% Total Fill
84.4% !
92.5%

% Bank Fill
84.4% !
92.5%

% Agency Fill
(Blank)

% Unfilled
15.6% !
7.5%



Demand: in Dec-2024 totalled 8,611 hours (869 shifts), a change of -7.2% on Nov-2024

Bank: in Dec-2024 totalled 7,269 hours (731 shifts), a change of -8.0% on Nov-2024

Unfilled: in Dec-2024 totalled 1,341 hours (138 shifts), a change of -2.5% on Nov-2024

Agency: in Dec-2024 totalled hours (shifts), a change of -100.0% on Nov-2024

KPI E-Roster December 2024
Period11th Nov-9th Dec 2024

RosterPerform 11 Overview														
KPI Description	The minimum no of days notice teams need to be given for shifts to be worked	% of changes made in roster since full approval	The number of contracted hours people owe or are owed (Negative = owed, positive = owes)		The % of shifts filled by temporary staffing	The total number of hours filled by temporary staff	The number of shifts created ontop of the establishment	The % of shits in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)		<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days **(11th November - 8th December)**	% Changed Since Approval	Net Hours (1 pro rated day per person)	Net Hours	Bank / Agency Use %	Bank / Agency Usage Hours	Additional Duties	Unfilled Roster %	Annual Leave %	Study Day %	Other Leave %	Sickness %	Parenting %	Total Unavailability %
Accident & Emergency - APNP (912201)	54.00	28.99%	80.00	630.38	0.00%	0.00	0.00	25.61%	8.52%	8.34%	0.45%	11.07%	0.00%	28.38%
Accident & Emergency - Nursing (912201)	42.00	44.03%	720.00	221.40	13.74%	1367.50	1.00	20.90%	13.18%	1.11%	2.02%	9.67%	8.27%	34.81%
Burns Unit (915208)	44.00	23.50%	140.00	283.25	2.90%	68.50	4.00	3.01%	9.68%	3.52%	0.39%	1.43%	0.00%	17.89%
Critical Care Ward (913208)	44.00	27.23%	1200.00	1642.50	8.23%	1656.25	2.00	11.94%	10.70%	3.66%	1.42%	5.65%	3.81%	25.24%
High Dependancy Unit (HDU) (913210)	44.00	29.15%	640.00	122.61	12.43%	1071.17	7.00	20.90%	12.27%	4.39%	0.71%	10.09%	8.40%	35.86%
Medical Daycase Unit (911314)	45.00	27.69%	50.00	-34.22	1.38%	15.00	13.00	14.23%	7.70%	2.28%	0.00%	9.29%	0.00%	19.27%
Outpatients (916503)	41.00	41.24%	420.00	759.67	13.23%	874.42	8.00	40.84%	8.01%	0.61%	1.55%	19.40%	2.69%	32.26%
Sunflower House (912310)	31.00	47.53%	190.00	1428.88	25.71%	1151.17	81.00	21.55%	9.43%	0.35%	2.46%	9.90%	3.77%	29.29%
Surgical Daycase Unit (915418)	44.00	48.85%	85.00	-4.17	4.12%	119.00	9.00	31.96%	9.39%	0.27%	0.38%	13.16%	0.00%	23.21%
Theatres - Cardiac & Cardiology (915405)	44.00	21.54%	130.00	18.00	4.68%	103.50	3.00	12.03%	7.60%	1.02%	3.11%	15.57%	0.00%	27.29%
Theatres - Emergency (915420)	44.00	18.51%	230.00	102.00	1.73%	39.00	1.00	0.43%	14.64%	0.42%	0.40%	1.15%	0.00%	22.34%
Theatres - IP Anaesthetics (915423)	44.00	25.17%	82.00	3.25	0.92%	31.00		6.81%	10.15%	1.56%	3.16%	9.21%	3.55%	27.62%
Theatres - IP Porters (915435)	44.00	24.20%	101.00	53.14	8.21%	111.97	1.00	17.61%	8.03%	0.00%	0.82%	20.08%	0.00%	28.92%
Theatres - IP Recovery (915422)	41.00	25.46%	103.00	30.55	12.84%	201.00	1.00	7.52%	13.11%	1.95%	7.13%	6.21%	0.00%	28.40%
Theatres - IP Scrub (915424)	44.00	26.24%	128.00	116.93	13.22%	222.00	1.00	12.15%	11.46%	0.61%	0.35%	6.13%	1.52%	39.04%
Theatres - Ortho & Neuro Scrub (915436)	44.00	25.09%	37.80	4.50	19.08%	455.50		6.66%	11.41%	2.66%	1.41%	3.79%	0.96%	39.03%
Theatres - SDC Anaesthetics (915429)	44.00	58.40%	58.40	-7.25	42.40%	454.00		10.21%	2.01%	5.35%	11.07%	12.08%	15.89%	46.40%
Theatres - SDC Recovery (915430)	44.00	38.04%	177.30	-3.62	10.43%	163.00		3.83%	11.46%	1.12%	4.38%	7.75%	2.16%	26.87%
Theatres - SDC Scrub (915421)	44.00	43.95%	532.00	-10.60	11.39%	302.25		7.78%	11.00%	0.00%	2.87%	24.89%	0.00%	38.76%
Ward 1C Cardiac (913307)	44.00	36.84%	361.00	1036.73	5.74%	416.33		11.21%	12.11%	1.15%	2.22%	8.58%	6.50%	30.64%
Ward 1C Neonatal (913310)	41.00	42.21%	556.00	1021.55	0.86%	46.00	1.00	18.82%	10.15%	5.83%	0.54%	6.38%	4.67%	33.03%
Ward 3A (915309)	44.00	32.85%	371.00	144.97	17.60%	1394.75	82.00	17.08%	12.73%	0.75%	4.76%	13.10%	7.54%	39.07%
Ward 3B - Oncology (911208)	41.00	15.31%	555.00	348.20	3.44%	180.50	45.00	14.35%	12.20%	1.43%	1.93%	5.10%	4.45%	29.11%
Ward 3C (911313)	44.00	29.85%	607.00	1542.23	12.51%	1066.25	32.00	17.69%	11.76%	3.25%	2.64%	6.63%	4.57%	32.13%
Ward 4A (914210)	44.00	31.70%	634.00	221.25	9.35%	798.00	39.00	20.40%	6.87%	4.46%	1.43%	12.91%	2.92%	30.84%
Ward 4B (914211)	41.00	32.21%	533.00	955.84	12.25%	1106.00	28.00	23.19%	13.86%	1.26%	1.90%	7.62%	6.70%	31.34%
Ward 4C (912207)	41.00	41.76%	280.00	188.08	12.49%	967.50	26.00	9.50%	10.37%	1.79%	1.99%	7.80%	5.13%	29.04%

Summary

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.

- Lead time has increased from 41.8to 43.2 and is now within the KPI.

- Net hours have increased from 9443 to 10816 with 18 out of the 27 units still within KPI. Areas of focus are Critical Care, Sunflower House, Ward 1C Neo, Cardiac and Ward 3C.
- Bank hours/Agency has increased from 13812 to 14382 (Period 11th November -8th December)
- Number of shifts created over establishment has continued to reduce and is at its lowest for the last 10 months.
- Annual Leave is low with the average being 10.4% which is outside of the KPI target of 115-17%. Low annual leave may result in some departments not being able to accommodate all annual leave requests by the end of the financial year.
- Sickness continues to increase and remains high at 9.8%.

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

BOARD OF DIRECTORS

Thursday, 6th February 2025

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

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 Q3 & Q4 – Completed Schemes:

- Springfield Park Phase 2
- Fracture/Dermatology Outpatients
- Social Prescribing Base Camp (final fit out in progress)

2025/26 Q1 & Q2:

- Alder Park Phase 1
- Elective Surgical Hub

2025/2026 Q3:

- Neo-Natal Unit & Emergency Floor
- Springfield Park Phase 3

The sprinkler system to Catkin & Sunflower building under-croft is not to be progressed. A separate paper was approved by Finance, Transformation and Performance Committee on 27 January 2025 to support the Trust with an immediate need for a temporary surface car park, and to highlight potential options for the future use of the Catkin/Sunflower Building under-croft. Plans to be developed in line with the requirements of the wider site master plan for the Alder Hey site.

Capital bids approved for '24/'25 and submitted for '25/'26 will be reported in future reports to the Board.

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	6	2	4	
Site Tidy/ Master Planning	KOT	7	1	6	
Neo-Natal Unit/ Emergency Floor	JG	17	3	14	
Alder Park: Phase 1	KOT	14	3	11	
Elective Surgical Hub	JVH	6	1	5	

Regular Principals' meetings for each project remain in place with Mitie and the SPV to check, challenge and manage any implications associated with projects in the main hospital building. Updates are noted within Section 4 of this report.

Key Risks Descriptor

Project	Description	Ref	Score	Status
Springfield Park	Failure to deliver long term vision for park	BAF 3.1	8	Phase 1&2 complete. New planning application submitted. Phase 3 detailed plan being developed.
Neonatal Unit & Em Floor	Affordability	Not assigned	12	Development team managing mitigation plan for SPV/other costs. Draft services Deed of Variation to be finalised Sept ’25.
SF/Catkin	Contractor Compensation Events (CEs)	Not Assigned	12	Informal discussions have resumed between the contractor and the Trust to establish the contractor’s position.

3. Construction Programme Delivery Timetable

Project	Deliverable	2025												2026												2027+
		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 3: Park Handover																									
Neo-Natal & Emergency Floor	Main Construction Period																									
Alder Hey: Site Completion & Master Plan	Phase 1 Enabling (scope TBD)																									
	Phase 2+ Site Plan (scope TBD)																									
Alder Park: Lyndhurst Building & Master Plan	Phase 1 Refurbishment (EDYS, Therapies & SALT)																									
	Phase 2 Construction TBC (Sefton CAMHS)																									
Elective Surgical Hub	Refurbishment																									

4. Project Updates

Neonatal Unit and Emergency Floor

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Programme Completion 20.10.25: • ED Waiting decant completed. • RIBA Stage 5 Design Review/Sign Off by technical & clinical teams Mar '25. • Draft services Deed of Variation (lifecycle & maintenance) to be completed September '25. Two risks being managed: 1. Delay with Mitie completing the PAU services disconnection and re-connections – the Trust has not yet been formally advised of impact or delay to programme. 2. Design & Technical Changes in relation to regulatory requirements/latest guidance: ventilation, fire, water safety, decontamination, and some clinical functionality requirements arising from RIBA Stage 5.		Completion of main construction works. Increased construction & SPV costs. Delay to unit opening.	RIBA Stage 5 sign off. Finalise & approve any agreed water safety, design and technical changes. Cost & programme update to be presented at next Finance, Transformation & Performance Committee.

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.

Space Utilisation & Working Environment: Office Buildings and Staff Facilities

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Demolition of Histopathology Building by Dec '25 (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.		Histopathology building to be vacated by early summer. Potential resistance from teams to new ways of working, sharing space with other teams and re-locating.	Full staff engagement exercise to agree final desk allocation, move dates and operational logistics. Budget and scope of works to be finalised.

Springfield Park Reinstatement

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Completion Works: • Phase 1 & 2 complete. • Retrospective planning application submitted to LCC on 15.10.24. • Phase 3 Full Site Handover (Dec '25): programme of works and supporting costs being developed.		Completion and funding of all remaining demolition and works.	Planning approval.

Site Completion / Master Site Planning

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Site Completion/Tidy: • Priority works to be finalised. Master Site Planning: • Key stakeholder engagement underway.		Availability of funding. Refer also to Springfield Park Reinstatement above.	Update NE site master plan to reflect emerging developments, inc temporary car park and sub-station locations.

Elective Surgical Hub

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Construction Programme: • Construction completion reported as July '25. Mitigations being explored to fast-track priority works with the contractor. • Updated budget cost report issued and being assessed. Two risks being managed: 1. Endoscopy Room structural coordination including slight impact on Innovation Hub space. 2. Building Safety Act requirements as part of Building Control sign off, 12 not 8 weeks as previously reported.		Programme completion dates. Final cost plan.	Equipment & Furniture requirements confirmed and costed. The Trust is liaising with NHS England to update on progress and for support & due diligence with specialist advisors and the SPV.

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

Deliverable	RAG	Risks/Issues	Actions/Next Steps
Main Construction: • Contract with Krol Corlett Construction signed and in place. • Ground and First Floor completion April '25. • Second Floor completion May '25.		Unforeseen issues arising on site / Trust changes.	Equipment & Furniture requirements to be signed off. Draft move plan to be developed.

4. Conclusion

Trust Board is requested to receive and acknowledge the update provided as of 6 February 2025.

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	Children and Young People's Gender Service (CYPGS) National Provider Network
Report of:	John Grinnell, Chief Executive Officer
Paper Prepared By:	Emily Gardner, Associate Programme Director

Purpose of Paper	Decision ☐ Assurance ☒ Information ☒ Regulation ☐
Summary / Supporting information	Previous Trust Board papers (2024)
Action required	To Approve ☐ To Note ☒
Strategic context **This paper links to the following:**	Oustanding care and experience ☒ Collaborate for children & young people ☒ Revolutionise care ☒ Support our people ☐ Pioneering breakthroughs ☐
Resource implications	

Does this relate to a risk? Yes ☐ No ☐						
Risk Number/s	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

Purpose of report

The purpose of this report is to provide an update to Trust Board regarding the development of the National CYPGS Provider Network and National MDT.

1. Background

In 2020, NHS England commissioned Baroness Cass to review gender identity services for children and young people, because of several factors including significant increased demand; long waiting times and lack of evidence to support clinical decision making. In July 2022, in a letter to NHS England, Dr Cass recommended that the new regional centres for the re-named Children and Young People's Gender Service (CYPGS) should be led by experienced providers of tertiary paediatric care to ensure a focus on child health and development, with strong links to mental health services.

Alder Hey Children's NHS FT and Royal Manchester Children's Hospital (MFT) work in partnership to provide the North West service. Great Ormond Street Hospital for Children NHS FT (GOSH), Evelina London Children's Hospital (GSST) and South London and Maudsley NHS FT provide the London service and University Hospitals Bristol and Weston NHS Foundation Trust provide the South West service. It is expected that NHS England will commission a further 3 or 4 services by 2026.

The final report of the Cass Review was released on 10 April 2024 and the implementation plan was published by NHS England on 07 August 2024, accepting all recommendations from the Cass Review. A priority task is to establish a national provider collaborative/"Network", to ensure quality and consistency across CYPGS providers.

2. Context

In September 2024, a paper was provided to Alder Hey Trust Board which detailed NHS England's request for Alder Hey to act as host of the proposed new National CYPGS Provider Network ("the Network"). This was supported in principle by Trust Board and since then, work has been ongoing to mobilise the Network. This paper provides an update on that work to date.

3. Progress

Several key activities have been delivered since September 2024, ahead of the formal commencement of the National Provider Network on 01 February 2025, including:

- Recruitment to the Chair of the National Provider Network and National MDT. The Chair is due to commence for both posts on 01 February 2025.
- Recruitment due to commence for other key posts including Network Director, Programme Manager and Business Support in February 2025.
- Network Mobilisation Group meeting regularly and have developed key Network outputs such as a draft Memorandum of Understanding and Network Board Terms of Reference.
- Planning underway for the Network Board to convene from February 2025.
- Year 1 planning event to be held 05 - 06 February 2025. Under the leadership of the Chair, clinical leads from across the current live services and programme will meet to develop key strategic outputs, such as referral criteria to the puberty suppressing hormone trial and the working definition of 'extreme caution' for the referral of young people for gender affirming hormones, as recommended by the Cass Review Final Report.

- National MDT is established and ready to receive referrals in accordance with the agreed Terms of Reference (Terms of reference to be ratified at the first Network Board). Further detail around the work of the National MDT is provided below.
- Network programme and work plan developed in draft form, prepared for endorsement at the first Network Board
- Ongoing engagement with NHS England in relation to the national gender programme and related activities which are proposed to be handed over to the Network, guided by NHS England's Implementation Plan of the Cass Review

4. National MDT

The National MDT is a vital part of the Network and for the services, as it is the only mandated route for referrals into endocrinology and the puberty suppressing hormone research trial. In addition, the National MDT will review referrals for complex cases, where extensive work has taken place within one of the regional services but national direction and assurance is needed.

The National MDT previously met on a monthly basis between April 2024-September 2024 and focused on development of a Terms of Reference and operational processes. The National MDT has been on a hiatus whilst a substantive Chair was appointed, following the term of office of the interim Chair ending in September 2024.

In lieu of the Network Board being established, the ToR, operational processes and membership has been signed off by NHS England's National Portfolio Board. The endorsement of key documents for the National MDT will be an early agenda item for the Network Board. The National MDT is now ready to receive referrals from in scope services which includes, live CYPGS providers, endocrine providers (UCLH and Leeds Teaching Hospitals) and Young People's Gender Service, Nottingham.

5. Memorandum of Understanding and the Host role

A draft Memorandum of Understanding (MoU) has been developed with support from provider's legal representatives. The MoU will be legally binding in some areas e.g. confidentiality. New providers will need to sign a Memorandum of Adherence, effectively agreeing to sign up to the MoU between existing providers. It is proposed that the Network is accountable to CYPGS Providers who are members of the Network.

Since the update to Trust Board in September 2024, conversations have taken place with endocrine providers (UCLH and Leeds Teaching Hospitals) and it is planned that endocrine providers will be members of the Network. This will ensure an equitable approach for providers delivering the national CYPGS pathway.

A final version of the MoU will be proposed for signing to Trust Board in March 2025.

6. Finance

Following NHS England's support of a submitted resource proposal to support the Network, a part year allocation was received in November 2024. As recruitment to roles has not yet taken place, the Network is holding an underspend and will do so for the remainder of the financial year.

7. Risks

Whilst significant progress has been made with the mobilisation of the Network, there remain two key risks to be noted by Trust Board, both as a proposed member and as Host. These risks will be escalated to NHS England through the structure of the Network following the commencement of the Network Board:

Description of Risk: (risk of…due to...)	Impact/Consequences (if risk is not addressed)	Likelihood	Impact	Risk Score RAG
There is a risk that the Network will not be able to fulfil its core duties to ensure consistency, quality and safety across providers through a collaborative, if member organisations are commissioned inconsistently	The obligation to join the Network must be clearly and accurately outlined in the NHS England commissioning framework for new services (including the endocrine specification) otherwise there will be inconsistency within the national services, with impact on patient experience and outcomes across the country. Phase 2 providers are mobilising within a separate programme at NHSE and there is no formal engagement with live providers	3	5	**15**
There is a risk that the effective commissioning of the National Provider Network will be impeded by the misaligned CYPGS contractual cycles for current and new providers.	Until all providers are live, they will join the Network at different times, with differing contractual cycles, meaning that any changes to the framework of the Network are not realistic	4	3	**12**

8. Recommendations

Trust Board is asked to note the contents of this paper, with particular focus on:

- The noted risks and plan to escalate to NHS England through the Network governance structure
- The forthcoming ask for signing of the MoU, planned for March 2025
- The National MDT is established and ready to receive referrals, noting no referrals have been received to date
- The formal commencement of the Network from 01 February 2025.

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	**Chair's Report from the Safety Quality Assurance Committee meeting held on 22nd January 2025**
Report of:	**Fiona Beveridge, Committee Chair**
Paper Prepared by:	SQAC Committee Administrator

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 22nd January 2025, along with the approved minutes from the 18th December 2024 meeting.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF Risks 1.1 1.2 1.4	• Inability to deliver safe and high-quality services • Children and young people waiting beyond the national standard to access planned care and urgent care • Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies					3 x 3 =9 4x5=20 3x 5 = 15
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Introduction

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

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

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

Minutes of the meeting held on 18.12.24	Minutes Approved subject to a minor amendment
Policies Deep Dive (Document Management System	Report noted
ED monthly report: MH attendances and ED@itsBest	Report noted
Nuclear Medicine CQC Improvement Notice–Closedown Report	Report noted
Divisional updates	Reports x4 noted
Sepsis Quarter report	Report noted
Quarter 3 Drugs & Therapeutics Committee quarterly report	Report noted
Patient Safety update	Report noted
Fuller Inquiry Action Plan	Report noted
Clinical Effectiveness & Outcomes Group Chairs Highlight report	Report noted
Liverpool Neonatal Partnership Monthly update	Report noted
Healthcare Transition Report	Report noted
Board Assurance Framework	Report noted
Board Assurance Framework deep dive of BAF Risk 1.4 CAMHS -waiting times)	Report noted
High Profile Patients and Families Policy	Policy Ratified
Document Management Policy – M38	Policy Ratified

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

- SQAC received a deep dive into the declining compliance with in date policies, guidelines and patient information leaflets held on the DMS. SQAC received an update from each of the Divisions regarding the current challenges. SQAC requested a report for the February 2025 SQAC meeting detailing actions to be immediately implemented, together with a forward view.
  SQAC requested a monthly compliance update to be included within the Divisional updates as an appendix with the SPC charts from February 2025 onwards.
  NA would follow up separately regarding a wider governance review.
- Challenges were noted with the collection of data with regards to transition and that colleagues within the transition team are exploring making fields mandatory within transition forms to ensure that data collection is easier and is more accurate. SQAC also noted that wider discussions are taking place regarding resources required for Healthcare Transition. SQAC agreed to receive quarterly Healthcare Transition updates.
- SQAC received a comprehensive Board Assurance Framework deep dive of BAF Risk 1.4 (CAMHS waiting times). There had been 18 actions completed and closed, with no change in the current risk score during 2024. A full review of the risk was undertaken in June 2024 and actions updated.

- An action relating to lack of/incomplete data for Mental Health Services via NHS England reporting systems to the national Mental Health Services Data Set (MHSDS) and actions being taken were added to the BAF risk (linked to service risk 214).

  SQAC agreed that Risk 1.4 needed to be rearticulated and refreshed for the new financial year.

4. Positive highlights of note

- Improvements with triage times, for first clinical reviews and improvement in handover performance were noted within the ED monthly report.
- SQAC welcomed the success regarding the management of the ED waiting room, as the recent move had occurred seamlessly and had been well managed.
- SQAC welcomed the Nuclear Medicine CQC Improvement Notice – Closedown Report – and congratulated the teams for the ongoing work to achieve this result. SQAC welcomed a reflective update which would be presented in due course detailing general advice for other areas of the Trust.
- SQAC welcomed the Sepsis update with good discussion held and good assurance received.
- SQAC welcomed the Quarter 3 Drugs & Therapeutics report. 1 risk had been closed regarding Smoking cessation and NICE guidance
  SQAC received an update on the Sodium valproate CAS alert and the requirement to complete work in relation to people becoming pregnant and the risk to unborn children, with a completion date by 31.1.24. SQAC noted the significant work involved and that the Trust is working closely with the ICB, and working internally and externally to ensure that dashboards are in place. Whilst this is overdue the Trust is not an outlier and the Trust had been provided with assurance that the ICB is happy with the progress being made.
- Positive reporting culture for incidents continues across the organisation
- SQAC received the Fuller Inquiry Action Plan and acknowledged the leadership from N Osborne. SQAC noted that the Trust is awaiting final recommendations from Phase 2, and that many of the actions would be imminently closed. SQAC noted the challenge regarding CCTV and its appropriateness, and the management specifically relating to the post mortem room, with the requirement for a detailed and thoughtful options appraisal.
- CEOG reported on an improved position for the Division of Surgery regarding the closing of overdue divisional audits.
- LNP policy guidelines – task and finish group are progressing the review and streamlining of Alder Hey and Liverpool Women's NHS Foundation Trust documents across the LNP.
- Continued improvements are noted with oversight and learning from clinical audit
- SQAC noted the progress that had been reflected at the last LNP Board, with improvements noted with BI issues regarding data collection from both organisations. A joint IPR is in development.
- LNP had been successful regarding the recruitment of a Speech & Language therapist which had been a challenging role to recruit to.
- SQAC noted that there had been a positive reduction in the number of over 18's in both inpatient and outpatients and noted that the Transition team had been working with the BI team to update transition forms that are available to clinicians.
- SQAC RATIFIED the High Profile Patients and Families Policy

- SQAC RATIFIED the Document Management Policy -M38, subject to minor amendments on page 17. SQAC noted that a further update would be expected within 6 months establishing whether any further additions or amendments are required.

5. Issues for other committees

None to report

6. Recommendations

The Board is asked to note the contents of the report

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 18th December 2024
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing, AHP and Experience Officer	NA
	Alfie Bass	Chief Medical Officer	ABa
	Adam Bateman	Chief Operating Officer	AB
	Rachael Pennington	Associate Chief Nurse - Surgical Division	RP
	Kerry Byrne	Non-Executive Director	KB
	Lisa Cooper	Divisional Director – Community & Mental Health	LC
	Ian Gilbertson	Deputy Chief Digital and Information Officer	IG
	Gerald Meehan	Non-Executive Director	GM
	Laura Rad	Head of Nursing – Clinical Research	LR
	Melissa Swindell	Chief People Officer	MS
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Jill Preece	Governance Manager (minutes)	JP
	Jackie Rooney	Associate Director for Nursing & Governance	JR
	Pete White	Chief Nursing Information Officer	PW
Item 24-25-188/192	Bea Larru	Director of Infection Prevention & Control	BL
24-25-188	Andrew Taylor	AMS Pharmacist	AT
24-25-193	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	NO
24-25-197	Dan Hawcutt	Clinical Director of Research	DH
24-25-199	Sue O'Neill	Acting Head of Neonatal Nursing, LNP	SON
24-25-201	Carla Thomas	Clinical Lead for Organ Donation	CT
Apologies:	Erica Saunders	Director of Corporate Affairs	
	Urmi Das	Director of Medicine	

	Welcome and Apologies The Chair welcomed everyone to the meeting and apologies were noted.
24/25/183	**Declarations of Interest** None declared.
24/25/184	**Minutes of the Previous Meeting** The Committee members were content to APPROVE the minutes of the meeting held on 20th November 2024.
24/25/185	**Matters Arising/Review of Action log** The action log was reviewed and updated.
	---- Delivery of Outstanding Care ----
24/25/186	**Antimicrobial Resistance (AMR) Deep Dive** BL delivered a presentation on antimicrobial resistance and referred to the Policy Paper '*UK 20-year vision for antimicrobial resistance'* set out by the government which calls for a collective, global effort to combat resistance. She talked to the Committee about impact of AMR on infants which has grown exponentially over the years due to increased consumption with antibiotics being the most common drug used worldwide.

	Additionally, new antibiotics are not being discovered at a rate that they were in the 1970s meaning that fifty plus years later, the organisms that cause infection have evolved and are no longer affected by the antimicrobial medicines available. BL reported that a number of workstreams have been developed across the divisions to support the global effort to combat resistance, these report into the Antimicrobial Resistance Steering Group to provide Trust wide education in the inappropriate use of antibiotics. The IPC Team continued to link with the communications team to raise awareness of this issue and the work ongoing. FB thanked BL for informative presentation and all of the work being undertaken in this area given the scale of the challenge. KB talked about the resource required to deliver the training and education around AMR and sought assurance if this was adequate. BL stated that the data being developed by UKHSA would be the driver to help deliver this training. It is hoped that hard data would help engage staff. AT commented that he was confident he could dedicate time to project lead on AMR. LR suggested the opportunity to link into the Seedcorn funding from a Research Strategy perspective. GM talked about prescribers giving antibiotics to children and young people 'just in case' and welcomed further feedback on getting it this right. BL stated that there was a behavioural component to this and managing the uncertainty of prescribing was very important. She went on to advise that a psychologist sat on the AMR Steering Group to help staff understand this. **Resolved:** SQAC **NOTED** the contents of the AMR presentation and would continue to receive updates through the Patient Safety Report.

24/25/187	**ED monthly report: MH attendances and ED@its best**
	CW presented the Emergency Department (ED) Monthly Report sharing key highlights and challenges:
	
	Challenges:
	• November was a very challenging month in the Emergency Department with only 73.7% compliance against the national 4-hour standard of 78% being achieved; this was the first time since October 2023 that the Trust had not managed to achieve the standard.
	• There was a 6% increase in attendees from previous month (and 10% increase from Nov 2023).
	• A downward trend had been noted across a number of ED metrics including:
	  ○ Time to be seen by a clinician had increased to 52 minutes above the national target; this was due to an increase in attendances and workforce challenges which is being managed on the risk register.
	  ○ Children and Young People waiting longer than 12h in ED had seen an increase in month (40 in total) but remained within target. CW provided assurance that the patients waiting for long periods were being well managed, but the team were looking into this matter from an experience perspective. In some cases, and where appropriate long stayers in ED require involvement from external agencies.
	• There had been a Norovirus outbreak on PAU and 4C during November 2024; both of which had been managed well.
	
	Highlights:
	• The transition to a new provider (PC24) for the Urgent Treatment Centre had gone smoothly despite the increase in capacity & utilisation.
	• Continuing to deliver on the Winter Plan.
	• No surgical cancellations in-month despite a reduction in beds.
	• Utilisation of PAU is in line with previous year despite challenges with the environment.
	• Increased Consultant presence on PAU.
	• Plans to operationalise the new waiting room are on track for 7th January 2025.
	• Work remains ongoing for Ground Floor Emergency Expansion (December 2026) including review of pathways.
	
	CW assured the committee that any emerging issues are closely looked at and subject to a deep dive in respect of safety and patient experience issues and specifically.

	FB referred to the CYP waiting for long periods and asked if there were any themes in terms of presentation of these patients. CW advised that no particular themes had been identified but were all triaged as green and deemed safe to wait. LC added that the teamwork with local authorities/agencies at the appropriate seniority in cases where this is needed. FB stressed the need for a piece of advocacy work in this area. NA took the opportunity to inform colleagues that Alder Hey was now a part of the work with NHSE and the Department for Education looking at the issue of inappropriate discharges to healthcare. **Resolved:** SQAC received and **NOTED** the ED Monthly Report.
24/25/186	**Nuclear Medicine CQC Improvement Notice** The Committee noted the contents of the report noting the progress made against the actions to remediate the improvement notice. **Resolved:** SQAC received and **NOTED** the Nuclear Medicine CQC Update
24/25/187	**Divisional Updates** **Clinical Research Division** LR presented the Research Division update and drew attention to a few key points from the report including: • First official wellbeing week had been held in November which had been very well received by staff. • Launch of the Mobile Research Unit with a number of events scheduled for the wider organisation. • The Division had seen an increase in information governance incidents namely relating to new staff not being aware of Trust procedures. Training reminders have been issued to staff and spot checks would be undertaken during December 2024. • An audit of the Essence Study had been undertaken by the Sponsor. The Division was awaiting the formal report but are expecting one major critical finding in relation to missing documentation. This concerned a patient from 7 years ago when paper records were still being used and therefore no improvement action is expected. **Community and Mental Health Division** LC presented the Community and Mental Health Division update and drew attention to a few key points from the report including: • First divisional risk masterclass for managers held during the month with positive feedback received. • Speech and Language Therapy have reduced the wait for first assessment and have achieved a 95% RTT. The risk relating to this issue has now been reduced. • Specialist Speech and Language Therapy held a national study day with colleagues from across the country which was well attended and valued by all. • Children and Young People with additional needs being supported within the hospital setting is continuing to increase. Actions are underway to work more proactively in this space. • Sickness absence within the Division has increased and colleagues are working closely with HR, occupational therapy and SALS to understand why this is. • Getting new or replacement posts approved for recruitment is becoming a challenge in terms of the new process required by the ICB which is causing delays. The Division are continuing to seek alternative ways of managing without additional resource in the affected teams. • Sunflower House – Tier 4 Inpatient Unit was inspected by QNIC and accredited to April 2027 without conditions. **Division of Medicine** CW presented the Medicine Division update and drew attention to a few key points from the report including: • The Division has maintained 100% compliance with complaint responses for the past twelve months with learning shared. • Sepsis training compliance had reached 90.37% compliance.

	Surgery Division RP presented the Surgical Division update and drew attention to a few key points from the report including: • Critical care capacity had been maintained despite huge pressures on resource. • Excellent and compassionate team working in supporting a complex patient on 3A. • One moderate harm relating to delayed follow up in orthodontics. A review is underway. • Sepsis compliance remains a continued focus to improve compliance. • In terms of risk, the Division has one high risk which continues to be monitored. • The Division presented at the December Risk Management Forum in relation to its risk management processes. FB acknowledged the outstanding performance across the surgery division despite recent and ongoing pressures. **Resolved:** SQAC received and **NOTED** the Divisional Assurance Reports.
	---- *Safe* ----
24/25/189	**Quarterly Infection Prevention and Control Update Q2** BL introduced the Infection Prevention Control (IPC) activity and reporting for the Q2 period (1st July – 30th September 2024). The Committee noted that there had been 6 healthcare associated *Clostridiodes difficile* infections identified during the quarter, all of which were from Oncology. PIR's for the cases identified that there were no identified lapses in care, all cases were long-term-frequent hospital attenders, and all had exposure to multiple antibiotic treatment prior to their C. diff infection. Since January 2024, UKHSA has alerted of a sharp increase in C. difficile cases across the UK, for which there is no clear explanation. The North West is the third area worst affected. Plans have been developed by the IPC Team to test and isolate patients in a more timely manner. Capacity for cleaning has been increased including the use of fogging machines. **Resolved:** SQAC **NOTED** the contents of the report and actions being taken to ensure compliance with the expected Health and Social Care Act 2008: IPC code of practice.
24/25/190	**Safeguarding Assurance Report (Q2)** NO introduced the Safeguarding Assurance Report detailing the work completed during the period 01 July – 30 September 2024. The following key points were highlighted: • Level 3 safeguarding training remains below the 90% target at 85.80% (a reduction from last quarter). The plans previously communicated in relation to charging for 'no shows' are now being implemented and communicated out to all Departmental Managers where appropriate. • From January 2025, all safeguarding training will be provided face to face to enable greater attendance. • Attention was drawn to the additional requirements to the Local Safeguarding Practice Reviews from Q1 which would be reported on in detail going forward. • The Named Doctor for Safeguarding now commenced in post. • The volume of Rapid Reviews had increased during both Q1 and Q2. The Safeguarding Team continue to work with designated professionals and support partners to actively address any areas for improvement. • Workforce was highlighted as a challenge during Q2, but key posts have since been recruited to. • The Safeguarding Team had been required to respond to major incident following the tragic events in Southport during Q2 which supporting with Trust Tactical Command, overseeing statutory child death processes, supporting the criminal investigation, and taking a lead in the safeguarding response regarding the victims and the alleged perpetrator. • A Chaperone training package was being developed in line with the new Chaperone Policy

	• MIAA had commenced an audit of the Safeguarding service; the outcome of which would be included in the Q3 report. FB thanked NO for the comprehensive report detailing the vast amount of work undertaken by the Team acknowledging the added pressure of supporting the Southport incident. GM sought assurance in relation to the Multi-Agency Safeguarding process in terms of healthcare representation. NO advised that this was indeed the case. **Resolved:** SQAC received and **NOTED** the Safeguarding Quarterly Update and assurances within the report to ensure the Trust fulfils its statutory safeguarding responsibilities.
24/25/191	**Fuller Inquiry Action Plan Quarterly Report** This item was deferred to the January 2025 meeting.
24/25/192	**Patient Safety Strategy update** JR introduced the report detailing the work undertaken during November 2024 by the Patient Safety Programme Board (PSPB) and drew attention to the following key highlights: Highlights: • Assurance reports had been received from HMRG, tissue viability, trauma, Transfusion Committee. • There had been no significant change in reporting trends. • The positive reporting culture for incidents continues and the Trust remains on track for achieving a reduction in harms. • Recruitment of Patient Safety Partners had been a huge success with 55 recruited and a proposed start date of January 2025. • 98.7% compliance for L2 patient safety training. • The TPN workstream had now been closed and transitioned to business as usual. The Patient Safety Programme Board would receive 6 monthly reports going forward to ensure the programme remains on track. • Work remains ongoing regarding unacknowledged notices. Over 100,000 notifications have been completed since the system was implemented, 77% completed within 28 days. • Excellent progress made towards pressure ulcer prevention. Challenges: • An upward trend of patients deteriorating on HDU and being transferred to PICU was highlighted but, following investigation there were no areas of concern to report. • Two issues had been raised following the Trauma peer review: o Rehab clinical lead – unable to recruit to. Work is ongoing with to seek mutual aid with other major trauma centres to offer support for this role. o Psychology services - the current trauma load is placing pressure on the psychologist allocated to the service. A business case has been written and is currently under review by 3 ACOOs prior to submission to IRG. • Progress has been slow with patient safety and civility training; new proposals are now being drawn up for both of these offers. • A new workstream looking at the mislaying of samples will be set up in the New Year. **Resolved:** SQAC received and **NOTED** the Patient Safety Strategy update.
24/25/193	**Never Event – Retained Surgical Instrument** SQAC received the Patient Safety Incident Investigation Report in relation to a never event: retained surgical instrument. JR presented a number of summary slides describing the circumstances surrounding the incident which left patient Lacey, who had waivered her choice to anonymity, with a surgical instrument (retractor) left inside her tummy following surgery. JR informed the Committee that this was classed as a never event and as such a patient safety investigation was commenced in line with the PSIRF

	Framework. Commissioners and the CQC had been informed of the incident and Duty of Candor applied. A review team had been appointed and a family liaison officer to work with Lacey and her family. Psychological support was provided and compassionate engagement sessions for all parties involved. Several key findings were reported to the committee including inconsistencies with the accountable items count process, missed notification of missing instruments from the decontamination organisation (STERIS), distractions within theatre during Lacey's operation, evidence of a perceived hierarchical gradient and some Policy & training issues. Areas for consideration and improvement had been discussed with all staff involved in the incident as well as Lacey and her family. These related to process and training specifically related to NatSSIPs and LocSSIPs standards, culture changes within theatres and a review of STERIS pathway, all of which would form the basis of the action plan. FB thanked JR for her presentation and welcomed sight of the action plan once complete. JR stated that this would be presented to the January 2025 SQAC. Action. GM sought assurance around the culture/hierarchy issue and was informed by JR that the STAT programme and NatSSIPs would look to address this going forward. **Resolved:** the Committee NOTED the report on the never event relating to the retained surgical instrument.
	----- *Effective* ----
24/25/194	**Quarterly Research Report Q2** DH presented the report detailing performance of the Clinical Research Division (CRD) during Q2 sharing key highlights and challenges: Highlighted: • Increased integration/joint working with between Research and Innovation (Futures) particularly in areas including grants. • Growing activity in relation to strategic research programmes and partnerships. • The CRD had been successful in securing funding from the Children's Hospital Alliance for a Research Project Manager post based at Alder Hey to drive forward research priorities for children and young people. • Funding of 1.1M secured from NIHR for new research equipment (ophthalmology, MRI and dentistry/max fax/rheum). • Commercial income was ahead of plan at M6 however, the risk relating to NIHR funding being capped should performance not be met was highlighted. This was being actively managed, however. • Improvement in research being delivered equitably to diverse groups. FB thanked DH for the report and welcomed oversight of the level of jeopardy on all studies DH informed SQAC that the CRD had been in discussion with the research network trying to understand how studies are judged and any exceptions and undertook to feed back any findings to the Committee. The work relating to equitable access to studies was very much welcomed. **Resolved:** SQAC received and **NOTED** the Clinical Research Division Quarterly Report (Q2).
24/25/195	**Clinical Effectiveness & Outcomes Group Chairs Highlight report** **Resolved:** SQAC received and **NOTED** the Clinical Effectiveness & Outcomes Group Chairs Report.
24/25/196	**Liverpool Neonatal Partnership Monthly Update** SON introduced the Liverpool Neonatal Partnership update report and highlighted the following key points:

	• Improvement in PDR compliance to 89.8% with only a few outstanding. • Appointment of a B7 dietician. • Sickness absence for 1C has seen an improvement from 5.46% to 3.7%. • Occupancy for 1C remains above 80% for November 2024. • Compliance rates for both RCP screening and parental consultation within 24h were 100% with an improving trend in QIS qualified nurses. • In relation to the BAPM Standard to have a Speech and language therapist within the Neonatal Team, SON reported that this had been out to advert again, and that one shortlisted candidate had been shortlisted to be interviewed. • Data sharing agreement between LWH and AH was now in place. • 24/7 medical cover on the Alder Hey site was still not in place, but a plan was in place for this to be implemented in April 2025 for AH. • Two moderate harm incidents had occurred since the last report both had been on LWH site. FB thanked SON for further alignment of the report in support of the single service approach and welcomed the theme of delivery of education across the two organisations. Awareness of the upcoming challenges and thoughtful way of addressing them was very much welcomed. AB took the opportunity to inform colleagues of the Exec-to-Exec discussion held with University Hospitals, the Liverpool Group and Alder Hey to talk about working together. Learning from this will be applied to enable the partnership to grow. SON added that a working group had been established to review the harmonisation of Policies, SOPs and clinical guidelines across both sites in order to enhance collaborative working. **Resolved:** noted the Liverpool Neonatal Partnership update report.
24/25/197	**Mortality Report Q2** ABa presented the report detailing the work of the Hospital Mortality Review Group (HMRG) and the Q2 mortality data which included a review of statistical analysis in PICU, place of death, teams involved and specifics about expected vs observed deaths. In terms of the HMRG, the Committee noted the improving performance. ABa drew attention to the themes and was pleased to report that there were no concerning trends. The new Medical Examiner process was now fully implemented and in place and had not raised any concerns to date. There had been two potentially avoidable deaths during the quarter, neither of which related to care received at the Trust. ABa went on to report that the number of deaths occurring in PICU during the quarter had stabilised following an increase previously that had led to an external team requesting clarification of those cases. The data on Neonatal deaths remained in development and would include graphs going forward in order to identify any spikes. **Resolved:** SQAC received and **NOTED** the quarter 2 Mortality Report.
24/25/198	**Organ Donation Annual Report** The Committee received the Organ Donation Annual Report. CT was pleased to present a positive picture in terms of organ donation and reported that there were no missed referrals to NHS blood and transplant. During the year, there were 6 medically suitable eligible donors. The families of all 6 medically suitable eligible donors were approached for organ donation. Of the 6 families who were approached for organ donation in 2023/24, 3 families gave consent for organ donation. Work would need to be undertaken during the coming weeks to ensure Trust policies and guidelines support organ donation, are up to date and are in line with national guidance. The promotion of organ donation was an area that required continued focus, but CT reported that to date, a lot of work had been done in this area including website publicity, Organ Donation week fed

	out through the Trust's social media channels and a presence in a local school. The Team were also looking to engage The Forum in conversations. Overall, the Trust was performing well against its peers and meeting the expectations of the NHS Blood & Transplant. NA thanked CT for her leadership in this area and welcomed a conversation regarding presence of the organ donation nurse to further increase uptake. CT agreed that there is more work to do in this area, and that key to success was ensuring early referrals are made to the transplant team so they can come and talk to families. Logistically, this process is more difficult for Alder Hey given its location geographically and this had been recognised by NHS Blood & Transplant. **Resolved**: The Committee received and **NOTED** the Organ Donation Annual Report.
24/25/199	**Bi-Annual Aggregated Analysis Report** JR introduced the aggregate analysis of incidents, complaints, patient advice and liaison service (PALS), claims and inquests Q1&2 2024/25 (April – September 2024). The Committee noted the contents of the report and assurance that Trust is compliant with NHS Quality Contract. JR was pleased to advise that the next iteration of the report would follow the Brilliant Basics format. **Resolved:** SQAC noted Bi-Annual Aggregated Analysis Report.
24/25/200	**Gender Development Service** LC presented the Quarter 2 Children and Young People's Gender Service report and drew attention to the following key points: • The caseload of children remained at the same level as point of transfer into the service. • There is some work to be done to reduce waiting times, however it was noted that some of the long wait times related to distance that families are having to travel (due to transferring from the South). • As per the agreement with NHSE, the service was accepting Children and Young People (CYP) from the national wait list. • No safeguarding incidents reported during the quarter. • Friends and Family Test data would be included in the quarter 3 report. • Positive feedback had been received from the CYP using the service who are also part of The Forum. KB referred to the current workforce arrangement which appeared to be on a full-time basis despite the recommendation from the Cass Report that this shouldn't be the case. LC stated that the Division were in conversation with Hilary Cass regarding the current arrangement. The risk of staff feeling isolated in the service was being mitigated risk through involvement of activities across the Division as a whole. The Management Team are mindful of the recommendation and will continue to keep this under review. **Resolved:** the Committee received and NOTED the Quarter 2 Children and Young People's Gender Service report.
24/25/201	**Confidential Enquiries Repot Q2** SQAC received the Confidential Enquiries Repot detailing the learning following the Trusts participation in the National Confidential Enquiry into Patient Outcome and Death programme, Perinatal Mortality, and Morbidity Confidential Enquiries and any national service improvement programmes for the reporting period Q2 - 2024-2025. JR reported that the Trust has participated in 6 National Confidential Enquiries during the reporting period and drew attention to the actions required by the Trust to improve quality of care from NCEPOD published reports in 2023/24.

	Resolved: SQAC noted progress with compliance against the National Confidential Enquiry submissions.
	---- *Well Led* ----
24/25/202	**Board Assurance Framework** NA presented the Board Assurance Framework for the month of November 2024 and drew attention to the Executive Summaries within the report. **Resolved:** SQAC received and **NOTED** the Board Assurance Framework.
	---- *Any Other Business* ----
24/25/203	No further business was raised.
	---- *Board Assurance* ----
24/25/204	The key assurances and highlights report was presented to the Board meeting held on 9th January 2025.
	Date and Time of Next Meeting: 22nd January 2025 at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	**Chair's Report from the LNP Board meeting on 20th January 2025**
Report of:	**LNP Co-Chair, Christopher Dewhurst**
Paper Prepared by:	Divisional Manager – Vicky Clarke

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:	None

Does this relate to a risk? Yes ☑ No ☑

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

Risk Number	Risk Description	Score
Various	Refer to LNP risk register	

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

1. **Introduction**

The Liverpool Neonatal Partnership (LNP) is a collaborative partnership between Alder Hey Children's NHS Foundation Trust (AHCH) and Liverpool Women's NHS Foundation Trust (LWH), providing care and treatment to neonatal babies in line with national service standards for neonatal care and improve the quality of care and families' experience of neonatal services. The new build surgical unit is expected to go live in January 2026.

As part of the Governance and assurance principles a Board (the "LNP Board") has been established to oversee the implementation of the new service. The founding of the LNP does not impinge upon the legal sovereignty of AHCH and LWH, each of whom will retain responsibility for meeting all expected quality and service standards, including performance to the relevant regulatory standards specifically the Care Quality Commission's Fundamental Standards and the requirements set out in NHSI's Single Oversight Framework. The Board of Directors of each organisation continue to be accountable for its own service provision in accordance with its Constitution, Provider License, and statute.

2. **Agenda items received, discussed / approved at the meeting**
   - Operational Mobilisation Group Chairs Report
   - Project Update
   - Operational Update
   - Governance Update
   - Workforce Update
   - Collaborative Working, Safety & Culture
   - Finance & Commissioning
   - Build Update
   - Communication Plan
   - Neonatal Transformation Update from NHS England

3. **Key risks / matters of concern to escalate to the Board and Committees**
   - The Board discussed water safety and potential implications for current unit design. It was agreed that immediate decisions on how to proceed needed to be made due to the significant risk that this present in terms of unit design, delivery timeframes and cost. LNP Board were assured that these discussions are being progressed at pace, with all key stakeholders engaged in the process. Identified changes have been captured in the change control process.
   - Morgan Sindall Construction (MSC) have formally raised concern in regard to programme delays. LNP is yet to receive an official extension of time request. Initial assessment indicates a 6-week delay; it is yet to be determined which specific clinical areas will be impacted. A formal response from the contractor is expected imminently, which will then allow the Programme Team to enact change process protocols to assess and manage any deviation to project plan and delivery timescales and to assess impact.
   - Alignment of key HR policies and procedures was previously highlighted as a potential issue and was discussed at a recent Exec to Exec meeting. A meeting is planned for 7 February 25 between executive colleagues from both

organisations and the Partnership Senior Leadership Team (SLT) to share the recommendations agreed at the joint executive meeting.
- Potential changes to clinical leadership. Partnership SLT will present recommendations to LNP Board to address any potential gaps.
- Review of non-pay expenditure is ongoing to understand requirements once the new unit is operational.

4. Positive highlights of note

- Improved documentation of parental communication within 24 hours on 1C – significant improvement with 100% compliance.
- Recruitment of Deputy Head of Neonatal Nursing.
- Successful recruitment to SALT vacancy.
- A comprehensive training schedule has been developed, with the inclusion of a Simulation Room, which is facilitating real time training and education.
- Joint team meetings are underway, which has led to improved team relationships and is providing an opportunity to share feedback and perspectives.
- Engagement continues across multiple clinical disciplines, which will support the NICU delivery model.
- Data sharing agreement and ongoing work with partner organisation System C has enabled data flows to be shared across both organisations, which has allowed the continued development and maturity of an Integrated Partnership Dashboard. A snapshot of joint reporting was demonstrated at January 2025 LNP Board and will be further developed.

5. Recommendations

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

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	People Plan Strategic Update
Report of:	Chief People Officer
Paper Prepared by:	Sharon Owen, Deputy Chief People Officer Dr Jo Potier, Associate Director of OD Dr Katherine Birch, Academy Director

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	To present to the Trust Board a monthly update on progress against the People Plan.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☑ **Pioneering** breakthroughs ☐
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

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

1. Executive Summary

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

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

2. Background

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

- One vision for CYP and staff
- One Alder Hey where everyone belongs
- One inclusive community united by a core set of values expressed by everybody, everyday, everywhere, in every interaction
- One unifying approach for individuals, leaders, teams, organisation, reducing inconsistency of experience & performance
- One integrated safety culture
  AND
- Values & behaviours that are clear, agreed, visible and translated into lived experience for every member of staff
- A real time feed of staff & team functioning (measuring success & difficulty)
- Intelligence that is used effectively to create systems that continually improve the quality of management (& intervene early when problems arise)
- Empowered teams able to manage issues themselves with clear guidance on where to go if need support
- Development opportunities which are more personalised, more frequent and cover the whole life cycle of people's time with us, whatever their job role or level
- Colleagues feeling supported to develop new skills (aligned to our core priorities/Futures) and to adopt new ways of working
- A great place to work that attracts and retains the best talent
- An organisation that is an exemplar for our inclusive recruitment and pre-employment programmes across Cheshire and Merseyside
- Exemplar People Practices. Working in Partnership with staff side and unions to create a positive working environment and adopting best people practises, thus preventing avoidable employee harm
- Business Critical roles that are identified with a diverse and readily available pipeline for replacement.
- Embedded new roles that focus on the skills, values, tasked and competencies to complement our existing roles to deliver future models of care.
- A clinical strategy that is underpinned by sustainable workforce models and workforce plans

3. Priority actions:

One Alder Hey & Thriving

Inclusion & belonging:

- We continue to work with our networks to respond to improvements in colleague experience. The implementation of the NHS EDI Improvement Plan and the 6 High Impact Actions, remain on track and monitored through the Trust ED&I steering group.
- We will continue to promote our Anti-Racism Statement and Commitment with plans to work towards the NW BAME Assembly Bronze Status in 2025.

Values:

- A proposal for a revised set of values is in development as part of a broader organisational culture statement. This will be shared with the organisation as part of the People Plan. The values will reflect what staff have told us, year on year, about working here and the things that have identified as being important in achieving our mission.
- The revised values will link to the four key cultural shifts identified as critical to the achievement of Vision 2030 and the overall Alder Hey mission: empowered teams; clinically-led decision making; breaking silos and bureaucracy; and exceptional experiences for all.

Integrated safety culture:

- Safety culture has been identified as a key priority as part of the Quality and Safety strategy. Key to an integrated safety culture will be the alignment of restorative just and learning approaches across patient safety and staff safety.
- The concept of Avoidable Employee Harm in people practices and processes will help to further develop an integrated safety culture as will ensuring that staff safety is reflected and considered as part of the patient safety culture workstream.
- After the success of the first Avoidable Employee Harm workshop held with the senior HR team, a second learning workshop will be held to progress this work to include staff side. The outputs of these workshops will be to agree a collective definition of avoidable employee harm and assess changes needed to policy and practice to reflect the evolving culture.

Thriving Leaders framework:

- The Thriving Leaders working group continues to meet to further develop and review the 8 core workstreams which are as follows:
    - Strong Foundations
    - Management Essentials
    - Clinical Leadership role
    - Leadership Induction
    - BAME Aspiring Leaders Programme
    - Operational Leader Programme
    - Consultant Induction
    - Leadership Faculty
- The Thriving Leaders group has been a great first step to bringing all the work that is ongoing around leadership development together in one space. It has allowed us to benefit from joined up thinking across a range of programmes, utilising expertise from across a wide range of functions across the Trust.
- As a number of these programmes become BAU, we are keen to ensure that the benefits of having such a group thinking about leadership support and development as a collective is not lost and as such will soon begin transitioning into a new Leadership Faculty. This will be a place where key staff come together to focus on ensuring we

have a joined up and effective offer to support and develop our leaders at all levels across the Trust
- The Faculty will be closely linked to the Professional Development Hub.

Thriving Teams:
- A draft Thriving Teams Index is in development using staff survey team-level data as a starting point. Teams are being clustered according to their People Promise scores on the staff survey.
- After consultation with divisional leads through February, a briefing paper will be taken to the next People Committee regarding the further development of uses of the Index.

Thriving Staff Index:
- The Thriving Staff Index is still in development phase with the Innovation Team. Progress has been delayed due to internal resource constraints and complexities in meeting the full requirements of the tool as tested in the pilot phase.

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

- Continued mapping of roles and **career pathways** is underway, capturing the opportunities available for staff across a number of core staff groups, grades areas and roles. With the new L&D facilitator joining the team (Feb 25) it is expected that progress in terms of mapping non-clinical roles in particular will be accelerated.

- Development of **virtual hub**. The virtual hub is now live (soft launch) and feedback from colleagues is being sought. The Hub has been developed to provide a range of information, advice and guidance (IAG) for colleagues as well as offering the opportunity to schedule 121 discussions. In addition, the Hub will signpost to internal and external workshops and courses and funding support. The skills scan is currently under development which, when available, will offer further opportunity for colleagues to further consider their development needs across a number of core domains .

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

Future Workforce

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

- **Supporting Services and Teams –** review of Trust Workforce planning continues and is aligned to the workforce efficiencies programme. This has been further aligned to the current work underway in relation to the Integrated Annual Plan 2025/26

- Comprehensive workforce planning templates will be used to shape ongoing discussions in January 2025 in respect of sustainable workforce models aligned to vision 2030 as well as operational need. HR and finance colleagues working closely on Trust workforce numbers currently.

4. Conclusions & next steps

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

Appendix 2: PERSONAL & PROFESSIONAL DEVELOPMENT			
Our Strategic Ambitions	How are we doing?	Priority Actions	Evidence of success?
Development opportunities which are more personalised, more frequent and cover the whole life cycle of people's time with us, whatever their job role or level	Progress on track Core pathways being mapped Refreshed induction and preceptorship programmes in place. New framework for consultant induction being finalised Pilot underway – re supporting staff in applying for new roles / redeployment	Establishment of the Hub (virtual 24/25; physical 25/26) Detailed mapping of a number of core roles and career pathways Effective information, advice and guidance in place to support those new to the organisation and under-represented groups Expand programme of L&D opportunities	Hub (virtual) offering IAG which is positively rated by staff (detailed metrics in development – also linked to Matrix accrediation for IAG) Increase in staff survey metrics (we are always learning) across all staff groups Enhanced focus on personal development within appraisals and talent conversations L&D embedded from the outset (induction onwards)
Colleagues across the organisation actively engaging in conversations about their role, their development, their ambitions and feeling supported to achieve these	Revision to TNA framework (24.25) Review of PDR process Discussion ongoing re talent management strategy required	Refreshed approach to PDRs and TNA at team and individual level Managers Toolkit reflects team and individual expectations	Enhanced focus on personal development within appraisals and talent conversations Increase in staff survey metrics (we are always learning and feeling suported) Hubusage and associated KPIs
Colleagues feeling supported to develop new skills (aligned to our core priorities/Futures) and to adopt new ways of working	Initial mapping underway Refreshed L&D programme in place	Incusion of Futures focus in career mapping exercise 25/26 Refreshed programme which links shifts required in terms of knowledge and skills to development opportunities.	L&D offer reflects core workstreams across Vision 2030. Targeted suport for specific roles / groups

Appendix 3.

Our Ambitions	Progress	Priority Actions	Evidence of success
We are seen as a great place to work, that attracts and retains the best talent **&** **We are an exemplar for our inclusive recruitment and pre-employment programmes across Cheshire and Merseyside**	Digital capabilities have streamlined and improved transactional recruitment processes. Candidate experience is largely positive. Reductions seen in time to hire as a result of automation. These changes have now allowed for review of candidate experience	Focus on enhanced employer brand – (Vision 2030), as part of our attraction strategy. What makes us stand out from other employers (USP) – Develop Values based recruitment (Link to Culture) Develop suite of recruitment material for advertising- bespoke packages for hard to fill roles. Recruitment tailored to meet needs of those from under represented backgrounds, working with local community organisations and LCR. WRES/WDES actions to be embedded. Including removing barriers via traditional recruitment methodologies (Golden ticket – for supported interns) Review and enhance Consultant recruitment, induction and development process. Using new approach as a blueprint.	Stable turnover rates. Diverse pool of experienced candidates Positive candidate and Recruitment Manager experience. Increased % of underrepresented groups appointed. Reduced time to hire. Improved patient and colleagues experience (Staff/patient survey) Reduced Vacancy rate
A leader demonstrating best practice in people Practices. Working in partnership with staff side and unions to create a positive working environment, and adopting best people practices, thus preventing avoidable. employee harm	Policies relaunched in line with a just and restorative approach. Working closely with Staff side colleagues	The implementation, coaching and education of the people policies is crucial in creating a positive working. environment. It is therefore the vision that training and education on people practices is also undertaken in partnership, also adopting a learn & improve approach.	Reduced Grievances, Disciplinaries & ET's

Ensuring business critical roles identified, with a diverse and readily available pipeline for replacement	Job redesign/review currently in place, at point of Organisational change. Enhanced processes in respect of Job evaluation in place.	Future Talent management development Identify plans for Executive roles and critical service roles AH Community Portfolio careers (beyond retirement) Future entrepreneurs Identify future role requirements for revolutionising care.	Staff identified for all business critical roles Reduced time to hire for business critical roles Increased job satisfaction (staff survey) Workforce pipeline identified with increased stability reduced turnover

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

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	People Committee
Report of:	Jo Revill, Non-Executive Director
Paper Prepared by:	Jo Revill

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent People Committee meeting held on 17th July 2024, along with the approved minutes from the 15th May 2024 meeting.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☑ No ☐

Risk Number	Risk Description	Score
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 People Committee (PC) 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.

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

- PC received a progress update on the People Plan, indicating that all developments remain on track and continue on target for delivery

- PC received the Trust Wide Metrics: Mandatory Training maintains over 90% compliant, sickness has seen an increase due to seasonal fluctuations Focus remains on PDR completion for Q4.

- PC received the Divisional Metrics Reports which continue to be managed and maintained. PDRs remains an area of focus across all areas.

- PC received the Leadership Development Update Report. This comprehensive report provided assurance to the committee that a significant amount of work is being undertaken in this area, and the report demonstrated the breadth of scope of support across clinical, non-clinical, senior and junior leaders.

- PC received confirmation of the final Staff Survey Response Rate which was 62%. The committee also received the headline results for the 2023 Staff Survey, which show very positive trends. (data is currently embargoed).

- PC received the FTSU Report, detailing the specific activity being undertaken by the service in Qu 3, and progress to date for improving and enhancing mechanisms for staff to raise concerns.

- PC received the Workforce Efficiencies Update Report, detailing the work of the newly formed workforce efficiencies programme group, who are taking forward a range of measures to control workforce spend and increase efficiencies.

- PC received, for information, the NHS England letter sharing the national position on Physicians Associate Review

- PC received the Equality, Diversity & Inclusion – Monitoring Process update. Report provided assurance of progress against the 6 High Impact Changes.

- PC received the Board Assurance Framework for November 2024.

- PC received the Board Assurance Framework Deep Dive (Risk 2.1), and agreed to re-focus on BAF risks 2.1 and 2.2 in the next Committee meeting in March 2025

- PC received the Consultant and SAS Doctors Leave Policy and approved for ratification

- PC received the LNC Minutes (October 2024) for Information
- PC received the JCNC Minutes (September 2024) for Information
- PC received the EDI Group Minutes (September 2024) for information

4. Recommendations

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

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 13th November 2024
Teams

Present:

Jo Revill	Non-Executive Director **(Chair)**	(JR)
Adam Bateman	Chief Operating Officer	(AB)
Katherine Birch	Director of Alder Hey Academy	(KB)
Sarah Bowman-Jones	Service Manager – Surgery	(SBJ)
Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
Garth Dallas	Non-Executive Director	(GD)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
Sarah Leo	Associate Chief Operating Officer – Research	(SL)
Jo Potier	Associate Director of Organisational Development	(JP)
Melissa Swindell	Chief People Officer	(MS
Kate Warriner	Chief Transformation and Digital Officer	(KW)

In attendance:

Jeanette Chamberlain	Staff Advice & Liaison Service Manager	(JC)
Joe Fitzpatrick	Internal Communications Manager	(JF)
Veronica Greenwood	Acting Director of Allied health Professionals	(VG)
Katie Jones	Head of Operational HR	(KJ)
Darren Shaw	Head of Organisational Development	(DS)
Neil Thomas	Acting Health & Safety Manager	(NT)
Kerry Turner	FTSU Guardian	(KT)
Jill Preece	Governance Manager	(JP)
Jennie Williams	Head of Quality Hub, Brilliant Basics	(JW)
Angela Ditchfield	EDI Lead	(AD)
Julie Worthington	Staffside	
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Apologies:

Nathan Askew	Chief Nursing, AHP and Experience Officer	(NA)
Fiona Beverage	Non-Executive Director	(FB)
Pauline Brown	Director of Nursing	(PB)
Lisa Cooper	Director of Community & Mental Health Services	(LC)
Carolyn Cowperthwaite	Acting Associate Chief Nurse – Surgery	(CC)
Urmi Das	Director, Division of Medicine	(UD)
Chloe Lee	Associate COO – Surgery	(CL)
Greg Murphy	Local Security Management Specialist	(GM)
Erica Saunders	Director of Corporate Affairs	(ES)
Julie Worthington	Staff Side Representative	(JW)
Sharon Owen	Deputy Chief People Officer	(SO)

24/25/060 **Declarations of Interest**

No declarations were declared.

24/25/061 **Minutes of the previous meeting held on 19th September 2024.**

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

24/25/062 **Matters Arising and Action Log**

Action log was updated accordingly.

24/25/063 **Internal Communications Update**

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

- The first annual Alder Hey Star Awards since 2020 was relaunched 2024 which received positive attendee feedback.
- Black History Month showed some success in anecdotal feedback which was supported by the REACH staff network.
- Ask The Execs weekly meeting remains in place with a commitment to ensure this forum remains as useful as possible for staff. All colleagues are welcomed and encouraged to join the broadcast and put forward their questions for consideration.
- The internal email analytic metrics continues to be unavailable. The Medication Safety pilot is not providing a positive increase in data as intended, tracking and other options for creating an email performance system will also continue to be explored.
- The Communications Team will conduct their Away-Day in November 2024. All future planning will continue to be considered and explored.

JF added, all activities will continue to run on course and all development projects continue to push forward and remain on track.

In relation to the staff awards, KW made a plea for planning to be explored at an earlier time to ensure sponsorship opportunities from key partners can be sought.

Staff Network Exec Chair, KW formally thanked the Staff Network Team who continue to thrive and support showcasing good working engagement and relationships.

JR thanked JF for the detailed overview on the current progress of the internal comms projects which is making good progress.

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

24/25/064 **Monitor Progress against the People Plan**

The Committee received the People Plan document which had been approved by the Board at its October 2024 meeting detailing the next steps of our journey in relation to Vision 2030.

MS drew the committee's attention to the Strasys report against the five workforce groups which had undergone further analysis with a specific emphasis on the ethnicity, Despite showing some positive trends in relation to new starters, the report highlighted further areas to explore particularly in relation to the 'stayers' group to understand areas such as their dissatisfaction with development and high proportion of absence. Questions around health

had seen a decrease across all staff groups. This re-analysed data would be the focus for the coming months informing operational plans.

AD talked about better supporting staff in relation to sickness absence and sought clarity on whether the report had looked at staff with disabilities. MS stated that this hasn't been looked at in detail but would pick this up with them for future reporting.

AB suggested the need to link more closely with the staff networks to try and understand this data more clearly. MS agreed that greater engagement is needed and does form part of future plans.

JR referred to the main reason for Senior Management leaving being promotion opportunities and stressed the need to understand what the trust could offer to reduce this area of turnover.

The Strasys data would now be shared more widely with the organisation including the Executive Team Meeting.

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

24/25/065 **Trust Wide Metrics**

The Committee received the Trust Wide metrics report (September 2024) data. MS highlighted the following to the committee:

- PDR compliance remains a challenge and all divisions have set action plans in place to address and manage.
- Sickness Absence has shown a slight uptake in short term cases. An analysis had been undertaken into the data which confirmed most cases related to seasonal causes,
- Turnover remains steady with regular monitoring.

Resolved: The Committee noted the Trust Wide Metrics Report.

- **Divisional Metrics**

<u>Surgery Division</u>

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

- Mandatory Training is above trust target reporting up to 94% to date.
- Sickness absence shows no specific theme and remains stabilised.
- PDR compliance has taken an upward trajectory compared the last 3 months of being below trust target and reported 74% to date. All data continues to be reviewed weekly to ensure compliance is reaching above trust target.
- Return to Work data is being shared with all divisional managers to manage and maintain compliance.
- Medical Appraisals remains over 80% to date.

- A piece of work has been undertaken in theatres in relation to recruitment along with a longer-term review of wellbeing and focus on retention.

JR asked what measures are in place to improve our colleague's wellbeing. SBJ advised that the physical environment and facilities had been looked at and there are developments in place to provide staffroom access to colleagues and improve changing facilities.

JP asked what the divisions current position looks like in terms of staff survey completion rate. SBJ commented will review those figures and report that back to the committee in order to provide accurate data.

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

- **Clinical Research Division**

The Committee received the Clinical Research Division metrics report (September 2024) data and noted progress to date. SL pulled focus to the following:

- Sickness Absence continues to be managed across service provisions.
- Return to Work compliance reports 100% to date.
- Mandatory Training compliance remains at trust target.
- PDR compliance remains challenging in some areas. Senior Leaderships are taking all measures to ensure dates are secured and completed accordingly.
- Turnover position remains stable. All senior leaders continue to manage.
- Staff Survey relating to Innovation reported at 85% and Research reported around 60%. Teams continue to push.

The division recently undertook some initial background work around fix term contracts working with HRBPs to manage data. All nurses are fixed term contracts but there are stable funding streams in place to maintain Alder Hey's position.

The Clinical Research division has created an EDI project looking at participation within the clinical research department supported by Delo Deliso and Joanne Keenan from the Community and Mental Health Division. The development of the projects remains in early stages but is well underway.

SL highlighted to the committee that the division has lot of planned activity coming up across departments for our children and young people including wellbeing activities.

SL added the announcement of the arrival of mobile research unit. There is presently a call-out requesting all ideas and thoughts are welcome and encouraged colleagues to take part to help improve across our community.

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

- **Medicine**

The Committee received the Medicine Division metrics report (September 2024) data and noted progress to date. SC noted the following for the committee's attention:

- PDRs remains an area of focus. Data for band 7 and above increased by 1%. Senior Leadership are reviewing data across the division to identify areas of need.
- Palliative Care have received the extra funding needed to move forward with the palliative care project which will start to make good headway.

JR noted it is good news to hear the Palliative Care project will move forward.

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

- **Community & Mental Health**

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

- Sickness Absence shows a slight uplift in data. Trent shows same data compared to last year and remains top priority.
- Mandatory Training reports above trust target.
- Return to Work has shown improvement and remains sustained.
- PDR compliance reports 82% showing good progress of data. Band 7 and above reported 92% to date. Weekly reports continue to be shared supported by HR and the L&D Teams.
- Bank usage remains an area of challenge with continued monitoring.
- Staff Survey completion rate was reported at 65% to date.

RG highlighted that sickness within OPD remains a challenge. JR sought assurance around the plans to address this. RG stated that action plans were developed following a number of listening sessions with staff in the department but was disappointed to report that progress to date had not been as advanced as hoped. The matter had been discussed with the Executive Team outlining the core challenges in this area and changes needed. An update would be included in future divisional reports.

The Community and Mental Health Division conducted their second Divisional Deputy Team Away-Day as part of their quarterly Divisional Leadership Team Development Session which plans to start rolling out across the division.

The Division continues to review all workforce requirements and now have in place an education and training team who are linked into the Trust L&D team.

JR referred to PDR compliance particularly for those band 7 and above which was reported at 45% for the whole Trust and asked what additional focus was needed here. JW stated that PDRs were seeing an upward trend across three of the four divisions but failing to reach the Trust target and offered a focussed piece of work in this area in the form of an improvement collaborative. She went on to add that the Brilliant Basics Team were actively working with divisions on return-to-work compliance but welcomed a further piece of problem solving work in this area.

KJ highlighted the technicalities within the system and explained that return to work compliance rate will never appear as 100% complaint due to the timeframes of the e-

roster and ESR inputting data timelines. Return to work has been put forward as an RPA project to further scope and ensure data is recorded in a timelier way.

The Committee welcomed a focussed piece of work to look at PDR compliance.

JP suggested the need to reference PDR and Health & Wellbeing conversations back to the data we are seeing to ensure nothing is being missed to ensure we are covering all aspects of data for assurance and oversight showing we are seeing a decline in some of our core groups.

Action: JR asked MS/AB to pick the PDR piece of work up outside of the meeting and report back in January 2025 meeting.

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

- **Corporate**

The Committee received the corporate metrics report (September 2024) data and noted progress to date.

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

24/25/066 **Workforce Efficiencies**

The Committee received the Workforce Efficiencies Report for September 2024.

KJ informed the Committee that a Workforce Efficiencies Group had been established meeting on a bi-weekly basis to ensure grip and control on agency spend. KJ was pleased to report that the group had developed a workforce dashboard in order to better analyse workforce data looking at whole time equivalent figures, sickness absence and bank/agency spend for oversight and assurance.

The most up to date information had become available earlier that day for the month of October 2024 and the live dashboard was reviewed at the meeting. KJ provided the committee with an overview on current live October data which shows a split by division with further granular data sitting behind this including bank and agency usage through various cost centres etc. This data was noted as invaluable in terms of supporting divisions with understanding their workforce, improved planning and the efficiencies needed going forward. A number of actions remain in place with the current aim to focus on bank and agency spend. Further plans involve a review of the medical workforce and efficiencies.

JR thanked KJ for the data presented and welcome this as a tool for holding rich conversations with divisions in relation to spend control.

MS drew attention to the whole-time equivalent figure versus ICB target which was currently 92 whole equivalents over plan. The team continues to review all divisional data in respect of workforce challenges against the financial plan.

MS suggested workforce efficiencies becomes a regular agenda item going forward.

Resolved: The Committee welcomed the workforce efficiencies report as a source of assurance.

24/25/067 **Organisational Health & Wellbeing Plans**

The Committee received the Organisational Health & Wellbeing Plans and noted the contents. JC highlighted the following activities from the Health and Wellbeing Forum:

- All planned activities continue to run on course support by the wellbeing forum.
- All forms of finance sustainability continue to be available to colleagues supported by HR and the Finance Team. Alder Hey is reviewing partnership with CAB in effort to decrease cost supported by the Procurement Team.
- The Physical Health & Wellbeing stream continue is making a positive impact.
- "Queen of the Greens" company will be reviewed in terms of having fruit & vegetables available onsite for colleagues across Alder Hey.
- Springfield Park remains under construction with the architecture Team and all colleagues are encouraged to take walk throughout the park area.
- The Menopause Group aligned to our physical health and wellbeing continues to take place on a monthly basis with drop-in sessions available to ensure all colleagues have the opportunity to attend.
- Alder Hey have now sustained free access to period products in relation to period poverty and menopause available across the organisation.
- SALs continue to provide all level of support for colleagues across the organisation.

All projects undertaken via SALs/PALs is moving forward in support of our colleagues at Alder Hey. A communication message has recently been shared across the trust on how the team are taking this forward.

A physical Health and Wellbeing Day will be planned to take place in January 2025 to support all colleagues across Alder Hey. KW talked about the event held at LHCH which showcased a preventative care offer i.e. blood pressure and cholesterol testing etc. and asked for this to be considered at the event. JC confirmed that this was indeed being looked at as part of the planning.

JR stated it's good to see the help and support relating to poverty in helping to support our colleagues here at Alder Hey.

GD stressed the need for more communications being shared in advanced of planned awareness days to ensure all messages are being shared and received across the trust. The Staff Network group have reported this as part of their high impact actions with plans in place to provide more positive communication and engagement for all colleagues at Alder Hey. JC commented the team conducted a one-week campaign set up in the atrium with comms to alert staff of the menopause policy awareness and drop-in sessions.

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

24/25/068 **Raising Concerns/Freedom To Speak Up (FTSU)**

The Committee received the Raising Concerns/FSTU update and noted the contents.

KT provided the committee with a summary of the activities of the FTSU Team Q2 data.

- The number of concerns raised during the quarter had increased demonstrating that staff feel safe to do so via the route available. The top two themes being inappropriate attitudes & behaviours and Policies and Processes. Particular concern has been raised regarding the Organisational Change Policy and ensuring it remains fit for purpose in terms of the direction of travel the Trust is headed. The continuing education & development for managers and leaders and application of reasonable adjustments has been raised as an area of concern.
- The FTSUG Visibility Programme continues with walk abouts supported by Senior Management.
- Staff induction continue to run smoothly and FTSU is now a regular part of this programme.
- Uptake of the Speak Up training continues to remain on an upward trajectory and was reported at 94.8%.
- FTSU App development was formed at the start of this year was recently paused due to other work undertaken and will re-launch in due course.

JR noted good headway is being made on the visibility programme showing good work being achieved.

Resolved: The Committee noted the contents of the FTSU report.

24/25/069 **Pay progression proposals for non-AFC staff and on call allowances**

The Committee received a paper outlining proposals for consideration regarding remuneration of individuals on non-AFC contracts for 2024/25 and for on call allowances.

KJ reminded colleagues that staff sitting under AFC terms and conditions had been awarded a 5.5% consolidated pay increase for 2024/25.

There remains a cohort of staff members who have remained on historic Whitley T&C and pay, therefore not covered under the AFC principles and not eligible for the pay increase award in 2024/25. In addition, the Trust has locally agreed on-call allowances that were previously reflective of AFC rates of pay but are not automatically amended by the national pay award.

The Committee was asked to consider the following proposals:

a) not awarding any pay increase in line with AFC awards as there is an acceptance that retaining the Whitley terms is on a marked basis AND
b) to increase the on-call availability allowance by 5.5% in accordance with the 2024/25 pay award.

JR asked for further clarity that those on the pay based on Whitley are on a higher hourly rate and asked if this is correct under our terms. KJ advised that this was correct, and they have a higher annual leave allowance due to a mixture of AFC and Whitley terms & conditions. KJ stated that this needed to be addressed going forward to ensure alignment.

Resolved: The Committee **APPROVED** options a) and c) above:

b) The Whitley recommendation of not to apply the 5.5% back dated increase to those that remained on the T&C was agreed.
c) to increase the on-call availability allowance by 5.5% in accordance with the 2024/25 pay award.

24/25/070 **Health & Safety Performance Dashboard Q1 & Q2**

The Committee received the Health & Safety Dashboard. NT drew the Committees attention to the following:

- In terms of mandatory training: Health & Safety, this was reported at 95% against a trust target of 90%. Moving & Handling training compliance was reported at 97% against a 90% trust target rate.
- Non-Mandatory Training for both Risk Assessments and First Aid Training has now been completed by majority of staff and the position now remains steady.
- 67 sets of RAMS (risk assessment method statement) were reviewed during the period. Building Services and the Development Team are working alongside our site inspections to ensure all systems in place are working safely and continues to be regularly monitored.
- Three RIDDORS (Reporting Incidents Diseases and Dangerous Occurrence Regulations) were reported in the first two quarters.
- The Health and Safety department have two open risks on the Risk Register. Both risks are being effectively managed and controlled with mitigations in place.
- ND informed the Committee that the Sharps Safety Group is being reinstated to look at needle stick injuries and how we better support staff in the safe disposal of needles.

JR thanked ND for the detailed report shared with the Committee.

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

24/25/071 **Equality, Diversity & Inclusion Plans - Monitoring Process of High Impact Changes**

The Committee received the Equality, Diversity & Inclusion Plans - Monitoring Process of High Impact Changes.

The EDI improvement Plan set 6 high impact changes following publication in June

2024 which displayed the actions needed to implement certain initiatives to measure our success at Alder Hey.

SO provided the Committee with update on our current position highlighting progress we are making.

- The Team have reviewed each high impact and pulling out key improvements supported by our Senior Leaders and Recruitment Team.
- The Gender Pay Gap is being further explored around ethnicity pay gap which is now a mandatory report and will be reviewed in line with the disability pay gap.
- The inequalities piece of work supported by JC is making good progress and moving along really well.
- Our international education staff continue to receive wide range of engagement which continues to progress aligned to leadership development for our internal educated nurses.
- Bullying and Harassment plans to launch an updated policy support via Veronica Greenwood with continued work and engagement with the staff network groups.
- The Anti-Race statement has now been approved by the Trust Board.
- Senior Leaders continue to work with the Liverpool City Region which provides positive collaborative pieces of work being achieved. There is an operational group from the ACE Equality Hub who are conducting a piece of work regionally around anti-race and have developed a tool kit to share across the region which showcases we are aligning together and sharing good practice to support our staff.

Resolved: The Committee noted the Equality, Diversity & Inclusion Plans - Monitoring Process of High Impact Changes.

24/25/072 **Board Assurance Framework – monitoring of strategic workforce risks**

The Committee received and acknowledged the Board Assurance Framework Report detailing updates for the month of September 2024.

24/25/073 **BAF Risk Deep Dive (Risk 2.3)**

Failure to successfully embed workforce equality, diversity and inclusion (EDI) across the organisation.

MS drew attention to the gaps in controls and assurance along with the actions identified to mitigate against these and sought views from colleagues if these felt adequate. Both Non-Executive Director colleagues (JR, GD) confirmed that they were assured that the actions outlined within the risk would address the gaps highlighted.

JR welcomed the piece of work underway in relation to EDI staff training and development. GD stressed the need for this training to be proactively fed into the staff networks.

The huge amount of work on this risk was acknowledged, the Committee was therefore content with the risk score of 4x3=12 (major consequence & possible likelihood).

Resolved: The Committee received and noted the deep dive report for Board Assurance Framework risk 2.3.

24/25/074 **Policies for ratification**:

- **Control of Substance Hazardous to Health**

The Committee received The Control of Substance Hazardous to Health Policy and noted the detailed overview of recent updates.

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

- **Latex Policy**

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

Resolved: The Committee APPROVED the Capability & Performance Policy.

- **Personal Protective Equipment Policy**

The Committee received The Personal Protective Equipment Policy and noted the detailed overview of recent updates.

Resolved: The Committee APPROVED the Supporting Colleagues Policy

- **Provision and Use of Work Equipment Policy**

The Committee received The Provision and Use of Work Equipment Policy and noted the detailed overview of recent updates.

Resolved: The Committee APPROVED the Supporting Colleagues Policy

24/25/075 **LNC Minutes**

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

24/25/076 **Education Governance Committee (EGC) Minutes**

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

24/25/077 **JCNC**

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

24/25/058 **Health & Safety Committee**

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

24/25/079 **Equality, Diversity & Inclusion Steering Group (EDISG) Minutes**

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

24/25/080 **Any Other Business**

No issues raised.

24/25/081 **Review of Meeting – Chair's Report to Board**

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

Strategy Update:
Progress of the People Plan continues to progress forward in line with vision 2030. Good, updated Plan and refreshed workforce segmentation data.

Divisional Metrics:
Divisional metrics reports continue to be managed and maintained. All senior leaders continue to stabilise across service provisions.
PDRs remains an area of focus across

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

Mitigation remains in place to review manage and maintain.

Policies for Ratification: APPROVED
- **The Control of Substance Hazardous to Health**
- **The Latex Policy**
- **Personal Protective Equipment Policy**
- **Provision and Use of Work Equipment Policy**

The Chair noted good progress being made across all areas.

Date and Time of Next meeting.
Wednesday 15th January 2025 at 2pm – The Tony Bell Boardroom

BOARD OF DIRECTORS

Thursday, 6th February 2025

Report of:	FTSU Guardian
Paper Prepared by:	FTSU Guardian
Subject/Title:	Freedom to Speak Up – Progress Update Report
Background Papers:	FTSU Board reports from September 2016 onwards NGO Guidance Staff Survey
Purpose of Paper:	To provide the Board with a summary of progress to date to improve and enhance mechanisms for staff to raise concerns and describe the actions planned for the coming period.
Action/Decision Required:	The Board is asked to note the progress made to date and to support the further actions outlined.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Best people doing their Best Work**
Resource Impact:	To be identified

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

1. Purpose

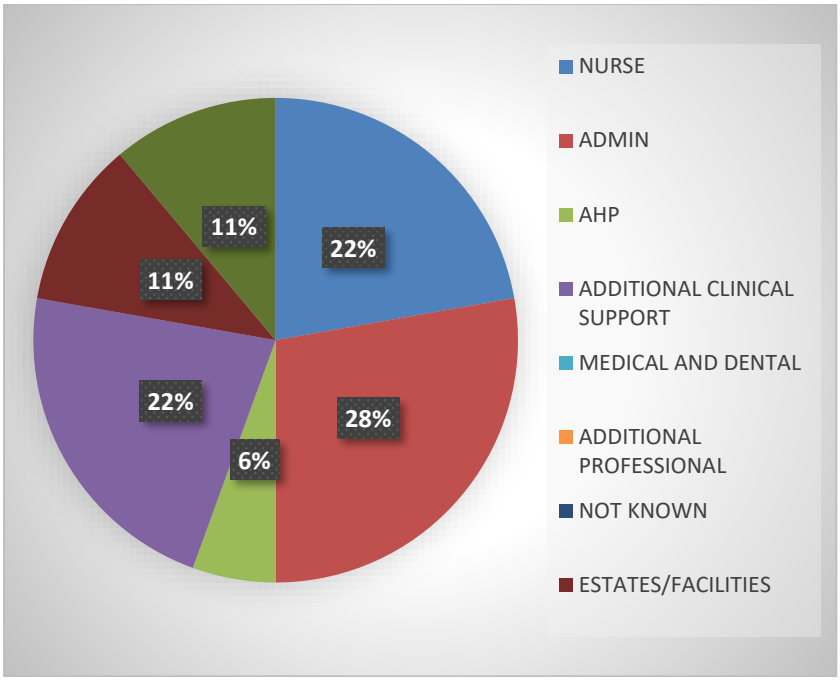
The purpose of this paper is to provide the Board with a summary of the activities of the FTSU service for the Q3 data and to outline the actions planned for the coming period.

2. Recommendation

The Board is asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed.

3. FTSU Q3 Activity

Q3 Data



Contacts by Professional Groups

There is a wide cross-section of the Trust workforce, that have contacted the FTSU guardian, from a range of worker/professional groups and levels of seniority.
A comprehensive definition for professional groups forms part of the updated guidance.

Recording Cases and Reporting Data (nationalguardian.org.uk)

Themes highlighted in bold are reported as part of the mandated quarterly data collection and returned to the National Guardian's Office.

Theme	**Open**	**Closed**	**Total**
Patent Safety and Quality	0	0	0
Worker Safety and Wellbeing	0	0	0
Inappropriate Attitudes and Behaviours	5	3	8
Policies, Processes, Procedures, Systems	6	4	10
Infrastructure/Environment	0	0	0
Cultural	0	0	0
Leadership	0	0	0
Senior Management Issue	0	0	0

Middle Management Issue	1	0	1
Total	12	7	19

*Speak Up cases often contain multiple themes; therefore, data sets do not always equate together. Issues are recorded under the workers own description. In cases relating to Inappropriate attitudes and Behaviours, it should be considere that there will potentially be an element of staff safety.

Of the 12 cases that remain open in Q3:

Cases remaining open (5) related to Inappropriate Behaviour and Relationships

- 2 have a plan in place to address the concerns and are awaiting follow up meeting with the potential to close
- 2 remain open relating to behaviour and relationships, this concern has had other staff raise the same concern, however this was in January 2025, so are not captured in Q3 data, however the concern has been escalated to include these additional staff members and there is a planned approach to address the concerns raised.
- The final concern, is also pending closure, but wishes to have the final follow meeting with their line manager prior to closure

Cases remaining open (6) in relation to Policies, Processes, Procedures. Systems

- 1 pending closure once clarification of issue has been confirmed, which may result in there not being a case to answer
- 1 case open, as further discussion required in relation to some elements of the concern, it should be noted that the individual who had raised this concern, has now resigned from the post.
- 2 case open however it is unsure whether this is a case for FTSU, awaiting further information prior to decision on how to proceed
- 1 case open, pending follow up meeting.
- 1 case remains open, as further clarification of the concern is required.

Feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again scoring the process highly in terms of satisfaction.
Staff response to the question '*when people speak up in this organisation, things change'* is indicating, that of those who have raised a concern and responded to the survey, 10.7% of those staff did not believe things changed, this has decreased from 16.7% in Q1 therefore an improvement of 5%

To view results from the questionnaire post closure please click on the link below:
https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=OVmEMfpVb8x8dRhYPVxLZDFdyaHIx6lu&id=G888R1c5sE6Cur6KaqH2Sri2S89zA4NJtHQSSVjh0UBUQktJNk5OWUNCN01YUVNOWjlSTkVQSFBDMC4u

4. Lessons Learnt

A significant barrier for staff in raising concerns relating to inappropriate behaviour, is that staff would like to achieve a resolution, with the hope of maintaining and potentially repairing relationships, but believe that taking these issues via the HR processes, would not deliver this outcome, there is now a proposal for the development of a framework, which will look to map a process by which staff can raise a concern without the need to go 'formal', this work will initially start with HR and the Chair of staff side.

A number of cases have been raised regarding the recruitment process, these were in relation to one division, changes have now been put in place, that include additional checks, this is to provide assurance, that the potential for similar errors occurring will be mitigated.

Concerns were raised regarding staff off duty and changes made, highlighted a need for clarity to be provided, to staff , around employees contracts and related policies and to ensure that communication is effective and in line with trust values.

5. MIAA Audit update

A review of MIAA recommendations was undertaken in January 2025, this review demonstrated that 3 of the 5 recommendations have been implemented, Table 1

Table 1

1.	Low	The Trust should ensure all staff members complete their Freedom to Speak Up E-learning.	The roll out of the Speak Up training was only mandated in August 2023, the FTSU Guardian and Champions, promote this training to staff in their areas of work and the Guardian promotes this via the FTSU Visibility Program and at trust induction both for new starters and new nurses. September 24 FTSU Guardian	**Implemented** It was confirmed that 97% compliance has been achieved for the Freedom to Speak Up E-learning. It was confirmed that training is being promoted at Induction for new starters and via the Visibility Programme.
4	Low	The Trust should share Lessons learnt through the Trust to prevent the same issues being repeated.	The Thriving Together MDT meeting, chaired by Jo Potier, aids in the lessons learnt issue, with a focus on the triangulation of data from a number of services, including SALS and Brilliant Basics and a focus on supporting teams to make change. There is a requirement however to review the process of lessons learnt to ensure all concerns are actioned appropriately and learning, were appropriate, is embedded within the organisation. September 2024 FTSU Guardian	**Implemented** It was confirmed that lessons learnt are reviewed within the Thriving Together MDT meeting which includes SALS. The Trust completed a FTSU survey in the summer of 2024 which confirmed that staff felt that concerns were being actioned appropriately and learning embedded.
5	Low	The Trust should provide a Freedom to Speak Up Annual Report.	Annual reports will be submitted in Q1. September 2024 FTSU Guardian	**Implemented** It was confirmed that the Freedom to Speak Up annual report was completed in May 2024 and reported to Board. The

				Trust has put a process in place to ensure that this will be repeated in future years.

The 2 recommendations outstanding have been partially implemented. Table 2

Table 2

2	Med	The Trust should implement and embedded the new Risk Management system 'InPhase' for the logging of Concerns.	This work will commence, once we have received assurance that this data is not visible to other staff with permission rights to access InPhase , as it has been identified that currently they can access the FTSU element of InPhase which is contrary to NGO guidance on the holding of staff information. September 24 / extension request to April 25 FTSU Guardian	**Partially Implemented** The Trust has developed an App for the logging of the FTSU concerns with the Innovation team with an estimated launch date of Spring 2025.
3	Low	The Trust should identify individuals with the skills and competencies required to be a Deputy Freedom to Speak up Guardian and who can make a positive impact	A business Case is currently under development, once completed it will progress through the relevant channels. September 24 / extension request to April 25	**Partially Implemented** The business case was developed, however, was put on hold. At the date of follow up, it was confirmed that the business case has been completed and the Trust will be advertising the post of Deputy Freedom to Speak Up Guardian in the early part of 2025.

6. FTSUG Visibility Programme

The FTSU visibility programme, continues, being well received across the organisation and a key component to the FTSU communication plan. As previously indicated, the walkabouts are supported by members of the Executive and Non-executive team, these are well received by staff and demonstrate the commitment of the executive team to the FTSU principles.

There remains barriers for staff, to speak up and raise concerns, with some of these barriers being more prevalent in staff who may fall under either the ACE,REACH, LGTBQ+ Networks, because of this the FTSUG and Chair leads, along with executive support from Racheal Lea, are looking at developing a collaborative safe space for all staff, part of which will include the network chairs also supporting the FTSU walk about. Further development of this piece of work will be shared once completed and ready for launch.

7. Mandatory training

The Speak Up training module as of the 18th December 2024 was 97.23% compliant. Currently it is not possible to launch the Listen Up, Follow Up training as the ESR system requires adaption to accommodate these training.

Kerry Turner
Freedom to Speak Up Guardian
January 2025

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	**Update to Corporate Governance Manual (Standing Orders, Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD)**
Report of:	**Interim Chief Finance Officer**
Paper Prepared by:	**Deputy Director of Finance**
Purpose of Paper:	Decision ☑ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	Update to the Corporate Governance Document should ensure clarity over the governance arrangements of the trust, and that all current governance arrangements are accurately reflected in the trusts Standing Orders/SFIs/SORD
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:	N/A

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

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

1. Executive Summary

This paper reflects the output of the annual review of the Trust's Corporate Governance Manual. Given increased scrutiny on grip and control of expenditure at a national and regional level, upcoming changes to procurement regulations, as well as several changes in Executive portfolio over recent times, an in-depth review of the Corporate Governance Manual has been completed.

The key changes relate to;

- Updating executive responsibilities within the document in line with current executive portfolios
- Updated references to internal and external regulations/guidance/policies/bodies to ensure up to date and consistent throughout the document
- Updating the Scheme of Reservation and Delegation (SORD) to reflect expected changes as a result of the new Procurement Act (PA23) and Provider Selection Regime (PSR)
- Updated SORD to create clarity on the difference between raising a requisition, completing a tender/quote and signing a contract, to ensure appropriate scrutiny is undertaken for each activity
- Updating procurement limits for requisitions, to simplify governance, and ensure strong oversight. This includes a reduction to Associate Chief of Operations (ACOO) limits from £50k to £20k for non pay, in order to give better oversight of non pay spend. ***This change will be subject to review in 6 months time to ensure that the change has had a positive effect and is not creating undue workload at the ACOO level.***
- Updated SORD to create a requirement that contracts with a financial impact are approved through Boards/Committees prior to signature, in line with business case limits, to create stronger governance around contract sign off. ***This change will be subject to review in 6 months time to ensure that the change has had a positive effect and is not creating undue workload.***
- Adding in section on insourcing/outsourcing to ensure NHSE/ICB requirements around notification are met
- Added in section on consignment stock to ensure stronger governance around this, in line with best practice, to minimise risk if consignment stock recalled, and to create a better knowledge base around what consignment stock is held.
- Added in a section on external bid submission to align with previously approved Finance Governance Framework, with the addition of new exemptions and delegated approval limits to make the requirement more workable, and less likely to deter bidders (nb it was noted when the Finance Governance Framework was taken through ARC that exemptions would be worked up). ***This change will be subject to review in 6 months time to ensure that the change has had a positive effect and is creating the right level of scrutiny of external bids.***
- Document updated to ensure consistency with other Trust policies/documents – e.g. removal expenses reduced to £5k in line with current policy/ business case limits updated in line with Finance Governance Framework etc.

The updated manual has been reviewed by the Audit and Risk Committee and supported to be presented to Board for final approval. Changes made subsequent to audit committee following feedback at ARC, and feedback from MIAA and SDG are as follows.

- Updated SORD so that contracts under £250k do not need SDG/Divisional Committee approval prior to signature. This is replaced with a requirement to report retrospectively on contracts signed of this value on a quarterly basis (contracts under £50k to Divisional Boards, contracts between £50k and £250k to SDG).
- Updated Fraud references to refer to appropriate anti-fraud manual and counter fraud body as per feedback from MIAA
- Update SFI to include a requirement to complete appropriate due diligence checks as part of tender process in line with procurement policy, following recommendation from Anti-Fraud National Proactive Exercise MIAA report.

The Board are asked to approve the updates to the Corporate Governance Manual as set out in Appendix A. A full copy of the update Corporate Governance Manual is available on request.

The Board are also asked to note the proposal to review the change to external bid submission process, the requirement to seek committee approval for contracts over £250k prior to signature, and changes to non pay requisition levels in six months' time in order to gain assurance that the changes proposed are workable and are having the desired effect to create the right balance of grip and control vs operational delegation.

2. Background and current state

The Corporate Governance Manual is a document that sets out the key governance requirements of the trust. It is made up of three constituent parts as follows.

- **Standing Orders**, as a framework for internal governance
- **Scheme of Reservation and Delegation** which describe the powers reserved to and delegated by the Board
- **Standing Financial Instructions** as a framework for financial governance

The above-mentioned documents together provide a regulatory framework for the business conduct of the Foundation Trust.

There is a requirement to review the Corporate Governance Manual annually. Given increased scrutiny on grip and control of expenditure at a national and regional level, changes to procurement regulations, as well as several changes in Executive portfolio over recent times, a full scale in depth review of the Corporate Governance Manual has been completed on this occasion.

3. Review of the Corporate Governance Manual

This paper reflects the output of the annual review of the Trusts Corporate Governance Manual, which is good practice. The proposed updated Corporate Governance Manual is available on request. A full list of changes proposed can be found at appendix A and summarised in section 1, however changes of particular note, worthy of discussion are as follows.

- **Updated SORD to create a requirement that contracts with a financial impact over £250k are approved through Boards/Committees prior to signature, and that contracts under £250k are reported quarterly retrospectively through Divisional Boards (up to £50k), and SDG (up to £250k). The aim of this requirement is to create stronger governance around contract sign off.**

The SORD has been updated to create a requirement that contracts over £250k are approved through relevant committee in line with the same approval limits applied to business cases (e.g. Ops Board/Exec £500k, FTPC £1m, Board >£1m). Contracts under £250k will be reported to SDG quarterly, and under £50k to Divisional Board quarterly. This has historically not been a requirement but has been advised by HPL in line with best practice at other trusts. It is proposed that by creating this requirement, there will be greater scrutiny of contracts that create a financial impact for the trust, and will likely improve compliance with procurement requirement (e.g. quotes/tenders/framework award, and timeliness of raising requisitions), which we are aware from the recent HPL review and action plan, requires strengthening.

SDG have approved this change but have committed to a review in six months' time to ensure this solution is fit for purpose and is not creating undue additional workload.

- **Updating procurement limits to simplify governance, and ensure strong oversight, particularly of agency, and consultancy spend**

The SORD has been updated to remove a number of sections with regard to requisition approval to simplify the requisition approval landscape. The sections removed, listed below, are no longer deemed to be relevant, and are seen to be just as easily covered by the approval hierarchies that remain. It is believed by minimising the number of procurement approval hierarchies to a small number, it will easier to understand and interpret guidance, and consistency of application is more likely to be applied.

Section proposed for removal are as follows.

- Building and engineering works (non-capital)
-Call off orders (annual value)
-Capital Expenditure
-Alder Hey in the Park Project
-Periodic Payment (gas, electricity, rates, telephone, water)
-Services over lifetime of contract
-All other requisitions

Sections proposed to remain are as follows.
-Non pay expenditure
-Agency staff
-Management consultants
-Removal expenses

It should be noted that the procurement hierarchy that is uploaded on the NEP system is the non pay expenditure hierarchy. Application of the agency, management consultancy and removal expense hierarchy will be offline, and will be overseen by HPL as it is currently.

In addition to removing sections of the requisition hierarchy, the non-pay hierarchy has been updated to reduce the £50k limit for ACOO/Divisional Directors to £20k. It is intended that this will create greater grip and control of non pay spend. By aligning the limit to the value at which procurement activity should have been undertaken at the point of requisition (e.g. 3 quotes/procurement through a framework), it is intended that adherence to procurement rules will again gain more scrutiny across divisions.

SDG have approved this change to the hierarchy but have committed to a review in six months' time to ensure this solution is fit for purpose, and is not creating undue additional workload for ACOOs/Divisional Directors.

- **Added in a section on external bid submission to align with previously approved Finance Governance Framework, with the addition of new exemptions and delegated approval limits**

A new section has been added to the SORD within the Corporate Governance Manual for External Bid Submission approval. This section reflects the recent changes to the Finance Governance Framework for the same, which were approved by ARC in October. In summary this section stipulates a requirement that all external bids should have a business case approved prior to submission in line with the normal business case process, or in the event that timescales do not allow for this, or several speculative claims are being submitted which would make multiple business cases a nugatory exercise, there is an option to submit a decision document for approval to the Executive in lieu of a business case. The expectation is that a business case would follow if the bid were to be successful.

In addition to the section approved in the Finance Governance Framework, this update to the Corporate Governance Manual also includes some proposed exemptions to the requirement above and a hierarchy for approval such that decisions documents would flow to differing levels for approval dependent on bid value.

The exemptions proposed are as follows;

Excerpt from SORD table B section 11;

"A Decision Document in lieu of business case ahead of bid submission should be approved in line with hierarchy, other than when the submission is for NIHR, Research Council or External Charities bid and does not create any funding requirement for the trust. In these circumstances local governance arrangements will apply

Exceptions do not apply if any of the following scenarios apply

- ***The bid is novel and contentious***
- ***The bid commits to match funding from the trust***
- ***The bid creates an unfunded ongoing pressure once external funding ends***
- ***The bid is for capital funding***

The approval hierarchy proposed is as follows.

- Up to £50k – Divisional Boards
- Up to £500k – Chief Finance Officer and at least one Exec member responsible for Futures (e.g. Chief Operating Officer or Chief Scientific Officer)
- Over £500k- At least 4 members of Executive including Chief Finance Officer and at least one Exec member responsible for Futures (e.g. Chief Operating Officer or Chief Scientific Officer)

It is believed that the proposed changes above should ensure that the appropriate level of scrutiny is given to different types of bids, and that the exemptions and hierarchy mean that the bids that create larger risks for the trust or are more contentious are given due attention.

It should be noted that it was highlighted that exemptions would be required when the Finance Governance Framework was approved at ARC in October. Any changes made to the Corporate Governance Manual, will also be updated in the Finance Governance Framework in due course to maintain consistency.

It should be noted this change will be subject to review in 6 months' time to ensure that the change has had a positive effect and is creating the right level of scrutiny of external bids.

4. Recommendations & proposed next steps

- The Board are asked to review and approve the proposed changes to the Corporate Governance Manual.

- The Board are asked to note the proposal to review the change to external bid submission process, the change to the requirement for committee review prior to contract signature, and the change to non-pay requisition levels in six months' time in order to gain assurance that the changes proposed are workable and are having the desired effect to create the right balance of grip and control vs operational delegation.

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

Appendix A – Summary of Proposed Changes

Section	Sub section	Topic	Change	Rationale
General	n/a	Procurement Act	Update references to Procurement regulation to refer to new Procurement Act (PA23) and Provider Selection Regime	To reflect statutory change
General	n/a	n/a	Update for technological advances - e.g. tenders received digitally via e-tender system so no longer need physical opening of tender	To reflect current reality
General	n/a	n/a	Remove reference to Director of Finance and replace with Chief Finance Officer or Deputy Director of Finance as appropriate	To reflect current structure
General	n/a	n/a	Updated SORD Table B and C to reflect current executive portfolio responsibilities (e.g. Research decisions allocated to Chief Scientific Officer, Digital responsibilities to Director of Digital and Transformation, Legal/Consultancy decisions to Director of Corporate Affairs etc)	To reflect current Executive Portfolio
General	n/a	n/a	Remove reference to EU with regard to regulations	No longer applicable
General	n/a	n/a	Replace references to Monitor with NHS England	Monitor no longer exist as a statutory organisation
General	n/a	n/a	Replace references to CCG with ICB	CCG no longer exist as statutory organisations
Standing Order	Contents	n/a	Removed section 13 - change to Standing Orders from contents list.	Variation to standing orders covered by para 4.11 of SO. There was no para 13 in the actual body of the report, so removal from contents page creates internal consistency within the document.
Standing Order	Para 4.1.5	Meetings of the Board	Updated to refer to correct paragraph on constitution, and note that documents only available on prior request (used to have printed copies but don't do this now?).	Used to have printed copies at Annual Public Meeting, but don't do this now
Standing Order	Para 7	Declarations of Interest	Updated to reflect Register of Interests policy	Consistency with existing policies
Standing Order	Para 13	Changes to Board Standing Orders	Added section back in	Section was referred to in contents page but not in body of document. Assumed deleted in error.
SORD	Table B	n/a	Correcting cross referencing between Table B and Table C of SORD	Correction - many of the references in Table B referred to Table B in error (should have been Table C)
SORD	3.7 (4)	Decisions reserves to the Board of Directors - Strategy and Business Plans and Budgets	Updated to refer to all business cases, not just capital	Consistency with existing policies (Finance Governance Framework)
SORD	3.7 (11)	Decisions reserves to the Board of Directors - Strategy and Business Plans and Budgets	Updated to require all contracts and requisitions over £1m go to Board. Increased from £0.5m.	This is in line with business case sign off at board and sub committees.

SORD	1.4	Absence of Directors or Officer to Whom Powers have been Delegated	Updated who should take on Accounting Officer (AO) responsibilities if AO unavailable for more than 4 weeks from Chief Medical Officer to Deputy Chief Executive Officer	As requested by CEO
SORD	Table B Section 5c	Leases (property and equipment)	Include reference to IFRST 16 impact with regard to leases	To reflect current accounting standards applicable to the NHS
SORD	Table B Section 5d	Alder Hey in the Park (variation to business case/annual review of reference cost)	Deleted section	Alder Hey in the Park now part of BAU. No longer required to be considered separately.
SORD	Table B Section 23B	Contracts for Computer Services	Now joint responsibility of Chief Digital and Transformation office and Chief Procurement Officer previously Chief Digital Officer	As agreed with CPO and CDTO
SORD	Table B Section 24	Legal Proceedings	Updated to state if document has financial impact must be signed in accordance with Table C (delegated limits). If no financial impact - can be signed by Executive Director. Previously could be signed by an executive director.	To ensure strong oversight on contracts signed that have a financial impact
SORD	Table B Section 25	Losses	Updated to show losses report to FTPC as they arise (not ARC annually)	In line with current practice
SORD	Table B New section 31	External Funding Agreements	Section added on External Funding Agreements - costing/submitting bids/deviating from costing principles.	Section added to align to Futures Financial Framework, agreed in Futures Committee (with new exemptions included - which was an actions from Futures Committee to confirm).
SORD	Table B SECTION 33 f	Personnel and Pay - Establishments	Made clear that changes to establishment should be subject to business case as per limits set out in table C.	
SORD	Table B SECTION 33 f	Personnel and Pay - Establishments	Added section on nursing establishment changes to clarify that changes to nursing establishment is the responsibility of the Chief Nursing Officer	To ensure safer staffing limits maintained when nursing establishment changes proposed
SORD	Table B Section 33g	Personnel and Pay - Authority to authorise travel & subsistence expenses	Updated to have operational responsibility to reference table C, where as previously stated ACOO. Table C states the up to £2,500 can be signed off by budget holder, and over £2,500 to be signed off by ACOO and Deputy Director of Finance.	Sign off by budget holder is in line with Expenses Policy. Expenses policy may need to be updated to reflect sign off requirement above £2,500 at ACOO/Deputy Director of Finance level, to ensure sufficient scrutiny of high value claims.
SORD	Table B Section 33g	Personnel and Pay - Changes to standing data	Split section on standing data form approval to make clear any changes outside NHS T&C to be approved by Chief People Officer or Deputy Chief People Officer	In line with current practice
SORD	Table B Section 33h	Personnel and Pay - Shared parental leave	Added in section as policy now applies	Consistency with existing policies

SORD	Table B Section 33h	Personnel and Pay - Agency and bank	Added distinction between medical, nursing and other bank and agency to make clear who is accountable for each area. Also added in clarity around need for exec vacancy panel approval for non clinical bank/agency, and requirement for break glass process where relevant.	Agency approval in line with current practice. Clarity around break glass and exec approval added to clarify and simplify process.
SORD	Table B Section 33h	Personnel and Pay - Agency and bank	Booking agency - updated operational responsibility from line manager to ACOO/CAN/Clinical Director/Divisional Director as appropriate	To ensure sufficient grip and control of agency spend
SORD	Table B Section 34	Quotations, Tendering and Contract Procedures - oversee and manage contract	Added in differing requirement for Gold Tier Contract and Silver Bronze Tier Contract (as defined by HPL Contract Management Policy) so that CPO and ACOO jointly operational responsible for Gold Tier, but ACOO responsible for Silver and Bronze contract oversight.	In line with HPL policy
SORD	Table B Section 34	Quotations, Tendering and Contract Procedures - waivers	Updated waivers to be responsibility of CFO delegated to Deputy Director of Finance. Previously stated CEO, and referred to Table C (which was silent on who could sign off waivers)	Provide greater clarity on who can sign off waivers.
SORD	Table B Section 41	Stores of Receipt of Goods	Added section on theatres stock taking with operational responsibility of ACOO surgery.	Theatres stock not currently managed by HPL, so important to separate out responsibility for stock take arrangements in this regard.
SORD	Table B Section 42	Insourcing/outsourcing decisions	Added in section on insourcing/outsourcing decisions, with operational responsibility sitting with COO (subject to approval at SDG and Ops Board).	In line with current guidance requiring COO to inform CMAST of any changes to insourcing/outsourcing arrangements
SORD	Table C Section 1	Gifts and Hospitality	Have changed proposed limit to "over value of £50" - previously said "up to value of £50"	Have assumed previous version was "up to" in error
SORD	Table C Section 2	Litigation claim	Updated limit to be above and below excess, rather than above and below £15k.	This bring consistency with Table B of the SORD
SORD	Table C Section 4	Outline & full business case	Updated business case limits to bring in line with current practice, and remove reference to IRG (no longer in existence).	To bring in line with existing policy (Finance Governance Framework)
SORD	Table C Section 4	Outline & full business case	Clarified that the limits reply to gross costs not net costs, to ensure that even costs that are offset by income should be captured by the business case process.	To add clarity as to how the business case limits should be applied

SORD	Table C Section 6	Requisitioning Goods and Services and Approving Payments	Simplified section to help improve application. Removed the following sections; - Building and engineering works (non capital) -Call off orders (annual value) -Capital Expenditure -Alder Hey in the Park Project -Periodic Payment (gas, electricity, rates, telephone, water) -Services over lifetime of contract -All other requisitions Categories that remain are; -Non pay expenditure -Agency staff -Management consultants -Removal expenses	It is proposed that by limiting the number of categories the SORD will be easier to interpret and apply. The majority of spend is captured via non pay expenditure, which is what the NEP hierarchy is based upon. All other limits will need to be applied offline by HPL, and therefore minimising is preferable.
SORD	Table C Section 6.1	Requisitioning Goods and Services and Approving Payments - Non pay expenditure	Updated to remove £50k limit, and reduce £30k limit to £20k sign off aligned to ACOO/Divisional Manager (previously ACOO had £50k limit and Deputy ACOO had £20k limit).	This means that there will be ACOO/Divisional Manager involvement for all requisitions that should have been through quote/tender/framework process. It is hoped this will aid compliance with following the correct procurement process.
SORD	Table C Section 6.2	Requisitioning Goods and Services and Approving Payments - agency staff	Updated sign off to; - up to £50k to ACOO or Clinical Director (medical), ACN (nurse), and ACOO or Divisional Director (other), - up to £100k to be CMO (medical), CNO (nursing) + COO (other) plus CFO for all categories -over £100k CEO Was previously CEO for up to £100k, Executive for up to £10k and ACOO up to £5k. With any non clinical requiring sign off by DOF and Chief People Officer. Also added note to confirm break glass policy must be followed prior to requestion being raised if relevant..	Updated to ensure accountability lies with correct exec lead, and ensure strong grip and control around agency spend. Given increased controls through exec vacancy panel it is no longer deemed necessary for Chief People Officer and DOF to sign off all non clinical agency. Up to £50k this will now be signed off by ACOO or Divisional Director, but only once break glass process has been followed and exec panel has approved.
SORD	Table C Section 6.3	Requisitioning Goods and Services and Approving Payments - management consultancy	Broadened definition to include legal spend and changed delegated officer up to £100k to Director of Corporate Affairs (from CEO) Added in up to £50k category to differentiate between those which need NHSE sign off and those that don't. Board of Directors sign off still required for over £100k	Updated in line with existing policy (Finance Governance Framework). Clarity given to ensure appropriate grip and control of legal and management consultancy spend.
SORD	Table C Section 6.4	Removal expenses	Reduced limit from £8k to £5k.	In line with current policy

SORD	Table C Section 7	Quotations and Tender	Updated to bring in line with Procurement Act (PA23) and Provider Selection Regime (PSR)	Updated for new statutory requirements
SORD	Table C Section 8	Approving and signing contracts/agreements with financial impact	Added in section on approving and signing commercial agreements with a financial impact proposing contracts with a financial consequence should go through committees (aligned to business case sign off), with clarity given over who can physically sign the documents following committee approval. Previously only Table B referred to contracts and it was not clear to all readers who could sign, or what governance was required.	Provide greater clarity on contract signature for those contracts with financial consequence.
SORD	Table C Section 9	Consignment Stock	Added section on Consignment Stock - requiring delegated approval in line with procurement hierarchy for approving consignment stock agreements, with a requirements the Chief Procurement Officer (CPO) reviews T&C prior to approval.	Ensures stronger governance around consignment stock. Important to be clear on level of stock/assets held both for insurance purposes and also risk management of consignment stock recalled etc.
SORD	Table C Section 10	Costing external bids (grants/national funding)	Add in section on costing external bids requiring financial sign off of bid costing.	In line with Futures Financial Framework
SORD	Table C Section 11	Submitting bids for external funding	Add in section on approval required ahead of submitting external funding bits, and exceptions that apply to this process.	In line with Finance Governance Framework, updated for exemptions, and hierarchy of sign off agreed with executive colleagues, for approval by ARC.
SORD	Table C Section 12	Allowable budget virements	Updated limits. Previously had anything above £40k to be reported to Board, which was not being consistently applied. Updated so that up to £50k ACOO, up to £250k ACOO and Deputy Director of Finance, Up to £500k CFO, Up to £1m CEO, Over £1m CEO on behalf of Board. Also added requirement that anything over £50k reported to FTPC retrospectively	Updated in line with discussion at SDG
SORD	Table C Section 13	Travel and Subsistence	Added in Travel and Subsistence section to ensure any spend over £2,500 is signed off by ACOO and Deputy Director of Finance (may need to update T&S policy and forms to reflect this)	To provide greater clarity on who can sign of T&S claims, and ensure strong grip and control.
SFI	Reference section	Reference section	Included reference to NHS Act 2022	Bringing references to statutory acts up to date
SFI	3.1.2	Preparation and Approval of Plans and Budgets	Added requirement for financial plan to accord with activity plans as well as workforce plan.	Sets out clear intent that financial plan should triangulate with both workforce and activity plans

SFI	3	Preparation and Approval of Plans and Budgets	Added in section on business cases	To ensure consistency between SFI and SORD
SFI	6.2	Fees and Charges	Updated to align responsibility for agreeing fees and charges with Associate Director of Finance	To ensure consistency between SFI and SORD
SFI	Section 7	Tenders and contracting procedures	Updated several sections to cross reference to SORD	To ensure consistency between SFI and SORD
SFI	7.4.3	Tenders	Clarified that spend between £20k and £49,999, 3 quotes are required, and updated to reflect the circumstances where tenders are not required	To ensure consistency between SFI and SORD
SFI	7.4.4	Fair and Adequate Competition	Relaxed the wording re what to do if only one bid received, to make it clear that tender can proceed at the discretion of CFO and CPO. Previously 7.4.4 required no less that two firms/individuals.	To allow tender exercise to proceed if only one bid received if CFO/CPO deem to be good value for money and appropriate procurement route.
SFI	7.5.1C	Invitation to Tender	Updated references to standard contract to current standard contracts	Updated to reflect correct reference to standard contract provided by NHSE/DHSC etc.
SFI	7.5.7	Tender reports to the Trust Board	Updated section on reporting of tenders to say they should go to relevant committee in line with SORD - (rather than to trust board on an exceptional basis)	To give clearer governance around agreeing contracts before signature
SFI	7.6.3	Quotations and tenders to be within financial limits	Broadened definition to include tenders as well as quotes, and changed wording from "accepted" to "agreed to", to make it clear it is not about receiving the quote/tender but agreeing/signing up to it.	Providing greater clarity around governance arrangements for quotes/tenders
SFI	7.10.8	Tendering	Included reference to due diligence checks to ensure VFM obtained	Fulfil recommendation made by MIAA as part of National Procurement Exercise Audit
SFI	7.13	Disposals	Included reference to Capital Manual	To ensure that any update to capital manual (ongoing) is cross references in SFI
SFI	7.16	External Funding Agreements	Added in section on external funding agreements	To ensure consistency between SFI and SORD
SFI	7.17	Insourcing/outsourcing decisions	Added in section on insourcing/outsourcing decisions	To ensure consistency between SFI and SORD
SFI	8.2.2	Legally binding contracts	Removed reference to CQUIN and left as just targets	To allow for changing targets set by NHSE

SFI	9.2	Funded establishment	Broadened who can approve change in establishment to CEO or delegated officer (previously only CEO could approve change)	To ensure consistency between SFI and SORD
SFI	10.2.1	Requisitioning	Made clear that procurement advice required prior to requisitioning	To make clear that procurement should be engaged as part of requisitioning process, and not retrospectively.
SFI	10.2.5	Official orders	Updated to make clear that PO now issued via computerised system	In line with current practice
SFI	10.2.6C	Consultancy advice	Added in requirement to seek NHSE approval for consultancy spend over £50k	In line with current NHSE requirements
SFI	14.3.1	Goods supplied by NHS Supply chain	Updated to reflect that goods receipting is now system based	In line with current practice
SFI	14.3	Goods supplied by NHS Supply chain	Added in wording re HPL checking supply chain invoice against goods receipt, as advised by HPL (activity not currently undertaken by AH, but is undertaken by others in HPL group). To be implemented at AH forthwith.	As advised by HPL as best practice
SFI	15.2.4	Losses and special payments	Updated to show that losses and special payments approved through FTPC not ARC	In line with current practice
SFI	16.2	Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application	Updated responsibility to Director of Transformation and Digital from DOF	In line with current exec portfolios
SFI	16.5	Risk assessment	Updated responsibility from DOF to Director of Corporate Affairs	In line with current exec portfolios
SFI	18	Acceptance of gifts by staff and link to standards of business conduct	Updated responsibility from DOF to Director of Corporate Affairs	In line with current exec portfolios
SFI	18	Acceptance of gifts by staff and link to standards of business conduct	Updated with reference to current guidelines	In line with current NHSE requirements
SFI	22.1.1	Review of SFI	Updated to state copy available on intranet (rather than handed to new staff)	In line with current practice
Appendix	Appendix A	List of changes	Included full list of changes in January update	In order to maintain audit trail of changes
Appendix	Appendix B	Futures Financial Framework	Included Futures Financial Framework as an appendix	Document referred to in SORD Table B 31c - so makes sense to append

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	**Chair's Report from ARC meeting, 16th January 2025**
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	
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 on risk management processes within Medicine Division
- Board Assurance Framework
- Risk Management Forum Update including Chair's Report and Minutes from most recent meeting
- Corporate Risk Register
- Trust Risk Management Report
- Update on the roll out of Risk Appetites and Tolerances
- Draft Internal Audit Plan for 25/26
- Internal Audit Progress Report, including the outcomes of audits of Key Financial Controls (Substantial), EDI (Moderate) and E-roster (Moderate)
- Internal Audit Follow Up Report
- Anti-Fraud Services Progress Report
- Briefing on circumstances that led to a staff member retaining possession of lease car for 9 months after leaving the Trust
- Capital Improvement Plan Update
- InPhase Phase 2 Programme Update
- Quarterly updates on compliance with Data Protection Act and Freedom of Information Act
- Update on changes required to the Trust's procurement processes as a result of changes to the Procurement Act (from Health Procurement Liverpool) – Approved
- Report on the Trust's performance in relation to purchasing processes (from Health Procurement Liverpool)
- Review of ARC's Terms of Reference, Workplan and Schedule of Meetings for 25/26
- Outcome of the recent self-assessment of ARC effectiveness
- Agreement of "light touch" questionnaires to review the effectiveness of Internal and External Audit
- Agreement of a detailed questionnaire to review the effectiveness of the Anti-Fraud Service
- Update to the Corporate Governance Manual – Approved
- Information on treatment of specific accounting transactions, ahead of the year end audit
- Update on actions taking following the cyber incident in November 2024

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

None

4. Positive highlights of note

- FTPC commissioned HPL to undertake a review of procurement processes as part of a sprint to minimise procurement costs. The outcome of this review was also provided to ARC and it provided benchmarking of our processes against other Trusts in the region. ARC retrospectively monitors waivers granted against quotations and tenders and this benchmarking suggests that our performance is very behind that of comparators (i.e. that we grant higher volumes of waivers. ARC will continue to review performance in this area, with improvements expected.
- Since the last detailed self-assessment of ARC there has been two new NEDs join the Committee. They provided valuable new insights and views and we agreed a small number of enhancements to the Committee's processes including one additional meeting in the year to provide space across all the meetings to allow horizon scanning and risk anticipation.

5. Issues for other committees (including Safety & Quality Committee)

None

6. Recommendations

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

Appendix 1 – 2024/25 Internal Audit Plan Outcomes

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 10th October 2024**
Meeting Room 20, Institute in the Park

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 A Bateman	Chief Operating Officer	(AB)
	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Ms. E. Kirkpatrick	Assoc. Director of Finance - Commercial, Control and Assurance	(EK)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRO)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Item 23/24/83	Ms. S. Leo	Head of Research Operations	(SL)
Observing:	Mr. L. Stark	Trust Governor	(LS)
Apologies:	Mr. J. Grinnell	Managing Director/Chief Financial Officer	(JG)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Mr. D. Spiller	Senior Manager, Ernst & Young	(DS)

24/25/79 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received. Thanks were offered to all those involved in meeting the deadline for reports thus ensuring that all papers were circulated on time ahead of the meeting.

The Committee was advised that one of the Trust's Governors, Lachlan Stark, was joining via Teams to observe the meeting.

24/25/80 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.

24/25/81 Minutes from the Meeting held on 20.6.24 and the 7.7.24
Resolved:
The minutes from the meeting held on the 20.6.24 and the 7.7.24 were agreed as an accurate record of both meetings pending the removal of a duplicated line in June's minutes.

24/25/82 Matters Arising and Action Log

Matters Arising

The Chair drew attention to the following points:

- *Briefing for ARC Members on budgetary management and CIP* - Training on budget and CIP management is going to be provided for all NEDs by the Director of Finance and Development, Rachel Lea. This will take place during a NED briefing session.
- *Confirmation of position of actions following the theft of Trust iPads* - MIAA have confirmed that the actions that form the piece of work commissioned by the Chief Digital and Transformation Officer (CDTO), Kate Warriner, following the theft of Trust iPads have been completed.
- *Updating the Risk Management Strategy & Policies* – It was reported that risk appetite and tolerances are going to be a theme in the Risk Management Strategy and associated policies therefore the review date of these documents will be deferred to enable risk appetite and tolerance information to be included.

Action Log

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 agreed to liaise with Michelle Perrigo to confirm as to whether the amendments have been made to the 2022/23 Annual Non-Claims Report. **ACTION TO REMAIN OPEN**

Action 24/25/21.1: *External Audit Planning Report for Year-ended 31.3.24 (Discussion to take place once (Ernst & Young (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)* – It was reported that discussions have taken place with the external auditors in relation to the additional fees that E&Y have charged the Trust in respect to the 2023/24 audit. The Committee was provided with a breakdown of the costs and an overview of the reasons for the additional fees which amount to £25.6k (reduced from £31.5k following discussion).

The Chair advised of her disappointment in light of the request made by the Committee in April for an update from E&Y in the event of any changes to the cost of the audit. It was reported that the Committee is going to implement a process for the 2024/25 audit where a detailed plan is received from E&Y on a weekly basis to enable this area of work/costs to be monitored. **ACTION CLOSED**

Action 23/24.97.1: *Risk Tolerance and Appetite (Discussion to take place with Jill Preece re the inclusion of advocacy in the Risk Tolerance and Appetite report as a subset of Reputational risk. John Grinnell to be part of these discussions)* – Discussions are to take place with colleagues, including John Grinnell, and an update will be provided in January. It was pointed out that the Charity has launched its campaign relating to advocacy plans and it was felt that it would be beneficial to consider this work in order to have a clear understanding of where the Trust needs to position itself. **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)* – Discussions have taken place regarding how the Trust seeks assurance on clinical governance, and it has been agreed by the Executive to undertake mini-internal reviews using the Trust's CQC readiness plan. Suggestions were also made about producing a heatmap of the whole organisation to identify vulnerabilities/services that are struggling (which Will Weston is currently looking at) and having a more specific workstream around statutory processes and new CQC regulations. It was felt that it would be beneficial to submit a paper to SQAC to describe the

process and advise of the potential timescales. The Chair agreed to liaise with Fiona Beveridge (Chair of SQAC) regarding this matter**. ACTION TO REMAIN OPEN**

Action 24/25/44.1: *E&Y External Audit Year End Report on the Trust's Accounts for 2023/24 (Submit a formal response to ARC in the next three months which includes a recommendation to address the two high rated observations that relate to capitalised payroll and capital expenditure)* – The Committee received the Capital Improvement Plan which provided an update in respect to this action. **ACTION CLOSED**

Action 24/25/44.3: *External Audit Year End Report on the Trust's Accounts for 2023/24 (Capital is a key risk for the Finance, Transformation and Performance Committee (FTPC) - Include timing as part of the risk and oversight process for capital)* – It was confirmed that the FTPC will monitor this area of work going forward as capital is one of the Committee's top five risks. **ACTION CLOSED**

Action 24/25/44.4: *E&Y External Audit Year End Report on the Trust's Accounts for 2023/24 - Provide FTPC with an update on the outcome of the work that is being undertaken via the follow-up investment review)* - It was confirmed that performance against plan is monitored via the FTPC. **ACTION CLOSED**

Action 24/25/55.1: *Waiver Activity Report Q3&Q4 23/34 (Provide an update on the outcome of the joint work that is taking place with HPL on the retrospective look of purchase orders)* – It was agreed to submit the report compiled by HPL on the Trust's purchase order performance to the Audit and Risk Committee (ARC) in January.
ACTION TO REMAIN OPEN

Action 24/25/68.2: *Corporate Risk Register Report Overview (Corporate Risk 226 - Provide an update to FTPC on the outcome of the validation work that is being undertaken to check patient accounts to ensure that the Trust hasn't lost any income as a result of this issue/risk)* – A deep dive into corporate risk 226 took place during September's Risk Management Forum (RMF). As a result of mitigations being implemented, this risk has been reduced. A working group has also been tasked with overseeing this risk which is proving to be effective. It was reported that the team have undertaken a number of teaching sessions to raise awareness of this issue. **ACTION CLOSED**

Action 24/25/70.1: Chief Digital and Transformation Officer (*CDTO) Quarterly Updates for Data Protection (DP) and Freedom of Information (FoI) Act Compliance (Provide details of the nature of the FoI requests in future reports)* – The Chair agreed to liaise with the CDTO, Kate Warriner, to ask as to whether an appendix can be included in the quarterly FoI report to provide details of the nature of FoI requests that the Trust is receiving.
ACTION TO REMAIN OPEN

Action 24/25/72.1: *Annual Assurance Report for 2023/24 and Forward Plan for 2024/25 – Clinical Claims (Include trend analysis of the values of claims for the last five years and re-circulate the report to the Committee)* – The Chair agreed to liaise with Michelle Perrigo to confirm as to whether the amendments have been made to the 2022/23 Annual Clinical Claims Report. **ACTION TO REMAIN OPEN**

24/25/83 Update on the Risk Management Process within Research and Innovation

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

- Summary position as of October 2024 for Innovation;
  - Innovation currently has 4 open risks, of which, one is to be reviewed at the Senior Management Team meeting on the 10.10.24.
  - Research currently has 3 open risks. It was reported that 1 Clinical Research Division risk was closed in month following assurance at the Divisional Research Management Board that the Liverpool Joint Research Office activities are fully integrated into Divisional processes.
- Key governance structures for assurance, approval, decision making, and monitoring.
- The Committee was advised that the Research Department has a lot of patient facing risks that are discussed at the Divisional Assurance Group with an escalation route, if required, via the Research Management Board and Futures Committee. Risk is also discussed on a weekly basis by the Senior Management Team.
- The Innovation team don't have a Divisional Assurance Group therefore any risks identified are escalated via the Innovation Management Team and from thereon to the Futures Committee.
- A joint monthly team meeting takes place with the Associate Director of Nursing and Governance, Jackie Rooney. It was reported that the Research Team has a greater understanding in terms of addressing risk, and Clinical Research now participate in the Quality Assurance Round process. Discussions are to take place about whether this framework will fit the Innovation Team.

The Chair queried the process for raising awareness of risk across Research and Innovation for all staff. The Committee was advised that a monthly risk bulletin is circulated to staff in the Research Department and risks are displayed in the Clinical Research Facility. From an Innovation perspective, it was pointed out that further work is required on risk and there are plans to take this forward.

A question was raised about the preventiveness of the risk management process and whether it is stifling research and innovation. It was reported that the risks that relate to Innovation are legacy risks and work is going to take place to update them to reflect the current position. The Committee was informed that the risk management process is also being used to raise awareness of risk.

The Chair advised that the Committee has some learning to do in terms of the commercial aspect of risks relating to innovation and it doesn't want to curb R&I work, but attention was drawn to the importance of it being undertaken in a safe way. It was pointed out that the Trust will have to accept an appetite for risk otherwise it will hinder progress. Work is ongoing to evolve a governance process for Innovation in a way that doesn't stifle the experimental element of innovation. The Director of Corporate Affairs, Erica Saunders, reported that a discussion has taken place regarding risk appetite and tolerances and R&I are keen to adopt this process. The first step will be to develop a heat map and populate it with current information.

A suggestion was made about organising risk management training for the Innovation Team. It was agreed that a meeting will take place with Sarah Leo and Iain Hennessey to discuss this matter further.

24/25/83.1 Action: JR

The Chair asked that regular updates be provided to ARC on the roll out of risk appetite and tolerances.

Resolved:
ARC noted the update on the risk management process within Research and Innovation.

24/25/84 Board Assurance Framework

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

- In depth discussions have continued with the Trust's Assurance Committees.
- *Safety and Quality Assurance Committee (SQAC): BAF Risk 1.2 (Children and young people waiting beyond the national standard to access planned care and urgent care)* – The Trust has reported above national targets in terms of performance, urgent care has been strengthened as detailed in gaps and assurance, and a huge piece of follow up work has been undertaken which will update the gaps in control.
- *FPTC: BAF Risk 3.4 (Financial environment)* – The articulation of risks in terms of patient safety and quality is becoming more visible in the BAF as a result of the external financial environment. Regular discussions on the financial risk are taking place in numerous forums, including the Trust Board. This risk will change month on month and there is evidence that risk owners are taking this matter seriously. The RMF also review this risk on a regular basis.
- *BAF Risk 1.5 (Lack of visibility at Board level across the Gender Service)* – It was confirmed that risk 1.5 is to be updated in greater detail following a discussion with the Director of Community and Mental Health, Lisa Cooper.

Resolved:
ARC noted the content of the BAF for August 2024.

24/25/85 Risk Management Forum Update, including the Corporate Risk Register 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 23.9.24.

It was reported that the meeting was well attended, and a deep dive discussion took place into Risk 197; Gender Development Service (GDS) and Risk 266; Meditech Expanse - Surgery Division. Reference was made to the deep dive relating to GDS and it was pointed out that many of the risks currently associated with this service aren't specific to GDS and could equally apply to most services across the Trust therefore a challenge was put to teams to reflect upon this from their own service's perspective in order to be sighted on any potential/forthcoming risks.

The Committee was informed that a number of checks and challenges were undertaken to determine whether risks are being scored at the right level. Risk Owners present at the meeting provided reassurance that the risks are being managed effectively, with appropriate actions to mitigate them. It was pointed out that there is a lot of review work taking place on risks, especially around Medicine. It was reported that there are two interchangeable risks relating to anaesthetic cover in ED and on the wards that require mitigation, and there are fewer risks past the review date.

Corporate Risk Register

The Committee received the Corporate Risk Register (CRR) for the reporting period from the 1.7.24 to the 31.8.24. The following points were highlighted:

- There are a total of 19 high risks open during this reporting period.
- 1 new high risk has been reported in this period.
- There are 2 high risks with an increased risk score.
- 2 high risks have been reviewed and a reduced risk score has been applied.
- 1 high risk has been closed
- There are 12 high risks with a decreased risk score.
- There are 2 risks with no agreed actions plans, which have since been addressed.
- There are 6 risks with actions past their expected completion dates.
- All long-standing high risks (greater than 12) continue to be individually reviewed with risk owners.

JR asked whether the Winter Plan will help towards reducing some of the risks in the CRR and queried whether there is any relationship between the two documents. It was reported that some of the work that has been undertaken on the Winter Plan may prompt the triangulation of performance, waits etc in terms of the alignment to a risk but it was felt that it is important to ensure that both documents are synchronised as the Trust embarks on the Winter period.

GM queried whether the Trust has an awareness of the impact that system risks will have on the organisation, especially from a financial perspective. It was reported that a deep dive on partnership risks was undertaken at the RMF with the support of the Chief Strategy and Partnerships Officer, Dani Jones, and further discussions are to take place to provide more in-depth detail on broader system risks. The Trust is also working with some of its partners on risks too.

The Chair advised that the partnership risk has been removed from the BAF but pointed out that there are specific risks that will have more of an impact on the Trust, therefore it is necessary to look at how these risks can be articulated.

The Chair referred to the two high risks that have been reviewed and had the score reduced, and queried whether this action was slightly premature. It was agreed to look into this matter.

24/25/85.1 Action: JRO

Resolved:
ARC noted the RMF update, the CRR and the approved RMF minutes from the meeting held on the 24.6.24.

24/25/86 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 1.7.24 to the 31.8.24. The assurance presented in this report is a direct reflection of the evidence available on InPhase at the time of reporting. The following points were highlighted:

- There are 262 risks on the Trust Risk Register (TRR) for the reporting period. This is a decrease compared to the previous reporting periods.
- The highest number of risks remain in the moderate category (193) accounting for 73.6% of the total number of risks on the TRR. Proportionately, a decrease with 75.9% (202) reported in the previous report.
- There were 10 new risks identified in the reporting period, 29 risks closed, and 10 risks overdue a review. There are also 33 risks without an ongoing/agreed action plan, and 30.4% risks with overdue actions which is a 10 percentage point improvement compared to the previous reporting period (40.50%).
- Open dialogue continues in terms of challenging services/departments who declare they have zero risks, and risk management training has also been offered.
- Notifications for upcoming risk actions has been requested. This remains under review with InPhase and escalation has occurred via the Chief Nursing Information Officer. It was confirmed that the Executive Vacancy Panel approved the business case for the recruitment of the InPhase developer role.
- The Committee was advised that the number of open long-standing high-moderate risks/high-moderate risks with reduced scores have shown an improving trajectory since the last report presented at the RMF.

The Chair offered thanks for the update. It was felt that the general trend is that of an improving trajectory but drew attention to the 33 risks without an agreed action plan.

Resolved:
ARC noted the content of the paper and the level of assurance provided in the report.

24/25/87 Rollout of Trust Risk Appetite and Tolerances

An update was provided on the rollout of the Board approved risk appetites and tolerances. The next step in the process is for discussions to take place with the various teams across the organisation. It was reported that the Community and Mental Health Division has agreed to be the first Division to take this area of work forward therefore meetings are to be scheduled with Risk Owners to progress this. A report on the outcome of the work will be submitted to the RMF in February 2025 but the Committee was advised that the overall process Trust-wide will take approximately twelve months.

Resolved:
The Committee received and noted the latest position with regards to the rollout of risk appetite and tolerances across the Trust.

24/25/88 Fraud Risk Assessment Matrix

The Committee was advised that the Trust has undertaken a process to review and update its Fraud Risk Matrix using the format provided by the Government Counter Fraud Profession. Risks and themes remain consistent with the prior year, with the exception of strategic risks that have been included for 2024/25. Leads for each risk area have reviewed the risk assessment from the prior year to determine if the articulation of risk and mitigations remain relevant, and have updated them where appropriate. It was reported that risks ranked at 10 and above have been captured individually on the Trust's risk register.

The Chair drew attention to the lack of improvement in risk scores and queried as to whether Risk Owners are being held to account. It was reported that all leads have reviewed the

matrix in order to confirm/amend narrative and scores. The Committee was advised that risks around fraud are being actively managed/mitigated where possible, and will be managed on an ongoing basis via relevant risks on the risk register

Resolved:
ARC noted the update on the Fraud Risk Matrix.

Being the conclusion of the risk items, AB left the meeting.
LS left the meeting at 14:35 due to technical issues with Teams.

24/25/89 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the 2023/24 Internal Audit Plan during the period from July 2024 to September 2024. The following points were highlighted:

- There have been two reports finalised in this reporting period;
  - National Cost Collection – Substantial Assurance.
  - Fit & Proper Persons Requirements – Substantial Assurance
- The following reviews are currently in progress;
  - Equality, Diversity, and Inclusion – Fieldwork
  - Risk Management Core Controls – Fieldwork
  - Key Financial Controls – Fieldwork
  - E-Roster – Fieldwork
- There is one change to the Internal Audit Plan; removal of the ICB Expenditure Control Audit. This change has occurred due to the NHSE commissioning a detailed review of this area to be co-ordinated by C&M ICB and therefore an audit by MIAA is no longer required. As a result of this there now is spare capacity in the Internal Audit Plan.
- *National Cost Collection Review* – The review confirmed that the Trust is compliant with the latest NHS Costing guidance and submitted its National Cost Collection (NCC) in line with the required deadlines.
- *Additional information for the Data Security and Protection Toolkit* - The Accountable Suppliers Standard concluded as Moderate because of due diligence checks for third party suppliers not being evidenced as completed during the onboarding process and demonstrating that they are reviewed at least annually, and the roles and responsibilities of third-party suppliers and the Trust being fully documented. In line with NHS Digital audit guidance, if one of the Standards falls into Moderate Assurance this means that the whole assessment of the Standards is assessed as Moderate Assurance.

  The Chair advised that there were 6 non-contentious findings following a request by the Committee for further information and asked that the recommendations be included as part of the follow up process.

24/25/89.1 Action: KS

The Chair asked as to whether the NHSE system investigation and intervention review could be included in the Internal Audit Follow Up Process to enable the Committee to monitor the actions that arise from the audit, especially as it is a high-profile piece of work in the system. It was felt that the Trust has an established mechanism in place to report back on this area of work, but it was agreed to discuss this matter further outside of the meeting.

24/25/89.2 Action: KB/RL/GB/KS

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

24/25/90 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 July 2024 and September 2024. The following points were highlighted:

- MIAA are tracking 31 recommendations. Of the two which have fallen due in this reporting period, both have been confirmed as implemented.

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

24/25/91 Anti-Fraud Services Progress Update

The Committee received the Anti-Fraud Progress Report for the reporting period from the 12.4.24 to the 3.10.24. An overview of the content of the Report was provided and attention was drawn to the following key points:

- In September, the NHS Counter Fraud Authority (NHSCFA) announced as part of their Fraud Hub Stakeholder Engagement work planning for 2024/25, that they will be undertaking engagements with organisations to discuss performance and effective practice and support organisations with their counter fraud work. As part of the of this work they are undertaking an exercise which will focus on NHS Requirement 9: Access to Trained Investigators. The exercise initially consists of a questionnaire, which the AFS completed and submitted on 27.09.2024. The answers to the questionnaire will help the NHSCFA Specialist Learning Team identify any potential gaps in training and development.
- The Counter Fraud Functional Standard Return (CFFSR) submission against the Government Functional Standard 013 for Counter Fraud was submitted on 28.05.24, in line with the national deadline. The Trust received a Green rating overall and across all 12 components. The return was reviewed and approved in advance of its submission by the Director of Finance and the ARC Chair.
- Current compliance figures for staff completion of the fraud module are 98.78%.
- The AFS commenced the two NHSCFA National Procurement Exercises for 2024/25 in relation to Due Diligence which is at the draft stage, and Contract Management which is in progress. The national deadline for submission of outcomes from the exercise has been extended by the NHSCFA from 30.09.24 to 08.11.24. An update on the exercises will be provided in January 2025.
- A total of 70,471 creditor matches were identified during the exercise. 69,113 matches have been acknowledged and actioned by Finance staff, which identified a total of £516,738.44 of duplicate payments/overpayments. The majority of these have now been recovered.

The Chair asked for an update on the issue relating to a member of staff who had left the organisation nine months previously but still had ownership of a lease car. It was reported that the process for salary sacrifice has since changed, and a quarterly review now takes

place. A member of the team is also liaising with ELFS on this matter too. Following discussion, it was agreed to submit a briefing to provide further detail on this event and the actions taken to address this issue.

24/25/91.1 Action: RL

The Chair requested that recommendations from the National Procurement Exercises (Due Diligence and Contract Management) and follow up be included in future Anti-Fraud Services Progress Reports.

24/25/91.2 Action: VM

Resolved:
ARC received and noted the Anti-Fraud Progress Report for the reporting period from the 12.4.24 to the 3.10.24.

24/25/92 Auditor's Annual Report Year Ended 31.3.24

The Committee received the final version of the Auditor's Annual Report for year ended the 31.3.24. Attention was drawn to the point made by the auditors about E&Y having to report to the National Audit Office on the Trust's arrangements, and a question was raised about the purpose of this. Following discussion, it was agreed to raise this matter with the auditors and provide the Committee with an update. The Chair also felt that it would be beneficial to receive feedback from the auditors on the analysis that is generated from the Trust's data that they collect.

24/25/92.1 Action: RL

Resolved:
ARC received the final version of the Auditor's Annual Report for year ended the 31.3.24.

24/25/93 Capital Improvement Plan

The Committee was provided with an update on the progress that has been made against the Capital Improvement Plan in order to provide assurance ahead of the year end. The following points were highlighted:

- A Capital Management Group was established in April 2024 which it was reported has been very effective. Respective leads attend the meeting to provide regular updates on schemes and discussions take place regarding challenges/risks to future spend.
- A Capital Improvement Plan was agreed with the Committee in June 2024 to ensure that the recommendations made by the auditors were actioned. A total of 11 actions were agreed and, as at the end of September:
    - 6 are now complete in line with the timeframes agreed.
    - 4 are partially complete with further work in progress.
    - 1 is on track to be completed by March 2025 in line with timeframe agreed

An update on the five outstanding actions was provided, as detailed in Appendix A to the report. It was agreed to submit the Capital Improvement Action Plan to the Committee in January to provide a further update.

24/25/93.1 Action: RL

The Chair asked as to whether the organisation is assured that the appointed Quantity Surveyor is qualified to undertake valuations. It was reported that the Trust commissions a

different qualified company for each project that it undertakes. It was pointed out that the initial issue related to valuations not being completed within the appropriate timeline. It was confirmed that the team are now aware of the process and dates.

Reference was made to action 7*(for all capital bids, agree and implement a SOP which outlines a criteria and process before the bid is submitted)* and it was queried as to whether the criteria will include a process that will determine the capital impact on the Trust's accounts prior to submitting a bid. It was reported that a decision document has been established to clarify the purpose of the bid, timeframes, and whether it is deliverable. This document is then submitted to the Executive for approval ahead of compiling a business case to ascertain costs. Work is also being undertaken with R&I to focus on specific exclusions to ensure they don't have an impact and stop work being progressed.

The Chair asked as to whether there are any bids in the pipeline that could be problematic. It was confirmed that there aren't, but attention was drawn to digital funding that might be available in March with the caveat that it is used by the 31.3.25.

Resolved:
ARC noted the update on the Capital Improvement Plan.

24/25/94 Clinical Audit Mid-Year Progress Report

The Committee was provided with oversight and assurance that the Trust's clinical audit activity is progressing in line with Plan to support improvements in patient care and outcomes. The following points were highlighted:

- At the time of reporting a total of 18 nationally mandated audits are included on the Trusts Clinical Audit Plan for 2024-2025.
- 2 national audits were completed in-month; Testicular Torsion and National Comparative Audit of Blood Transfusion. It has been requested that the Surgical Governance Team and Urology Surgical Team undertake a baseline assessment against key recommendations in the Testicular Torsion Study Report 'Twist and Shout'. The outcome of the assessment will be fed back via CEOG in October 2024.
- Epilepsy 12 (cohort 6) Audit and National Paediatric Diabetes Audit (NPDA) are currently now on track with timely submission of 2024/25 data requests.
- The UK Renal Registry Annual Report noted several gaps in the data fields from the Trust due to IT issues. This has been escalated to the Digital Team and a scoping meeting has been scheduled to take place w/c 7.10.24. A plan of support has been developed with indictive timescales of 8 weeks proposed for the design and implementation of the data collection forms in Meditech.
- At the time of reporting there was 1 internally chosen regional audit for the Surgery Division.
- There were 90 identified local Divisional Audits registered between April 2024 and September 2024. It was confirmed that these audits are being monitored with the Divisions.

Reference was made to the ongoing challenges with the submission of data for the UK Renal Registry Chronic Kidney Disease Audit, and it was queried as to whether the pressure on Resident Doctors is having an impact in terms of their time for uploading data. It was reported that this matter relates to a number of issues; systems not linking in with each other resulting in missing data, submissions taking up to fifty minutes to complete,

etc. The Trust now has oversight of the level of detail that is required, and this is escalated on a quarterly basis to the respective Divisional Lead to ensure support is provided if necessary.

The Chair offered thanks for the update and advised that the Committee felt much more assured on this area of work.

Resolved:
ARC noted the Trust-wide Clinical Audit Programme activity for the report period; 1.4.24 to the 30.9.24.

24/25/95 CIO Quarterly Updates for Data Protection and Freedom of Information

Resolved:
ARC received and noted the:

- Data Protection update for Q2.
- Freedom of Information update for Q2.

24/25/96 Compliance with the Procurement Act 2023

The Committee was advised that compliance with the Procurement Act 2023 requires organisations to make key changes to their processes, culture, and behaviours. HPL have informed organisations that they plan to provide training ahead of the Act going live in February 2025, and have submitted a paper to their Board detailing areas for consideration when preparing for compliance. It was confirmed that HPL will provide a report to all Audit Committees in due course.

Further clarity is required on a number of matters therefore HPL are looking into relevant areas to ensure consistency and will provide trusts with an update in January 2025. It was pointed out that as a result of key changes to the Procurement Act 2023 the Trust's SFIs will need to be updated.

Resolved:
ARC noted the update on the changes to the Procurement Act 2023.

24/26/97 Update on Progress Against Actions from the ARC, IA and EA Assessment Reviews

The Committee was provided with an update on the progress against actions to date. It was reported that satisfactory headway has been made in implementing the actions from the ARC self-assessment and the effectiveness reviews of Internal and External Audit.

The Committee was informed of the intention to undertake the the first formal effectiveness review of the Anti-Fraud Service, a detailed self-assessment review of ARC and a 'light touch' single question review of Internal and External Audit. The timeline for this work is from October 2024 through to March 2025.

Resolved:
ARC noted the progress against the actions to date.

24/25/98 Financial Governance Policy

A report was submitted to the Committee that set out a proposed update to the Trust's Financial Governance Policy to reflect recent changes to financial governance in line with

best practice. The Committee was provided with an overview of the key changes to the policy, as detailed in the report.

The Chair queried as to whether the FTPC are agreeable to the increase in business case approval limits to £250k. Following discussion, it was agreed to discuss this matter with the Chair of the FTPC, to gain his steer.

24/25/98.1 Action: RL

Resolved:
ARC approved the proposed changes to the Financial Governance Policy pending agreement from the Chair of the FTPC re the increase in business case approval limits to £250k.

24/25/99 Waiver Activity Report

The Committee received an update on waiver and waiver exemption activity across the Trust within Quarter 1 and Quarter 2 of the 2024/25 financial year.

It was reported that there was a total of forty-five waivers signed off in Q1 and Q2, the total value of these waivers was £4,028,312.73. There were sixteen tender waivers that exceeded £50k, and twenty-nine quotation waivers between £20k and £50k. The Committee was provided with a summary of waivers signed off in Q1 and Q2.

The Chair felt that the report provides more detail as a result of the new format, but queried as to whether a graph could be included to track the reduction of waivers/retrospective purchase orders and benchmark the Trust against other organisations across HPL(HPL). It was agreed to look into this matter.

24/25/99.1 Action: EK/RL

A discussion took place about the importance of raising awareness across the Trust in terms of raising purchase orders and waivers in advance, and a suggestion was made about setting a target to help support the reduction of waivers and retrospective purchase orders. The Committee was advised that a meeting has been scheduled with HPL to discuss an action plan to take this area of work forward. An overview was provided of some of the challenges that the Trust experiences; having time to go out to tender, purchasing goods of a special character where it is not possible or desirable to obtain competitive quotations.

Resolved:
ARC received and noted the content of the tender and quotation waivers for Q1 and Q2, 2024/25.

24/25/100 Any Other Business

There was none to discuss.

24/25/101 Meeting Review and Forward Look to the Next Meeting

The Chair drew attention to the Committee meeting schedule and advised that a balanced number of meetings will take place in person and via Teams in 25/26. It was confirmed that there will be no hybrid meetings when the Committee is scheduled to meet in person.

Date and Time of the Next Meeting: Thursday 15th January 2025, 2:00pm-5:00pm, Room 14.

BOARD OF DIRECTORS

Thursday 6th February 2025

Paper Title:	**Chair's Report from the Finance, Transformation & Performance Committee meeting held on 27th January 2025**
Report of:	**John Kelly Committee Chair**
Paper Prepared by:	Amanda Graham, Executive Assistant

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☑ ☑ ☐
Action/Decision Required:	To note To approve	☑ ☑
Summary / supporting information:	Finance, Transformation & Performance Committee minutes from the meeting that took place on 16th December 2024.	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care **Support** our people **Pioneering** breakthroughs **Strong Foundations**	☑ ☐ ☐ ☐ ☐ ☐
Resource Implications:	None	

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF Risks	1.2, 1.3, 1.4, 3.1, 3.2, 3.4, 3.6, 4.2					
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Introduction

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

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

- Top Five Risks update
- M9 Financial update including forecast for year end
- Overview of 2025/26 annual plan process
- Sunflower / Catkin parking business case & ASD assessment business case
- M9 Integrated Performance Report
- Divisional performance updates to M9
- Campus update

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

- Potential risk within 2025/26 Planning Guidance around ERF cap on activity in 2025/26 – Finance team working through scenarios to assess impact.
- ICB approach to Capital to be discussed ahead of Trust Board
- Potential risks emerging in NICU development re completion – awaiting formal notification but not expecting cost implications
- Expected delay of up to 4w for Elective Hub due to building control process, being mitigated by discussions taking place with NHSE

4. Positive highlights of note

- Approval given to Sunflower / catkin parking business case.
- Approval given to ASD assessment business case.
- Detailed discussion on planning for 2025/26 & considerations required for Alder Hey. Agreement to undertake full deep dive at FTPC in February ahead of the submission in March

5. Issues for other committees

- None noted

6. Recommendations

The Board is asked to note the Chair's Highlight report for the Finance, Transformation & Performance Committee meeting that took place on 27th January 2025.

Finance, Transformation and Performance Committee
Minutes of the meeting held on Monday 16th December 2024 at 15:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive Director	(SA)
	Dame Jo Williams	Non-Executive Director	(JW)
	Adam Bateman	Chief Operating Officer	(AB)
	Rachel Lea	Director of Finance & Development	(RL)
	Melissa Swindell	Chief People Officer	(MS)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Katherine Allsopp	Associate Director of People	(KA)
	Nathan Askew	Chief Nursing Officer	(NA)
	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)

24/25/139 Apologies
Apologies were noted from:

Audrey Chindiya	Associate Finance Director	(AC)
John Grinnell	CEO	(JG)
Jayne Halloran	Deputy Development Director	(JH)
Dani Jones	Chief Strategy & Partnerships Officer	(DJ)
Erica Saunders	Director of Corporate Affairs	(ES)
Gary Wadeson	Associate Finance Director	(GW)

24/25/140 Minutes from the meeting held 2nd December 2024
The minutes were approved as a true and accurate record.

24/25/141 Matters Arising and Action log
Actions not on the agenda for further discussion were updated.

24/25/142 Declarations of Interest
There were no declarations of interest.

24/25/143 Top 5 Risks

1. **Immediate financial performance including system position**
Planning guidance still awaited. Currently away from plan largely related to pay awards; detail on M8 will follow. Large challenge within Divisions; System aim is to hit the revised trajectory at Y/E, however now also off-plan against that trajectory. ICB experiencing challenges in Pharmacy spend. Expecting an ERF restriction based on M7 forecast.
JW requested if the Children's Health Alliance is involved in discussion regarding the ERF cap for CYP. RL noted that this is on CHA Finance Group agenda and will be discussed. There is a risk that if we go above, we will not be paid.
SA asked whether achieving activity but having cap on payment is detrimental to financial position as we would continue to deliver; RL noted that this is the case if the activity was to continue without payment.

JK asked if the impact of activity required vs forecast can be assessed; RL noted that this is being checked for M7, but that next year will be modelled once the planning guidance is received. In year is manageable, but 2025/26 will be more challenging.

2. **Capital Programme**
Two business cases on agenda for discussion. An asset register cleanse has been undertaken resulting in a loss of disposal charge which is included in the current forecast. Bids continue to be submitted for decarbonisation, saving revenue in future years and 25/26 potential elective recovery (with short turnaround).

3. **Efficiency Programme**
Currently reporting to achieve in year, recurrent CIP slightly up at £13m but below where we need to be for Y/E. The programme is already in development for 2025/26, asking Divisions for effective targets / schemes; also, the Transformation team for 2030 programme have been asked to align efficiency savings against transformation.

4. **Benefits realisation, governance and prioritisation of change programme to 2030**
NP gave a presentation detailing benefits across the programme. Plans are ongoing to develop new programme for 2025/26, so the aim is to complete as many as possible. There are currently 17 high risk actions that are delayed, with 69% either at medium risk, on track or to be completed.

JK asked for a percentage of overall benefit to be shown for each action.

24/25/143.1 Action: NP

Martha's Rule pilot expected to commence in December. Workforce actions were on track apart from two which depend upon external capacity; mitigations are expected to be in place for these in the next quarter. Futures has some completed actions and some higher risk – AB noted that the Transform Pillar is in good shape, but that recruitment for future researchers & innovators may be an issue due to ICB workforce controls. Most actions within Collaborative Communities are met, but Green is outstanding with high risk due to the departure of the Programme Manager with mitigations in place to recruit the necessary expertise. RL added that plans were in place to cover the gaps within this team.

JK noted that if 20-30% of activity is to be community-based, there are not enough resources or capacity to support this shift; NP replied that there are plans with Divisional teams to work through this and will bring outcomes to a future meeting.

24/25/143.2 Action: NP

Revolutionising Care, Treat More Children and Home First are all mainly on track. Outpatient Transformation is progressing with some changes needed to the scope moving forward. Digital Highway milestones are generally on track with no major risks.

JK noted that this was a useful way to review the programmes but consideration needs to be given to tracking multi-year ambitious programmes, also noting that some Futures actions are operational such as leadership; AB and SA responded that mobilising was the first priority, with recruitment being an issue for leadership roles.

5. The Campus & Park developments

The Campus paper outlines progress, with an annual review & look back of schemes. Two risks – construction completion dates for the elective hub & Alder Park. Elective hub challenge is relating to endoscopy work, as a structural issue necessitates a redesign, so this won't be fully complete by Y/E.

JK noted that the importance of completion by year end to manage capital programme. RL noted the capital programme is monitored closely bringing forward medical equipment spend where appropriate.

24/25/144 Finance Report

Month 8 Financial Position

EK gave an overview of the financial position as at M8, noting the following:

- Challenging M8, reporting broadly on plan in month driven by adverse within clinical divisions being offset by underspend in Community and brought-forward future benefits.
- Lots of work ongoing to ensure forecast positions do not slip too much over next few months.
- WTE over plan with future meeting planned with HR and Nursing to discuss plans going forward.
- Capital bids are being requested & submitted on very short turnaround however looking to secure additional capital where appropriate to manage ongoing capital restrictions and risk.

RL noted risk on cash in system and agreement for further discussion in that at Trust Board.

24/25/144.1 Action: RL

Resolved:

FTPC received and noted the M8 Finance report.

24/25/145 5-Year Capital Plan

1. Second CT Scanner Business Case

Business case presented for the purchase of a 2nd CT scanner following the major incident last year to ensure resilience for major trauma or critical incident, but also to support the mobilisation of the new scanner coming in and to significantly reduce downtime. Discussion took place on revenue costs and the requirement to allocate CDEL given the critical need to have a 2nd scanner. This may cause Trust to go above the current CDEL limit although it was noted that this had been flagged to ICB and a bid had been submitted. Discussions with charity also underway for options on funding.

JW noted agreement & wish to approve to allow process to move forward ASAP.

GW noted risk re income due to potential changes next year.

NA noted a need to understand replacement timescales to ensure phasing of replacement of key equipment as risk regarding this taking place at the same time in the future. Also noted ensuring maximum utilisation through other opportunities i.e. non-NHS etc.

AB noted aspects of business development around the second scanner. We cannot have scanner downtime or a scanner in the carpark because of major trauma needs, it's just not appropriate so a second scanner gives resilience but needs to be viable, sustainable & work hard to offset investment.

2. Alder Park Business Case

RG gave a brief overview of the business case for investment in full development of Alder Park (formerly the Dewi Jones unit). The Trust has received a capital allocation from NHSE for the development of an ED day-case unit, based in buildings at Alder Park however seeking to realise development of the full site. The impact & mitigations of the funding gap between the capital allocation & the costs are contained within the paper.

JK noted the future proofing of the development and additional capacity this creates and importance of ensuring rationalisation of estate and future use.

KW suggested clinical transformation for OPD; RG replied that this has been considered that in the design, with more consulting / examination rooms & more clinical space than that just for Physio / OT / SALT teams, so there is some growth ability & capacity.

Resolved:

FTPC received and approved the Second CT scanner and Alder Park business cases.

24/25/146 Month 8 Integrated Performance Report

AB gave an overview of the IPR as at M8, and highlighted the following:

- Position has decompressed from November but still challenging in Critical Care, with occupancy and ED improving over the last ten days.
- Expecting December to be better than November performance-wise but expecting high demand to return mid-January into February.
- IPR shows great performance in Diagnostics and productivity.

MS gave an overview of the Workforce position, noting that conversations have been held with the Executive team on managing the workforce numbers and potential options to manage both short term and long term. trying to work through workforce reductions such as recruitment freeze. Proposal to introduce an affordability cap and encourage new ways of workign through use of technology. This will be form part fot he 25/26 efficiency programmes and further detail o be shared.

MARS scheme to be discussed in NEDs meeting

24/25/146.1 Action: JK / SA / JW

JK noted that there appears to be less grip on Corporate areas than within clinical areas; RL replied that the leads for these areas are to be reviewed alongside development of a refreshed review process.

24/25/146.2 Action: RL

Resolved:

FTPC received and noted the M8 Integrated Performance report.

24/25/147 Board Assurance Framework

The BAF report was included in the meeting pack. The digital risk score has been updated in light of recent events, with work ongoing to reduce level and a paper will be aken to the next Audit & Risk Committee in January. RL noted that expected and planned financial changes will impact scores which will be updated for January.

Resolved:

FTPC noted risks recorded within the Board Assurance Framework.

24/25/148 Any Other Business
No other business was recorded.

24/25/149 Review of Meeting
The Chair noted that the brevity of the meeting, adding that there are big things to look forward to, and that it feels like everyone is doing the right thing at the moment.

Date and Time of Next Meeting: Monday 27th January, 1pm rooms 2/3 Innovation Park.

24/25 FTPC Key Risks – Month 9 Position

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M9
Financial Performance including system position	Challenging 24/25 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High	Month 9 position reported £0.6m adverse to plan in month and a £1.1m deficit to plan ytd. In month medicine and surgery were off plan, however this was offset by community and corporate underspends, and technical benefits (circa £1.4m) supporting the position. Forecast for year remains in line with plan £3.3m, however following another challenging month, the trust has submitted a risk adjusted forecast to the ICB of £2.2m. A number of mitigations are being explored, including finance improvement workstreams (workforce, drugs, coding) as well as increased technical improvements, income opportunities and programme/vacancy slippage giving the trust assurance to continue to report a forecast a risk adjusted forecast of £2.2m. System gap remains with ongoing national discussions . Weekly gold command now in place FICC return from all providers.	High
Capital Programme	Limited CDEL allocation in 24/25 Significant capital investment required and prioritisation required.	Medium	Capital broadly on plan YTD however forecast is ranging from -£0.9m underspend to £2.9m overspend against budget, following decisions to progress with AlderPark second floor, second CT and bring forward £1.3m of urgent medical equipment spend from 25/26 (in order to manage risk of underspend at year end). National funding has been granted for LED lights (£0.5m), and Lab equipment (£0.2m) which will be added to the forecast for M10. Several national funding bits submitted still outstanding (e.g 2nd CT scanner, and Digital bid). Conversations ongoing with ICB around potential for further additional capital. Final capital position will be driven by progress on major capital schemes, and review of all remaining planned spend, and accruals. Position to be closely managed between now and year end.	Medium
Efficiency Programme	Plan assumes delivery of £19.3m recurrent savings. Highest level set in any one year. Managing of message to organisation alongside delivery of 2030 vision.	High	M9 reporting ahead of plan and forecast to achieve in full in year. Recurrent CIP forecast now stands at £14.7m (green and amber schemes) significantly higher than previous year achievements. Planning underway for 25/26 CIP development	Medium
Benefits Realisation	New benefits realisation framework launched to ensure delivery of benefits across all programmes.	Medium	We have completed a stock-take on our approach to 2030 delivery and the results from the which have been reviewed alongside the benefit review and assessment on our delivery milestone.	Medium
Campus	Complex campus programme across multi sites.	Medium	All schemes progressing as detailed in the Campus Update within the full Committee pack. Two risks are highlighted for the attention of Committee members in relation to construction completion dates for Elective Surgical Hub and Alder Park (EDYS).	Medium

BOARD OF DIRECTORS

Thursday, 6th February 2025

Paper Title:	**Board Assurance Framework (BAF) Report December 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 December 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 10th January 2025

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	4x2	3x2
3.2 KW	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	FT&P	4x3	4x2
3.4 RL	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	**4x4**	2x4

4. Summary of December 2024 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  BAF 1.1 has been reviewed. Gap in assurance and action 3 relating to ionising radiation is now closed. The working group have provided all information relevant to the action plan and the removal of the enforcement notice has now been received. Risk 1.1 will be updated in light of the next phase of delivery on 2030 vision.

- ***Lack of visibility at Board level across the Gender Service (LC).***
  BAF risk reviewed and actions up to date. Quarter 2 reported presented to SQAC and submitted to NHSE. All assurance reports to also be added to risk evidence.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  Review of BAF risk and actions completed. Work remains ongoing to support children & young people to access medication despite national shortages. Ongoing discussion with executive team regarding support needed. Pilot due to commence providing medication for children identified at risk. Update paper to be added to documents.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in October maintains above the national standard of 78%, achieving 83%.

  Capacity to reduce long waits (RTT) continues to remain the focus for services. The access target for 24/25 is to have a maximum of 278 patients waiting over a year for treatment by March 2025. The trust is currently on track to achieve this target with 251 patients waiting over a year.

- ***Building and infrastructure defects that could affect quality and provision of services (AB).***
  Meetings with Project Co-partners and execs over corroded pipework have taken place to discuss the future repair/replacement of the affected areas. Further meetings are planned and to date good progress has been made.

  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.

  Green roof works are now complete.

- ***Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (LC).***
  BAF risk reviewed and actions updated as required. Issues relating to MHSDS and reporting remain and additional support in place temporarily within digital team to report. Full review of BAF risk to be undertaken when MHSDS issues are resolved.

- ***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 reviewed and work continues to update in line with the 2030 Vision.

- ***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 controls and actions reviewed and updated. No change to risk rating.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risks reviewed. Head of EDI will be full time at the Trust as from May 2025 increasing resource. Work is underway to develop leadership opportunities for staff with protected characteristics. EDI Objectives for 2025-2028 set and awaiting approval. All equality reporting on track. We continue to progress the implementation of the NHS EDI Improvement Plan.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk Reviewed. No change to score. Phase 3 on target for completion 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).***
  Following the Strategy Board session in December 2024, the leadership team has prioritised a significant amount of leadership capacity for the development of the emergent strategic programme. Key mitigating actions include:

  Development of a comprehensive milestone plan with a focus on delivering actions between now and March 2025.
  Oversight and management of these actions by the Executive Team to ensure alignment with strategic objectives.

  Intention to finalise the 24/25 single-year programme and multi-year strategic programmes by March 2025, enabling rapid delivery as we transition into the new financial year.

  This approach is expected to mitigate the risk of failing to deploy the strategy effectively by ensuring clear leadership, actionable milestones, and robust oversight.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***
  Risk reviewed with no changes to the risk score. Actions reviewed and still underway with most due to be completed by March 25.
  Ongoing reporting of financial position and forecast through FTPC. Annual planning for 25/26 is underway with planning guidance yet to be shared however local discussions with ICB no principles and approach to inform initial submission due February/March.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; no change to score in month. Controls and actions updated. Key discussions inc. ICB leadership scheduled for Jan 25.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***

All actions reviewed and updated. Investment Zone application has progressed through external panel with internal review planned for Feb 25 and final decision expected in March 25. Delay with sign off of Futures comms post. No change to risk score in month.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***
  Cyber Recovery plans still in progress and will be reviewed at Audit and Risk Committee. Cyber resources, toolsets and protocols all under review in light of incident. AlderCare development roadmap established and will be reviewed via relevant committees in January.

5. Corporate risks (15+) linked to BAF Risks (as at 6th January 2025)

There are currently 24 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	There will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres, Major Trauma, specialist surgery, burns and ECMO. Inability to provide 24/7 haematology laboratory service.	5x5	Medicine	2.1	Jul 2021	Mar 2024
2635	Risk to business continuity of radiography services trust wide due to staffing availability and skill mix resulting in interruption to elective services and delay to non-elective services	4x4	Medicine	2.1	May 2022	Oct 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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post.	4x4	Medicine	2.1	Feb 2023	Oct 2024
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	2.1	Apr 2023	June 2024
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	4x4	Community	2.2	Feb 2023	*Apr 2023
117	Safe follow up care	4x4	Business Support	1.2, 2.1 & 2.2	Dec 2023	Dec 2023
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	4x4	Community	1.6	Jun 2024	Jun 2024
253	Loss of GRID posts	4x4	Business Support		Sept 2024	Sept 2024
2606	Children at risk of a decline in clinical condition requiring Emergency Department attendance and/or Hospital admission	3x5	Community		Apr 2022	Sept 2024
2704	Potential reduction in ultrasound service provision	3x5	Medicine	2.1	Oct 2022	Sept 2024
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support	1.2, 2.1 & 2.2	Feb 2024	Feb 2024
173	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties	3x5	Business Support		Mar 2024	Mar 2024
189	EPRR Assurance Non-Compliance	3x5	Business Support		Jul 2024	Jul 2024
271	Safeguarding Nursing Team Capacity	5x3	Community	2.1	Nov 2024	Nov 2024
299	Nurse Led Ultrasound for Nephrology ***(NEW)***	3x5	Medicine		Dec 2024	Dec 2024
288	CAMHS Planned Safeguarding Supervision ***(NEW)***	3x5	Community	2.1	Nov 2024	Nov 2024
2491	Risk of burnout of current workforce ***(NEW)***	4x4	Community	2.1	Sep 2021	Nov 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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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
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	There will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres, Major Trauma, specialist surgery, burns and ECMO. Inability to provide 24/7 haematology laboratory service.	5x5	Medicine	1.1	Jul 2021	Mar 2024
2704	Potential reduction in ultrasound service provision	3x5	Medicine	1.1	Oct 2022	Sept 2024
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.2	Aug 2022	Jan 2024
117	Safe follow up care	4x4	Business Support	1.1, 1.2 & 2.2	Dec 2023	Dec 2023
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	1.1	Apr 2023	June 2024
2100	Risk of inability to provide safe staffing levels due to absence.	4x4	Business Support	1.1	Jan 2020	*Apr 2023
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a	4x4	Medicine	1.2	Feb 2023	Oct 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post.					
2635	Risk to business continuity of radiography services trust wide due to staffing availability and skill mix resulting in interruption to elective services and delay to non-elective services	4x4	Medicine	1.1	May 2022	Oct 2024
271	Safeguarding Nursing Team Capacity ***(NEW)***	5x3	Community	1.1	Nov 2024	Nov 2024
288	CAMHS Planned Safeguarding Supervision ***(NEW)***	3x5	Community	1.1	Nov 2024	Nov 2024
2491	Risk of burnout of current workforce ***(NEW)***	4x4	Community	1.1	Sep 2021	Nov 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					
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 Programme	4x4	Surgery		Aug 2022	Feb 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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)						
229	PIMP end-of-life server which is no longer supported by the supplier	4x4	Business Support		Jul 2024	Sep 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..

Jan 2025	
Control Description	Control Assurance Internal
Monitoring of KPIs at SQAC and within divisional governance structures	Monitored monthly through SQAC
The Trust has a quality improvement programme 'Brilliant Basics', where quality improvement is at the heart of everything we do and provides staff with the skills, knowledge and confidence to learn, lead and deliver in an improvement style.	Formal and informal training and coaching available to support departments to make positive changes. Outcomes shared through the SharePoint site and reported to board bi-annually against agreed plan.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I).	Annual QIA assurance report
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes.
The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Patient safety meeting actions monitored through SQAC
Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
The STAT education and training program is in place in theatre to improve safety awareness and culture	monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC
Proactive programme of work in place to reduce medication errors	Monitored via Patient Safety Board

Gaps in Controls / Assurance
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis 2. Robust reduction programme in the number of medication incidents and near misses 3. The CQC will move to a new oversight framework which may reduce our CQC ratings 4. The 2030 vision sees a shift towards and experience led organisation without additional resources for delivery of the plan 5. The new models of care workstream will need to redefine the delivery of services whilst maintaining the principles of the strategy 6. Alder Care (Expanse) has been implemented across the organisation which poses risks until stabilisation.

Action	Description	January 2025	
2. Medication Errors and Near Misses	2. Proactive programme of work in place to reduce medication errors (no further controls required, monitoring controls are in place)	31/03/2025	no further controls required, monitoring controls are in place Dashboard in place with insight into the causes of medication errors and a proactive reduction plan monitored through Patient Safety board.
3. New CQC Assessment Framework	3. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2025	Monitoring control in place - no further controls required 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
5. New Models of Care	5. Clinical leaders will need to be appointed to oversee the process and provide challenge on the principles of the strategy	31/03/2024	Clinical summits have been held which will prioritise the changes that will have the biggest impact.
6. Alder Care (Expanse)	6. 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,.
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 (no further controls required, monitoring controls are in place)	31/03/2025	no further controls required, monitoring controls are in place There has been improvement in administrations times which continue to be monitored through SQAC to embed improved performance.

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 modeling undertaken during March 2023 shows that a small number of specialties have a long term challenge relating to waiting times for planned care.

Jan 2025	
Control Description	Control Assurance Internal
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	Daily reports to NHS England -@ Daily Performance summary -@ monthly Performance report to Operational delivery group -@ Performance reports to 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 SALT -@ 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	
Control for overdue follow up Working group established which focus on eliminating patients waiting over 2 years past their intended review date by March 25	Fortnightly meeting - Group has created a process for recording clinical validation and automated part of the process to reduce workload - follow up dashboard created on power bi and speciality data packs created - Specialities with the highest volume will present to safe waiting list programme board

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	January 2025	
Follow up working group	Aim: zero patients waiting >2 years for a follow up appointment by March 2025 Tasks: Submit paper to request funding to undertake clinical validation - complete, funding granted Follow up dashboard to track progress - in development Specialty-specific action plans to achieve zero patients waiting over 2 years for a follow-up. - specialities with a high volume are due to present at safe follow up programme board	31/03/2025	
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. All services working towards zero 65 week waiters by 31st March 2024. Particular concern in ENT, Dental and Spine where additional investment continues in insourcing and theatre time protection for services.
Urgent and Emergency Care Standards	Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	31/01/2024	

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

Jan 2025	
Control Description	Control Assurance Internal
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations. Review of the action plan takes place monthly to ensure all remains on track.	
Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact.	
Regular oversight of issues by Trust committee (FT&P)	Monthly report to FTP on progress of remedial works
Trust Board aware of the ongoing status and issues.	Monthly report to Board on mitigation and remedial works
Gaps in Controls / Assurance	
Remedial Works not yet completed; lack of confidence in timescales being met.	

Action	Description	Due Date	January 2025 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
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

Jan 2025	
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
Ongoing attendance at Cheshire and Merseyside Mental Health Workforce Planning groups	- Reviewed attendance across the range of meetings and Alder Hey lead/s identified - Feedback loop agenda item as part of Mental Health Business Meeting - Cheshire and Merseyside Lead attends Alder Hey business meetings.

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	January 2025	
		Due Date	Action Update
Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	30/04/2025	
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting Extended date due to MHSDS work ongoing.	31/01/2025	
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/03/2025	
Review of RTT performance trajectories and improvement plans for Liverpool and Sefton CAMHS	Performance trajectories and improvement plans to be produced and shared at Access to Care on a regular basis to track progress. Latest date for performance (Sefton) to be met end of September 2025. Liverpool's trajectory in progress - capacity and demand underway to be reviewed monthly as part of BAF Risk Review	30/09/2025	

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
		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.

Jan 2025	
Control Description	Control Assurance Internal
Dedicated communications lead and communications plan in place to manage internal and external communications and media.	Internal and external communications plan
Monthly Operational and governance meeting to be in place to review service delivery and escalate key issues to Division and Trust Board.	Divisional governance meeting minutes
All identified risks within the Gender Service are reflected on the risk register. Appropriate controls and actions are in place and are reviewed on a fortnightly basis with Gender Service Senior Leadership Team.	risks on InPhase being managed closely
Regular operational performance report (to be further developed as the service embeds) to SQAC	Operation Performance Reporting
Regular reports to Parts 1 and 2 of Board from Director Community & Mental Health Services on development of the GDS within Alder Hey and nationally, and on the relationships with other providers	Board reports received

Gaps in Controls / Assurance
o Extensive media attention o Risk of involvement with a range of legal proceedings o Unknown changes or asks to the service

Action	Description	Due Date	January 2025 Action Update
Annual Review of Gender Service to Board	Provide an annual review of Gender service to Board / SQAC to consider learning from current and prior years to identify potential changes in treatment pathway and follow up of prior CYP to understand if they subsequently dropped out of the service or transitioned / de-transitioned and potential learning from this	15/10/2025	
Comprehensive suite of KPIs to be developed	Comprehensive suite of KPIs for GDS to be developed and reported to Board / SQAC including: demographics of referrals (1), compliance with service specification relating to number of appointments / interventions and time taken (2), compliance with the % "drop out" rates at the various assessment stages in the service specification (3), any contact from external activist / pressure groups (4), trends in active caseload and waiting list size (5), referrals to research trials, income / expenditure v budget (6), complexity of cases (e.g. what % have eating disorders, ASD/ADHD/OCD (7), details of % of staff time spent inside / outside of the service by individual (8), gap between appointment versus service specification requirements (9), compliance with data recording requirements (10)	30/09/2025	Request in with BI for data dashboard to include all KPI requirements. On track.
Escalation of Key Issues to Divisional Integrated Governance Meeting	Key Issues to be reported to Divisional Integrated Governance Meeting on a monthly basis.	25/06/2025	Reporting into Divisional Integrated Governance to be embedded.

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

CQC Domains	Linked Risks	Owner
		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.

Jan 2025	
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	Due Date	January 2025 Action Update
Risk 236 - Action 1	Engagement with suppliers to increase knowledge and seek support.	30/06/2025	
Risk 236 - Action 2	Increase capacity to the prescription rota to cover the additional work.	28/02/2025	New prescribers now in the process of being signed off in order to independently staff the rota. Action on target. This work continues as the medication shortage continues- More nurses have now completed their V300 training and will be ready to support the rota by February. Pharmacy technician is being recruited to support the advice and guidance and support element of the prescription rota. 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 efficient as it can be.
Risk 236 - Action 8 (carried over from Risk #70)	Daily reviews to take place to monitor progress against actions and monitor supply of relevant medications.	31/10/2024	medication shortage continues still reviewing this weekly(not on a daily basis) this is because all other stocks of ADHD medications are now at sufficient supplies within our area . 12 hour medications prep still unable to obtain supplies, Alder Hey ADHD CYP being moved over to different medications . Currently no end date
Risk 236 - Action 9 (carried over from Risk #70)	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative if necessary	30/09/2024	ongoing

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

Jan 2025	
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 PC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
PDR and appraisal process in place	Monthly reporting to Board and PC
Nursing Workforce Report	Reports to PC, SQAC and Board
Nurse Retention Lead	Bi-monthly reports to PC
Recruitment Strategy currently in development	progress to be reported PC
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files
Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030	

Gaps in Controls / Assurance
1. Not meeting compliance target in relation to some mandatory training topics 2. Sickness absence levels higher than target 3. Lack of workforce planning across the organisation 4. Lack of robust talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity across the organisation

Action	Description	January 2025	
1. Not meeting compliance target in relation to some mandatory training topics	Head of L&D has a full action plan in place to increase compliance across the organisation and this is supported by the Academy Director.	31/03/2025	Mandatory training activity is monitored by Education Governance Committee as a standard agenda item. As at May 24 overall trust compliance was 93.00%. Areas of concern are highlighted, discussed and supported with subject experts. The current area under review is SEPSIS.
2. Sickness absence levels higher than Trust Target	Ongoing interventions remain in place to support the management of sickness, however until the absence has had a sustained reduction it will continue to 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	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, business case has been shared with Exec Team - outcome awaited.
6. Lack of inclusive practises to increase diversity across the organisation	A comprehensive EDI plan is in place, which is aligned to the NHS England gh 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.

Jan 2025	
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	January 2025	
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards. Thriving Staff Index and Thriving Teams Index to be developed.	30/04/2025	Thriving Teams Index proposal paper to be presented at the People Committee in March. Interim plan to be proposed for agreement by the committee to use the staff survey data to ensure that struggling teams are identified at divisional level with action plans in place and monitored to improve team functioning and culture. Proposal to include systematic assessment of small teams who are not currently captured in staff survey results. 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). Staff Thriving Index pilot complete and implementation plan being developed. Thriving Teams MDT up and running with work planned to develop metrics for identifying vulnerable teams as part of this process. Discussed with CPO. Methodology to be agreed and to incorporate work already done by Director of Medical Services in discussion with MD Staff survey data packs complete with methodology developed by BI. Work now in progress to develop a BI dashboard beginning with the staff survey results. Safety Culture data available at an organisation level and shared with Patient Safety lead. Work underway to ensure safety culture metric developed and part of overall team effectiveness dashboard. Staff Thriving Index pilot complete and index agreed with CPO. Implementation plan now in development. Staff survey data deep-dive planned with OD team to establish areas of excellence and challenge Staff Thriving Index in pilot stage Thriving Teams MDT operational and feeding into OD, QI, Transformation, HR, FTSU and Divisional Leadership meetings.
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.	31/03/2025	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 Developing culture strategy to be presented and discussed at Trust Board in June.
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.
Restorative just and learning culture	Restorative just and learning principles to be embedded through patient safety work and all people practices. Consultation on approach to be provided to patient safety leads and investigators to support the implementation of PSIRF and to help to facilitate learning reviews where indicated. Work to be progressed about Avoidable Employee Harm with HR, staffside and other key stakeholders through workshops, consultation, policy review and training	31/03/2025	Avoidable employee harm session delivered to senior HR colleagues on 9th October to discuss this concept and reflect together on how we need to develop as an organisation to understand and minimise the risk of harm to employees that can come through people and change practices. Agreed to run a second workshop with case examples on 13th November and then agree next steps in terms of implementation of this approach in policy and practice
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

Action	Description	January 2025	
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.	31/03/2025	Clinical leads listening sessions complete and feedback to be presented at Clinical leads Summit on 15th Nov with a view to agreeing next steps in consultation with clinical leads. Management essentials sessions reviewed with plans for further development of the programme agreed. 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. Strong Foundations review planned with a view to enhancing culture component. Clinical Leadership review in planning stage following Clinical Leaders away day. Plan to engage in individual listening sessions with all clinical leads in July. Insights to inform second Clinical Leads away day and to inform potential redesign of Clinical Lead roles to include consistent and robust set of leadership competencies coupled with an enhanced development and support offer.
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.	30/04/2025	Culture document/blueprint in development with CPO and CEO to include revised values. Document to be shared with organisation when ready for consultation, feedback and engagement. 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

Jan 2025	
Control Description	Control Assurance Internal
Establishment of 4 x Staff Networks	All networks have appointed chairs, supported by Head of EDI. members of EDI Steering Group and report bi-monthly
Education and Training in EDI	Mandaotry EDI Training for all staff. current compl;iance above Trust target of 90%.
Head of EDI (0.6wte) in post. joint post with Clatterbridge Cancer Centre.	
Actions taken in response to Gender Pay Gap	
PAWC Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PAWC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PAWC
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	monitored through PAWC
People Policies	People Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	monthly recruitment reports provided by HR to divisions. -@Workforce Race Equality Standards. -@ bi-@monthly report to PAWC.
NHS England Improvement Plan supported by Trust Board, and associated actions into action plan	NHSE EDI Improvement Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 3 of delivery, continues to include a focus on inclusive leadership
EDI Steering Group established - Chaired by NED	Minutes reported into PAWC
actions taken in response to the Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to EDS22	Reported to People and Wellbeing Committee

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

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

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

CQC Domains	Linked Risks	Owner
Responsive		Rachel Lea

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

Description
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.

Jan 2025	
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	Due Date	January 2025 Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	30/11/2025	Meetings will continue with LCC until full legal agreement of transfer of Park to the Council.
Adoption of the SWALE by United Utilities	Engaged with planning consultants to assist with planning requirements.	09/05/2024	
Funding availability and potential market inflation	Continual monitoring of market inflation	30/04/2025	Regular updates continue to be provided to RABD and Trust Board as appropriate
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	30/04/2025	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves: 1) Vacate 3SM & move staff to former police station and other (Summer 2024) 2) Vacate Histopathology and mover staff to alternative accommodation (Winter 2025)	28/02/2025	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell
Weather conditions causing potential delays	Dry season now upon us – all works now in accordance with revised programme and on target.	30/11/2024	

Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan					
Risk Number			Strategic Objectives		
3.2			Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	RM03 Risk Rating		
			Actual	Target	Assurance Committee
Well-Led		Kate Warriner	12	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.

Jan 2025	
Control Description	Control Assurance Internal
Collaborating in Communities is a key theme in the 2030 Change Programme: assurance received through Strategy Leadership Group and Strategy Board	
2030 Vision: Alder Hey strategy refresh - Q4 23/24 - delivery of brochure and final comms collateral	Council of Governors strategy session (full overview) (Jan 2023) Strategy 2030 - Approved at Trust Board (March 2023) Strategy 2030 wider Staff Launch (May 2023)
CYP System update report to Strategy Board, incorporating partnership assurance periodically throughout the year.	Building upon Growing Great Partnerships report
Operational Plan incorporates Vision 2030 deliverables (2024/25)	Operational Plan
Executive Portfolios all incorporate elements of Vision 2030 delivery	
SRO Group established	
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	

Gaps in Controls / Assurance
1. 2030 delivery programme and plan in development 2. Failure to develop capacity for delivery 3. Failure to build capacity and skills within our workforce to deliver the 'new' aspects' of the 2030 Strategy 4. Failure to deprioritise to enable requisite focus on areas of need and transformational change 5. Risk of 'mission creep' associated to the Strategy

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

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

Description
Failure to meet NHSI/E targets. Inability to invest in the capital programme.

Jan 2025	
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	January 2025 Due Date	Action Update
Changing financial regime	1. Close monitoring of financial directions from NHS England to ensure the Trust delivers its Plan	31/03/2025	
Delivery of 5 year programme	4. Risks around Capital Plan to be monitored closely	31/03/2025	
Devolved specialist commissioning	3. Regular reporting to strategic execs and assurance to FTP and Trust Board Financial Analysis required to understand risk	31/03/2025	
High risk recurrent Efficiency programme	6. transformation efficiency schemes now in place and monitored through Sustainability Delivery Group to ensure financial saving captured.	31/03/2025	
Inflationary pressures	7. Monitor closely impact of inflation increases working with HPL to obtain data on supplier increases and inflation avoidance through negotiations.		
Shortfall against Long Term Financial Plan	5. Long Term Financial Plan to be updated for latest position and to take us to 2030 as part of financial strategy. 2030 financial strategy to be completed in Q2.	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

System working to deliver 2030 Strategy	
Risk Number	Strategic Objectives
3.5	Sustainability Through External Partnerships

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

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

Description
System working to deliver 2030 Strategy

Jan 2025	
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 Neighbourhood Model - system wide development with Place Partners
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 Partnership Plans developing with CYP focus.
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 capacity in the central strategy team and wider distribution of system-working leadership and capability across divisions and corporate teams.	Incorporated into Executive Away Day planning discussions and development of 2025+ transformation plan

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	Due Date	January 2025 Action Update
1. Uncertainty over future commissioning intentions	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2025	Continual influencing of commissioning priorities to align with AH Vision 2030 ambitions e.g. Place priorities, C&M CYP Committee priorities, influencing NHS 10YP at National level
2. Future delegation of Specialist Commissioned services into ICSs	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2025	Delegation in shadow form of specialised services completed into ICB's. NW Joint Specialist Committee established - leadership via 3 x ICB CEO's. Low emphasis on specialist services in current NHS policy / 10year plan development - however Alder Hey and Children's Hospital Alliance incorporating clear asks pertaining to acute CYP illnesses into 10YR plan engagement process.
4. National mandates forcing us to prioritise unexpected programmes of work	4. Horizon scanning	31/03/2025	Formal contribution to NHS 10 Year Plan development on behalf of both Trust and CYP being undertaken by Chief Strategy Officer and Policy Lead/Advisor to CEO - in order to optimise reference to CYP and AH priorites within 10YP
Stakeholder & Partnerships Plan - Phase 2 of Vision 2030	A stand back on stakeholders and approach to partnership governance will be undertaken alongside re-framing of next phase of Vision 2030 - in line with transformation plan shape for 25/26+	31/03/2025	

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
Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People

Jan 2025	
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	January 2025 Due Date	Action Update
2a. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2025	L&D Facilitator appointed - start date 6th Feb. External consultants continuing to support external partnerships activity until 31 March 2025 - review of options for longer term arrangements underway (John Chester, Amanda Lamb, David Cole,Sarah Leo).
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	Progress with Investment zone funding application for £4.1m to Combined Authority - progressed through external panel, internal panel scheduled for Feb 2025 and final decision expected in March 25
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	L&D Facilitator appointed and start date confirmed for Feb 25. Admin support identified for develop pillar. Work underway to align work across academy, CRDP programme and Starting Well programme.
4. Sustainable Activity Levels	Review of IC product pipeline	31/03/2024	Brilliant basics work completed (fist phase), Lyvalabs workshops taking place on 16th Jan and 6th Feb.
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	Awaiting full trac authorisation for comms post before it can be advertised

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
		Kate Warriner	16	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.

Jan 2025	
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. Continual review underway to assess additional requirements. 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 5. Aging hardware/device estate and financial restrictions preventing all equipment being replaced, most notably in clinical areas

Action	Description	January 2025	
		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	Continue to monitor during stabilisation phase	30/08/2024	Programme to commence Nov 2023
Cyber Assurance Framework	This has replaced the action around Cyber Essentials +.	31/07/2025	
Experienced Resources	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce	28/02/2025	
Strategic Review of Cyber Security	Strategic Review of Cyber Security	31/03/2025	