BOARD OF DIRECTORS PUBLIC MEETING
Thursday 1st May April 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 (9:00am-9:15am)							
BOARD PHOTOGRAPH (9:15am-9:20am)							
1.	**25/26/33**	**9:20 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**25/26/34**	**9:21 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**25/26/35**	**9:22 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **3rd April 2025.**	**D**	Read enclosure
4.	**25/26/36**	**9:24 (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.	**25/26/37**	**9:25 (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.	**25/26/38**	**9:35 (10 mins)**	**Deployment of Vision 2030:** • **Report from Portfolio Board.**	K. Warriner	To receive an update on the current position.	**A**	Verbal
Improvement Programme							
7.	**25/26/39**	**9:45 (25 mins)**	• **Financial Improvement Programme Update.** • **Decision Making**	A. Bateman/ R. Lea J. Grinnell/	To receive an update on the current position. For information and discussion.	**A** **N**	Presentation Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			Framework. • **Transformation Programme Update.**	E. Saunders N. Palin	To receive an update on the current position.	**A**	Read report
Performance Against Annual Plan							
8.	**25/26/40**	**10:10 (10 mins)**	**2025/26 Integrated Performance Report – Proposal.**	K. Warriner/ A. Bateman	For discussion and approval.	**D**	Read report
9.	**25/26/41**	**10:20 (40 mins)**	**Evidence of Our Performance:** • **Flash Report, M1.** • **Integrated Performance Report for M12, 2023/24:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.**	A. Bateman N. Askew A. Bateman J. Chester 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 reports
Unrivalled Experience							
10.	**25/26/42**	**11:00 (5 mins)**	**Learning from Patient Safety Incidents Report, Q4.**	N. Askew	To receive the Learning from Patient Safety Incidents report for Q4.	**A**	Read report
11.	**25/26/43**	**11:05 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 30.4.25.** - **Approved minutes from the meeting held on the 26.3.25.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 26.3.25.	**A**	Read enclosure
Pioneering Breakthroughs							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
12.	**25/26/44**	**11:10 (10 mins)**	**AI Strategy.**	K. Warriner	For approval.	**D**	Read report
Supporting our People							
13.	**25/26/45**	**11:20 (5 mins)**	**People Plan Highlight Report; including:** • **EDI update.**	M. Swindell	To receive an update on the current position.	**A**	Read report
14.	**25/26/46**	**11:25 (10 mins)**	**Freedom To Speak Up – Update.**	K. Turner	To receive an update on the current position.	**A**	Read report
15.	**25/26/47**	**11:35 (5 mins)**	**Freedom To Speak Up – Review Tool for Boards.**	E. Saunders	For information.	**N**	Read report
Strong Foundations (Board Assurance)							
16.	**25/26/48**	**11:40 (5 mins)**	**Statement of Going Concern for the 2024/25 Annual Accounts.**	R. Lea	To receive an overview of the current position.	**A**	Read report
17.	**25/26/49**	**11:45 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 17.4.25.** - **Approved minutes from the meeting held on the 16.1.25.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 16.1.25.	**A**	Read enclosures
18.	**25/26/50**	**11:50 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's verbal update from the meeting held on the 28.4.25.** - **Approved minutes from the meeting held on the 25.3.25.** - **2024/25 Top Key Risks, (M12).**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 25.3.25, and to receive an update on the top key risks for 2024/25.	**A**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
19.	**25/26/51**	**11:55 (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							
20.	**25/26/52**	**12:00 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
21.	**25/26/53**	**12:04 (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 12:05pm-12:30pm)							
Date and Time of Next Meeting: Thursday, 5th June 2025, 12:30pm, LT4, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in April: • 424: Lease between Alder Hey and JMU (Exchange Station, 2nd Floor, Tithebarn Street, Liverpool)

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M12, 2024/25	R. Lea
Children's Hospital Alliance End-year Report 2024/25 and Workstreams for 2025/26	J. Grinnell

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 3rd April 2025 at 9:00am**
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/Deputy CEO	(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	Interim 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)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/06	Mrs. N. Palin	Director of Transformation	(NP)
Item 24/25/18	Dr. J. Potier	Director of Culture	(JP)
Apologies:	Mr. D. Powell	Development Director	(DP)

Staff Story

The Chair welcomed members of the PICU Multi-Disciplinary Team (MDT) who were invited to April's Board to share the work that has been undertaken on 'Compassion in Conflict'.

The team shared the story of a patient named Harry, detailing his medical journey, the involvement of the various members of the team and the complex issues that arose, including a court case due to differences of opinion regarding Harry's treatment.

Team members discussed the psychological impact of Harry's case on the staff involved in caring for him, highlighting the emotional distress and moral challenges faced by the team. The Board was also advised of the ethical and legal challenges encountered during Harry's care, including disagreements between parents and the need for second opinions and court hearings. Attention was drawn to the importance of providing psychological support for staff, especially in challenging cases like Harry's, and the need for integrated clinical psychology within teams.

Team members gave an emotional account of how this case affected Harry, his family and themselves. It was pointed out that Harry's case challenged the moral code of individuals and made them question what was right which caused moral distress. The day that Harry was

admitted to Alder Hey triggered lots of emotions as he was a 13-year-old previously well boy who deteriorated quickly as a result of an unexpected illness. The team offered a space and support to staff who were looking after Harry so that they hopefully felt less stressed and isolated and could continue to look after him. It was reported that the case highlighted how important it is to give staff the opportunity to come together and connect.

The Board was advised that the Trust will see more of these types of case therefore what can Alder Hey do to prepare for future cases? The following points were put forward by the team:

- Reflect on personal and team experiences.
- Support and resources (*practical and psychological*).
- Training and professional development.
- Implement a framework to help the multi professional team.
- Senior Trust management response and support.

On behalf of the Board, the Chair thanked the team for sharing their experience of what must have been a very difficult time. The Chair advised the team that their story will not be forgotten and felt that they had demonstrated that so much can be achieved when a group of individuals work together as a team. It was reported that the Board will need to reflect upon the points raised in terms of preparing for future cases and it was confirmed that a member of the Executive Team will liaise with the team to see what actions can be taken forward.
Action: ABASS

25/26/01 Welcome and Apologies

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

25/26/02 Declarations of Interest

Non-Executive Director (NED), Gerald Meehan, declared that he is the Independent Chair of Liverpool's Children's Services Improvement Board.

25/26/03 Minutes of the previous meeting held on 6th March 2025.
Resolved:
The minutes from the meeting held on the 6.3.25 were agreed as an accurate record of the meeting.

25/26/04 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 24/25/301.2: *Evidence of Our Performance (Look at the possibility of having productivity measures for the innovative solutions that the Trust is implementing in order to gage the savings that are being made)* – There are real time feeds in place for the innovative solutions that have been implemented which provide data on the amount of people using robotic systems.
ACTION CLOSED

25/26/05 Chair's and CEO's Update

The Chair drew attention to the issues facing the organisation as the NHS enters a new era, the need for a different approach in terms of the Trust being flexible/ having a different pace of change, and the importance of prioritising safety and care. It was felt that in order to succeed it is imperative to empower senior managers and it was pointed out that there will be opportunities for Alder Hey to further engage/collaborate and develop new partnerships going forward.

John Grinnell reiterated the Chair's comments and highlighted the challenges and uncertainties of 2025/26 in terms of what the Trust is being asked to commit to. The Board was advised that if the Trust can be the most effective and productive provider of care for children and young people (CYP) there will be opportunities for Alder Hey especially with the brand and partners that the organisation has. John Grinnell reflected on 2024/25 and felt that the Trust should be proud of what it has achieved during the year.

The Board was informed of the inspection of the Trust's Specialist Community and Mental Health services that took place w/c 24.3.25 following receipt of a 48-hour notice of the inspection from CQC. The visit was supported by the Director of Community and Mental Health Services, Lisa Cooper, and her team. It was reported that the inspectors worked with the Trust within great compassion. A draft report is to be shared with the organisation in the next seven to eight weeks.

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

25/26/06 Vision 2030 Strategy Progress Update

Transformation Programme Update

The Board received an update on the progress in the initiation of the Trust's 2025/26 multi-year transformation programme.

It was reported that the Trust is making good progress and is looking to transform how it operates and distributes responsibility. It was pointed out that the Collaborative model will help break down silos, and the collective approach to change will deliver the financial targets. Work is taking place with the organisation's leaders to explain where the challenges and barriers are.

Over the past three months, the Trust has focused on mobilisation and establishing five cross-cutting collaboratives, aligning leadership and resources, embedding new governance structures, and standing up integrated delivery plans. Each collaborative is now operational with defined goals, leadership accountability, and growing portfolios of work, with a collective target of delivering over £10m in financial savings. Each programme has a plan, and the Board will be provided with assurance on each of these plans in due course.

It was felt that the update was positive, and attention was drawn to the importance of allowing the collaboratives to grow and having more clinical leadership as part of this programme.

Resolved:
The Board noted the Transformation Programme update.

25/26/07 Cheshire and Merseyside (C&M) Financial Update

It was reported that C&M did not submit a plan in line with the control total deficit that was allocated to them. There has been a real effort collectively as a system to achieve the year end position and demonstrate grip and control for 2024/25. C&M are yet to receive a position statement for the system, but further detail will follow in the next week.

Resolved:
The Board note the C&M financial update.

25/26/08 Annual Plan, 2025/26

The 2025/26 Annual Plan was reviewed collectively during an extraordinary meeting of the Board on the 25.3.25. The Board agreed to submit the plan based on the £3.4m control total. Assurance statements will be compiled on this basis with an opening statement advising as to why the plan is stretching and Alder Hey can go no further. It was confirmed that the 2025/26 Annual Plan is to be issued to the Trust's governors for information purposes.

Resolved:
The Board received and confirmed its approval of the Trust's Annual Plan for 2025/26

25/26/09 Evidence of Our Performance

Flash Report, M11

The Board received the Flash Report for March 2025. It was reported that the Divisions have achieved good levels of performance during the reporting period. The following points were highlighted:

- Diagnostic performance for March was 96%.
- The Trust achieved the Emergency Department four-hour target with 79.6% of patients being treated within 4 hours. As a result of this Alder Hey will receive capital incentive funding. It was confirmed that the Trust's Emergency Department is the fourth best performer in the country.
- There are 244 RTT patients waiting more than 52 weeks in comparison to 800+ during the same reporting period in 2024. It was reported that there were zero RTT patients waiting more than 62 weeks in March 2025.
- Follow up care has been one of the Trust's top operational challenges but as a result of the work that has taken place there are now only 300 patients waiting for follow up care two years past their expected date in comparison to the original 600 patients. It was pointed out that there is still a long way to go in terms of reducing numbers, but the Board was asked to recognise the progress that has been made. The Chair offered thanks to all those involved in this great achievement.

The Board was informed that work is ongoing to update the IPR and make if more focused and comprehensible. A proposal for the new format of the IPR will be submitted to the Board in May 2025. It was suggested that headlines and a trend graph would be useful to the reader.

Outstanding Care and Experience – Safe and Caring

- A C&M event was held on the 31.3.25 to celebrate the success of Martha's Rule pilot sites. It was reported that the programme is to be supported for a two-year period. The Board was advised that Alder Hey is the only trust to roll out Martha's Rule across inpatient areas. Thanks were offered to the Head of Nursing and AHP's for Clinical and diagnostic Services, Jayne Guy, for driving this area of work forward.

Revolutionise Care – Effective and Responsive

- The Personal Demographics System (PDS) is set to go live in April 2025. It is anticipated that this system will help reduce the Was Not Brought (WNB) rate. Additional actions are also planned, such as improving communication, trialling different booking approaches, etc.

Support our People

- A detailed report was submitted to the People Committee and the Executive Team following a review of sickness absence, which included an outline of the next steps. It was reported that there are c725 of people on sick leave due to a number of reasons with many of them being complex.

Community and Mental Health Division

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

A question was raised about the ongoing challenges with the shortage of ADHD medication. It was reported that the Trust is starting to see this issue resolve for some patients, but the situation is still not completely stable.

Division of Medicine

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

Division of Surgery

- The Trust is awaiting financial clarification to progress its plans for increased activity in two specialties.
- The Division achieved the national target for the expected number of cardiac procedures last year.

Resolved:
The Board:

- Noted the Flash Report for M11.
- Noted the content of the IPR for Month 10.

25/26/10 Gender Service National Provider Network - Memorandum of Understanding

The Memorandum of Understanding (MoU) for the Children and Young People's Gender Service National Provider Network was submitted to the Board to request support for the signing of the MoU.

The Board was advised that the MoU has been developed and reviewed by CYP Gender Service (GS) providers (North West, London and South West) and has been through a series of reviews with support from legal representation for each provider. For the North West service, this has been provided by Hill Dickinson.

The MOU, which outlines AH's role and responsibilities as the network host and as a member, is to be submitted to the board of each service that is either live or in the process of going live to provide clarity on the Trust's role and limitations in terms of liability. The MoU expires at the end of 2025 which will provide an opportunity to review this document in January 2026. The MoU also allows for new services to be included in the network.

It was queried as to whether the Trust receives funding for hosting the network. It was reported that the network and the Gender Service have different budgets which were agreed by NHS England on a full cost basis with an opportunity to discuss any increase in costs.

Reference was made to the Trust's responsibilities as a member, as detailed in page two and three of the report, and it was queried as to whether a short paper can be submitted to the Safety and Quality Assurance Committee (SQAC) to determine the actions that the Trust needs to undertake to meet these requirements thus providing assurance.

25/26/10.1 Action: LC

Resolved:
The Board agreed to delegate the signing of the MoU to the Chief Executive, John Grinnell. It was acknowledged that there may be some final minor amendments as CYPGS providers review the document for signing.

25/26/11 Mortality Report

The Board received the Mortality Report for Q3 which is developing, with review targets met and no themes or trends identified. It was reported that since July 2023 the requirement to report the deaths of CYP age 4 and over with a learning disability and/or autism to the Learning Disabilities Mortality Review (LeDeR) has been removed. Now, all deaths of young people will be reported via usual child death processes. As a trust, the plan is to continue to review all LD/autism deaths including less than 4 years old so they can be reviewed thematically and reported on to support internal learning and overview.

A question was raised and responded to about pre-hospital pathway issues and whether the Trust has a process in place to identify learning actions. It was confirmed that there are two cases under review at the present time.

The Chair offered thanks to the Hospital Mortality Review Group lead, Julie Grice, for the work that has taken place to develop the Mortality Report.

Resolved:
The Board noted the Mortality Report for Q3.

25/26/12 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 19.2.25 were submitted to the Board for information and assurance purposes.

During March's meeting there was a focus on the developing style for new clinical research reporting, the Ward Accreditation Annual Report, and the lessons learnt action plan that has been developed and signed off following CQC's inspection of Nuclear Medicine.

Resolved:
The Board noted the approved minutes from the meeting held on the 19.2.25.

25/26/13 Collaborate for Children and Young People: Partnerships and Neighbourhoods Update

The Board received a presentation that provided an update on Neighbourhoods and partnerships. A number of slides were shared that provided information on the following areas:

- Neighbourhoods are everyone's business;
  - Health services directly influence only around 20% of an individual's overall health outcomes. The remaining 80% is shaped by wider determinants of health including: socio economic factors (40%), health behaviours (30%) and physical environment (10%).
  - People live their lives in communities and CYP live in families therefore the system must work in partnership in a family model, with a targeted CYP Multi-Disciplinary Team (MDT) embedded seamlessly for the specific needs of CYP.
- Neighbourhood partner event for CYP that was jointly hosted with the Liverpool City Region Combined Authority *(key learning and next steps*).
- What is the approach for CYP?
  - To provide integrated care via primary care led teams, enhancing accessibility and outcomes for CYP by offering timely specialist advice, including paediatric and mental health expertise within community settings: hospital to community, child health GP Hubs, flexible MDT, etc.
- Alder Hey's multi-faceted system role; deliverer, partner, system leader.
- Summary and next steps;
  - Seeking new resources.
  - LCC/LCR/Alder Hey pitch.
  - Vision 2030 Collaborative: Neighbourhood preventative care models.
  - Test and learn approach.
  - Reciprocal learning.
  - Partnership and role of Alder Hey.
  - System governance and drive new incentive pilots.

An in-depth discussion took place on the shift in the overall dynamics of the system, the critical relationships that will help drive this work forward, key partners and their enthusiasm for the programme, governance, and the importance of recognising that Alder Hey is a facilitator.

The Chair referred to the 30% that relates to health behaviours in the overall health outcomes of an individual and drew attention to the importance of looking at what can be done within the neighbourhoods in terms of education and local voluntary organisations thinking about the dietary needs of CYP. Undertaking evaluation to gain evidence will also help drive change and it was felt that this is something that the Local Authority as a whole should be thinking about.

It was felt that there is a need to connect with those who are thinking about the elements required for a successful neighbourhood, think about social value, look at who the Trust is partnered with from a premises perspective and seek to attract others to those premises or adjacent ones so that everyone is contributing. It was pointed out that in order for this programme to thrive it will require true

partnerships, investment, commitment and an acknowledgement that this can't be delivered in a rush.

Reference was made to the outcomes detailed in the presentation and it was felt that it is imperative to carry out evaluation to understand the models. It was suggested undertaking a comparative study similar to the successful one that took place in Amsterdam to look at models that really work.

Resolved:
The Board noted the update on Neighbourhoods and partnerships.

25/26/14 Liverpool Neonatal Partnership Board

The Board received the Co-Chair's Report from the LNP Board meeting that took place on the 20th January 2025 which provided an overview of the partnership and activities in month. The following points were highlighted:

- Clinical 24/7 on call cover is due to commence on the 7.4.25.
- A consultation is currently taking place in respect to leadership.
- LNP Clinical Leads have scheduled to meet with the Surgical Divisional Leads on the 4th April to discuss the specialty level input and patient pathways for each department.
- The culture work previously discussed at the LNP Board has been paused to allow for further engagement with key team members. A follow up meeting with the Organisational Development (OD) Leads from both Alder Hey and Liverpool Women's Hospital (LWH) will take place in April with a view to launch the key activities at the earliest opportunity
- The LNP Board is due to meet on the 7.4.25 and will discuss the 'Ward Safe Environment' proposal and pharmacy to determine where responsibility lies.

A question was raised about progress on the governance of the partnership. It was confirmed that discussions are ongoing, and a meeting is scheduled for w/c 7.4.25. It was confirmed that this piece of work will take time to complete before reaching agreement on a longer-term view of the way things will work which will become clearer once the new unit opens.

It was queried as to whether the Trust now has the right line of sight across mortality. It was reported that it is improving but there are still several governance points that need resolving.

Resolved:
The Board noted the Co-Chair's report from the LNP Board meeting that took place on the 20.1.25.

25/26/15 Paediatric Open Innovation Zone Business Case

The Board received the full business case for the Paediatric Open Innovation Zone (POIZ). It was reported that formal approval was received on the 4.4.25 from the Liverpool City Region Combined Authority (LCR-CA) for the full business case which amounts to a £4.1m contract which Alder Hey will host over a four-year period. The Board was advised that Alder Hey is the only NHS organisation to be awarded revenue from the £80m Investment Zone (IZ) package, and is the Trust's first major injection of funds for research and innovation. Thanks were

offered to the Innovation Team for the work that has taken place on this successful project.

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

- IZ consortium members.
- What does POIZ offer for Alder Hey;
  - An unprecedented opportunity to grow, re-shape and re-invigorate innovation.
  - Become more financially sustainable.
  - A mechanism for achieving a strategic shift in emphasis.
  - The Trust will align NB LCR's primary objective (*economic impact via health innovation*) with the organisation's Vision 2030 Strategy in terms of addressing the unmet needs of CYP.
- POIZ's part in the on-going evolution of innovation at Alder Hey.
- Points to note; no additional funding required from the Trust or the Charity, great reputational benefits/status within LCR and beyond, conversely, poor optics if not supported and delivered upon and the importance of continuous monitoring/oversight.
- Support needed and next steps;
  - The Board is asked to support the decision to sign the Grant Funding Agreement (GFA) subject to key conditions through stakeholder review, safeguards on job targets, and clarity on match funding obligations.

The Chair felt that is a great achievement and on behalf of the Board confirmed its decision to support the signing of the GFA. A number of challenges were made about growing the commercial element of the work and producing narrative to determine the social value benefits of the project.

Resolved:
The Board approved the decision to sign the GFA.

25/26/16 Futures Committee

The approved minutes from the meeting held on the 26.11.24 were submitted to the Board for information and assurance purposes.

During March's meeting, the Committee discussed the next steps, resources and governance structure for the POIZ investment, and received a presentation on the 4 Pillars and an Etiometry Case Study (Artificial Intelligence augmented patient physiological monitoring).

Resolved:
The Board noted the approved minutes from the meeting held on the 26.11.24.

25/26/17 People Plan Highlight Report

The Board received a monthly update on the progress that has been made against the People Plan. The following points were highlighted:

- Attention was drawn to the Trust's attendance at the Health and Social Recruitment event that was hosted by the Race Equality Hub on the 19.3.25 to connect Black, Asian, and Minority Ethnic (BAME)

communities with meaningful career opportunities in the health and social care sector.

- It was reported that the Trust is progressing the concept of Avoidable Employee Harm in people practices and processes which 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.

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

25/26/18 New Trust Values and Behavioural Framework: A Proposal

The Board received a proposal for a new set of Trust values and accompanying behavioural framework. The paper that was submitted proposed four new values for Alder Hey; Compassion, Courage, Commitment, and Community along with an implementation plan, with the aim of ensuring that they become embedded and expressed every day, in every way throughout the organisation. Attention was drawn to the importance of having a robust implementation plan to make sure that the values become translated into lived experience.

A number of slides were shared to provide an overview of each new value in terms of what they mean/how employees will demonstrate them and the everyday actions that need to take place to make the values real. If adopted, built on these principles Alder Hey will be:

- *Compassionate* – Child-first and people-centred in everything that it does.
- *Community-minded and community-driven* – Connected and responsive to the needs of its population.
- *Committed* – Reliable, effective, and always striving for excellence.
- *Courageous* – Innovative, resilient, and unafraid to challenge the status quo.

Following discussion, the general consensus of the Board was that Alder Hey is ready for a new set of values, a new behavioural framework and a new way of bringing it all to life and confirmed their approval of the new values.

Constructive feedback was provided by Board members in terms of the next iteration of the values:

- Ensure the values reflect the Trust's need for change.
- Use the values to describe the Trust's offer of employment.
- Focus on accountability as the values are developed.
- Include the words culturally inclusive in the value relating to Community.
- Think about projecting the Trust's new values onto the organisation's partners so that they can reflect them too.
- Think about creating a safe space for staff to enable them to speak freely.

The Chair thanked the Director of Culture, Jo Potier, for the work that has taken place on this proposal and emphasised the impact that the new values will have internally and externally when brought to life, especially in terms of recruitment and retention.

Resolved:
The Board approve the new values of Compassion, Courage, Commitment and Community.

25/26/19 People Committee

The approved minutes from the meeting held on the 15.1.25 were submitted to the Board for information and assurance purposes.

It was reported that March's meeting was extended by half an hour in order to have a more in-depth discussion on various areas including the 2024 Staff Survey, the Gender Pay Gap and long-term sickness. Going forward meetings will be arranged to take place in person.

Resolved:
The Board noted the approved minutes from the meeting held on the 15.1.25.

25/26/20 Directors' Register of Interests, 2024/25
Resolved:
The Directors' Register of Interests for 2024/25 was noted, with a reminder to Board members to update the system to notify of any changes that may occur during the year.

25/26/21 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 24.2.25 were submitted to the Board for information and assurance purposes.

During March's meeting the Committee spent time on the Annual Plan, discussing the need for timely updates and live reporting in terms of having a connection between the Financial Plan and Operational Plan.

The Board was advised that some really positive work has been undertaken on live reporting and is due to be rolled out across the Divisions. An update on the implementation of live reporting will be shared with FTPC during April's meeting.

2024/25 Top Key Risks (M10)

The Board was advised of the latest position of the 2024/25 FTPC's key risks for M10.

Resolved:
The Board noted the approved minutes from the meeting held on the 24.2.25 and the update on the Committee's top key risks in M10.

25/26/22 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.

It was pointed out that the risk landscape is changing as a result of the challenges being experienced across the system therefore work is currently being undertaken

to review and update a number of BAF risks and to reflect the risks of the Annual Plan and assurance statements that have been identified. The Board was advised that the next iteration of the report will have a more refreshed feel to it.

Resolved:
The Board received and noted the contents of the Board Assurance Framework report for February 2025.

24/25/23 Any Other Business

There was none to discuss.

24/25/24 Review of the Meeting

The Chair felt that a number of constructive discussions had taken place during the meeting and thanked everyone for their contributions.

Date and Time of Next Meeting: Thursday 1.5.25 at 9:00am, LT4, Institute in the Park.

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

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for May 2025							
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	May-25	**3.4.25** - An update will be provided during May's Board. **ACTION TO REMAIN OPEN**
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	
3.4.25		Staff Story	Liaise with the Conflict in Compassion Team to see what support can be given to prepare for future complex patient cases.	A. Bass	Jun-25	On track Jun-25	
3.4.25	25/26/10.1	Gender Service National Provider Network - Memorandum of Understanding	Compile a short paper advising of the actions that the Trust needs to undertake in respect to Alder Hey's responsibilities as a member, as detailed in page 2 and 3 of the report, and submit it to SQAC for assurance purposes.	L. Cooper	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**
Actions for December 2025							
6.2.25	24/25/301.2	Neurodiversity Transformation Plan	Submit an update on the progress of the Neurodiversity Transformation Programme to the Trust Board in December 2025.	L. Cooper	4.12.25	On track Dec-25	

Status	
Overdue	
On Track	
Closed	

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	**Decision Making Framework – Financial Improvement Programme**
Report of:	**Chief Corporate Affairs Officer**
Paper Prepared by:	Chief Corporate Affairs Officer

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

1. **Purpose**

The purpose of this paper is to set out the proposed processes by which the Trust will support its intention to exercise '*safe and compassionate decision-making*' in the context of the current Financial Improvement Programme.

2. **Background**

The challenges posed to Alder Hey by the annual planning round for 2025/26 are unprecedented in terms of the external NHS landscape and the requirements of operating within one of the most financially compromised healthcare systems in the country. The Board has been open with the organisation in terms of the extent to which we will need to change the way in which we have worked in the past to achieve the expected level of financial savings and improve productivity and efficiency, whilst protecting resources ring-fenced for services for children and young people.

In developing an annual plan for the year that is compliant with NHS England requirements, the Board identified and has articulated its key risks as below, together with headline mitigations. The Trust's ability to navigate the challenges of delivering this plan will be dependent upon the development of detailed actions to underpin the mitigations described.

Risk	**Patient safety and quality:** *there is a risk that the constrained financial envelop will impact on our ability to deliver safe patient care*.
Mitigation	• Ensuring there are robust and transparent mechanisms for assessing the quality impact of decisions taken with regard to resource allocation based on clinical priorities. • Closely monitoring the impact of the cap on elective activity on our CYPF being able to access timely care.
Risk	**People and culture:** *there is a risk the external environment will undermine the work we have undertaken to develop a positive organisational culture, resulting in our people feeling disempowered, pressurised and divided.*
Mitigation	• Creating a less siloed and bureaucratic organisation, becoming more clinically led to ensure our decisions account for taken with staff, with compassion and transparency. • Developing a strong communication strategy with transparent decision-making • Engage teams and empower them lead transformation and financial improvement
Risk	**Financial sustainability:** *There is a risk that the current control measures imposed at national level will inhibit our ability to protect resources dedicated to the treatment, care and wellbeing of CYPF.*
Mitigation	• Developing an operating model so we are more productive and efficient • Financial Improvement Programme to improve our use of resource.
Risk	**Leadership and governance**: *There is a risk that we do not provide appropriate support mechanisms required by the organisation to effectively meet the challenges we face.*

Mitigation	• Instituting robust systems to ensure ongoing, authentic dialogue between senior leaders and frontline teams to enable shared solutions to be realised. • Reviewing our existing governance structures to reduce the time burden of meetings and reporting

A further requirement of the planning process was that each organisation's Board of Directors sign off a series of assurance statements, essentially to formally underwrite that the plan is deliverable and that risks to the quality of care would be fully mitigated. Alder Hey's Board was not able to respond to all of the statement requirements in the affirmative.

This document is part of the Board's response to the challenges posed by the current national environment and expectations, to assure itself and the organisation that our internal governance arrangements will enable a clear and collective understanding of the risks associated with the plan and make compassionate and thoughtful decisions that are in the best interests of our patients and staff.

3. Principles

If the Trust is to safely deliver a changed service, it must operate within a clear framework that is founded upon the organisation's values which should:

- be simple and built to enable a shared narrative focused on patient safety
- remove organisational silos and duplication
- take a programme-based approach
- focus on agreed outcomes not on functions
- foster cross functional conversations
- present clear distinction between mitigated and unmitigated risks
- define a clear rationale and methodology for decisions underpinned by data and evidence, backed by analysis of ethical considerations
- guard against making decisions for the short term that may damage longer term or more strategic progress
- avoid assessing issues in isolation but rather maximise the opportunities to consider wider choices in our decisions.

In overall terms:

- The Alder Hey Board of Directors will retain all overarching constitutional accountabilities and legal responsibilities.
- The Board assurance committees will retain their existing oversight roles but with clear focus on the work of the transformation programme and the work of the five collaboratives.
- The Financial Improvement Programme will operate via a Strategic and Tactical Command structure in the short term until such time as new decision-making processes have been tested, demonstrably effective and are embedded.
- The proposed Clinical Cabinet will undertake a crucial function in ensuring that a strong clinical voice is at the heart of decisions that may impact upon services, underpinned by evidence-based practice and robust data. It will play a key advisory role to the Board in fulfilling its accountabilities.

4. Structure

4.1 *Quality and Equality Impact Assessments* – the Trust has recently reviewed its existing QIA and EIA processes and associated documentation. Benchmarking with national peers indicated that the

content of Alder Hey's assessments is robust, however it is recognised that currently the process is not widely known or undertaken outside of a small group of managers.

It is therefore proposed to re-launch the QIA/EIA approach across the organisation with an updated set of principles and a simplified, web-based process to be undertaken collectively by clinical teams in order to properly understand and evaluate the likely impact of proposed changes on patients, families and staff.

- An EIA/QIA must be completed for any proposed transformation project, service change, savings scheme, service review or policy change to assess any adverse impact on equality, quality of care, patient safety, patient experience, clinical effectiveness or staff safety;
- The process of assessment must be undertaken and signed off by the relevant clinical team with management support;
- The EIA/QIA must be evidenced by relevant data analysis or research evidence, identify and score any potential risks and describe how they will be mitigated;
- The EIA/QIA must be undertaken at the planning stage; no project or change should commence without submission to and the approval of the Clinical Cabinet;
- Should any risks increase during the course of a project, the EIA/QIA must be reviewed and updated with a clear plan to mitigate the risk, escalated to the Divisional senior leadership team, and submitted to the Clinical Cabinet for further approval.

The revised Quality Impact Assessment webform is at Appendix 1.

- *Clinical Cabinet* – the Board has approved the establishment of a Clinical Cabinet to provide strong and visible clinical leadership at the heart of our decision-making process. It will work alongside the Trust Board and operate under its delegated authority to assess and scrutinise all proposals for service change put forward as part of the Financial Improvement Programme and Transformation Programme, or as a consequence of commissioning intentions. It will be co-chaired by the CMO and CNO and its membership will be drawn from the clinical divisions and will be multi-professional.

The draft Terms of Reference for the Clinical Cabinet are at Appendix 2.

4.2 *Strategic Command (FIP)* – the approach to the Financial Improvement Programme was agreed by the Board in April and Strategic and Tactical Command rhythms have continued to operate based on the three agreed parameters:

- Financial improvement taskforces – consumables, contracts and equipment; medicines optimisation; and pay.
- Participation and communication – dissemination of key messages Trust wide through a range of fora.
- Safe and compassionate decision-making – key components as set out in this paper.

5. Recommendation

The Board is asked to approve the decision-making framework and to receive reports from the Clinical Cabinet in support of the safe delivery of the annual plan.

Erica Saunders
April 2025

Quality & Equality Impact Assessment Summary

Quality & Equality Impact Assessment (QEIA)		**Date QEIA Presented at Review Group:**	
		Planned Review Date:	
Project Name:			
Name & Contact Details of Person Completing:			
Clinical Lead Name:		**Clinical Lead Contact Details:**	
Project Lead Name		**Project Lead Contact Details:**	
Programme Lead Name:		**Programme Lead Contact Details:**	

Project Overview

Current Service: (Provide full description of what is currently delivered, considering the volume of patients accessing and outcomes. Consider equity across the region)	
Previous Assessment Reference (if applicable)	
Strategic Theme	
Keep me healthy - How does this proposal contribute to a shift from ill health to prevention, and support neighbourhood-based care?	
See me quickly - Does this change improve access and timeliness of care, particularly through community or virtual models?	
Personalise my care - How will this decision enable personalised, specialist, or integrated care for children and young people?	
Keeping me safe - In what ways does this decision support a culture of safety, reduce variation, or empower children, young people, and families (CYPF)?	

Make it easier - make care more efficient, accessible, or easier to navigate?	
Planned Changes: (Outline planned changes e.g. decommission service, decommission and recommission in a different form, replace or partly commission)	
Future Services: (Outline the future appearance, deliverables and access arrangements. Include arrangements for patients currently accessing planned decommissioned services)	

ENSURE TO COMPLETE THIS DOCUMENT IN FULL AS REVIEW MEETINGS ARE UNABLE TO CONSIDER INCOMPLETE APPLICATIONS

Review Meeting

Meeting Date	Recommendation (in chronological order (first to last) (to be completed by QEIA Administrator):	Panel Outcome	Narrative
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		

REVIEWS

Planned Review Date:		**Actual Review Date:**	

1) Have the anticipated quality impacts been realised and mitigations identified?
2) Have there been any unanticipated negative quality impacts?

Comments	

Quality Impact Assessment (QIA) Risk Assessment	Project:			
	Date of QEIA Presented at Review Group:			
	Planned Review Date:			
What are the potential impacts of the project with regards to harm and risks to patient safety?	Details	Consequence	Likelihood	Overall risk before mitigation
Is there any impact to vulnerable patients?				
Will the project impact on the safeguarding of children?				
Does the project compromise patient safety in any way?				
Is there any impact of the project on preventing patient harm and healthcare associated infections?				
What are the potential impacts of the project with regards to harm and risks to patient safety?	Details	Consequence	Likelihood	Overall risk after mitigation
How will the project impact clinical effectiveness? Is the project applying the best knowledge derived from research?	Details	Consequence	Likelihood	Overall risk before mitigation
Does the project result in shorter lengths of stay?				
Does the project improve clinical outcomes?				
Does the project result in a higher likelihood of recovery?				
Does the project provide improved access to wider care pathways?				
How will the project impact clinical effectiveness? Is the project applying the best knowledge derived from research?	Details	Consequence	Likelihood	Overall risk after mitigation
How will the project impact patient experience?	Details	Consequence	Likelihood	Overall risk before mitigation
Does the project result in a more positive experience for patients?				
Does the project result in improved service access?				
Does the project require any level of public and/or patient engagement or consultation prior to implementation?				
Has the project been developed with public and/or patient engagement?				
Does the project require patients or their carers to travel further for service access?				
Will there be any impact on the setting, environment and place of care?				
How will the project impact patient experience?	Details	Consequence	Likelihood	Overall risk after mitigation
How will the project affect staff?	Details	Consequence	Likelihood	Overall risk before mitigation
Has staff engagement been included in project planning?				

	Details	Consequence	Likelihood	Overall risk before mitigation
What are the risks around disinvestment and contingency plans?				
Do plans include disinvestment? If so, what is the likely clinical effect?				
Does this project link with other which may have an unintended cumulative impact?				
Is there sufficient evidence the unintended consequences have been assess including patient experience, staffing and prescribing (including partners) if applicable?				
Are there contingency plans for unforeseen circumstances?				
	Details	Consequence	Likelihood	Overall risk after mitigation
What are the risks around disinvestment and contingency plans?				
What is the evidence base for making this change?				
Is there a robust evidence base for the imitative and potential outcomes?				
Are the plans underpinned by national evidence based guidance e.g. NICE?				
Does the scheme maximise value (personalisation or added population benefit)?				
Have clinical outcomes for the project been identified with mechanisms in place to monitor progress?				
Detail additional information around planned mitigations or to support the case for change.				
What are the project's interdependencies including predicted vs actual savings?				
Has sustainability been assessed at each quarter including the impact on staffing costs if discontinued?				
Is there evidence of clinical buy-in and support?				
Is the project interdependent on any previous initiatives or projects? If so, have they been assured for effectiveness and sustainability?				
Is there any data on predicted return on investments (if applicable)?				
Has modelling been completed around the savings saturation point? When will this point be reached?				
Does the project impact on partner agencies or stakeholders and the services they deliver?				
Has consideration been given to how the project will support Alder Hey's commitment to tackle climate change?				
Detail additional information around planned mitigations or to support the case for change.				
Governance				
Have the relevant clinical leads been engaged as part of project development?				
Have appropriate discussions been held with primary care, secondary care and any other health and social care providers impacted by the project?				
Has a patient and public involvement form been completed and submitted?				
Has the Equality Assessment form been completed?				
Has the Data Impact Assessment form been completed?				
Has the project plan been shared with stakeholders?				
Detail additional information around planned mitigations or to support the case for change.				
Overall Quality Risk Score (highest from domains after mitigation)				

Likelihood	Consequences				
	1 (Insignificant)	2 (Minor)	3 (Moderate)	4 (Major)	5 Cataphoric)
1 (Rare)	1	2	3	4	5
2 (Unlikely)	2	4	6	8	10
3 (Possible)	3	6	9	12	15
4 (Likely)	4	8	12	16	20
5 (Almost Certain)	5	10	15	20	25

The Equality Duty has 3 aims. It requires public bodies to have due regard to the need to:
- Eliminate unlawful discrimination, harassment, victimisation, and any other prohibited conduct under the Act.
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it.
- Foster good relations between people who share a protected characteristic and people who do not share it.

Having due regard means consciously thinking about the 3 aims of the Equality Duty as part of the process of decision making. This means the consideration of equality issues must influence decisions reached by public bodies - such as in how they act as employers: how they develop, evaluate and review policy; how they design, deliver and evaluate services, and how services are commissioned and procured.

When completing the assessment:
- Be proportionate to your work i.e. the more significant the change, the more rigours you need to be.
- Be honest in actions you state you will undertake to address any negative issues.
- Use intelligent information for your analysis that helps you to understand who your service users/patients are and how they will be affected by the change.
- Work collaboratively.

	Protected Groups	**Impact**	**Rationale** (Include impact source - how have you assessed the impact or potential impact? Is it from research, or other evidence? Data on user trends? Has a member of the public or a stakeholder informed you? Has there been any specific engagement with this group? If no does this require completion?
Q1	**Age** - Consider and detail impact and evidence across all age groups		
Q2	**Disability - Mental health, neurodivergent, physical health conditions or long-term conditions** - Consider and detail impact and evidence on disability (this includes physical, sensory, learning, long-term conditions and mental health		
Q3	**Gender Reassignment** - Consider and detail impact and evidence on people who are transgender/who have had gender reassignment treatment		
Q4	**Marriage and Civil Partnership -** Consider and detail impact and evidence on patients/employees who are married or in a civil partnership		
Q5	**Pregnancy and Maternity** - Consider and detail impact and evidence on people who are pregnant or planning pregnancy		
Q6	**Race, Ethnicity, Nationality** - Consider and detail impact and evidence on all ethnic groups including travelling communities		
Q7	**Religion, Belief or Culture** - Consider and detail impact and evidence on people of different religions, beliefs and on people of no religion		
Q8	**Sex (Gender)** - Consider and detail impact and evidence on males, females and other gender identities		
Q9	**Sexual Orientation** - Consider and detail impact and evidence on people with different orientations		
Others - the group below are of significance to the community and should be considered.			
Q10	Deprived communities, welfare benefits, unemployed/low-income, fuel poverty		
Q11	Carers, including paid and unpaid carers		
Q12	People and families from Armed Forces communities		
Q13	People living in overcrowded conditions		
Q14	Social Isolation		

Q15	People experiencing domestic violence and abuse		
Q16	Vulnerable migrants including, asylum seekers, refuges and undocumented refuges		
Q17	Vulnerable women facing exploitation (street workers)		
Q18	Homelessness		
Q19	Substance/Alcohol misuse		
Q20	People in prison, people being released from prison and their families		
Q21	Rurality		
Q22	Digital exclusion		
Q23	Modern slavery victims		
Inequalities Check			
Q24	**Eliminating discrimination -** How does your activity eliminate any discrimination that people with different characteristics may currently face? What activities are you taking to eliminate discrimination that may have otherwise been caused by your activity?		
Q25	**Advance equality opportunities and access** - Within your activity, how are you advancing equality of opportunity?		
Q26	**Foster good relations** - Within your activity, how are you fostering good relations between people with different characteristics? Are there any potential conflicts between different protected groups, and how are you addressing these conflicts?		
The FREDA principles (fairness, respect, equality, dignity, and autonomy) are a way in which to understand Human Rights .You should consider and evidence how your work impacts on these principles and respects human rights. For example the principle of autonomy informs the right to respect for private and family life and so could be involving people in decisions made about their treatment and care. For more information on Human Rights and the FREDA principles refer to the EHIA toolkit.			
Q27	Fairness		
Q28	Respect		
Q29	Equality		
Q30	Dignity		
Q31	Autonomy		
Summarise Next Steps			
Q27	Outcome		
Q28	Actions Required		
Q29	Timescale		
Q30	Responsible Officers		
Q31	How will we monitor this and to whom will we report outcomes?		
Note			
An EIA is a life document that should be reviewed and developed at intervals throughout and beyond.			
V1 - When agreed and a change is required, this EIA outlines the potential impact of moving from the status quo. Provides information to inform discussion. Identifies gaps in knowledge and understanding to inform communication and engagement plans.			
V2 - continues from V1 occurs following discussion regarding potential solutions to agree options. Requirement to update potential impacts and mitigating actions based on further discussion.			
V3 - Updated prior to any public consultation process. Outlines learning and considerations along with actual likely and potential impacts for all characteristics. All options should be considered.			
V4- Include all learning. Impacts should be considered alongside mitigating actions to ensure decision makers can make informed decisions and display due regard.			
V5 - Completed following the decision for reflection and detail mitigations for any negative impacts.			

Column1
Positive
Negative

Column2
1
2
3
4
5

Quality & Equality Impact Assessment Summary

Quality & Equality Impact Assessment (QEIA)		**Date QEIA Presented at Review Group:**	
		Planned Review Date:	
Project Name:			
Name & Contact Details of Person Completing:			
Clinical Lead Name:		**Clinical Lead Contact Details:**	
Project Lead Name		**Project Lead Contact Details:**	
Programme Lead Name:		**Programme Lead Contact Details:**	

Project Overview

Current Service: (Provide full description of what is currently delivered, considering the volume of patients accessing and outcomes. Consider equity across the region)	
Previous Assessment Reference (if applicable)	
Strategic Theme	
Keep me healthy - How does this proposal contribute to a shift from ill health to prevention, and support neighbourhood-based care?	
See me quickly - Does this change improve access and timeliness of care, particularly through community or virtual models?	
Personalise my care - How will this decision enable personalised, specialist, or integrated care for children and young people?	
Keeping me safe - In what ways does this decision support a culture of safety, reduce variation, or empower children, young people, and families (CYPF)?	

Make it easier - make care more efficient, accessible, or easier to navigate?	
Planned Changes: (Outline planned changes e.g. decommission service, decommission and recommission in a different form, replace or partly commission)	
Future Services: (Outline the future appearance, deliverables and access arrangements. Include arrangements for patients currently accessing planned decommissioned services)	

ENSURE TO COMPLETE THIS DOCUMENT IN FULL AS REVIEW MEETINGS ARE UNABLE TO CONSIDER INCOMPLETE APPLICATIONS

Review Meeting

Meeting Date	Recommendation (in chronological order (first to last) (to be completed by QEIA Administrator):	Panel Outcome	Narrative
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		
	QEIA Review Group discussions and proposed recommendation:		

REVIEWS

Planned Review Date:		**Actual Review Date:**	

1) Have the anticipated quality impacts been realised and mitigations identified?
2) Have there been any unanticipated negative quality impacts?

Comments	

Alder Hey Children's NHS Foundation Trust

CLINICAL CABINET – TERMS OF REFERENCE

Constitution	The Board hereby resolves to establish a formal advisory and decision-making body to be known as the Clinical Cabinet. The Clinical Cabinet will fulfil an advisory function in support of the Financial Improvement Programme and will report directly to the Trust Board.
Membership	• Chief Medical Officer (co-Chair) • Chief Nursing, AHP and Experience Officer (co-Chair) • Chief Operating Officer • Divisional Directors • Divisional representatives for doctors x 3 • Divisional representatives for nurses and AHPs x 3 • Trust Patient Safety lead • Senior finance representative • Senior HR representative
Attendance	The following are expected to attend each meeting: Representatives from the following professional groups: psychologists, clinical scientists, pharmacists. Other Executive Directors as appropriate to the business to be transacted. **Deputies** are permitted but must be of sufficient seniority to fully represent the views of their profession and/or Division and must be properly briefed. **As required:** other persons by invitation. The Chairs of the Clinical Cabinet shall have the power to co-opt additional members as necessitated by the work plan or agenda. In addition, the Chairs have the authority to request relevant reports from any member of Trust staff as required. **Note:** Members and attendees are selected for their specific role or because they are representative of a professional group/speciality or division. As a result, members are expected to: • Ensure that they read papers prior to meetings • Contribute fully to discussion and decision-making • If not in attendance seek a briefing from another member who was present or the person who deputised for them to ensure that they are informed about the meeting's progress • Represent their professional group or their speciality/division as appropriate in discussions and decision making

	• Disseminate and feedback the content of meetings to colleagues in their speciality/service via governance structures and processes.
Agenda setting and minute production and distribution	Agendas shall be agreed by the co-Chairs and will be in accordance with the annual reporting schedule of the group. Agendas, minute production, papers distribution is via the office of the Chief Medical Officer. **Work plan** The Clinical Cabinet will develop a work plan with sufficient flexibility to accommodate timely decisions and reporting balanced with regular review of its activities. It will review its operation after six months and adjust its terms of reference as required.
Attendance	Overall, throughout the working year, each member (or knowledgeable deputy) is expected to achieve 75% attendance at scheduled meetings.
Quorum	One co-Chair, at least one representative from each Division, at least one representative from each professional group.
Frequency / duration	Meetings shall normally take place monthly. Additional meeting may take place as required and/or called by one of the co-Chairs.
Responsibilities	➢ The Clinical Cabinet will be responsible for providing strong and visible clinical leadership at the heart of our decision-making processes, focused on safeguarding patient safety at all times. ➢ It will work alongside the Trust Board and operate under its delegated authority to assess and scrutinise all proposals for service change put forward as part of the Financial Improvement Programme and Transformation Programme, or as a consequence of commissioning intentions. ➢ It will represent the clinical voice of the organisation, ensuring transparency, equity and strong financial stewardship in decision-making whilst advocating for patients and modelling Trust Values and behaviours. ➢ Its decision-making will be data driven and evidence based; it will assess all risks associated to its decisions and provide its views to the Trust Board against the Assurance Statements agreed within the Annual Plan.
Duties	The principal duties of the Clinical Cabinet are to: • Shape the future vision for our clinical services in accordance with the Trust's 2030 strategy; • Analyse all proposed service changes in detail via Equality and Quality Impact Assessment (EIAs and QIAs) documents, probing the data as necessary and querying any areas of concern; • Set out its decision on each proposal in writing with clear reasons, particularly in the event that full consensus cannot be reached; • Work with the Executive to prioritise the allocation of resources and assess relative risk in accordance with annual planning intentions;

	• Strengthen the voice of clinical teams in strategic decision-making through the operation of robust and transparent processes that are inclusive and reflect the changing needs of our patient population.
Reporting	The Clinical Cabinet will report the outcomes of its decision-making processes to the Financial Improvement Programme Strategic Command. It will make a formal report to the Trust Board on a monthly basis in its first six months. Reporting arrangements will be reviewed thereafter.
Conduct	The Clinical Cabinet will develop a work plan which will be reviewed formally on an annual basis and submit an annual report to the Audit and Risk Committee. Agendas, papers and minutes to be distributed not less than 4 working days prior to meetings. Papers to be tabled in exceptional circumstances. Confidentiality to be strictly adhered to as required by the co-Chairs. Any other business to be notified to the co-Chairs in advance of the meeting.
Monitoring	The co-Chairs will ensure that an Annual Report of the Clinical Cabinet's activities is completed and that this is submitted to the Audit and Risk Committee for scrutiny and to the Board for approval.
Other Matters	These Terms of Reference to be reviewed after six months of operation and on an annual basis thereafter.

DATE: April 2025

REVIEW DATE: September 2025

BOARD OF DIRECTORS

Thursday, 1st May 2025

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

Purpose of Paper:	Decision ☐ Assurance R Information R Regulation ☐
Action/Decision Required:	To note R To approve R
Summary / supporting information	The purpose of this paper is to update the Board on the progress in the initiation of our 25/26 multi-year transformational programme. - Related information is contained in the annual plan 25/26, which provides a high-level summary of the scopes, aims of the AH – Transformation Collaboratives.
Strategic Context This paper links to the following:	Outstanding care and experience R Collaborate for children & young people R Revolutionise care R Support our people R Pioneering breakthroughs ☐ Strong Foundations R
Resource Implications:	None detailed within report

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score
3.2	BAF Risk 3.2 – Deployment of Vision 2030 – is scored at 16, reflecting limited financial confidence and the need for further quantified benefits. Mitigations to address this, including strengthened analytical support and clearer benefit articulation, form a key part of the approach to control and reduce this risk as transformation delivery progresses detailed within the report.	16

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

1. Executive Summary

This report provides a Year-to-Date (YTD) update on the Trust's Vision 2030 Transformation Programme, with a focus on progress since the establishment of the Transformation Board in April 2025. The Transformation Board now oversees five collaboratives:

- Reimagined Elective Care & Supporting Centres of Excellence
- Acute, Diagnostics & Urgent Care
- Neighbourhood, Prevention
- Fit for the Future
- Digital, Data & AI

Each collaborative operates on a 90-day delivery rhythm, supported by a shared benefit framework and accountable leadership.

Over the first part of the year, these collaboratives have begun delivering a mix of in-year operational efficiencies and longer-term transformational work. The programme is progressing as planned, though challenges remain — particularly around delivering the necessary in-year savings to support financial recovery. This risk is being actively managed through a combination of executive oversight, prioritisation of high-impact opportunities, and values-based assurance.

In parallel, we are responding to Board feedback from December 2025 by advancing an outcomes-led measurement and benefit framework, which builds on our existing approach. During Q1, we will begin testing the "Working Backwards" methodology to define clear outcomes from the outset and to underpin a new Transformation Scorecard. This will improve our ability to track the real-world impact of change for children, young people and families not just in terms of efficiency, but in terms of experience, equity, and system value.

2. Assessment of Current Position

- **Governance Maturity: Transformation Board**

The establishment of the Transformation Board on 15th April 2025 is a key step in strengthening accountability and integration across the Vision 2030 portfolio. It enables clearer oversight of collaborative interdependencies, milestone delivery, and benefit tracking. Meeting monthly, the Board provides a strategic forum to align activity, resolve issues early, and ensure transparent escalation to the Executive and Trust Board.
The Terms of Reference confirm a dual focus:

- Programme interconnection and dependency management
- Delivery fundamentals: milestone assurance and benefit realisation

- **Financial Planning and Delivery Confidence**

All five collaboratives have now submitted their initial Full Year Financial Plans, which form a critical part of the Trust's wider financial recovery approach. These submissions are currently undergoing detailed review and validation by finance and transformation teams.

The Trust has set a transformation-led benefit target of £25m for the year, with £10m expected from the current collaborative portfolio. While this represents a strong ambition, it is recognised that we are still in the early stages of delivery planning and benefit realisation, and therefore current levels of confidence remain cautious.

Each collaborative is currently assessed as having a low level of financial confidence. This reflects the early stage of benefit quantification and the complexity of the changes involved. The Transformation Board is providing oversight and applying a tiered model of support and escalation, aimed at proactively managing risk and building confidence in delivery over time.

This includes:

- Bespoke analytical support to sharpen benefit logic
- Delivery diagnostics to identify barriers to progress
- Escalation mechanisms to prioritise Executive focus where delivery risk is high

The process of financial plan refinement is ongoing, and it is expected that through May and June, each collaborative will update its forecasts, re-profile benefits, and where necessary explore more ambitious delivery options aligned to strategic priorities – this activity will be supported by the Executive team.

- **Forecasted Benefit Variation Across Collaboratives**

While detailed costing is ongoing, there is a marked variation in the **scale and timing** of forecasted benefits across the five collaboratives. A portfolio segmentation approach has been adopted to assess strategic contribution and delivery profile:

Collaborative	Target	Timing of financial Benefits	Description	Status
Elective Care & Centres of Excellence	£700k Centres of Excellence £1m In-patients £1m – **Total** £2.7m	**Short-term** (in-year) plus medium / longer-term (Centres of Excellence)	Forecasted to deliver early measurable savings through pathway reform and productivity gains, while supporting centres of excellence and improving access.	Operational; pathway reform and early benefit capture in motion – including early wins through a 2-day mapping session with Cardiology.
Acute, Diagnostics & Urgent Care	Net £0 *£2.9m efficiency reinvested in new SDEC model subject to business case approval.*	SDEC: **Medium-term** (starting 2026/27)	Primary benefits through SDEC models, dependent on infrastructure completion and test-learn cycles. Scaled delivery expected from 2026/27.	Pre-implementation; infrastructure / business dependencies in progress. Continuing to explore further benefit opportunities related to diagnostics / models of acute care.

Neighbourhood & Prevention	£0 Year 1	**Long-term** (2+ years)	Not expected to deliver significant in-year financial benefits, but strong potential for system-wide savings through upstream demand shift and neighbourhood model transformation.	Foundational stage; shaping neighbourhood models and system links. With a test of change scheduled for May 25.
Digital, Data & AI	£700k (2025/26)	**Short-term** and **Long-term**	Immediate in-year benefits via automation and reduced variation; long-term potential through AI, digital integration, and clinical decision support.	Active delivery: in-year benefit initiatives underway – including with AI solutions being tested and deployed. AI Strategy developed and ready for approval.
Fit for the Future	£4.4m (2025/26)	**Short-term** (in-year), plus **medium term**	Focus on governance and people-related change. Provides assurance across workforce and corporate redesign. Delivers in-year savings by streamlining corporate services.	Established – planning / delivery – early focus includes supporting workforce plans, non-patient facing
Transformational stretch	Transformation 1% ops budget £2.65m	**Short-term**		
Innovation and Research	£350k	**Short-term**		

This variation in delivery timing and benefit scale reflects the deliberate design of a multi-year transformation programme. From the outset, the Trust has recognised that not all collaboratives would yield immediate financial returns. Programmes such as Acute, Diagnostics & Urgent Care are dependent on enabling infrastructure (e.g. SDEC build), while Neighbourhood & Prevention relies heavily on external partnerships and system-wide engagement. These constraints limit the opportunity to accelerate returns in the near term.

Each collaborative plays a critical role in the Trust's transformation portfolio, balancing early efficiency gains with strategic investments that support our long-term future. The focus is on achieving strategic coherence and cumulative value rather than adhering to uniform timelines. The Transformation Board will assess programmes based on financial performance, long-term sustainability, risk mitigation, and alignment with Vision 2030 outcomes. As part of this work, long-term plans for each collaborative will be developed to reflect emerging system priorities, supported by forecasts that demonstrate value and impact.

- **Emerging Strategy: Experience and Needs Outcomes Framework Implementation**

Experience: In line with our ambition to become an experience-led, needs- and outcomes-driven organisation, the Executive Team has approved the next phase of the Experience and Engagement Programme. This phase will focus on three core areas: enhancing and streamlining our regulatory approach, developing a new governance model, and transforming how we deliver experience across the Trust. Key elements include aligning all first contact points, implementing real-time experience dashboards, and harnessing generative AI and digital tools to personalise care. This work is directly aligned with our CYPF promises and will span all collaboratives and our people. It will report into SQAC, with a detailed update scheduled for the next Strategy Board.

Outcomes framework: The Trust is implementing an experience and outcomes-led benefit framework, aligned to the 2030 Vision and building on the existing benefit realisation model. This work responds directly to the Strategy Board's December 2025 feedback, which highlighted the need to link strategic change to outcomes more explicitly as a key differentiator of value.

The "Working Backwards" approach, due to be trialled in Q1, will support the development of a prototype Portfolio Scorecard. This approach ensures every programme begins with a clear definition of success and identifies measurable outcomes from the outset.

Recognising the complexity of this shift, the Trust will adopt an iterative model, refining the framework through successive improvement cycles. Outcomes will be developed progressively, with indicators tested in real settings and refined in partnership with collaborative teams.

- **Early Signs of Collaborative Impact**

A notable cultural shift is emerging through the work of the five collaboratives. While still in early stages, there is growing evidence of:

- **Improved cross-functional problem-solving** teams are surfacing shared challenges and designing joined-up responses, particularly in diagnostics, workforce redesign, and digital triage.
- **Faster learning loops** the 90-day delivery rhythm is embedding a test-and-learn mindset, with real-time adjustments being made based on shared insights.
- **Increased mutual accountability** SROs and delivery leads are collectively owning interdependencies and escalating risks early for resolution.
- **Trust-wide engagement** early outputs from the Neighbourhood and Fit for the Future collaboratives have included diverse voices from clinical and corporate teams, enhancing the inclusivity of decision-making.

This maturing collaborative model is a critical enabler of the Trust's ambition to become an empowered and clinical led learning organisation and deliver integrated change at pace.

3. Risks and Mitigations

Risk Area	Summary of Risk	Mitigation

Sufficiency of Plans	Some plans may lack the boldness or scope needed to meet savings goals.	Collaboratives supported to re-test assumptions, explore ambitious opportunities, and strengthen benefit logic – supported with Executive oversight.
Safe and Sustainable Delivery	Risk that cost-saving efforts compromise quality, safety, or experience.	Quality and safety assured through benefit framework, clinical oversight, and use of Statistical Process Control where relevant.
Values and Strategic Alignment	Pressure for short-term savings may undermine values and Vision 2030 alignment.	Outcomes framework, EIA/QIA prompts, and Clinical Cabinet governance ensure values-led, future-focused decision-making.

4. Conclusion

The formalisation of the Transformation Board, maturing financial planning processes, and the roll-out of an outcomes-led evaluation framework represent critical progress in operationalising Vision 2030. These developments signal a shift from structural mobilisation to value delivery and lay the groundwork for consistent, evidence-led transformation.

Next Steps

1. **Finalise Financial Plan Validation**
    - Collaboratives to refine plans with finance and transformation colleagues. Where gaps are identified, action plans to be developed by end of May.
2. **Operationalise Outcome Framework**
    - Begin integration of "Working Backwards" metrics into programme reporting by June.
    - Launch pilot version of Power BI Portfolio Scorecard for internal testing.
3. **Accelerate Programme Delivery Where Possible**
    - Use assurance outputs to identify opportunities for acceleration or pivoting.
    - Prioritise areas with high-confidence delivery and measurable outcomes.

.

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	**Integrated Performance Report – 2025/26 Proposal**
Report of:	Kate Warriner, Chief Transformation and Digital Officer Adam Bateman, Chief Operating Officer, Deputy CEO
Paper Prepared by:	Matthew Upton, Acting Head of Performance Karl Edwardson, Head of Analytics

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

1. Executive Summary

As part of the Annual Planning process and the development of the 2030 Vision and strategy, the Integrated Performance Report (IPR) requires an update to align with the objectives and priorities contained in the 2025/26 Integrated Operational Plan.

This report proposes four key developments and enhances to the Integrated Performance Report for 2025-26:

- A new summary page
- Alignment with national objectives for 20225/26 Integrated Performance Report
- New metrics to monitor important service developments, for example virtual care and Martha's rule
- Focus on productivity and associated metrics

The paper requests approval for the proposed changes, with implementation scheduled for May and a new report available for the Trust Board in June.

Wider developments to our ass

2. Background

The 2025/26 Integrated Operational Plan, approved by Trust Board in March, sets out our objectives and priorities for coming year. Performance reporting is aligned to our long-term strategic goals as set out in the 2030 Vision, as well as national priorities and objectives.

The IPR has evolved for a number of years and is in line with NHS England's Making Data Count Framework. The IPR for 25/26 has further evolved with our Integrated Operational Plan and includes metrics from the development work undertaken in 24/25 including enhanced productivity approaches and some service developments into business as usual operational performance.

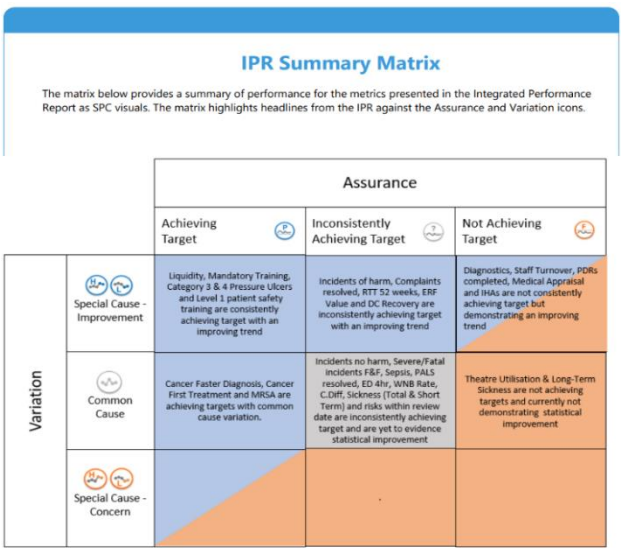
In addition, we are working on a new Transformation Report with outcomes and scorecard which will be live in Q1 2025- 26.

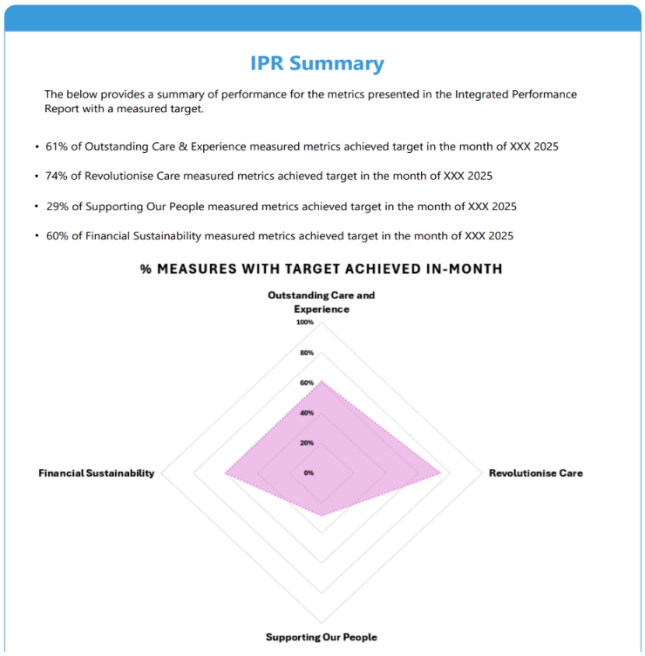
3. 2025- 26 Integrated Performance Report

Four developments are proposed to update the IPR for 2025- 25:

i. Summary of performance

A review of NHSE-recommended IPRs from NHS trusts across the UK has been conducted. All trusts identified as exemplars have chosen to use the IPR summary matrix, which will continue to be implemented for 2025/26. The IPR Summary format has been changed to remove the headline analysis of SPC metrics and primarily focus on performance versus target for the month. An example of the summary is shown below.





ii. Alignment to new national objectives

The current set of metrics has been reviewed in relation to the key national operating objectives outlined in the NHS Planning Guidance for 2025/26. Metrics that are not currently captured have been incorporated for the upcoming year. The metrics for 2025/26 have been reviewed and approved by the relevant Executive Lead for that strategic objective/ section of the report.

The updated metrics proposal can be found in Appendix A. The key changes are as follows:

- Collaborate for CYP has been removed from the IPR and will be included in the transformation scorecard.
- Percentage of patients treated within 18 weeks
- Percentage of patients waiting over a year
- Estimated time it would take to clear the waiting list if no new patients were added
- Percentage of ED attends over 12 hours
- Ambulance handover times
- Percentage of patients admitted as an emergency within 30 days of discharge
- Annual change in the number of C&P accessing MH services

iii. Focus on productivity

The key national operating objectives for 2025/26 include a productivity metric to be monitored by acute trusts, referred to as the rate of productivity. However, the technical guidance for this metric has not yet been published, and the C&M planning team was unable

to clarify how it will be calculated. This metric will be included once more information becomes available.

The following productivity metrics will be included in the IPR for Trust Board in June 2025:

- Cost per patient treated
- Patients per Daycase Theatre / Inpatient Theatre
- Income per theatre session
- Elective admissions per clinical WTE (currently captured in IPR)

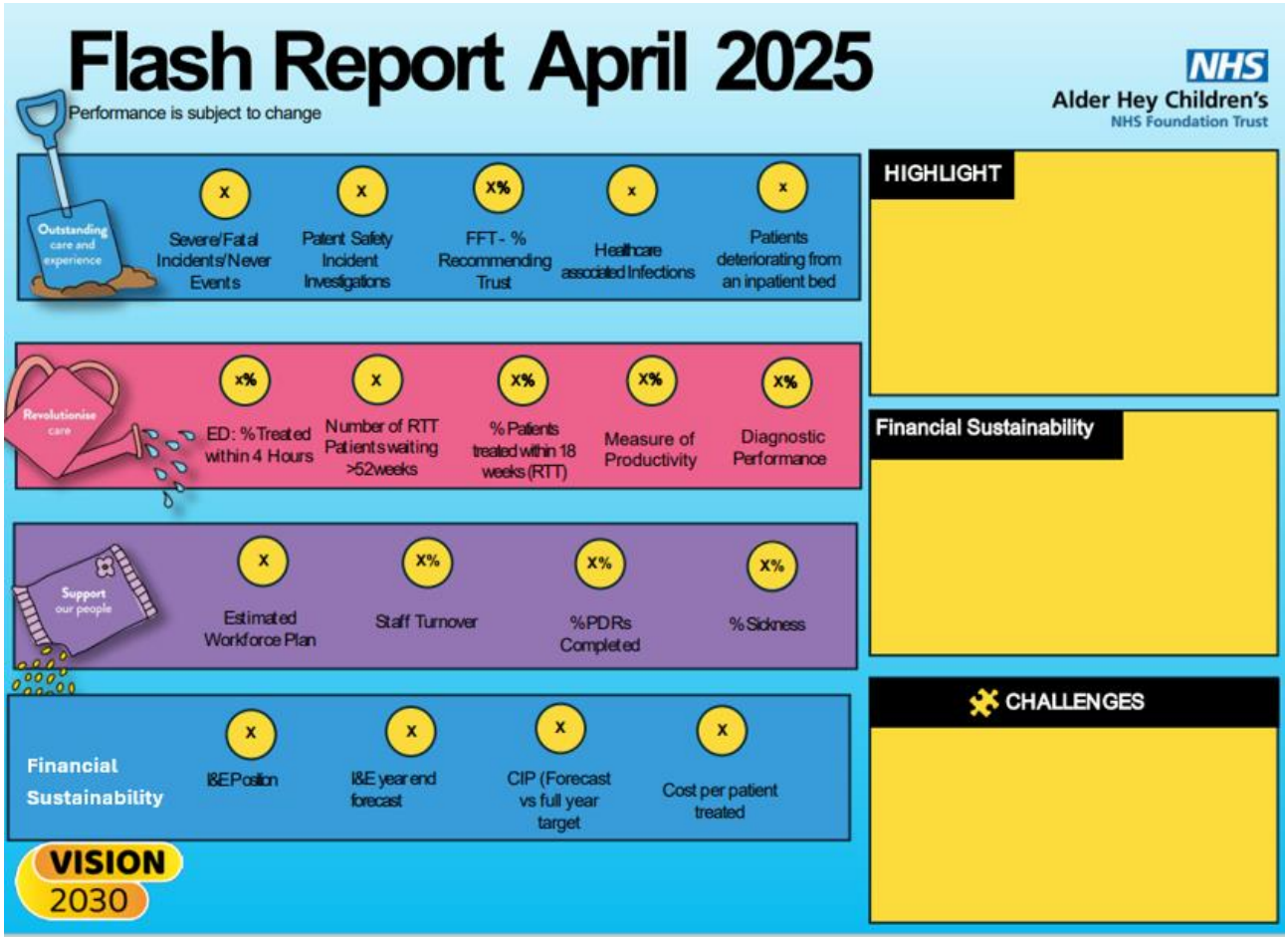
iii. New metrics to monitor important service developments

A number of service developments and transformation programmes delivered in 2024-25 should now be tracked to ensure they are being delivered reliably as 'business as usual'. New metrics will be included to provide data on virtual care and Martha's rule.

4. Flash Report

In addition to the IPR, it is proposed that the Trust Board continues to receive a Flash Report to enable access to the latest possible performance data for the period in the calender month which as closed days before the Trust Board sits. This is intended to supplement the more formal IPR report which covers performance from two months back.

The proposed format of the Flash Report is as follows:



5. Transformation Scorecard

Our multi-year transformation programme is focused on delivering Vision 2030. To achieve these goals, we have established five transformation collaboratives. A strategic outcomes framework is in development to support the measurement of the impact and outcomes of the transformation collaboratives. This report will produced in Q1 2025-26.

6. Data Platform

The Trust has invested in digital infrastructure and architecture in the form of a new platform. This is on the delivery plan for the digital, data and AI collaborative for 25/26. This will provide new capability in terms of an increase in data sets to incorporate into the Trust data warehouse and a more sophisticated and easier way to access this intelligence across the Trust.

This capability will enable us to further expand and develop our IPR and reporting capabilities over the next 12 months as this new platform is implemented and embedded.

7. Conclusion

Following the Annual Planning process, the IPR has been reviewed and updated to reflect the challenges and goals for the 2025/26 financial year. The changes include:

- A new summary page
- Alignment with national objectives for 20225/26 Integrated Performance Report
- New metrics to monitor important service developments, for example virtual care and Martha's rule
- Focus on productivity, with associated metrics
- Continuation of a Flash Report

The Trust Board is asked to approve these proposed changes, with the new report available for Trust Board in June 2025 reporting on April's performance.

Appendix A – Full Review of the Suite of Metrics for IPR 2025/26

Outstanding Care & Experience

IPR Metric 2024/2025	Proposed IPR Metrics 2025/2026
DRIVER METRIC F&F Test - % Recommend the Trust	F&F Test - % Recommend the Trust ***Change to Watch***
DRIVER METRIC Incidents of harm per 1,000 bed days (rated Low Harm and above)	***DRIVER METRIC*** Incidents of harm per 1,000 bed days (rated Low Harm and above)
DRIVER METRIC Number of Incidents rated No Harm per 1,000 bed days	***DRIVER METRIC*** Number of Incidents rated No Harm per 1,000 bed days
Patient Safety Incidents (All)	Patient Safety Incidents (All)
Severe or Fatal Incidents – Physical only	Severe or Fatal Incidents – Physical
Severe or Fatal Incidents – Physical & Psychological	Severe Incidents - Psychological ***Split Out / No Fatal label***
Number of PSIIs (Patient safety incident investigation) undertaken	Number of PSIIs (Patient safety incident investigation) undertaken
Number of Never Events	Number of Never Events
	Number of contacts of Martha's rule
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	Sepsis % Patients receiving antibiotic within 60 mins for Inpatients
Sepsis % Patients receiving antibiotic within 60 mins for ED	Sepsis % Patients receiving antibiotic within 60 mins for ED
Medication Errors resulting in Harm (Physical and Psychological)	Medication Errors resulting in Harm (Physical and Psychological)
Pressure Ulcers Category 3 and 4	Pressure Ulcers Category 3 and 4
Pressure Ulcers Category 2	Pressure Ulcers Category 2
Recording of restrictive interventions	Recording of restrictive interventions
Employees trained in new Level 1 of Patient Safety	Employees trained in new Level 1 of Patient Safety
F&F ED - % Recommend the Trust	F&F ED - % Recommend the Trust
Hospital Acquired Organisms - MRSA (BSI)	Hospital Acquired Organisms - MRSA (BSI)
Hospital Acquired Organisms - (C.Difficile)	Hospital Acquired Organisms - (C.Difficile)
Hospital Acquired Organisms - MSSA	Hospital Acquired Organisms - MSSA
% PALS Resolved within 5 Days	% PALS Resolved within 5 Days
Number of PALs contacts	Number of PALs contacts
% Complaints Responded to within 25 working days	% Complaints Responded to within 25 working days
Number of formal complaints received	Number of formal complaints received
Number of patients deteriorating from an inpatient bed admitted to Critical Care	***DRIVER METRIC*** Number of patients deteriorating from an inpatient bed admitted to Critical Care
Number of patients deteriorating from HDU admitted to PICU	Number of patients deteriorating from HDU admitted to PICU
	Preventable and predictable deteriorating patients

Revolutionise Care

Section	IPR Metric 2024/2025	Proposed IPR Metrics 2025/2026
Revolutionise Care (Adam Bateman and Kate Warriner)	***DRIVER METRIC*** ED: % treated within 4 Hours	***DRIVER METRIC*** ED: % treated within 4 Hours
	DRIVER METRIC Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)	***DRIVER METRIC*** **Percentage** of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)
	DRIVER METRIC % of children and young people who receive an outcome of their ASD and ADHD assessment within 65 weeks	***DRIVER METRIC*** % of children and young people who receive an outcome of their ASD and ADHD assessment within 65 weeks
		DRIVER METRIC Percentage of patients treated within 18 weeks (RTT)
	% Was Not Brought Rate (All OP: New and FU)	% Was Not Brought Rate (All OP: New and FU)
	Theatre Utilisation (Capped Touch Time)	Theatre Utilisation (Capped Touch Time)
		% of ED attends over 12 hours
		Average Ambulance Handover Time
	Elective admissions (IP & DC) per clinical WTE	***DRIVER METRIC*** Elective admissions (IP & DC) per clinical WTE
	Outpatient attendances per Consultant WTE	
	% Recovery for Daycase Discharges	
	% Recovery for Elective Discharges	
	% Recovery for DC & EL Activity Volume	
	% Recovery for OP New & OPPROC Activity Volume	
	Daycase Activity vs Plan (YTD Position)	
	Elective Activity vs Plan (YTD Position)	
	Op new & OPPROC Activity vs Plan (YTD Position)	
		Daycase & Elective Income and Spells vs Plan (% YTD Cumulative Position)
		OP New & OPPROC Income and Activity vs Plan (% YTD Cumulative Position)
	Reduce overdue Outpatient FU Waits 2 Years and over by 31st March 2025	Reduce overdue Outpatient FU Waits 2 Years and over by 31st March 2026
		% follow up waiting list on PIFU
		Estimated time it would take to clear the waiting list if no new patients were added
		Percentage of patients admitted as an emergency within 30 days of discharge
	ADHD/ASD Diagnosis Status	ADHD/ASD Diagnosis Status
	CAMHS: Number of CYP >52 Weeks	
	Number of Paediatric Community Patients waiting >52 weeks	
	Diagnostics Completed with 6 weeks	Diagnostics Completed with 6 weeks
	Cancer: Faster Diagnosis within 28 days	Cancer: Faster Diagnosis within 28 days
	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.
	31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

People

Section	IPR Metric 2024/2025	Proposed IPR Metrics 2025/2026
People (Melissa Swindell)	***DRIVER METRIC*** Total Workforce - WTE (Plan)	***DRIVER METRIC*** Total Workforce - WTE (Plan)
	DRIVER METRIC Staff Turnover	***DRIVER METRIC*** Staff Turnover
	DRIVER METRIC Sickness Total	***DRIVER METRIC*** Sickness Total
	Short Term Sickness	Short Term Sickness
	Long Term Sickness	Long Term Sickness
	Manadatory Training	Manadatory Training
	% PDRs Completed	% All PDRs Completed
		% PDRs Completed B7+
	Medical Appraisal	Medical Appraisal
	Workforce Stability	Workforce Stability
		Time to Hire

Pioneering Breakthroughs - *Although a significant growth in measures, it would lead to growth of +1 page only*

Section	IPR Metric 2024/2025	Proposed IPR Metrics 2025/2026
Pioneering Breakthroughs (John Chester)	***DRIVER METRIC*** Commercial and Non-commercial Income to Research and Innovation - Cumulative	***DRIVER METRIC* External income received by month across Research and Innovation (cumulative)**
		External innovation income received by month (commercial and non-commercial)
		External research income received by month (commercial and non-commercial but excluding NIHR)
		NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)
		Number of open commercial studies (recruiting and in follow up)
	Number of Patients Recruited into Research Studies	Number of open non-commercial studies (recruiting and in follow up)
		Number of participants recruited to all studies (include breakdown by Clinical Division)
		Number of participants recruited to all NIHR portfolio studies
	Number of Active (Open) Studies - Academic	Number of participants recruited to interventional studies (including CTIMPs, devices,
	Number of Active (Open) Studies -Commercial	Recruitment to time and target (RTT) – external target 80%
	Number of Chief Investigator led studies	RTT Alder Hey sponsored studies only – external target 80%
		***DRIVE METRIC* Number of AH Chief Investigators (substantive or honorary) leading NIHR portfolio studies (externally funded and peer-reviewed)** - include breakdown by clinical division
		Number of publications with AH author by quarter including journal impact factor
	DRIVER METRIC Manual hours saved through automation solutions - Monthly	Number of businesses supported by POIZ
		Manual hours released from automation/AI solutions
		Number of innovative treatments and diagnostics deployed to care
		Number of staff trained in innovation methods
		Number of staff trained in research methods
		Number of externally funded fellowships (R and I) cumulative
		Number of AH-hosted jobs created through new external funding (POIZ metric)
		Number of capacity building awards (funded through AH Charity, RCF and commercial
		Number of higher-level degree projects hosted by AH
		Number of primary and secondary schools engaged with Futures activities

Collaborate for CYP (removed from IPR and will be included in transformations scorecard)

Section	IPR Metric 2024/2025	Proposed IPR Metrics 2025/2026
Collaborate for CYP (Dani Jones)	***DRIVER METRIC*** Social Value Generated	
	Oral Health: Number of children 52wks for tooth extraction	
	Median Waiting Time (RTT) - LD Waiters Variance (Wks) to Non-LD	
	Alder Hey Community Mental Health Services : Number of CYP of BAME background referred	

Financial Sustainability

Section	IPR Metric 2024/2025	Proposed IPR Metrics 2025/2026
Financial Sustainability (Rachel Lea)	***DRIVER METRIC*** I&E Year End Forecast	***DRIVER METRIC*** I&E Year End Forecast
	DRIVER METRIC Recurrent Efficiency Plans Delivered (Forecast)	***DRIVER METRIC*** Recurrent Efficiency Plans Delivered (Forecast)
	DRIVER METRIC % ERF Value (Income)	
	I&E distance from target (cumulative YTD)	I&E distance from target (cumulative YTD)
	Liquidity	Liquidity
	Cash in Bank	Cash in Bank
		CIP (forecast vs full year target)
		Capital YTD spend against plan
		DRIVER METRIC Capital Forecast against plan
		Cost per patient treated

Risk Management

Section	IPR Metric 2024/2025	Proposed IPR Metrics 2025/2026
Risk Management (Erica Saunders)	***DRIVER METRIC*** Number of High Risks (Scored 15+)	***DRIVER METRIC*** Number of High Risks (Scored 15+)
	DRIVER METRIC % High Risks within Review Date	***DRIVER METRIC*** % High Risks within Review Date
	Trust Risk Profile	Trust Risk Profile
	% High risks with actions past expected date of completion	% High risks with actions past expected date of completion

Flash Report April 2025

Performance is subject to change and released 29th April

NHS
Alder Hey Children's
NHS Foundation Trust

0	0	93.6%	5	17
Severe/Fatal Incidents/Never Events	Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections	Patients deteriorating from an inpatient bed

86%	359	52.9%	1.67	94.6%
ED: %Treated within 4 Hours	Number of RTT Patients waiting >52weeks	% Patients treated within 18 weeks (RTT)	Elective activiy per clinical WTE	Diagnostic Performance

TBC	10.9%	80.7%	TBC
Estimated Workforce Plan	Staff Turnover	%PDRs Completed	% Sickness

Financial Sustainability

TBC	0	£13m	TBC
I&E position	I&E year end forecast to plan (Variance)	CIP (Risk adjusted)	Cost per patient treated

HIGHLIGHT

- Significant improvement time to be seen and treated in ED.
- High proportion of diagnostic tests completed in six weeks
- Good patient experience scores
- No never events or new patients safety incident investigations
- Reduction in number of patients deteriorating from an inpatient bed and admitted to PICU

CHALLENGES

- Increase in C&YP waiting > 52 weeks, caused by capacity challenge in ENT
- 5 healthcare associated infections with 4 Cdiff and 1 MSSA

Certain measures unavailble with the flash report released during the reporting month

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: April 2025

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, Category 3 & 4 Pressure Ulcers and Level 1 patient safety training are consistently achieving target with an improving trend	Incidents of harm, Complaints 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 Faster Diagnosis, Cancer First Treatment, Mandatory Training and MRSA are achieving targets with common cause variation.	Incidents no harm, Severe/Fatal incidents F&F, Sepsis, PALS resolved, ED 4hr, WNB Rate, C.Diff, Sickness (Total & Short Term) and risks within review date are inconsistently achieving target and are yet to evidence statistical improvement	Theatre Utilisation & Long-Term Sickness are not achieving targets and currently not demonstrating statistical improvement
Special Cause - Concern		Patient safety incident investigation (PSII) is inconsistently achieving its target but demonstrating declining trend and deteriorating patients demonstrating special cause concern	

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

- 54.9% of measured metrics have achieved target in the month of March 2025.

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

NHS Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

- 100% of inpatients and 91% of ED patients received antibiotics within 60 minutes for sepsis
- No Category 2 pressure ulcers reported for 4 months
- 91% of PALS concerns responded to within 5 working days

Areas of Concern:

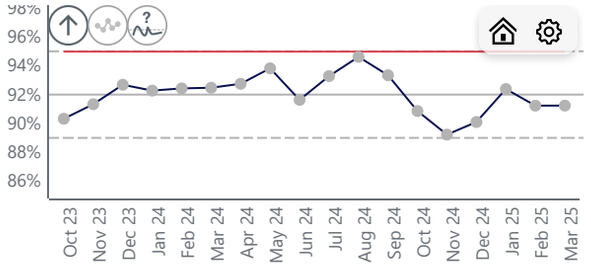
- One serious incident reported. Reviewed by PSIRI panel and PSII commissioned. Duty of Candour requirements met
- Increase in patients deteriorating from an inpatient bed and admitted to Critical Care; all cases of unexpected admission reviewed by the Response Team
- 80% of formal complaints responded to within 25 working days

Forward Look (with actions)

Response Team to review patients who have been admitted to Critical Care unexpectedly and identify and share any themes and learning with Deteriorating Patient working group

F&F Test - % Recommend the Trust

Target: Statutory



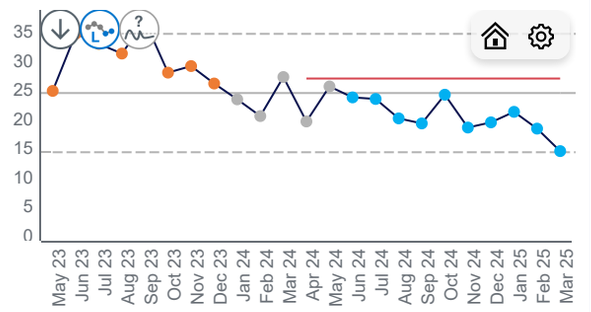
Technical Analysis:

Common cause variation has been observed with performance of 91% in March 2025. Level with February performance of 91%.

Actions:

91% of families would recommend the Trust. Quality Ward Round undertaken with the children and young people to review FFT

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



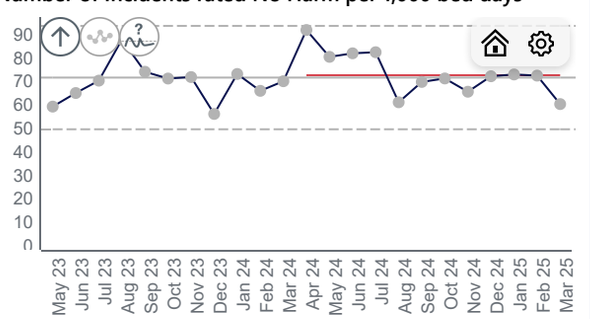
Technical Analysis:

Special cause variation of improving nature has been observed with performance of 15 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:

Decreasing trajectory of incidents resulting in harm. Continue to review all incidents reported as Moderate or above at PSIRI panel

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



Technical Analysis:

Common cause variation observed with 60 incidents of no harm per 1000 bed days, with a monthly average of 72. This includes 43 incidents with no harm assigned due to not involving a patient directly. Incidents are now assessed on Physical and Psychological Harms and target is set against a 5% improvement on 23/24 with monthly target 71.

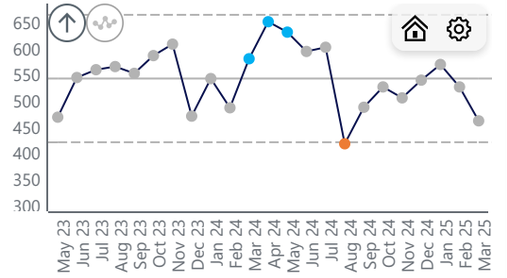
Actions:

Staff continue to report incidents of no harm which facilitates wider organisational learning

NHS
Alder Hey Children's
NHS Foundation Trust

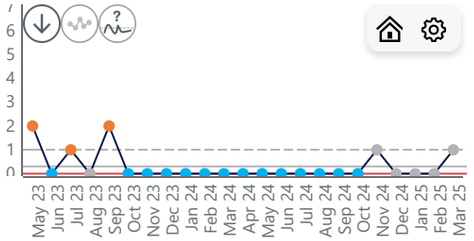
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



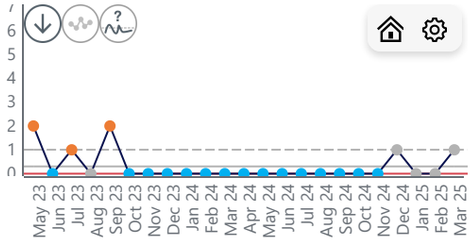
Severe or Fatal Incidents – Physical only

Target: Internal

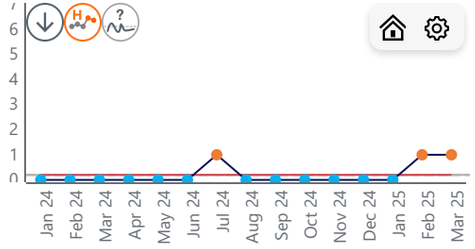


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

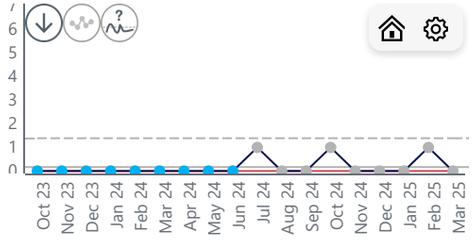


Number of PSIIs (Patient safety incident investigation) undertaken



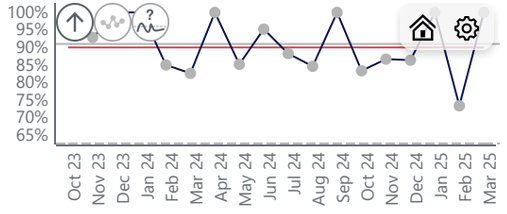
Number of Never Events

Target: Internal



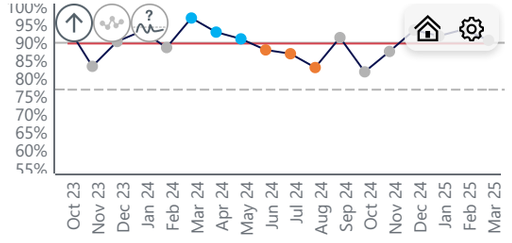
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

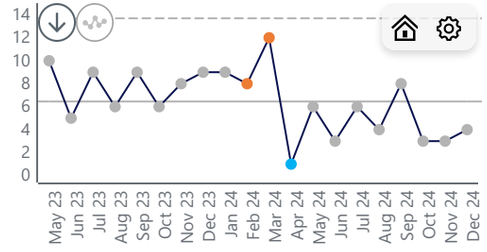


Sepsis % Patients receiving antibiotic within 60 mins for ED

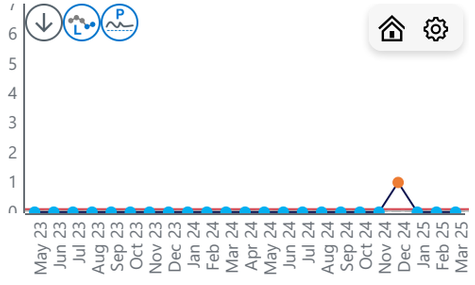
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

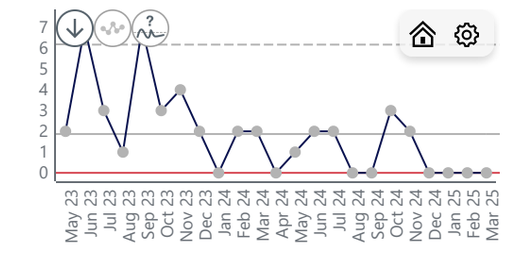


Pressure Ulcers Category 3 and 4

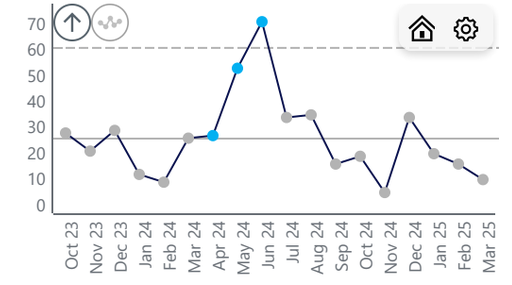


Pressure Ulcers Category 2

Target: Internal

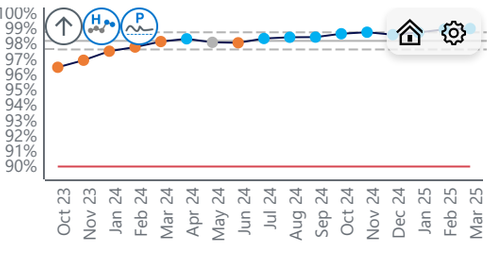


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal

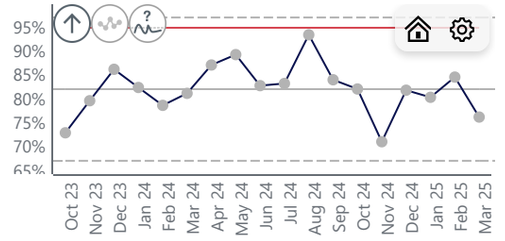


Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

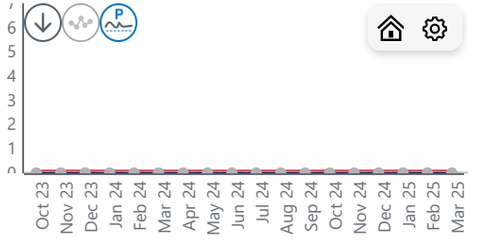
F&F ED - % Recommend the Trust

Target: Internal



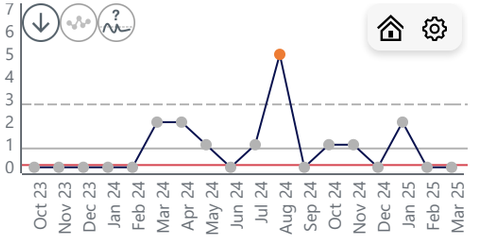
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



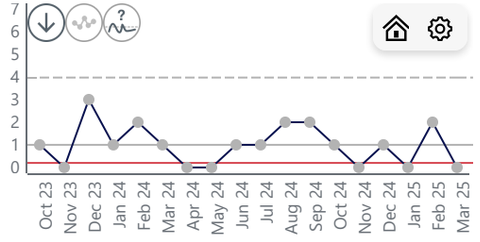
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



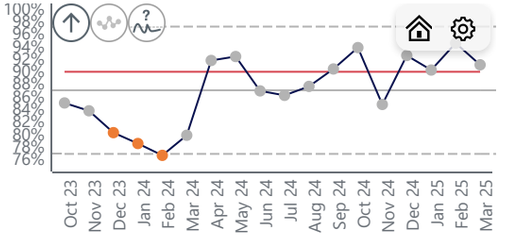
Hospital Acquired Organisms - MSSA

Target: Internal



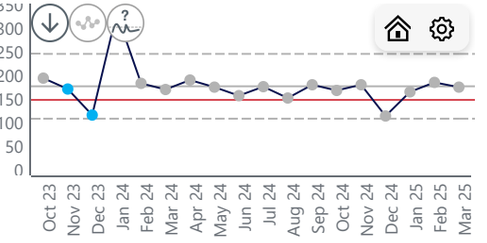
% PALS Resolved within 5 Days

Target: Internal



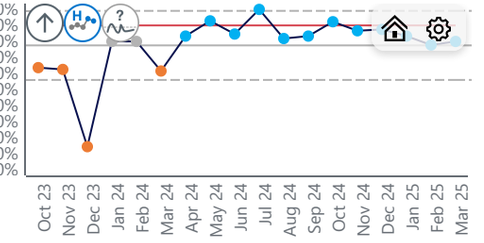
Number of PALs contacts

Target: Internal



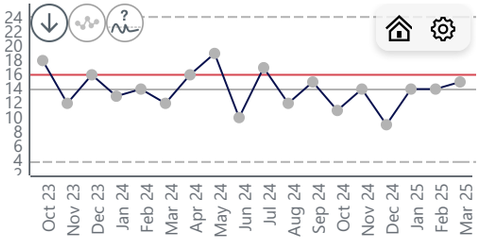
% Complaints Responded to within 25 working days

Target: Internal

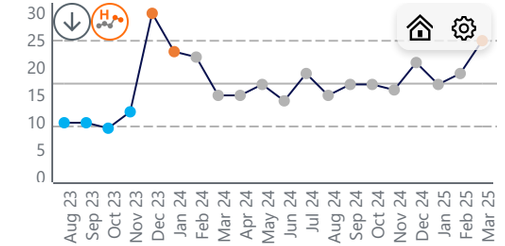


Number of formal complaints received

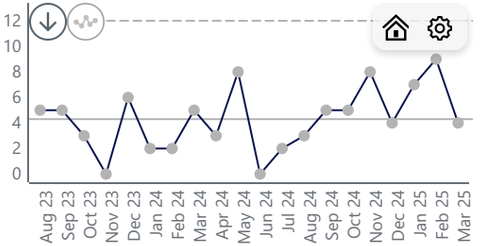
Target: Internal



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 exceeded its stretch target of 278 and concluded the year with 241 patients waiting over 52 weeks for treatment.
• Touchtime Utilisation remains at a YTD high of 80%.
• Fewer theatre sessions were delivered in March compared to the monthly average; however, activity levels remained positive with DC at 101% and EL at 93%. Outpatient (ERF pods) activity remained at >100% against plan.
• The national target for DM01 compliance was achieved with March performance at 96%.
• Performance against the cancer metrics returns to 100%.

Areas of Concern:

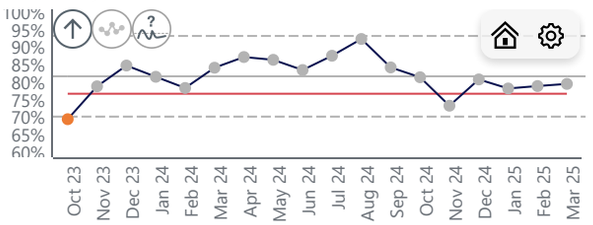
• WNB remains above trust target (reference action plans)
• The trust did not achieve its target of eliminating patients waiting two years past their follow-up date. Despite not achieving the target, 65% of this cohort of patients have been seen or discharged.

Forward Look (with actions)

• Two years overdue their follow-up appointment – Modelling for specialties who did not achieved the March 2025 target being undertaken with a Q1 and Q2 trajectory to be presented in May. • The WNB improvement work is ongoing with action plans for targeted specialties. These action plans include re-piloting different booking methods, auditing and implementing learning and exploring overbooking with clinical teams

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

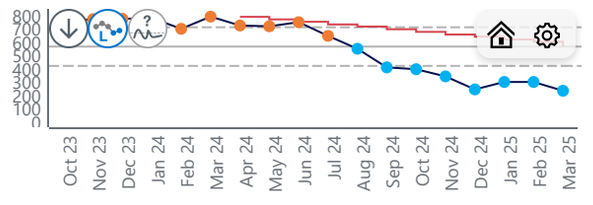
Achieved the national target in Mar-25. Common cause variation observed with performance of 79.8%, a rise from Feb-25 (78.5%). Feb-25 performance is +0.6% compared to Feb-24 (79.2%). Mar-25 seen 435 fewer attendances compared to Mar-24. Mar-25 +0.25% greater ratio of Resus and Very Urgent patients compared to Feb-24. 2024/2025 overall performance 82.7, a +0.3% increase on 23/24.

Actions:

Focused review of triage and maximise front end efficiencies; review and sharing of CRTP data; review of medical organisation to ensure split responsibilities for 'green' patients and higher acuity patients.

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

Target: Internal 24/25



Technical Analysis:

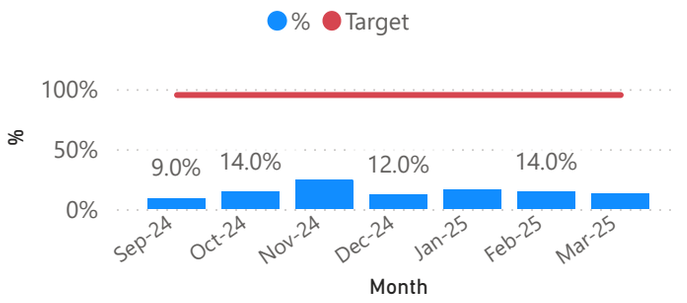
Demonstrating special cause variation of improving nature with number of patients waiting > 52 weeks at 244 for March 2025 against a trajectory of 575. Breaches reduced from Feb-24 position of 310. Top 3 services with waiters >52 weeks: Dentistry (n= 122), ENT (n=60) & Neurology (n=26).

Actions:

The trust exceeded its internal stretch target of 278 and concluded the year with 241 patients waiting over 52 weeks for treatment.

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 March 2025 is 13% against a target of 95% which is a decrease from performance of 14% in February 2025.

Actions:

Focus remains on longest waiting children and young people therefore % of young people receiving an outcome within 65 weeks of assessment remains lower as expected. Transformation programme work continues to reduce longest waiting times with internal actions in place and support provided by external providers for both ASD and ADHD.

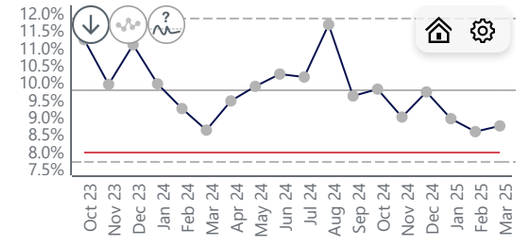
Integrated Performance Report | April 2025

Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

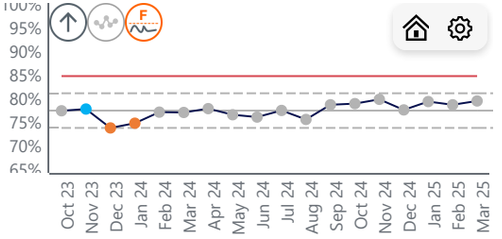
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

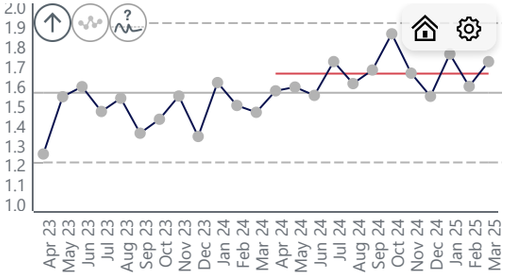


Theatre Utilisation (Capped Touch Time)

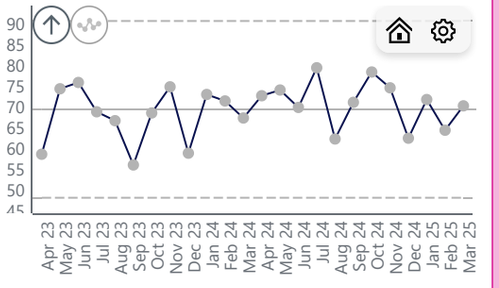
Target: Internal



Elective admissions (IP & DC) per clinical WTE

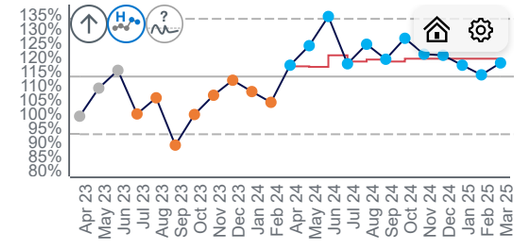


Outpatient attendances per Consultant WTE



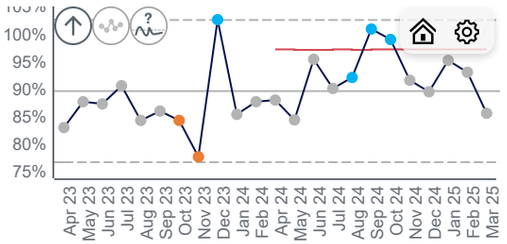
% Recovery for Daycase Discharges

Based on 19/20 baseline



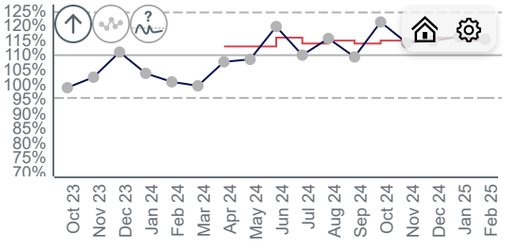
% Recovery for Elective Discharges

Based on 19/20 baseline



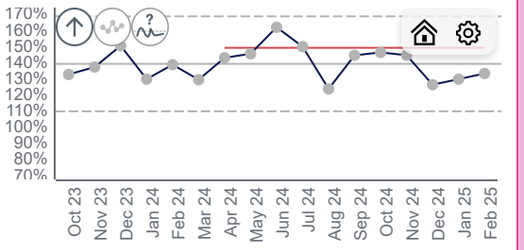
% Recovery for DC & Elec Activity Volume

Based on 19/20 baseline



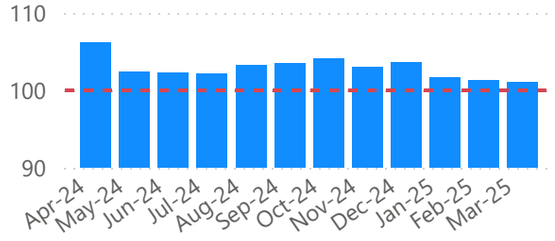
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline



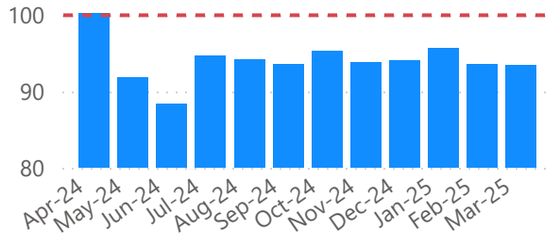
Daycase Activity vs Plan (YTD Position)

SLAM Performance (Volume)



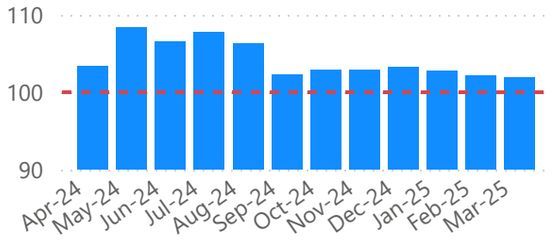
Elective Activity vs Plan (YTD Position)

SLAM Performance (Volume)

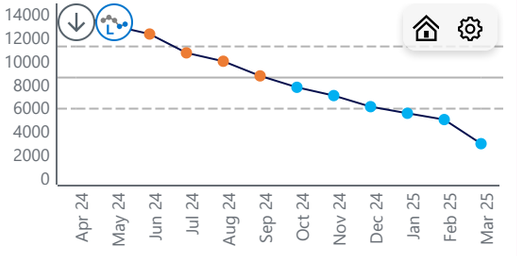


OP New & OPPROC Activity vs Plan (YTD Position)

SLAM Performance (Volume)



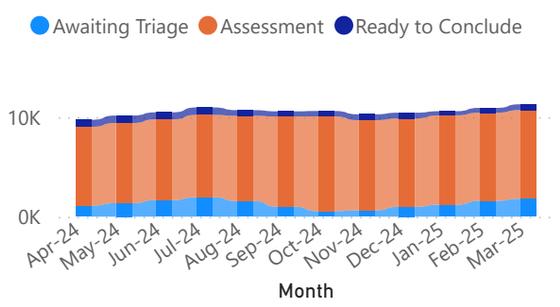
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



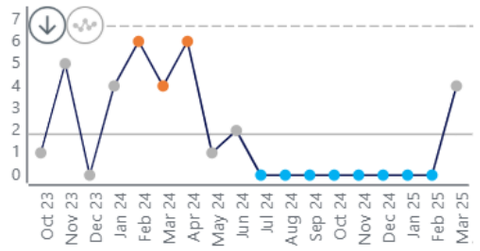
Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

ADHD/ASD Diagnosis Status

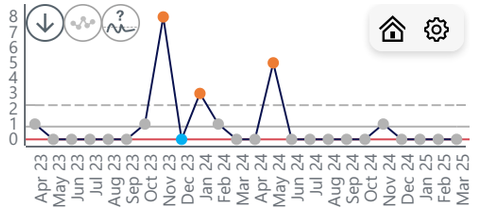


CAMHS: Number of children & young people waiting >52weeks



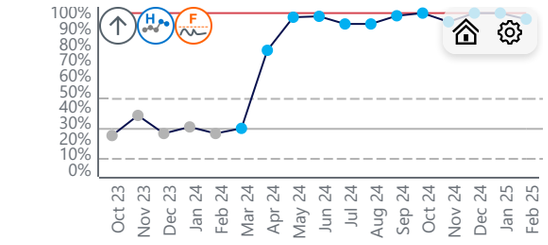
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



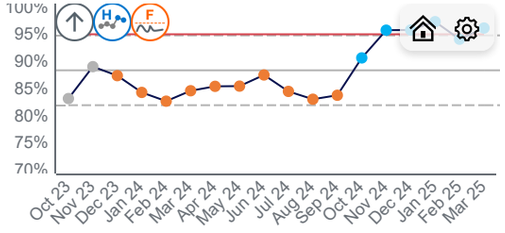
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



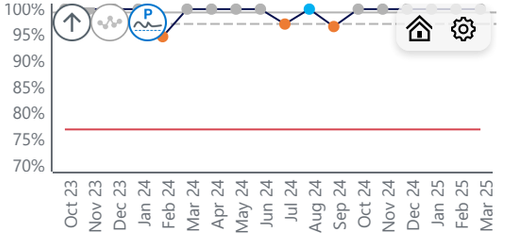
Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory



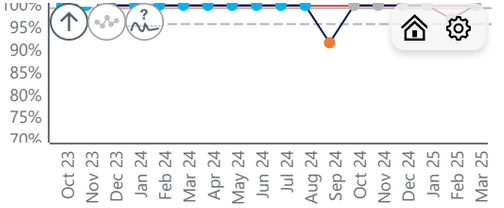
Cancer: Faster Diagnosis within 28 days

Target: Statutory



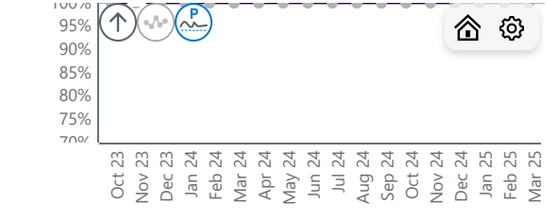
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

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% • % PDRs completed increased towards the end of 2024/25.

Areas of Concern:

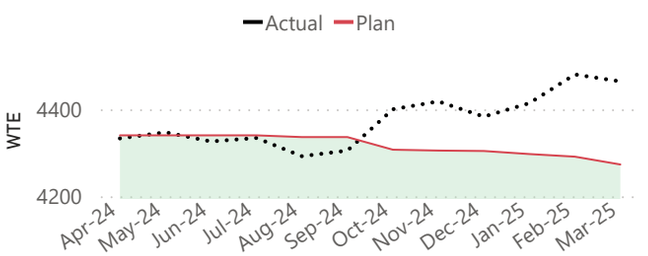
• Sickness absence levels are high, though declining since December. As part at the People Committee actions to support attendance, the return-to-work process is being reviewed and updated. • Total workforce (WTE) is a challenging position; the Trust will not meet the initial plan by the end of March 2025. A new plan for 25/26 has been submitted, with plans to meet the CIP being worked through.

Forward Look (with actions)

• Of note, the medical appraisal completion % resets each January; this is not an area of concern with robust support plans and prompts in place as consultant colleagues complete their PDRs throughout the calendar year • The 2025/26 PDR B7+ window resets from 1st April. The total PDR % will continue as a rolling position.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

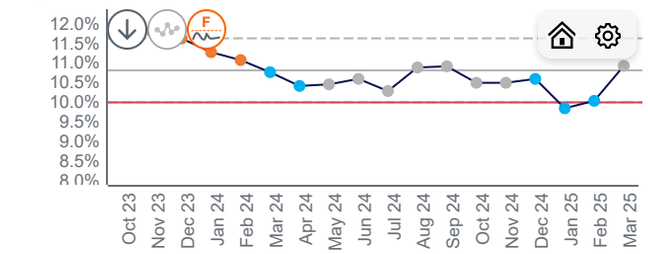
Total workforce for the end of March 2025 was 190 WTE above plan. Actual WTE was 4463 against a reduced plan of 4291.

Actions:

Total workforce (WTE) is a challenging position; the Trust will not meet the initial plan by the end of March 2025. A new plan for 25/26 has been submitted, with plans to meet the CIP being worked through.

Staff Turnover

Target: Internal



Technical Analysis:

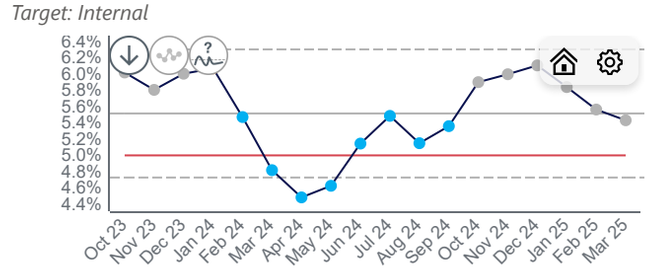
Common cause variation observed with performance of 10.9% in March 2025. Increase from February performance of 10%

Actions:

Staff turnover has increased into March 2025, with an increase in leavers in March 2025, primarily due to an increase in fixed term contracts ending compared to previous months.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in March 2025 is 5.43% which is above the 5% target although slight decrease from February 2025 at 5.56%. March 2025 performance comprises STS at 1.74% and LTS at 3.70%. Still demonstrating common cause variation, 9th consecutive month above the target in 24/25.

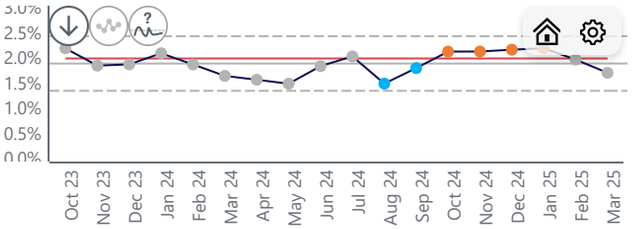
Actions:

Sickness absence levels are high, though declining since December. A review of sickness absence has been undertaken, including outlined next steps. A paper was submitted to People Committee in March 2025.

Supporting Our People - Watch Metrics

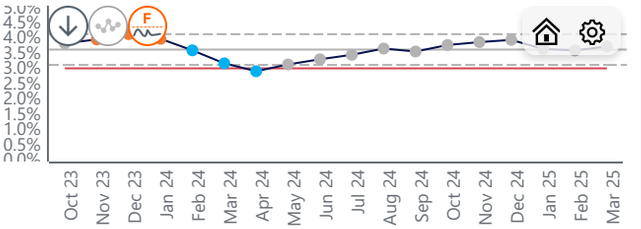
Short Term Sickness

Target: Internal



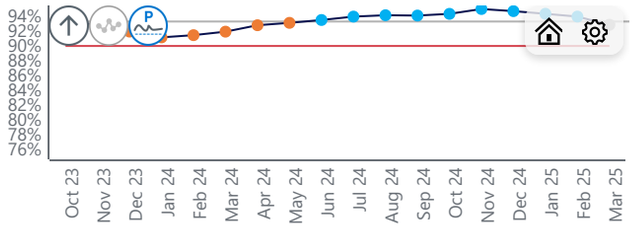
Long Term Sickness

Target: Internal



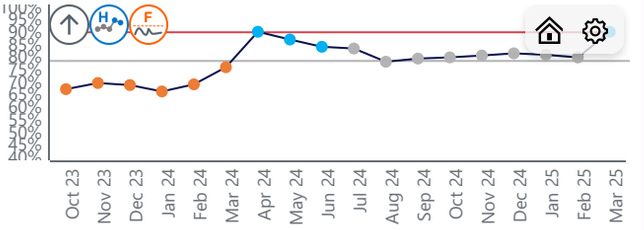
Mandatory Training

Target: Internal



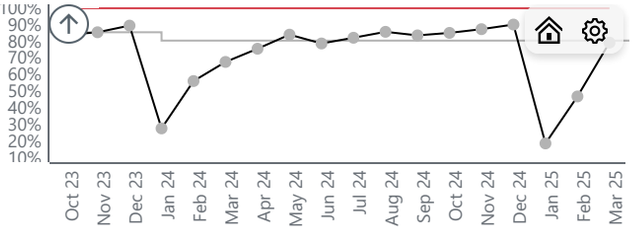
% PDRs Completed (Rolling 12 Months)

Target: Internal

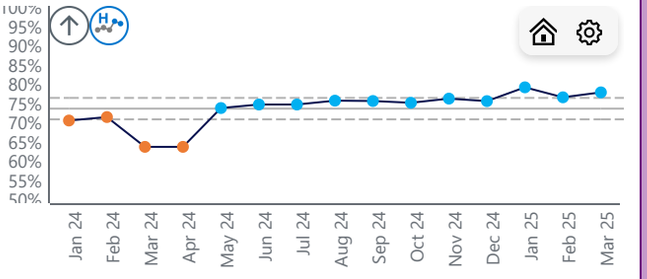


Medical Appraisal

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:

• Confirmation of support from LCR Combined Authority for Paediatric Open Innovation Zone (£4.16m award over 4 year) with planned start date of 1st April - Major investment in Alder Hey to make Liverpool City Region a global leader in children's healthcare innovation • 3 applications led by Alder Hey submitted to NIHR Regional Delivery Network strategic funding call to strengthen research in 3 areas – delivery of research outside of hospital settings, improving health equity in research and building capacity for ED research • Alder Hey also supported 2 additional linked applications to strengthen connections between mobile research unites across the North West and the build capacity for using a secure data environment for research across neuroscience and mental health • Overachievement of 24/25 research commercial income targets offsetting underachievement in research MRI activity • Development of research capacity building group to support Futures Develop pillar incorporating the AH Charity funded Clinical Research Development Programme for non-medical healthcare professionals.

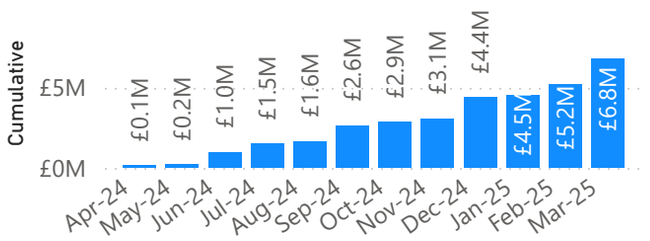
Areas of Concern:

• Underachievement against 3rd MRI scanner and RPA business cases for 24/25 - planning underway to ensure delivery in 25/26
•Underachievement of innovation external income target – partially offset by reduced pay and non-pay expenditure.

Forward Look (with actions)

• Planning underway for initiation of Paediatric Open Innovation Zone from 1st April • Finalisation of internal capacity building awards to support discovery – outcome letters to be issues in April

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



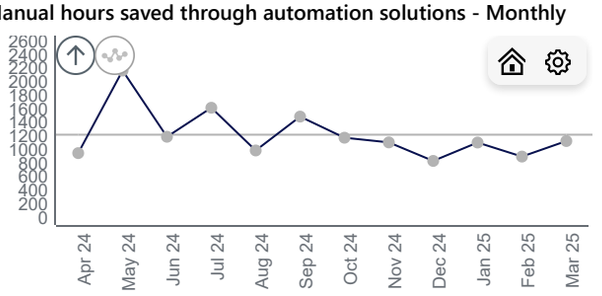
Technical Analysis:

Commercial and non-commercial income to Research and Innovation (cumulative)

Actions:

Potential external income for 25/26 boosted by LCR Combined Authority award which will leverage further opportunities. Focused work ongoing to build externally funded MRI research pipeline.

Manual hours saved through automation solutions - Monthly

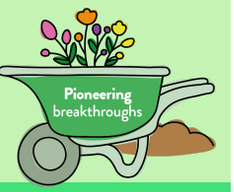


Technical Analysis:

Manual hours saved through RPA solutions

Actions:

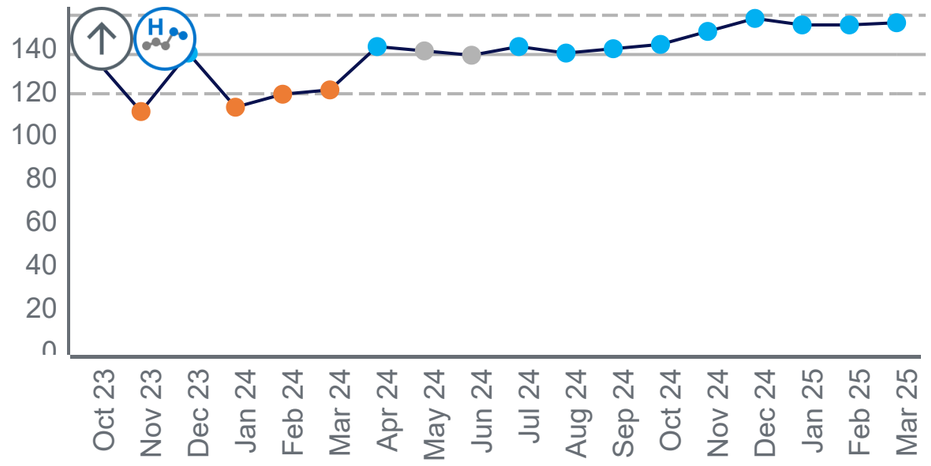
Business case review for 24/25 complete with planning underway for 25/26.



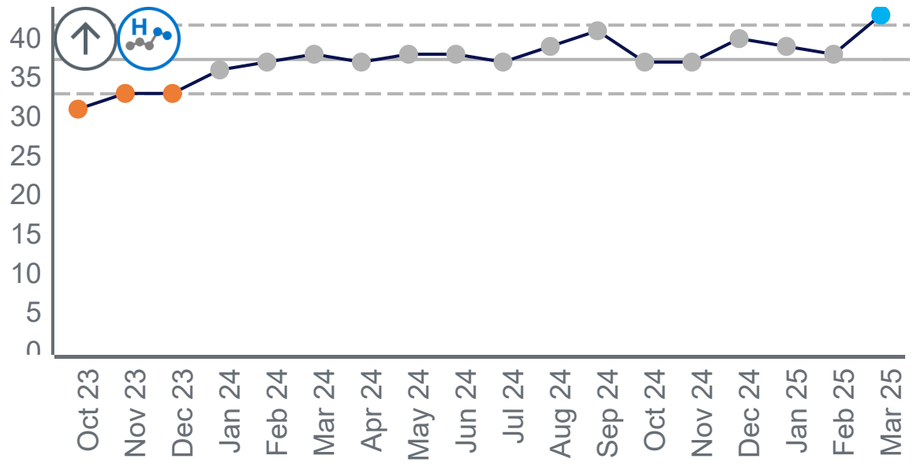
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

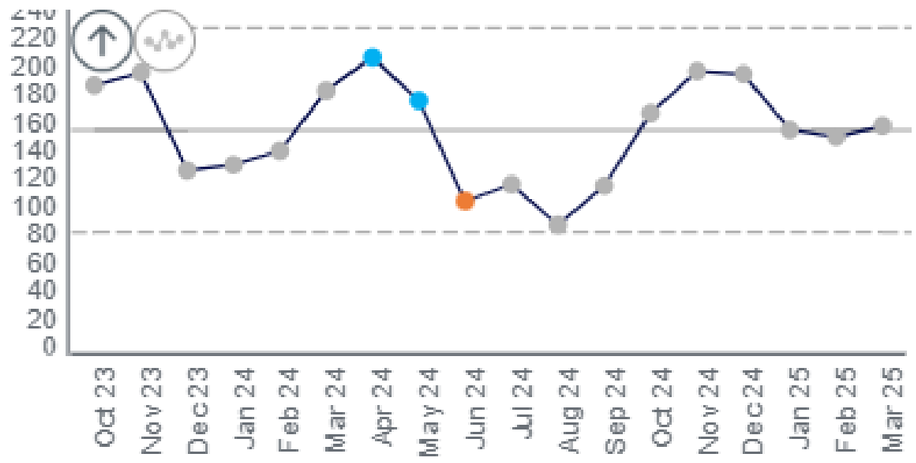
Number of Active (Open) Studies - Academic



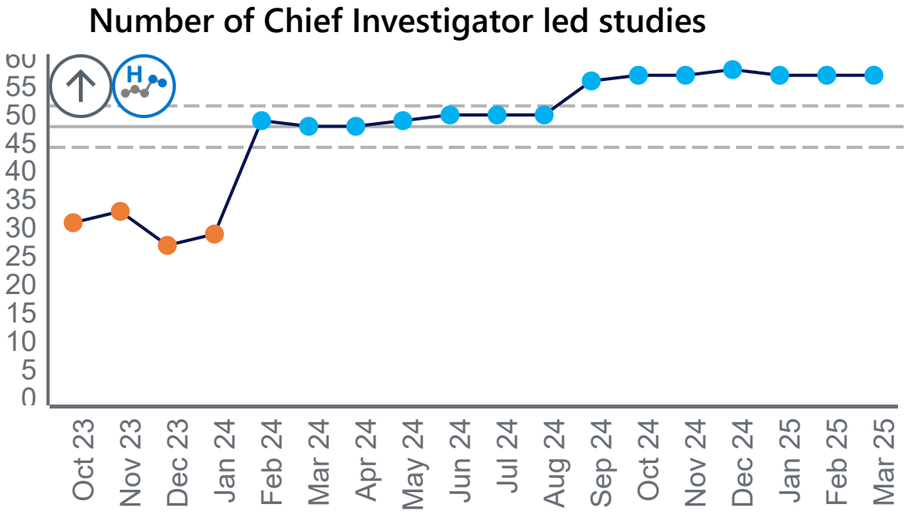
Number of Active (Open) Studies - Commercial

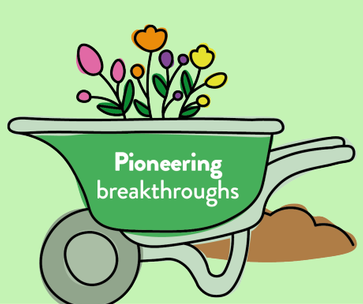


Number of Patients Recruited into Research Studies



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:

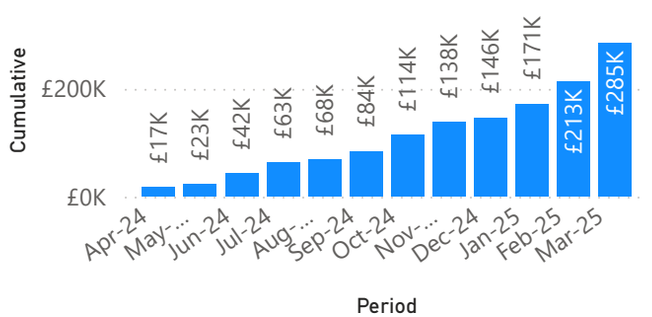
• Health Inequalities & Partnerships : Inpatient vaccination service has secured £80k from NHSE NW to continue the programme in 2025/26 (expanding to cover all vaccines, not just MMR) and negotiations are ongoing about funding for 2025/26 season's "flu fairies". Programme work presented at the Royal College of Paediatrics and Child Health annual conference within RI's invited keynote (British Association for Child and Adolescent Public Health) and as a poster (by Kate O'Hagan). Vaping clinic continues to have extensive media coverage and work is ongoing to disseminate to colleagues following a successful online "summit" on March 20th, attended by 85+ people from around the UK (public health, commissioners, researchers, clinicians, etc.). Exploring sources of funding to expand the service e.g. into schools, and open up other referral pathways e.g. self-referral for 14- and 15-year-olds. Opinion piece is in press in Perspectives in Public Health "Vaping-associated nicotine dependence amongst children and young people in the UK – time to act." Application submitted to "test and learn" for additional funding to support vaping service and evidence synthesis. Successful Improve My Life Chances event held on March 7th and the new (expanded membership) Partnership Meetings will start in June and Business Meetings in May (dates TBC). This includes proactive engagement with all nine Cheshire and Merseyside Public Health Teams. • Social Value & Widening Participation: The team has developed a robust offer for Primary schools and SEN provision. Connections with providers continue to be made and delivery has commenced, with very positive feedback being received. There have been new opportunities to support young people in school from a mentoring perspective. Over the last weeks 8 sessions have taken place with young people who identify as female.

Areas of Concern:

Forward Look (with actions)

The team continue to engage with partners to engage our united link, taking into account geographical deprivation. This includes the emergence of dynamic new opportunities plus strengthening ongoing partnerships including Everton in the Community, Virtual School and Knowsley locality.

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:

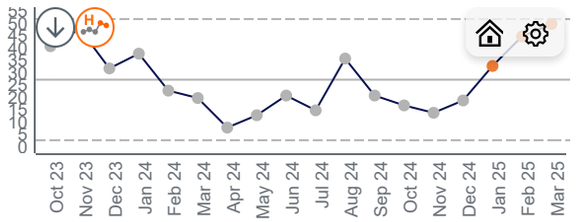
• Progressing Virtual Work experience • Continue to deliver Inspiring Futures Programme across primary, secondary and FE • Bespoke pre-employment workshops and sessions delivered • Delivery and review of BTEC placements • Grant application to be submitted April 25 to support Care Experienced Young People aged 14-17 • Supporting C&M ICS initiative targeting care experienced young people • New partnership with EiC and local Virtual schools in development

Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

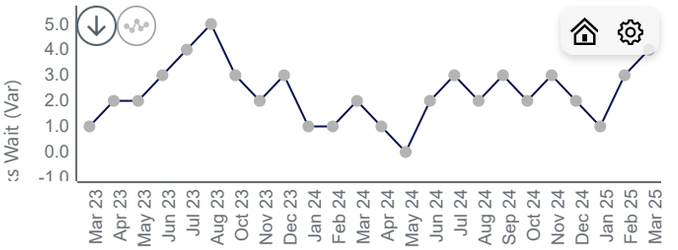
Oral Health: Number of children <10 years old waiting >52wks for tooth extraction

Sept-23 Unavailable

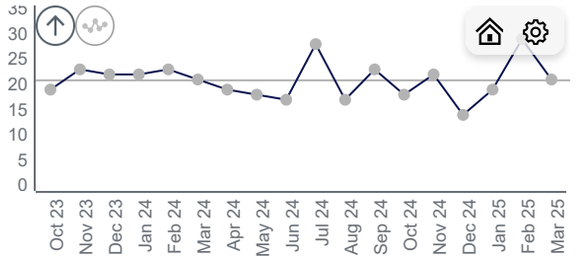


Median Waiting Time (RTT) - LD Waiters Variance (Wks) to Non-LD

Sept-23 Unavailable



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



Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

The Trust is reporting a £3.3m surplus position for 24/25, in line with plan. Despite the trust having signalled to the ICB at M11 significant risks to the delivery of the £3.3m target (c£1m), a number of mitigations materialised in M12 which supported the achievement of the £3.3m target. The mitigations were specifically around additional ERF income, procurement rebate, review of SPV deductions due, and further balance sheet opportunities. The full £19.9m CIP has now been achieved in year, with £13.6m identified as recurrent savings and the remaining £5.7m gap carried forward into 25/26. Cash has remained high & capital on plan and in line with expectations.

Areas of Concern:

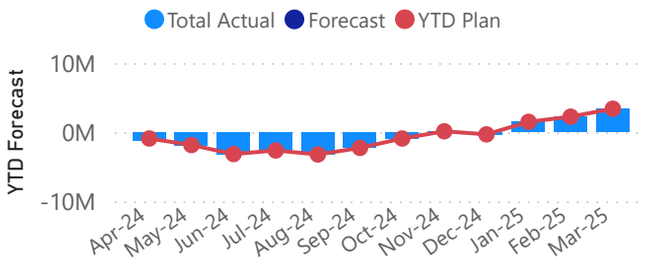
CIP gap is closed in year. CIP carried forward remains an area of concern given the gap recurrently is £5.7m which will be carried forward into 25/26. CIP target for 25/26 is substantial (£22.7m), however, significant progress has already been made to support the delivery of targets in 25/26 including the work of the finance improvement programme and clinical collaboratives.

Forward Look (with actions)

Continued cost control as we go into 25/26. Continued focus required on recurrent efficiency. Work also continues with divisions on transformation schemes to identify recurrent savings and benefits in 25/26.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

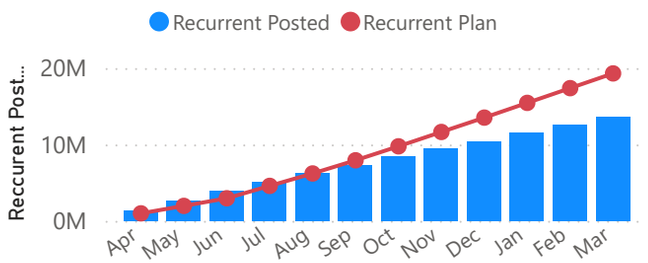
The trust is reporting a £3.3m surplus position.

Actions:

Plan set at the start of the year has been achieved

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

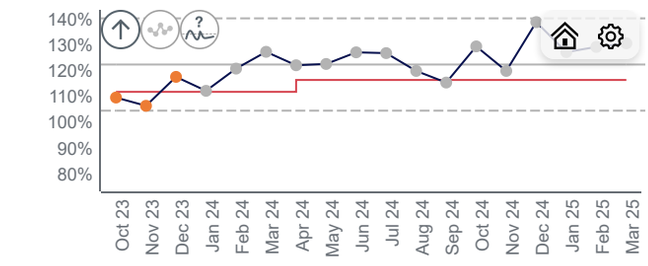
In year CIP identified is £19.9m so achieved in full. Of this, £13.6m is recurrent.

Actions:

Significant work is ongoing to support the delivery of efficiency targets in 25/26 across the Trust, including the work on benefits from transformation schemes.

% ERF Value (Income)

Target: Internal



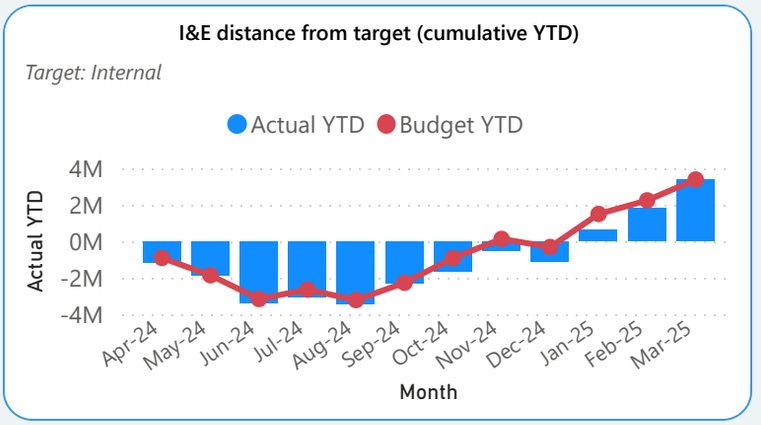
Technical Analysis:

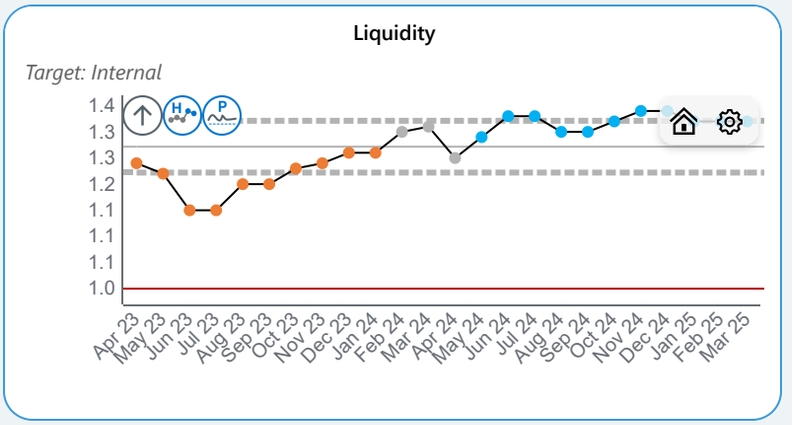
March performance estimated at 125%.

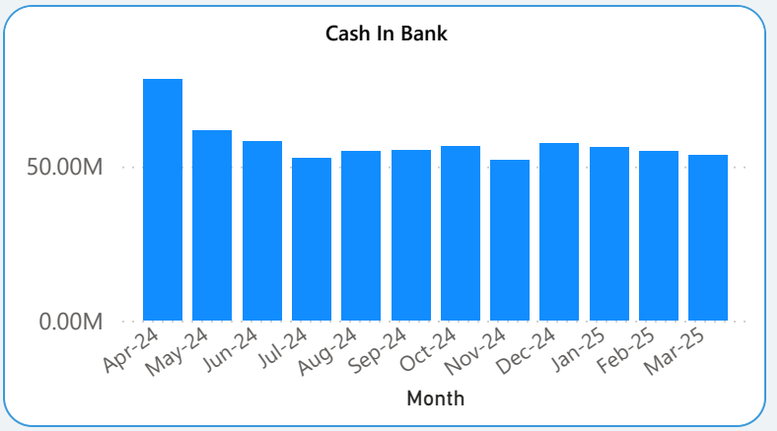
Actions:

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

Financial Sustainability: Well Led - Watch Metrics







Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

- Continued positive engagement with teams/services at risk oversight meetings
- MIAA Risk Mangement Audit-Substantial assurance

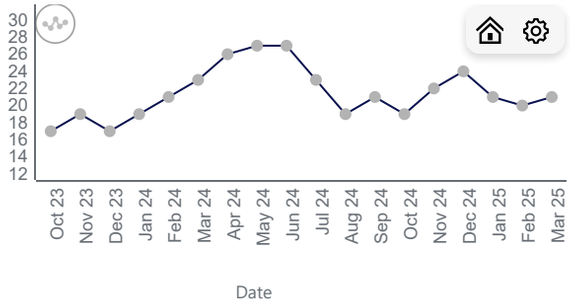
Areas of Concern:

- Meeting with C&MH division regarding risk appetite currently pending
- Declining position of high risks within review date

Forward Look (with actions)

- Wider meeting planned with wider digital team to review risks due to staff changes in digital team
- All overdue risk escalated to risk owners for immediate review
- 1 recommendation from MIAA audit findings being implemented

Number of High Risks (scored 15 and above)



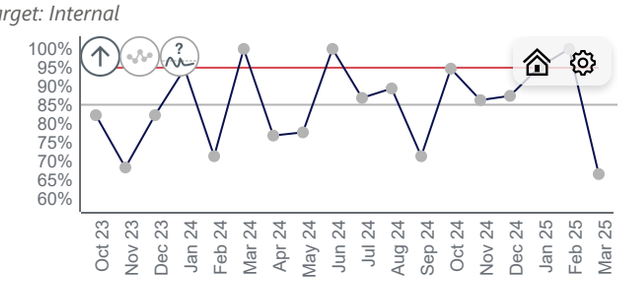
Technical Analysis:

21 high risks on risk register as of end March 24. Slight increase from 19 reported end Feb 25

Actions:

% of High Risks within review date

Target: Internal

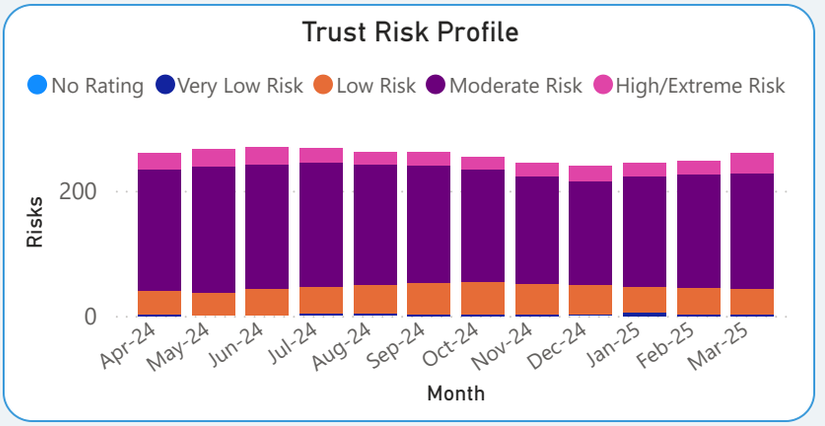


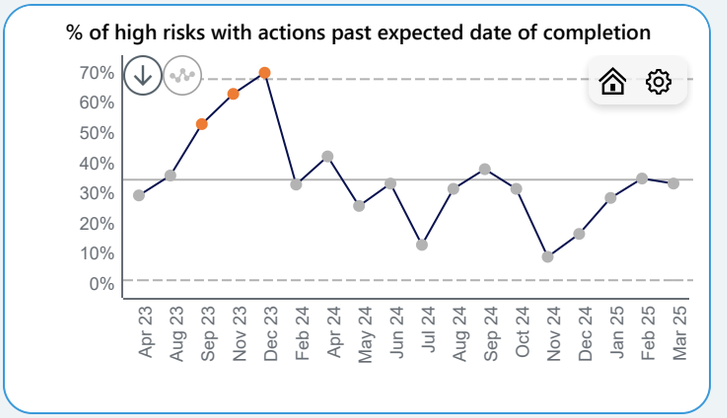
Technical Analysis:

66.7% (14/21) high risks within review date a declining position from last month. Risk watch metric 33.3% high risks with actions past expected date of completion (7/21)

Actions:

Well Led - Risk Management





Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• CQC inspection for Community Mental Health Services, Crisis Care, ASD and ADHD

• Improvement in Friends and Family responses for Outpatients, Mental Health and Community Services

• 96% Initial Health Assessments completed within 20 days of receiving referral

• Improvement in sickness absence rates (5.2%) – predominantly long term sickness (4%)

• Mandatory training compliance remains above Trust target (96%)

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

• Sustained improvement in RTT for SALT (98%) and Dietetics (100%)

• Sunflower House Meditech development work now complete and service using full EPR

Areas of Concern

• CAMHS 4x 52+ week waits – end of March 2025, appointments scheduled.

• Reduction in number of complaints responded to within 25 days (50%)

• Reduction in number of PALS resolved to within 5 days (75%)

• Slight reduction in WNB rate (12%)

• Work continued regarding data reporting for Mental Health Services via MHSDS due to data quality issues impacting on submissions. Data engineering rewrite commenced in November 2024 – Completion delayed until April 2025. Rewrite of Crisis Care data scheduled – date TBC

• Continued challenges with ADHD medication shortage which is impacting on waiting times for the diagnostic pathway

• Limited improvement in paired outcome scores (20%). Task and Finish group ongoing

Forward Look (with actions)

• Review of reporting measures for CAMHS to ensure consistency.

• Admin training package and SOP in development for CAMHS

• Introduction of choice (assessment) clinics for Liverpool CAMHS

• No CYP waiting longer than 2 years for follow up. Work ongoing to address 1+ year

• Contract awarded for external ADHD assessments – capacity due to start April 2025

• Continued work ongoing to improve Mental Health data reporting. Annual data re-submitted for 2023/24, awaiting feedback.

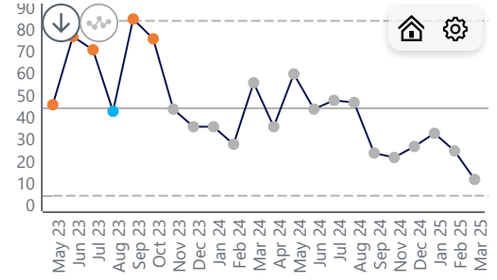
• ASD / ADHD transformation programme continuing with good engagement from teams and external colleagues. Clinical model development ongoing with provisional go live date Sept 2025.

• Work ongoing with Victim Support to provide psychological support to children impacted by the Southport critical incident. Review of model to consider sustainability underway with Place leads.

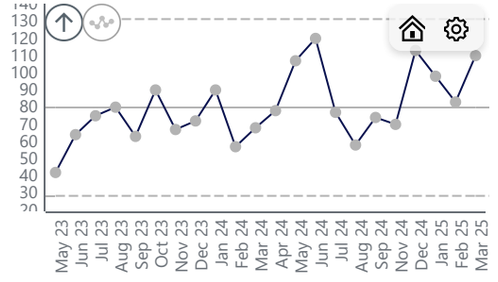
NHS
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

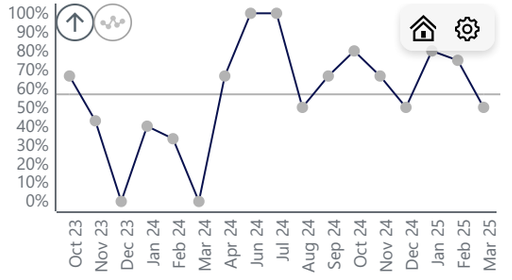
Patient Safety Incidents rated Low Harm & Above



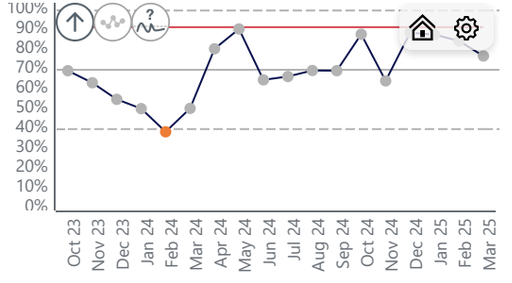
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

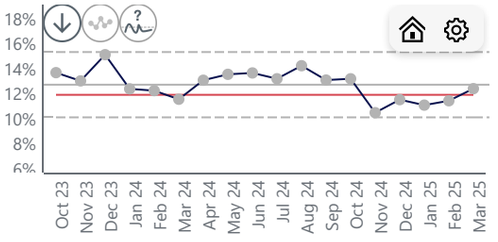


% PALS Resolved within 5 Days

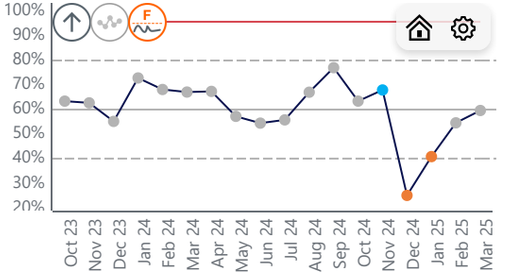


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

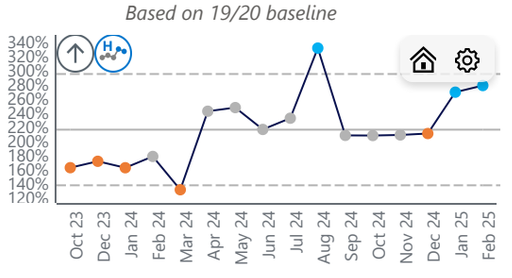


% of Clinical Letters completed within 10 Days

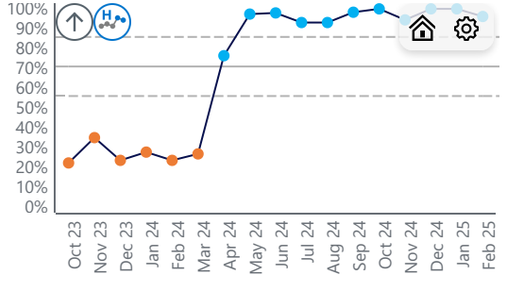


% Recovery for OP New & OPPROC Activity Volume

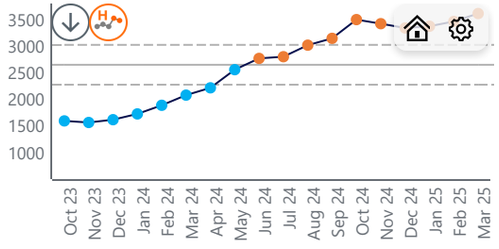
Based on 19/20 baseline



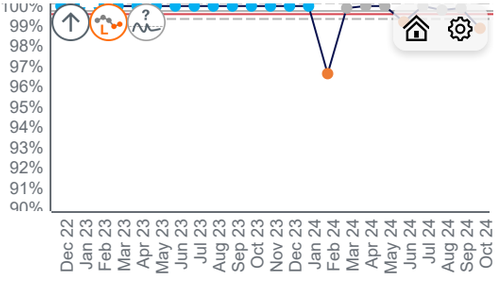
IHA: % complete within 20 days of referral to Alder Hey



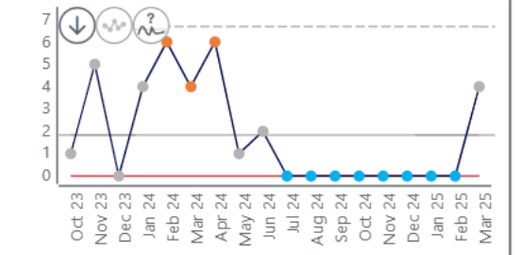
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



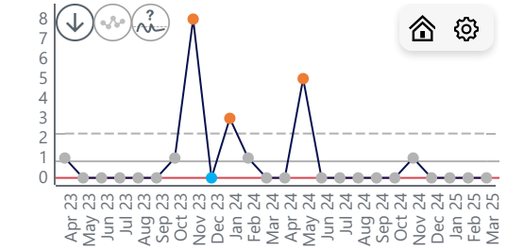
ADHD & ASD: % Referral to triage within 12 weeks



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



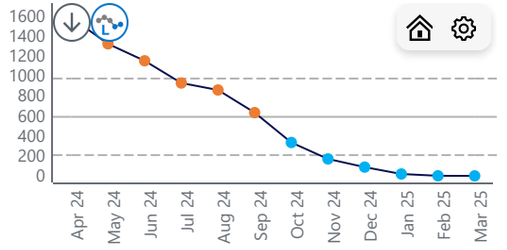
Number of Paediatric Community Patients waiting >52 weeks



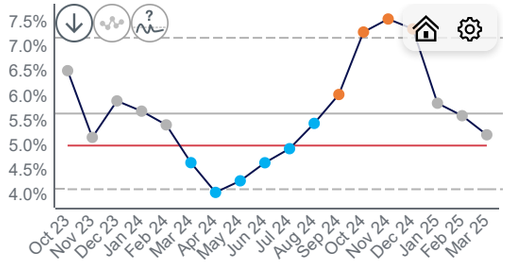
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

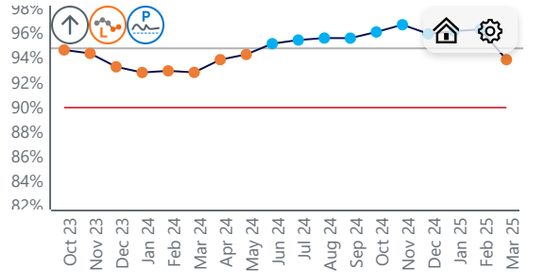
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



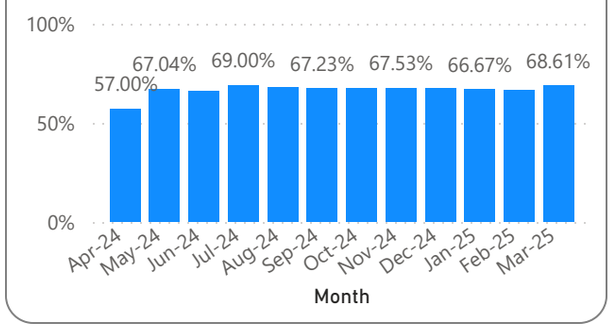
Sickness Absence (Total)



Mandatory Training

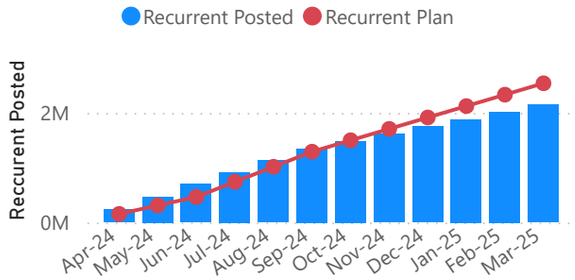


Workforce Stability

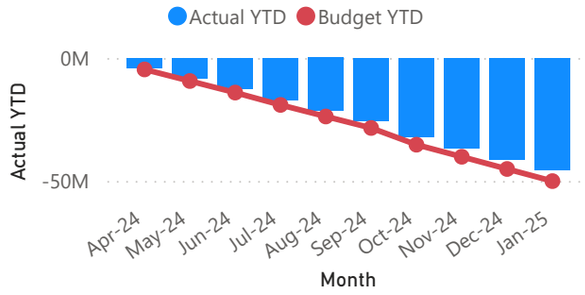


Staff Turnover

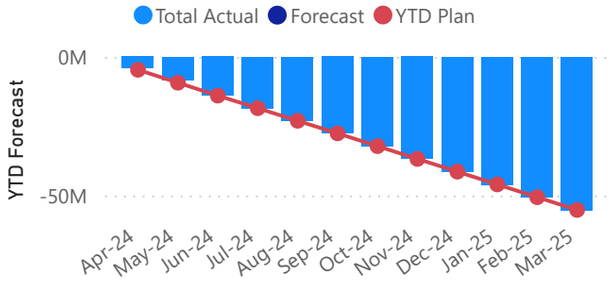
Recurrent Efficiency Plans Delivered (Forecast)



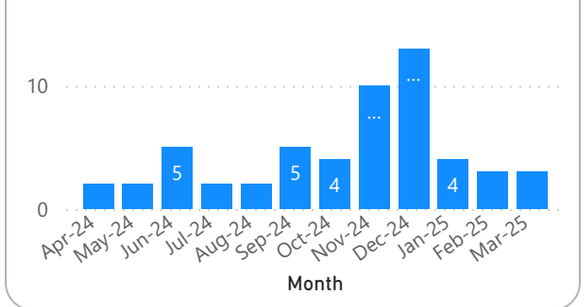
I&E distance from target (cumulative YTD)



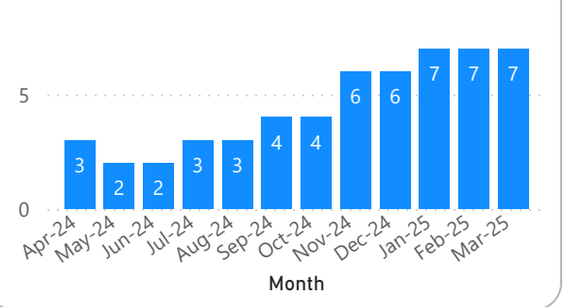
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Maintained increase in discharged per working day for 4 consecutive months

• Reduction in patients waiting over two years to be seen of more than 1000 over the last 12 months

• Both targets for Sepsis achieved in month for children treated in ED and on the ward

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

• 100% compliance in PALS

• ED achieved 4hour national standard despite challenging month both in volume of attendances and acuity of attendances, 80% of CYP were treated within 4hours. Annual performance likely to have resulted in securing additional capital investment for the Trust for 2025/26 (£2-£4M)

• WNB rate reducing further only 1% above trust target of 6%

• 0 patients waiting over 65 weeks for treatment at the end of March

• Reduction in total waiting list over past 12 months > 1346 CYP reduction

• DM01 performance achieved 95% target

• Increase in activity levels in March for all ERF PODs

• Sickness rates remain low at 5.5% (0.5% above trust target)

• 86% of staff within the division have received a PDR within the last 12 months

• Achievement of financial forecast position for March 2025

Areas of Concern

• Slight increase in ED triage time and time to see a clinician during March
• Maintained focus on super stranded over 21-day patients noting a slight improvement
• Financial challenges facing the year ahead, 1.4M cost pressure to mitigate within the division in addition to the delivery of CIP targets
Clinic letter sign off remains a concern within the division; however, a number of clinicians within the division are piloting Lyrebird which will support the sign of process in the med to longer term

Forward Look (with actions)

• Revised approach to CIP delivery for 2025/26 with an 8 week focus period over the first two months of the year to progress plans currently in Amber and Red

• Focused improvement of theatre utilisation with a review of list allocation and the booking and scheduling of patients

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

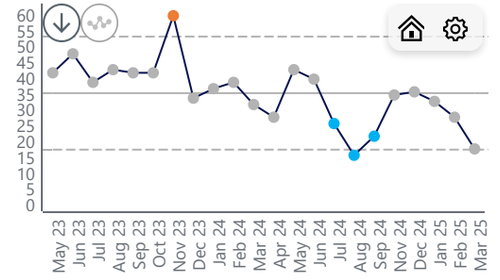
• Further improvement in the sustainability of Haematology and Transfusion laboratory services, securing investment for the case allowing recruitment to key and expansion of the core staffing

• Review of Interventional Radiology escalation SOP and interim measures when service provision is not available, recognising longer terms succession planning won't be in place until 2026/27

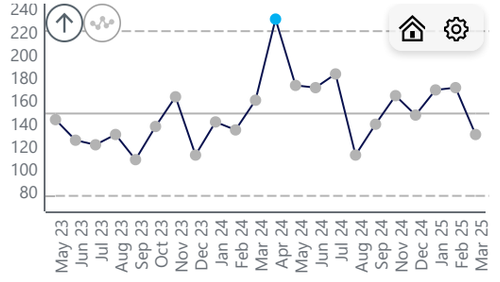
NHS
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Medicine

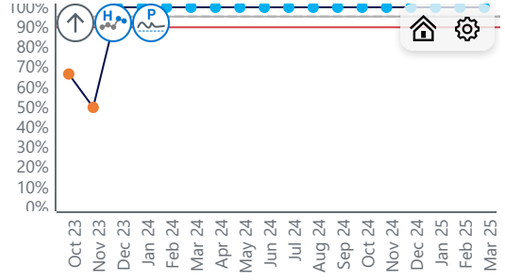
Patient Safety Incidents rated Low Harm & Above



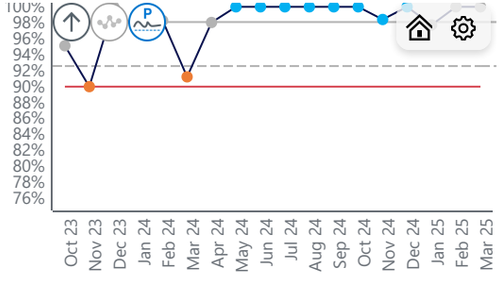
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

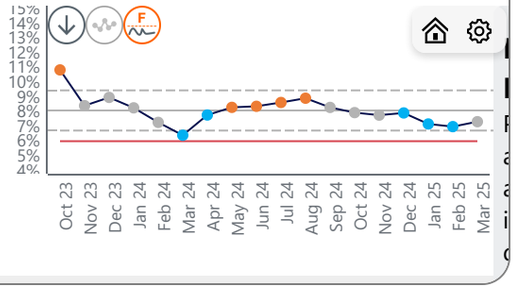


% PALS Resolved within 5 Days

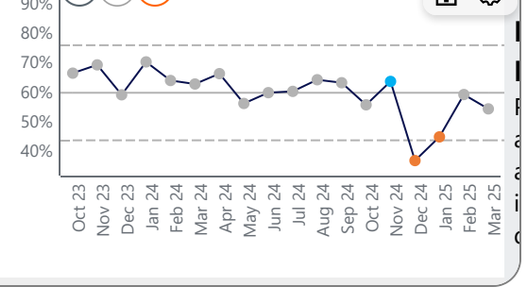


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

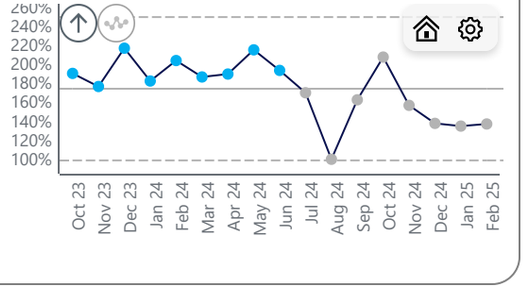


% of Clinical Letters completed within 10 Days

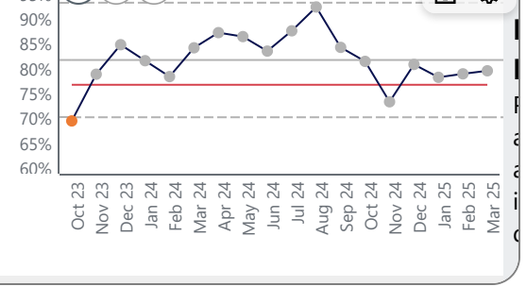


% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

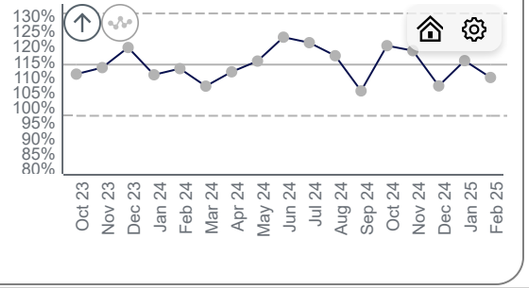


ED: % treated within 4 Hours

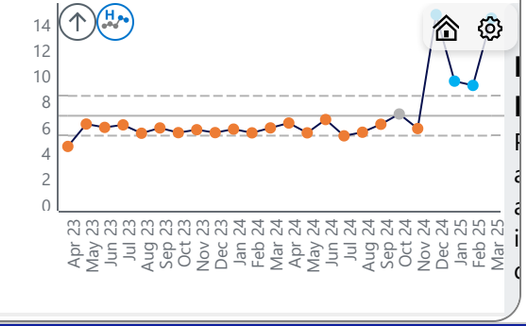


% Recovery for DC & Elec Activity Volume

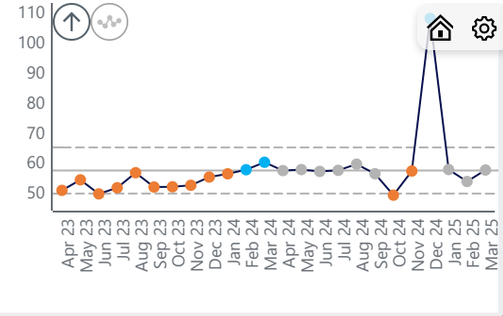
Based on 19/20 baseline



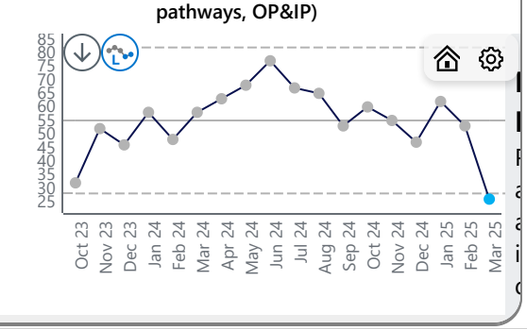
Inpatient Discharges per working day



Day Cases per working day



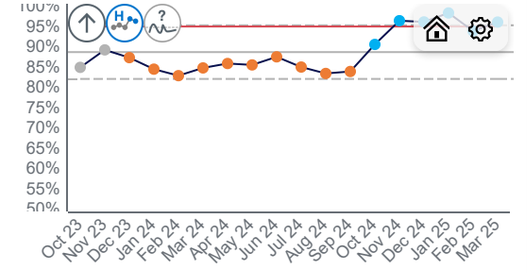
Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



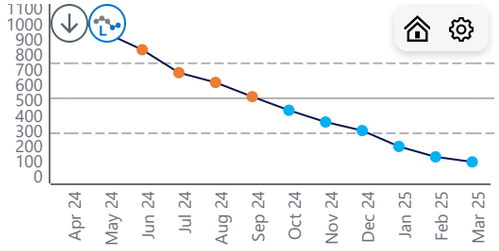
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

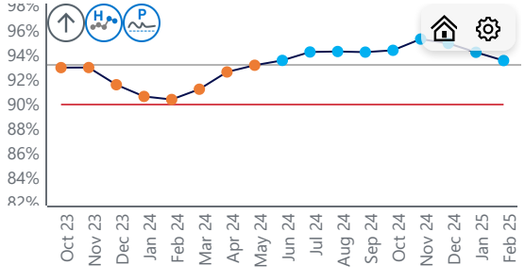
Diagnostics: % Completed Within 6 Weeks of referral



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

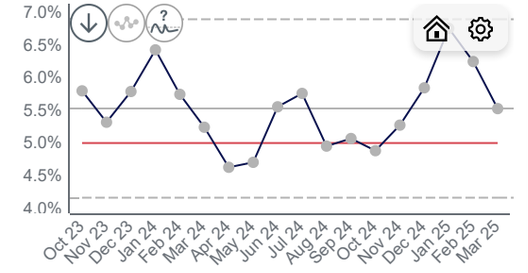


Mandatory Training

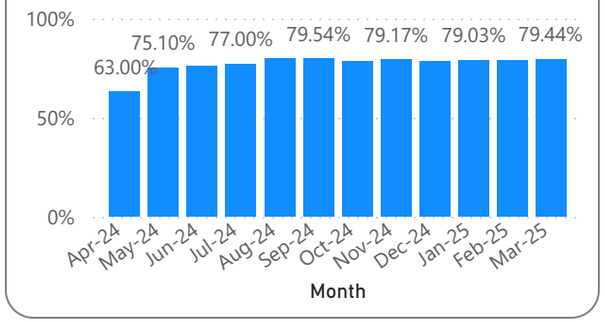


Staff Turnover

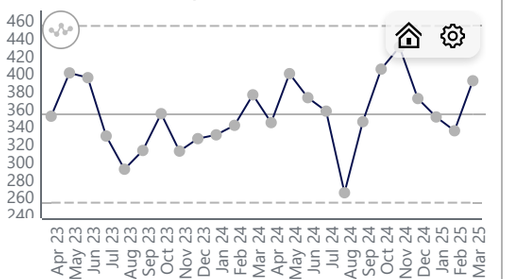
Sickness Absence (Total)



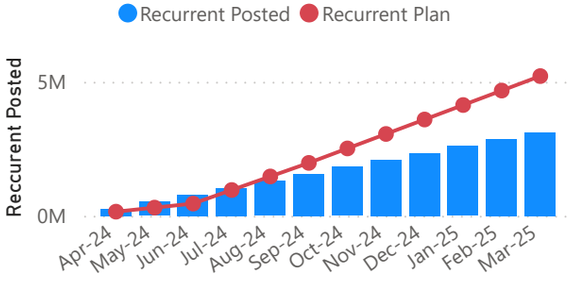
Workforce Stability



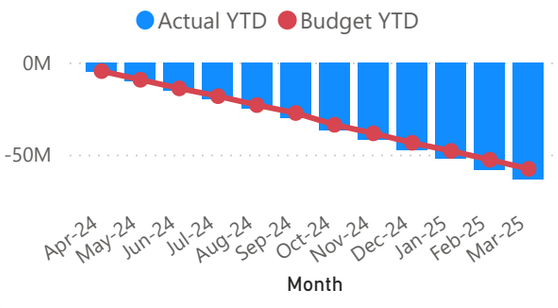
A&E Attendances per ED Consultant WTE



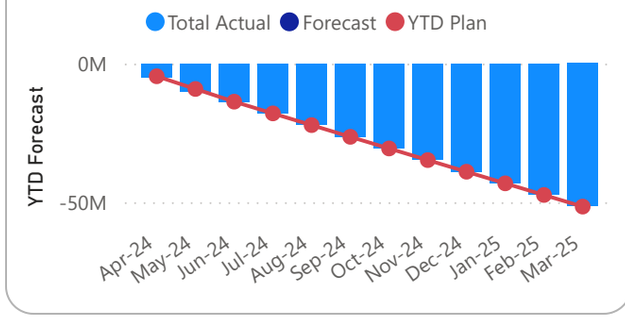
Recurrent Efficiency Plans Delivered (Forecast)



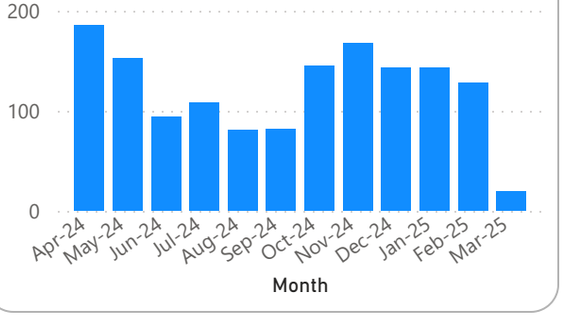
I&E distance from target (cumulative YTD)



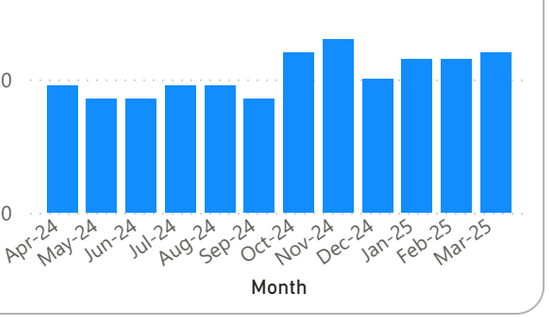
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Retained 100% response rate to PALS and formal complaints

• WNB rate although remains above trust target continues to be reduced compared to previous months

• DC per working day remain higher than previous 12 months

• DM01 above 95% target for the second consecutive month

• Number of CYP waiting more than 52 weeks continues to decline

• % recovery levels positive in all areas compared to baseline

• Mandatory training compliance remains above trust target

Areas of Concern

• Overdue FU remain a challenge despite significant reduction over previous months

• Sickness absence saw a slight increase compared to previous month and is above trust target

• Clinic letters remains a concern (require updated data). Good uptake of Lyrebird within the division which should support improvement in this area.

• CIP plans for the division remain a challenge for 2025/26- ongoing plans to ensure identified schemes in the coming weeks.

Forward Look (with actions)

• Ongoing work with specialities to reduce overdue FU. Areas of key challenge have key action plans to tackle future sustainability. In particular, ENT are looking to trial new pathways of working to support demand.

• Ongoing work to further reduce WNB rates and some pilots running in peak areas which will undergo further analysis & development.

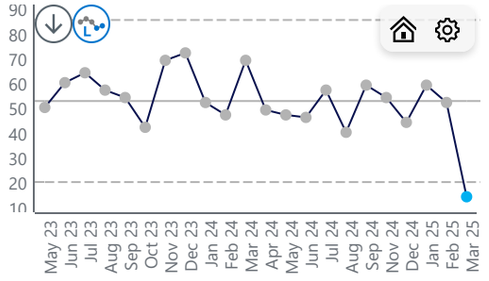
• Benefits realisation required to understand impact of Lyrebird on improving % of clinical letters completed.

• Ongoing transformation programme of work within Cardiology to support a number of key improvements within their outpatient pathways & to improve support for acute inpatient cover.

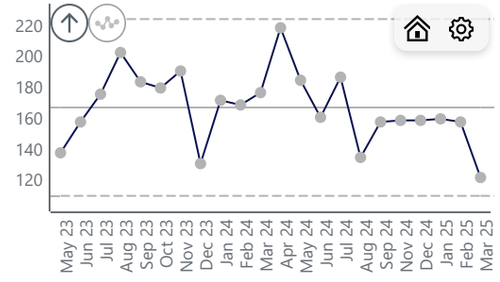
NHS
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Surgery

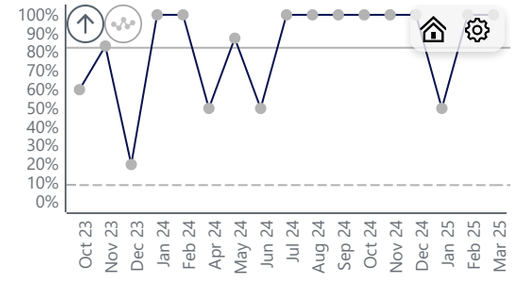
Patient Safety Incidents rated Low Harm & Above



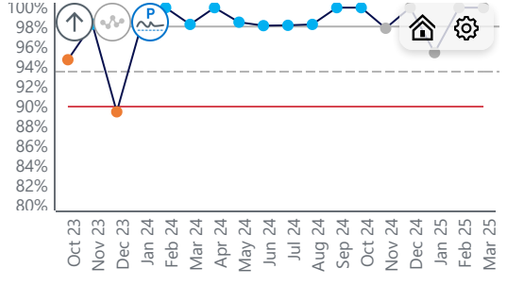
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

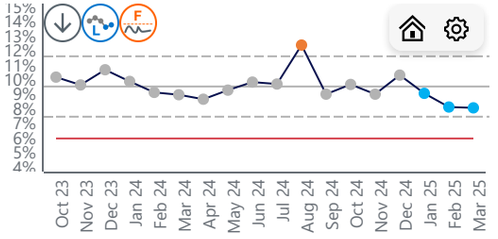


% PALS Resolved within 5 Days

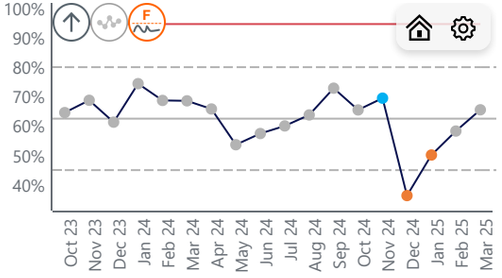


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

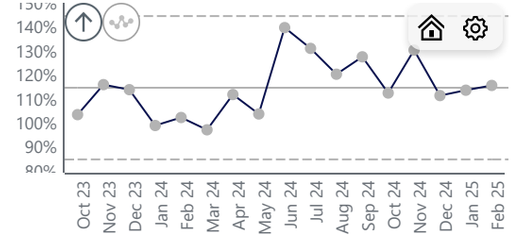


% of Clinical Letters completed within 10 Days



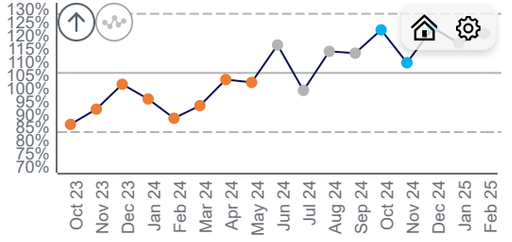
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

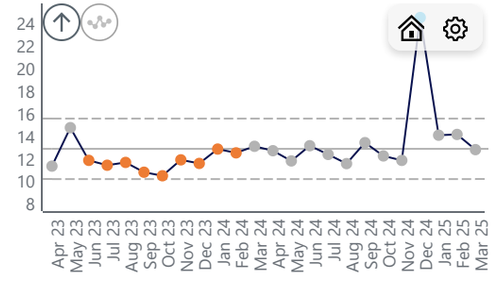


% Recovery for DC & Elec Activity Volume

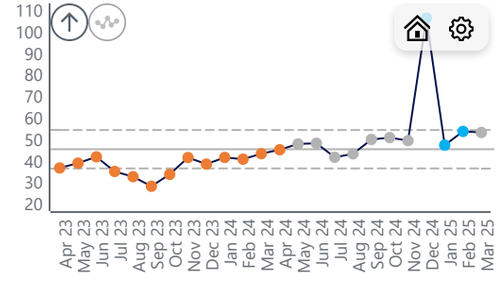
Based on 19/20 baseline



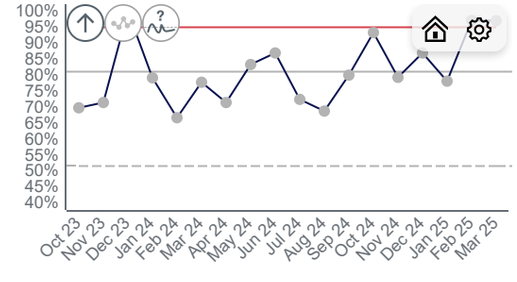
Inpatient Discharges per working day



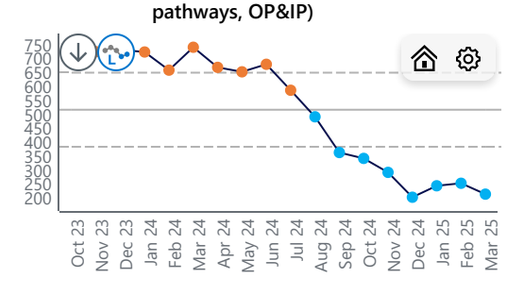
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



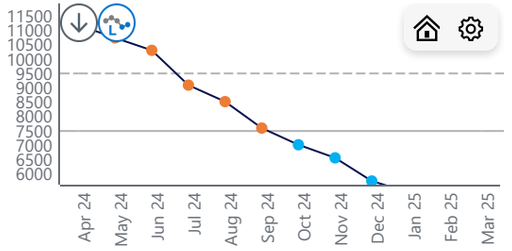
Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



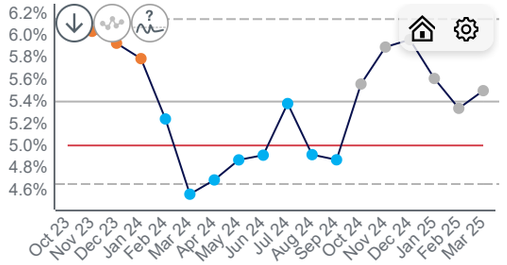
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

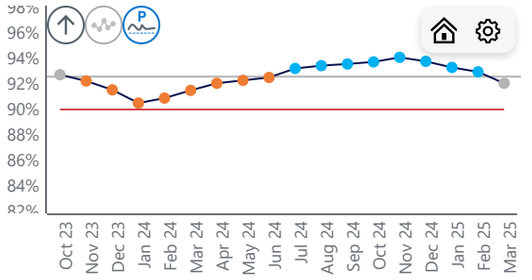
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



Sickness Absence (Total)

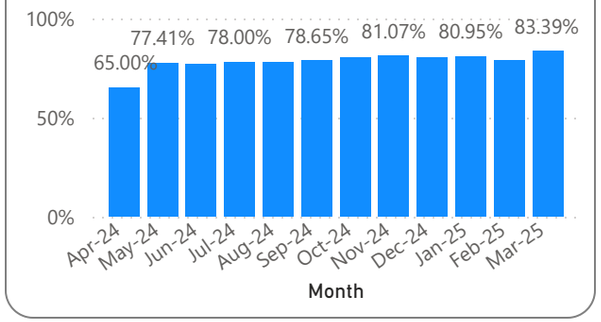


Mandatory Training

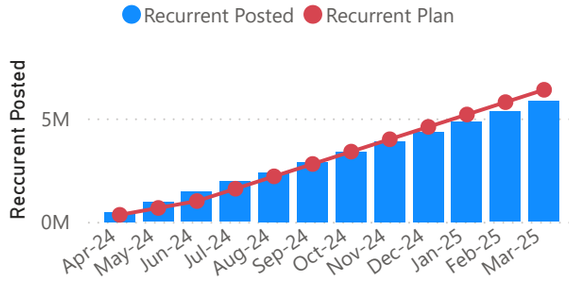


Staff Turnover

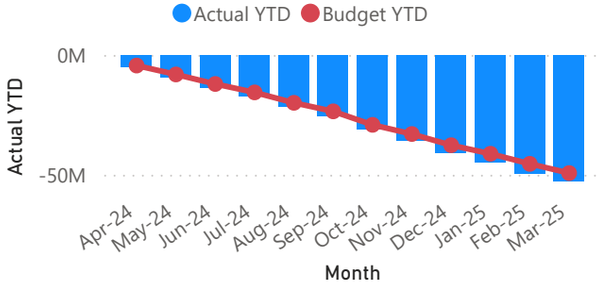
Workforce Stability



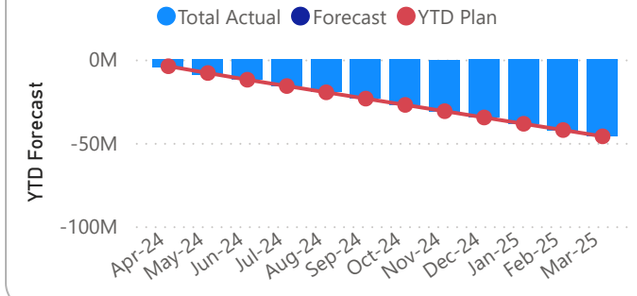
Recurrent Efficiency Plans Delivered (Forecast)



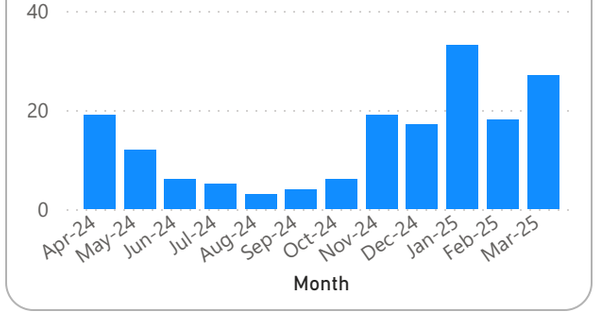
I&E distance from target (cumulative YTD)



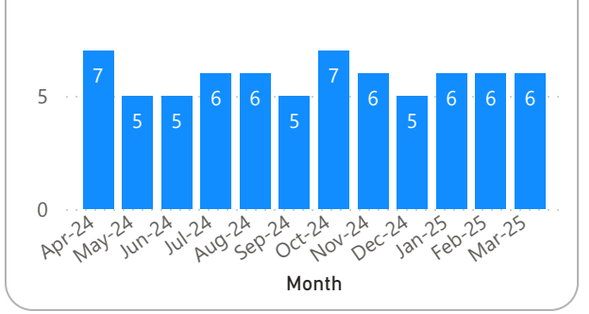
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• 3 applications led by Alder Hey submitted to NIHR Regional Delivery Network strategic funding call to strengthen research in 3 areas – delivery of research outside of hospital settings, improving health equity in research and building capacity for ED research.

• Alder Hey also supported 2 additional linked applications to strengthen connections between mobile research unites across the North West and the build capacity for using a secure data environment for research across neuroscience and mental health.

• Overachievement of 24/25 research commercial income targets offsetting underachievement in research MRI activity.

• Development of research capacity building group to support Futures Develop pillar incorporating the AH Charity funded Clinical Research Development Programme for non-medical healthcare professionals.

• Successful NIHR Senior Clinical and Practitioner Research Award for Helen Hartley (physio).

• Dedicated play space built within NIHR Clinical Research Facility

Areas of Concern

• Underachievement against 3rd MRI scanner business case for 24/25 - planning underway to ensure delivery in 25/26.

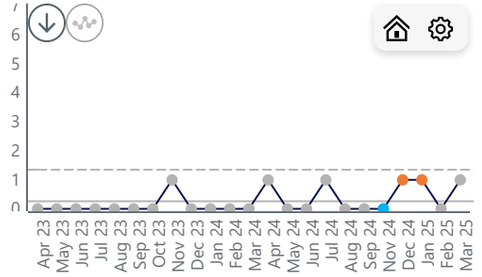
Forward Look (with actions)

• Clinical Research Division away day planned for 1st April with topics to include operational planning, increasing inclusion and improving the PDR process.

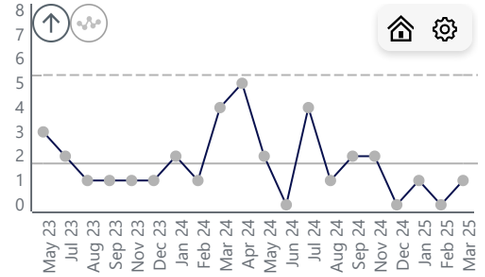
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

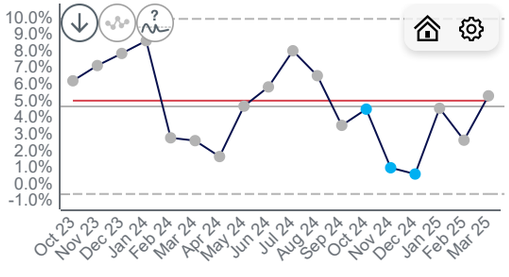


Patient Safety Incidents rated No Harm

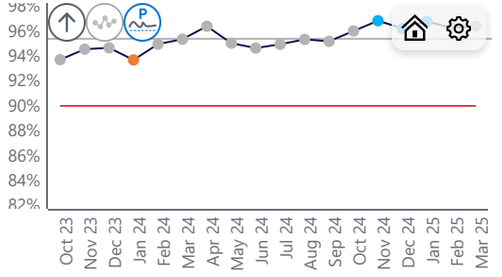


Staff Turnover

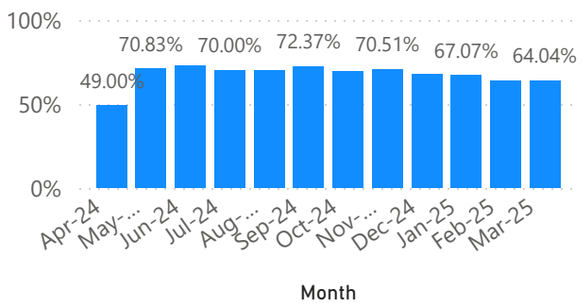
Sickness Absence (Total)



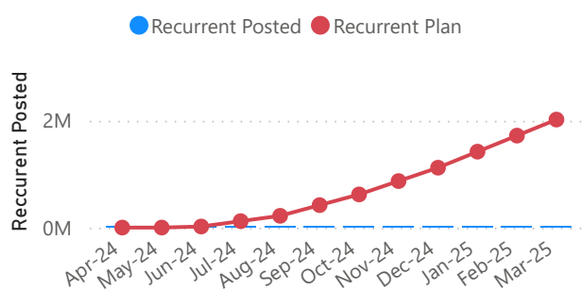
Mandatory Training



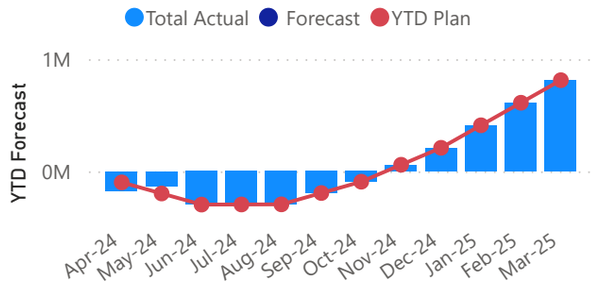
Workforce Stability



Recurrent Efficiency Plans Delivered (Forecast)

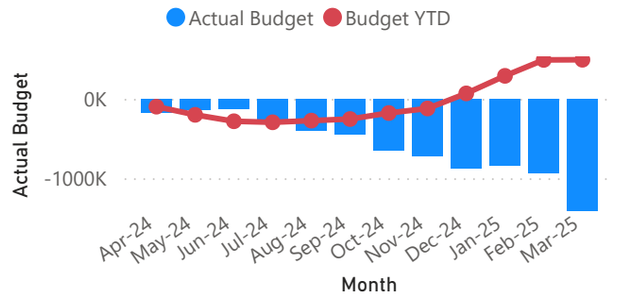


I&E Year End Forecast



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 15th April 2025. Highlights from the March data include:

- Mandatory training remains above Trust target at 93%.
- Short term sickness absence remains within Trust target at 1%.
- Long term sickness remains within Trust target at 4%.
- CIP achieved in year.
- Overall PDR compliance 95%.

Areas of Concern

- Time to hire currently 47 days.
- Despite a reduction in-month, overall sickness remains above Trust target at 5.5% (previously 5.7%)
- Return to work compliance currently 57% (target 100%)
- Corporate incidents open over 28 days = 207
- 54 corporate policies overdue

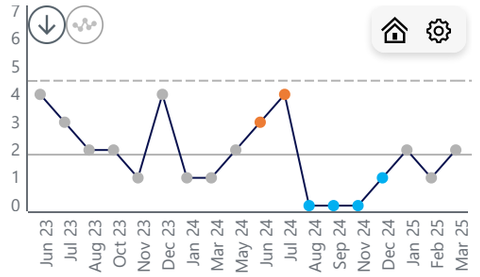
Forward Look (with actions)

Finalisation of internal capacity building awards to support discovery – outcome letters to be issues in April

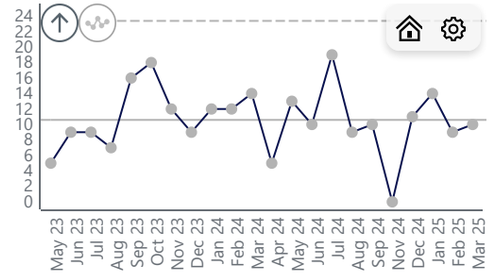
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

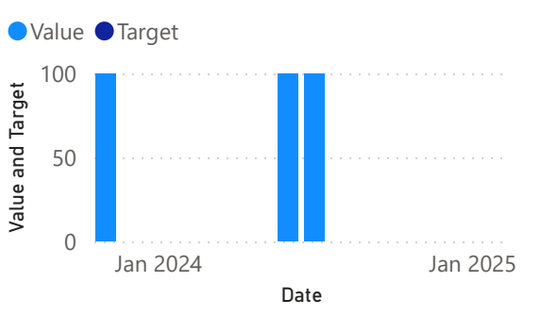
Patient Safety Incidents rated Low Harm & Above



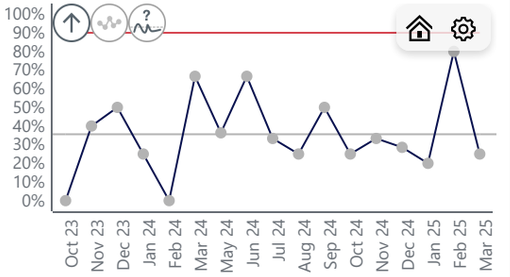
Patient Safety Incidents rated No Harm



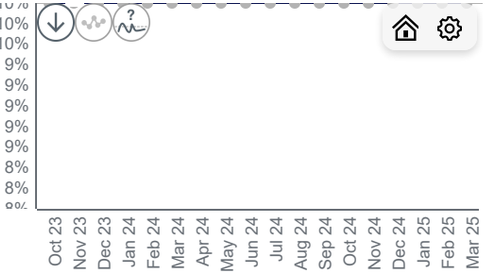
% Complaints Responded to within 25 working days



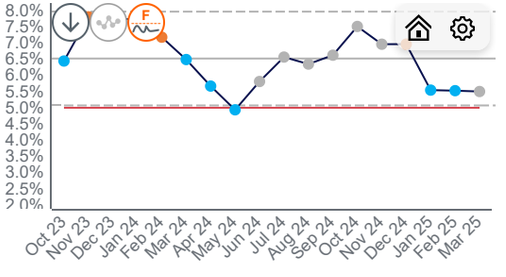
% PALS Resolved within 5 Days



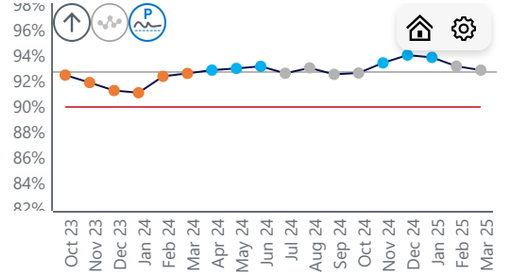
Staff Turnover



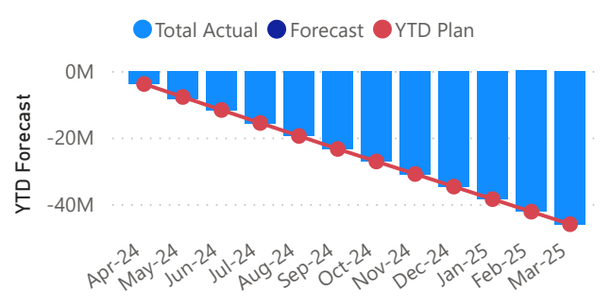
Sickness Absence (Total)



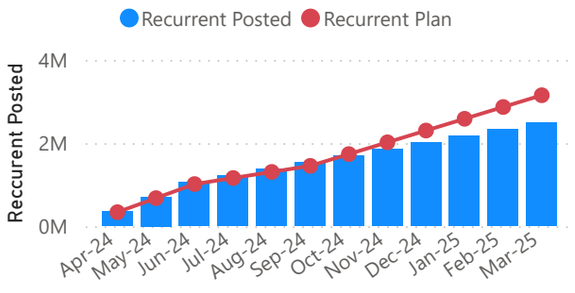
Mandatory Training



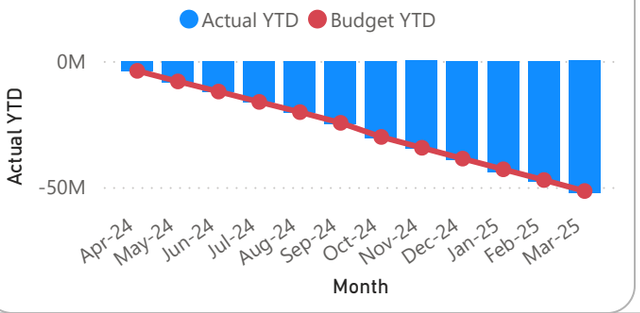
I&E Year End Forecast



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
March 2025 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	95%	-	100%	-	95	20.7	13.56	16.84	0.00%	1.00	100%	0.00	0.00%	0.00	0.00%	24.96	4.69%	0.00	0.00%	0	0	0	0	9	100%	1	0
HDU	75%	84%	73%	63%	327	24.1	27.35	75.67	4.00%	5.33	62%	2.69	3.63%	0.00	0.00%	202.80	8.77%	1.00	1.61%	9	23	0	0	5	100%	1	0
ICU	85%	113%	84%	94%	475	37.2	27.35	161.87	0.00%	4.17	0%	2.00	1.21%	0.00	0.00%	362.55	7.05%	0.00	0.00%	7	23	0	0	0	0%	2	0
Ward 1cC	89%	89%	85%	90%	563	12.6	12.41	58.43	0.00%	5.33	6%	0.00	0.00%	0.00	0.00%	196.35	10.02%	17.56	11.27%	5	14	11	21	15	93.33%	0	1
Ward 1cN	79%	12%	93%	-	223	17.9	15.09	35.21	14.00%	2.43	67%	0.00	0.00%	0.00	0.00%	72.23	7.68%	0.00	0.00%	3	11	0	0	2	100%	0	0
Ward 3A	95%	88%	99%	140%	848	9.7	10.17	49.23	0.00%	15.98	19%	0.00	0.00%	0.00	0.00%	122.05	7.26%	90.33	22.39%	3	21	2	5	16	87.50%	0	0
Ward 3B	90%	93%	92%	-	380	14.0	10	43.95	0.00%	5.28	10%	0.00	0.00%	0.00	0.00%	68.39	4.96%	3.45	2.34%	2	9	0	0	5	80%	0	0
Ward 3C	84%	49%	84%	77%	863	9.4	8.65	62.65	0.30%	19.26	49%	0.00	0.00%	0.00	0.00%	75.95	3.85%	63.57	20.70%	13	41	0	0	12	100.00%	1	0
Ward 4A	93%	56%	91%	81%	860	10.1	10.25	67.53	0.00%	5.71	16%	0.00	0.00%	0.00	0.00%	106.53	5.00%	4.91	3.31%	6	15	1	1	19	100%	1	1
Ward 4B	70%	81%	69%	92%	639	12.2	11.92	29.88	0.00%	46.77	22%	0.00	0.00%	0.00	0.00%	110.81	9.73%	43.48	3.81%	10	29	0	4	9	100%	1	0
Ward 4C	85%	43%	90%	51%	572	10.2	11.8	57.68	0.00%	11.69	4%	0.00	0.00%	0.00	0.00%	173.87	8.76%	51.92	14.94%	7	25	0	1	27	100.00%	1	1

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Fill rates are produced by setting out the planned number of hours required for Registered Nurses (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. Those areas highlighted red (HDU, Wards 3A and 4C) fall below this reported benchmark.

4C: CHPPD below the benchmark data. Fill rate above 80% for RN, however, HCA fill significantly lower, this is due to high levels of staff sickness and 2 WTE unavailable for other reasons. March reported levels of short term sickness above the Trust target in RN and HCA staff groups, however no staffing incidents reported. FFT continues to demonstrate an improved compliance.

HDU: Acuity high particularly with unplanned admissions so reflected in both the fill rate and the CHPPD data. Sickness also above Trust target however an improvement from February.

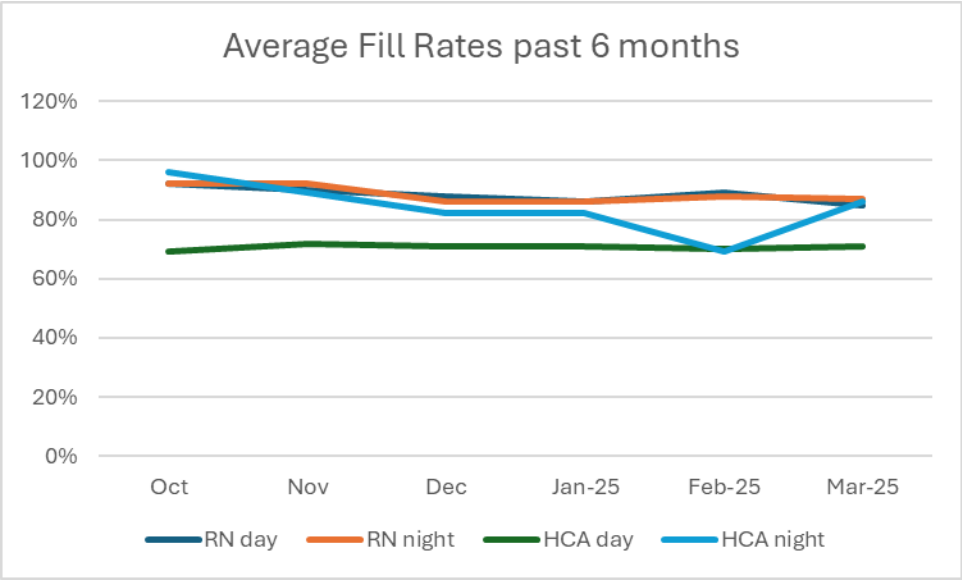
3C: CHPPD and fill rate for RN reporting a positive position. HCA rates below 80% due to a high vacancy factor. Medication incidents reported were all classed as no harm and demonstrates a strong reporting culture.

3A: Fill rate is very good across all disciplines. CHPPD slightly below the benchmark mainly due to acuity of the patients.

1C Neo: Fill rate for RN fell just below 80% on day shift but 93% on nights. This is explained by increased short term sickness. The ratio of staff to number of patients was safe and to note CHPPD was above the national benchmark.

Summary

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 most departments which impacts on the fill rate reported.



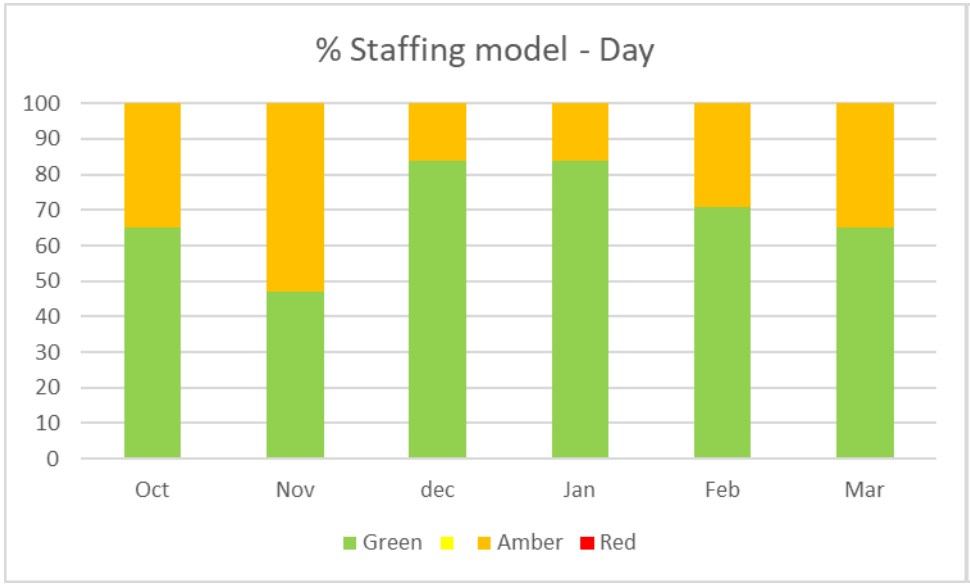
Nursing and care staff average fill rate March 2025	
Day and Night average fill rate	
Registered (%)	**Care Staff**
86%↓	**79%**↑

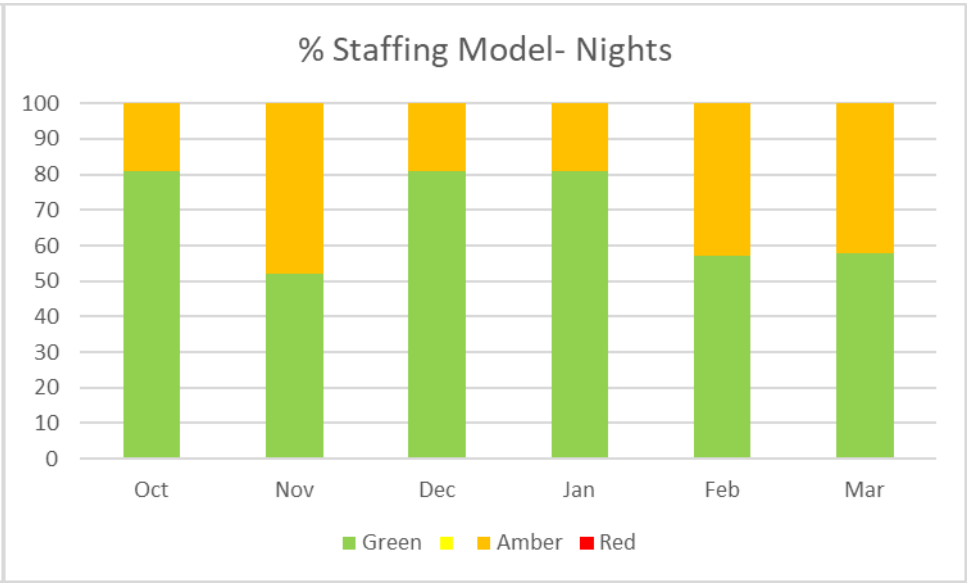
There has been a slight reduction in fill rate for registered nurses, with an increase reported for HCA's. There are vacancies within HCAs across the trust which impacts on the fill rate reported in some areas.

Summary of Staffing models October 2024 – March 2025

To Note only Red, Amber, and Green staffing status is now reported via the staffing template.

Data recorded for March is comparable to February with slightly more day shifts reported as Amber during the month.

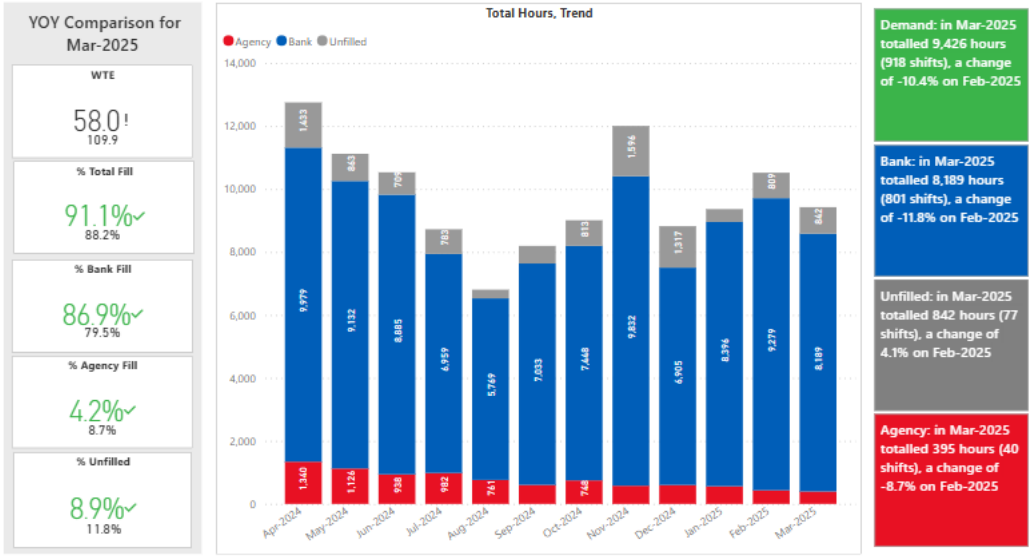




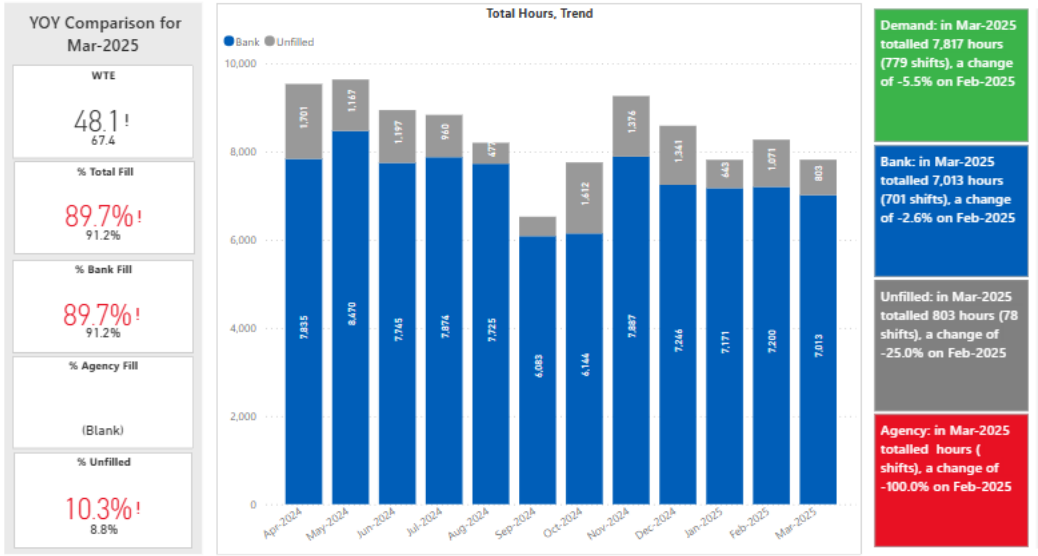
NHSP Bank Spend March 2025

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. As an additional measure for the month of March Director of Nursing and Associate Chief Nurses attended the daily safe staffing meeting allowing greater scrutiny over the present processes when booking NHSP shifts. To note there was assurance from this meeting that correct processes were being followed consistently and there was evidence of grip and control over temporary spend. Overall, we have seen a reduction of 11.8 % from previous month in Registered Nurse Bank spend despite high levels of sickness and increased capacity and acuity.
Unregistered Nurse Bank for the month of March has decreased by 2.6% compared to the previous month despite continued gaps in substantive HCA roles Recruitment for HCA is in progress and in the month of March Alderhey attended a Health and Social Care Recruitment event in Liverpool. This was the first of its kind and gave us the opportunity to extend the scope of our recruitment including both adults and paediatrics with many potential candidates already having the care certificate qualification. A number of appointments were made on the day and there continues to be ongoing recruitment with further interested candidates who attended. As a result of the active recruitment to vacant substantive posts we should see a further reduction in our HCA temporary bank spend over the next couple of months.

Registered Nurse Bank Spend



Unregistered Nurse Bank Spend



KPI E-Roster
Period covering 2nd -30th March 2025.

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 **(2nd March - 30th March)**	% 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)	47.00	41%	80.00	-94.95	0%	0.00	2.00	40%	17%	12%	0%	1%	0%	30%
Accident & Emergency - Nursing (912201)	42.00	30%	720.00	135.24	4%	403.75		23%	18%	2%	1%	8%	9%	37%
Burns Unit (915208)	44.00	21%	140.00	149.43	6%	126.50	2.00	10%	16%	2%	0%	4%	5%	29%
Critical Care Ward (913208)	44.00	26%	1200.00	1020.39	7%	1294.92	4.00	15%	14%	4%	1%	7%	4%	30%
High Dependancy Unit (HDU) (913210)	44.00	30%	640.00	146.43	9%	688.00		28%	15%	6%	1%	9%	6%	37%
Medical Daycase Unit (911314)	48.00	22%	50.00	-7.45	0%	0.00	13.00	13%	14%	2%	1%	0%	0%	17%
Outpatients (916503)	44.00	45%	420.00	-157.85	16%	760.50	10.00	33%	25%	0%	1%	7%	4%	38%
Sunflower House (912310)	44.00	59%	190.00	-62.67	31%	1478.27	41.00	15%	19%	3%	1%	10%	3%	39%
Surgical Daycase Unit (915418)	41.00	52%	85.00	243.33	7%	209.25		36%	20%	0%	1%	8%	4%	32%
Theatres - Cardiac & Cardiology (915405)	44.00	12%	130.00	-18.00	1%	14.50		10%	20%	0%	0%	7%	6%	33%
Theatres - Emergency (915420)	44.00	32%	230.00	-32.32	4%	92.25	1.00	4%	21%	2%	0%	4%	0%	27%
Theatres - IP Anaesthetics (915423)	44.00	27%	82.00	75.08	4%	119.75		6%	20%	2%	2%	8%	0%	32%
Theatres - IP Porters (915435)	44.00	41%	101.00	16.43	17%	221.25	2.00	8%	19%	0%	1%	22%	0%	43%
Theatres - IP Recovery (915422)	41.00	36%	103.00	17.55	13%	218.25		9%	18%	3%	6%	3%	0%	30%
Theatres - IP Scrub (915424)	44.00	26%	128.00	-4.75	3%	60.25		14%	20%	0%	1%	6%	6%	34%
Theatres - Ortho & Neuro Scrub (915436)	44.00	40%	37.80	3.20	14%	338.00		9%	15%	2%	1%	2%	8%	40%
Theatres - SDC Anaesthetics (915429)	44.00	55%	58.40	227.47	50%	503.50		14%	25%	1%	6%	0%	17%	50%
Theatres - SDC Recovery (915430)	44.00	30%	177.30	-7.27	7%	108.25		6%	13%	0%	0%	11%	7%	32%
Theatres - SDC Scrub (915421)	44.00	40%	532.00	-254.00	5%	122.00		15%	15%	0%	1%	19%	2%	38%
Ward 1C Cardiac (913307)	44.00	30%	361.00	155.42	4%	244.50	1.00	14%	15%	2%	2%	12%	4%	36%
Ward 1C Neonatal (913310)	46.00	45%	556.00	889.30	4%	181.00		21%	17%	6%	2%	8%	6%	45%
Ward 3A (915309)	44.00	30%	371.00	45.70	17%	1281.50	6.00	13%	14%	1%	4%	11%	7%	38%
Ward 3B - Oncology (911208)	45.00	21%	555.00	279.97	5%	237.00	4.00	15%	16%	4%	1%	6%	5%	36%
Ward 3C (911313)	47.00	29%	607.00	0.07	7%	582.50	16.00	24%	18%	2%	1%	7%	6%	36%
Ward 4A (914210)	45.00	22%	634.00	471.01	8%	653.50	9.00	14%	17%	3%	0%	6%	3%	32%
Ward 4B (914211)	44.00	35%	533.00	148.62	12%	964.00	6.00	22%	21%	1%	1%	8%	6%	37%
Ward 4C (912207)	44.00	32%	280.00	-25.73	5%	287.83	3.00	24%	19%	3%	4%	12%	5%	45%

Trust 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 44 days (KPI 42 days) All in-patients wards are above KPI.
- Net hours continue to decrease from 5628 to 3360. (KPI 9001to allow for up to one day to owe or be owed).
- Bank / Agency has decreased from 13009 hours to 11191 hours.
- Additional duties have reduced 241 to 120
- Sickness remains high at 7.6 %.
- Annual leave high at 17.9% and just above KPI. To note we have seen increased number of staff using their AL before end of the year. Matrons are working with ward managers to ensure AL is taken evenly throughout the year and is consistently within KPI. All other leave is at 1.5% and within agreed KPI, s (<5%)
- Study leave outside KPI at 2,5%. (KPI 2%)

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	Learning from Patient Safety Incidents Q4 January -March 2025
Report of:	Chief Nursing AHP and Experience Officer
Paper Prepared by:	Associate Director of Nursing Governance and Risk Patient Safety Incident Investigation Leads

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide the Trust Board with a summary of activity and system-wide learning following the transition to the Patient Safety Incident Response Framework (PSIRF) for Q4 2024/25 and next steps, noting that this is an iterative process as we continue to transition and embed PSIRF.
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 ☑						
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. Purpose

The purpose of this report is to provide the Trust Board with a summary of activity during Q4 January-March 2025 following the transition to the patient safety incident investigation framework (PSIRF) on 1 January 2024, highlighting any identified areas of system-wide learning and improvement and next steps.

2. Activity to date

2.1 Learning from Patient Safety Events (LFPSE)

The Trust continues to meet the reporting requirements of the LFPSE v5 with LFPSE v6 taxonomy (due to be released Feb 25) not yet been released.

Following a request received from NHSE in December 2024 the Trust has completed the request for organisations to validate data in their local risk management system (InPhase) against data that is held in a national recorded data dashboard (RDD).

The request was to verify the data held in InPhase matches with that held in the RDD prior to wider publication of incident data.

Minor discrepancies were identified between the Trust and RDD data sets as part of the validation exercise. Actions are in place with NHSE to address and mitigate the discrepancies between organisations.

The first set of national LfPSE organisational level data is due to be published mid-May 25.

2.2 Patient Safety Responses (PSRs)

All PSRs are conducted locally across the Trust with different techniques adopted depending on the intended aim and required outcome.

Initial reviews and/or SBARDs are initiated and completed by the relevant division and presented at the weekly PSIRI panel for discussion and potential consideration for commissioning of a learning response.

Table 1

Divisional led initial reviews Q4 2024/25	Number initiated by Divisions
Initial Review: The initial review is initiated and completed within **7 days** of notification of an incident by the relevant division and presented at PSIRI. This is an initial fact-finding that will inform whether a full patient safety incident investigation (PSII) or patient safety response (PSR) is required.	**26**
Situation, Background, Assessment, Recommendations, Decision (SBARD): Is structured communication framework that can help staff/teams share information about an issue that needs to be addressed. The SBARD is initiated and completed within **7 days** of notification of an incident by the relevant division and presented at PSIRI. The detail provided in the SBARD can be used to help inform any further learning response if required	**8**

2.3 Learning Responses

During Q4 2024/25 there have been 4 learning responses (excluding PSIIs) commissioned by the weekly PSIRI panel to investigate those incidents initially reported as moderate physical or psychological harm or above.

Table 2

Learning Response Types Q4 2024/25	Number Commissioned by PSIRI
After Action Review (AAR): A method of evaluation that is used to analyse what happened, why it happened, and how it can be done better by the participants, in the future. It is not an investigation process, but its purpose is to learn, support effective teamwork, motivation and implement improvements in a timely manner.	**4**
Learning Together Review (LTR): A LTR replaces previously named MDT and supports teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to obtain staff recollections of events either because of the passage of time or staff availability.	**0**
Thematic Review (TR): A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues.	**0**

2.3.1 Timescale compliance for patient safety responses/learning responses Q4 24/25

Initial reviews/SBARD (Completed within 7 days of incident being reported):

- Medicine – 25% compliance (12 completed, 3 within timescale)
- Surgery – 38.5% compliance (13 completed, 5 within timescale)
- Community & Mental Health 100% (8 completed, 8 within timescale)

After Action Review (Completed within 1 month of commissioned date)

- Medicine – 33.3% compliance (3 commissioned, 1 completed within timescale)
- Surgery – 0% compliance (1 commissioned, 0 completed within timescale)

There have been zero learning together reviews or thematic reviews commissioned for Q4 2024/2025.

Moving forward there will be increased focus on completing the respective reviews within the timescales which will be monitored through the weekly PSIRI meeting.

2.4 Commissioned Patient Safety Incident Investigations (PSIIs)

A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well-intentioned and strive to do the

best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

As of the 31 March 2025, the Trust had commissioned **two** PSIIs, both of which were related to national priorities. The commissioned PSIIs relate to the following:

- A never event (wrong site surgery): *National priority.*
- A never event (wrong route medication administration): *National priority.*

The wrong site surgery never event incident occurred in October 2024 within the Medicine Division, relating to Botulinum toxin (Dysport) injection given in the wrong limb. This PSII investigation concluded in March 25 within given timescales with final report being drafted and will be presented at SQAC in May 25.

2.4.1 PSII: Wrong site medication administration

The wrong site medication administration never event incident occurred in February 2025 within the Surgery Division, relating to the administration of medication given via a parenteral route when intended for enteral administration.

This incident met the Never Event criteria for a wrong route administration. The patient was immediately reviewed, observed and screen sent for infection and has since been discharged home.

The patient safety investigators will undertake the PSII with family and key stakeholders. Draft terms of reference for the PSII have been developed in conjunction with the surgery division and pharmacy leads for approval by Chief Nursing, AHP and Experience Officer and Chief Medical Officer.

2.5 System wide learning reviews -Thematic reviews

During Q4 2024/25 the Trust commissioned zero thematic reviews.

A data breach thematic review commissioned in Q3 2024/25, to understand the common links, themes, or issues within a cluster of reported incidents has concluded.

The draft report was presented and approved at Patient Safety Board in March 2025 and shared as part of the patient safety assurance update at Safety and Quality Assurance Committee (SQAC) in April 2025 (Appendix 1).

A meeting is planned in Q1 2025/26 with Chief Nursing, AHP and Experience Officer and Chief Digital Officer to discuss the findings and agree next steps.

2.6 Training and Education

2.6.1 Patient Safety e-learning

The table below demonstrates the Trust compliance against three role specific patient safety e-learning modules, introduced to support PSIRF.

E-Learning Modules	%Compliance
Level 1a Essentials for Patient Safety (All staff)	**99%**

The divisions of surgery, medicine and community/mental health now have a designated trained learning response and engagement lead meeting the PSIRF standards.

A CPD event, facilitated by Consequence UK, was delivered during March 2025 to ensure training/CPD was achieved for these members of staff including those in oversight roles.

2.7. Patient Safety Investigators

Our Lead Patient Safety Investigators continue to undertake PSII investigations, thematic reviews, audits and support the delivery of patient safety improvement programmes aligned to our patient safety plan.

They have also been instrumental in the continued delivery of PSIRF training to clinical and non-clinical staff across the Trust.

2.8 Internal Audit: clinical monitoring in the post-anaesthesia phase/recovery areas, discharge, and handover process

A retrospective audit was commissioned to internally assess the Trust's performance against the two Standard Operating Procedures (SOPs) in place at the time of a deteriorating child, to measure compliance against the Trust's expected standards:

- Assess compliance with clinical monitoring standards during post-recovery post-general anaesthesia.
- Evaluate adherence to discharge criteria and handover processes.
- Identify areas for improvement in recovery documentation and patient monitoring.
- Highlight deficiencies in patient monitoring, documentation, and risk assessment protocol
- Provide actionable recommendations to enhance patient safety.

Key audit findings:

- The audit highlights a high level of compliance with essential monitoring and discharge criteria but identified specific areas for improvement in the documentation of monitoring devices, dynamic risk assessments, and adherence to observation protocols. Addressing these gaps through training, system updates, and standardised SOPs/Policies will enhance patient safety and recovery outcomes.

Audit recommendations:

- To improve observation gaps identified, including handover documentation, documentation improvements, monitoring compliance, handover processes, and observation plan.

The findings of this audit have been shared and actioned with the surgery division and will form part of the recommendations and quality improvement deteriorating patient workstream.

2.9 Patient Safety Partners

In November 24 the Trust recruited 40 Patient Safety Partners (PSPs) following an active recruitment campaign supported by our Children and Young person’s forum.

An estimated start date of May 2025 is planned with the development of a bespoke programme being initiated and lead by our Patient Safety Investigators to ensure that the Patient Safety Partners contribution to both investigations and improvement is optimised.

3. PSIRF Annual Review of the Trust PSIRF Plan

Following the first 12 months following the Trust's transition to PSIRF there is a requirement for the Trust to undertake an annual review of the original PSIRF plan or PSIRP.

The 2025/26 Patient Safety plan was presented at Patient Safety Board and SQAC in February 2025 and approved at Trust Board in March 2025.

The meeting with Cheshire and Mersey Integrated Care Board (ICB), is planned for April 2025 to confirm acceptance and ratification of the trusts PSIRP for a further 12 months.

4. MIAA Audit Activity

In line with the Trusts annual audit plan Mersey Internal Audit Agency (MIAA) were commissioned to undertake 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.

Fieldwork commenced in Q3 2024. The review concluded in March 2025 with a substantial level of assurance and 2 recommendations as noted below:

Recommendation 1 (medium): Training

'The Trust should upgrade how training is recorded, so that it is easier for staff at all levels to keep track of their training, participation in learning responses and competencies. This would enable the Trust to increase assurance that PSIRF leads are suitably trained and can demonstrate they have the relevant competencies. The Trust would benefit from taking a more proactive approach to identifying candidates for level 2 patient safety training'.

Recommendation 2 (Low) Incident response documentation

'Trust staff should be encouraged to always document the response to all incidents, even if as simple as noting that the incident was discussed at Safety Huddle and no action or learning was identified. This would enable the Trust to have greater assurance that all incidents have received an appropriate response'.

Audit findings have been shared with Chief Nursing, AHP and Experience Officer and Chief Medical Officer as SROs for Patient Safety, with stakeholders at the Patient Safety Board in March 2025 and presented by MIAA at Audit and Risk Committee in April 25.

The following actions for both recommendations have been implemented:

- Level 2 of Patient Safety Syllabus training to be populated in ESR
- Learning and Development team to build a classroom on ESR which stores the detail of staff within learning / oversight and engagement roles with the correct competencies.
- Planned CPD sessions delivered in March 2025 by Consequence UK to achieve the PSIRF standards for those in oversight roles, learning response roles and engagement lead roles

- Continuation of a 6 monthly dip sample audit to monitor compliance with completion of all sections of the InPhase Incident module. This audit has been added to the Trust audit plan for 2025/26.

Oversight of actions will be reported to Patient Safety Board and assurance of delivery provide to SQAC by way of updates via Chairs report.

5. Next Steps

The Trust continues to navigate and embed the PSIRF framework, ensuring that there is a focus on shared learning, implementation of actions and consideration of the resources required to continue to maximise the value of the PSIRF approach.

An ongoing review of PSIRF processes and roles and responsibilities will be undertaken to consider the operating model during Q1/2 2025/26.

6. Recommandation

The Trust Board is asked to note the activity that has been undertaken during Q4 2024/25 following the Trust's transition to and embedding of PSIRF and next steps

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on Wednesday 26th March 2025 Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Alfie Bass	Chief Medical Officer	ABa
	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	AB
	Kerry Byrne	Non-Executive Director	KB
	Gerald Meehan	Non-Executive Director	GM
	Rachael Pennington	Associate Chief Nurse - Surgical Division	RP
	Laura Rad	Head of Nursing – Clinical Research	LR
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
	Jackie Rooney	Associate Director Nursing & Governance	JR
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Veronica Greenwood	Director of Allied Health Professionals	VG
	Peter White	Chief Nursing Information Officer	PW
24-25-263	Bea Larru	Director of Infection Prevention & Control	BL
24-24-264	Julie Grice	Mortality Lead	JG
24-25-266	Susan O'Neil	Head of Neonatal Nursing, Liverpool Neonatal Partnership	SON
24-25-267	Dan Hawcutt	Director of Research	DH
24-25-272	Jennie Money	Associate Director Workforce, Education and Quality	JM
Apologies:	Nathan Askew	Chief Nursing Officer	NA
	Pauline Brown	Director of Nursing	PB
	Lisa Cooper	Divisional Director – Community & Mental Health	LC
	Urmi Das	Divisional Director – Division of Medicine	UD
	John Grinnell	Chief Executive	JG
	Hilary Peel	Public Governor	HP
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health	JP
	Paul Sanderson	Chief Pharmacist	PS
	Melissa Swindell	Chief People Officer	MS
	Ian Gilbertson	Deputy Chief Digital and Information Officer	IG
	Jill Preece	Governance Manager	JP

Welcome and Apologies
The Chair welcomed everyone to the meeting and apologies were noted.

24/25/257 **Declarations of Interest** – Gerald Meehan declared that he is the Independent Chair of Liverpool Children Services Improvement Board.

24/25/258 **Minutes of the Previous Meeting**
The Committee members were content to **APPROVE** the minutes of the meeting held on 19th February 2025.

24/25/259 **Matters Arising/Review of Action log**
The action log was reviewed and updated.

---- Delivery of Outstanding Care ----

24/25/260 **ED monthly report: MH attendances and ED@its best**
CW presented the Emergency Department (ED) Monthly Report for February 2025 sharing key highlights:

- ED achieved 79.1% against the 4-hour KPI
- Median time to triage was 15 minutes in line with the national standard

- Improvement in time to clinical assessment of 81 minutes, with a maintained reduction from 112 minutes in November 2024
- Positive improvement relating to the risk regarding the number of consultants that had been absent from ED and the impact on the rota. CW advised that this risk is likely to be downgraded, as consultants had returned to work.The Division had also appointed a locum and are advertising a consultant post
- A decrease in month of Children & Young People waiting 12 hours or more, this is a maintained improvement from November 2024
- NWAS Turnaround times noted as 31 minutes in October 2024 and had reduced to 21 minutes in February 2025. CW advised the Division are liaising with NWAS regarding confirmation of dates for the agreed actions to be delivered
- There is a focus on achieving the urgent and emergency care capital initiative in March, with potential benefits of £1-4 Million if successful

FB advised that the ED report had helped the committee understand the flows between the different services that now manage the 'front door'. FB referred to the SQAC agenda for 25/26 and advised that colleagues are confident that the Division of Medicine are well sighted on the flow of patients and that this is being well managed. FB proposed that SQAC do not receive the ED monthly report: MH attendances and ED@its best report as a separate report, with the expectation that SQAC would receive key metrics/headlines within the Divisional monthly update, and on the basis that the divisional governance meeting would continue to ensure oversight.

ES advised on the adjustments to the proposed SQAC workplan for 25/26 to streamline the SQAC agenda to enable sufficient space for transformation work. ES stated that when large changes occur, SQAC would request a detailed report to be submitted.

Resolved: FB sought clarity that SQAC are supportive of this approach, Committee were all supportive

Sepsis performance

- CW advised on the ongoing work within ED to improve Sepsis performance, with an improvement reported over the last three month period. During February 2025 performance is at 94%. Sepsis week had entailed which had been successful. CW confirmed that trends and themes continue to be monitored on a monthly basis. FB sought clarity whether Sepsis week would become part of a regular refresher programme, CW confirmed that this would be held every quarter.

FB referred to an issue which related to a doctor who had prescribed antibiotics but hadn't directly made that known to the nursing team prior to leaving the cubicle, and sought clarity whether this is being managed separately. CW stated that the Mortality Lead (JG) is managing this within the team and this had been emphasised within the department.
Resolved: SQAC received and **NOTED** the ED Monthly Report.

24/25/261 Divisional Updates

Division of Medicine

CW presented the Medicine Division update and drew attention to a few key points from the report including:

Highlights:

- Since May 2024 the total number of children and young people waiting for care within the Division of Medicine had reduced by over 1,000, a plan is in place for those outstanding children to be treated in the month of March 2025
- A decease for in patient Sepsis performance noted for February 2025 at 77% . There were 9 sepsis episodes with 2 inpatients not receiving antibiotics within 60 minutes: 1 patient received antibiotics at 61 minutes, learning identified regarding issue with administration of Antibiotics, other delay related to a dialysis patient with a delay in accessing a dialysis line as Haemodialysis patients have specific lines and require staff to be additionally trained to access. Response team and staff on 3C are being trained and this issue has been addressed regarding accessing lines.
- Emergency Preparedness Business Continuity desktop exercise undertaken within the Division, with good attendance and engagement, with some areas of non-compliance. CW advised an update with positive improvement will be provided in the next 1-2 months.

Challenges:

- Worsening Financial Forecast, with specific challenges within non-pay position due to drugs and clinical contracts for equipment and maintenance and worsening ERF income opportunity
- Neurology service provision remains a risk within the Division due to the reduced workforce and inability to provide a full service provision. Significant actions completed in month including a change in formal leadership of the team, revised job planning for all consultants and clinical fellows and continued discussions with NHSE regarding regional and national on call provision, whilst also reviewing new pathways to increase capacity and revise clinical models within neurology.
- AB referred to Interventional Radiology, stating that the Radiology team had recently escalated concerns regarding service. AB advised that there had recently been 3 simultaneous cases which had resulted in service pressures for the Interventional Radiology service. AB advised there is a need to establish an urgent MDT internally when this occurs to enable patients to be expedited to theatre, and externally colleagues trying to create an interventional radiology network for time critical cases, with partnership work to explore with RMCH and others. ABA advised that he has had a discussion with counterparts at RMCH and would follow this up offline. ABA stated that Radiologist services at RMCH are not situated within the children's, hospital. CW advised that she is aware of the issues raised and confirmed that the Division have oversight and confirmed that SQAC would be provided with an update on progress within the Divisional report in April 2025.

GM referred to the worsening financial forecast and sought clarity regarding 25/26 and queried how concerned colleagues are within the Division of Medicine regarding budgetary pressures. CW stated that she is extremely concerned as this is a significant challenge
FB stated that some thought is required to gain assurance and identify risks as the year progresses, this would be considered at the pre SQAC meeting. ES stated that there would be a real focus for this Committee

Surgery Division
RP presented the Surgical Division update and drew attention to a few key points from the report sharing key highlight and challenges:-
Highlight:

- The Division had a launch of the Cardiology Transformation collaborative board, with good engagement, process mapping workshops are due to take place week commencing 31.3.25

Challenges:

- Increasing use of Prometheus to support children and young people with challenging behaviour, RP advised that a meeting is planned in early April 2025 to consider assurance processes
- Workforce plan and the need to restructure and work differently – RP advised on the challenges to replan workload across the teams and maintain business as usual whilst targeting resources to transformation work.
- EPPR – the lead within the Division of Surgery had left the Trust and the Head of Nursing & Allied Health Professionals-theatres, Critical Care is now leading on EPRR. RP advised that a monthly Safety and Quality group meeting is being established within the division, in addition to a divisional finance and workforce meeting, with the aim of aligning some of the workstreams into the divisional meetings to ensure further oversight. RP stated that she envisaged improvement in April 2025.
- RP referred to the High risk relating to insufficient capital funding and advised that she had recently met with the Head of Medical Engineering with a plan to review the breadth of capital replacement to enable a more risk based approach, and to ensure that the information is available to enable informed decisions to be made, and enable improved assurance and understanding.
- Sepsis performance – 1 patient did not receive antibiotics within 60 minutes, 1 patient received antibiotics at 64 minutes, as there was a delay in access and prescribing, there is a plan with educators to recommence sepsis simulation. 1 patient received antibiotics at 121 minutes with a delay in administration, communication within the team identified as the nursing staff was not aware that the antibiotic was prescribed, there was no harm to the patient.
- RP referred to Document Management and the document numbers, and queried whether there is a mismatch between the DMS system, as there had been instances when documents had already been updated and submitted. RP is liaising with the central team offline.

ES referred to capital replacement and queried whether there is any additional support or scrutiny required given the capital challenges, acknowledging that the situation regarding capital is evolving.

RP stated that it is challenging to manage in terms of the volume and complexity and stated that the volume of equipment that is end of life this year is vast. RP referred to the uncertainty regarding equipment which may go out of support at any point, and stated that is it right to review all equipment within every department to enable the breadth of information to understand the risk to appropriately manage.

Resolved: ES stated that this requires senior oversight which would be considered offline
Resolved: SQAC to continue to review capital challenges, in addition to other committees as capital programme is cross cutting.

Clinical Research Division
LR presented the Clinical Research Division update and drew attention to a few key points from the report sharing highlights and challenges:
Highlights:

- Division celebrated a continued increase of positive patient feedback
- Business continuity plan now in final draft, ready to be exercised in April 2025
- Staff turnover is at its lowest in over 2 ½ years
- EPRR training overview - LR is liaising with the EPRR Manager regarding individuals who require training, and are unable to complete training in May due to pre-approved leave, given staff cannot attend until November 2025.
- DMS-project to move relevant documents and SOPs to the DMS is making progress, with slight delays noted due to individuals working on the Essence investigation.

Challenges:

- Essence update – a full deep dive of the 21 patients affected in the missing records incident had taken place. Conclusion is that these were parallel notes, being kept in addition to their main clinical notes and thought to contain copies of consent forms, continuation sheets with notes made by research teams. All 21 patients were found to have all of their clinical data scanned or digitally submitted for clinical activity. 20/21 research consent forms had been retrospectively added back into the patients digital records.1 consent form is missing and CRD are recalling more boxes from the archive company. Study site files have been checked and contain all research records of adverse events and data/observations taken for the study. Discussion had taken place as Senior CRD team and colleagues feel that notifying families is not in the families interests as loss of information is so minimal and would not lead to clinical harm. LR had discussed this with Director of Nursing on 26.3.25 and agreed that all patients had been fully reviewed on an individual basis and no patients had any vital clinical information missing and that there would be little benefit from informing families. LR advised that CRD would proactively notify study sponsors to inform them of the investigation and notify them regarding information that had been lost, individual letters to sponsors had been drafted by DH. The Head of Information Governance/Data Protection Office had confirmed that this is not externally reportable, but need to agree if any further activity should be completed prior to the incident being closed. Agreement had been made to take this incident back to the PSIRI panel in a number of weeks to share findings and provide a final update.
  FB referred to duty of candour and robust discussion regarding any harm, and referred to the location of the records and who may have sight of the records. LR advised on the extensive checks that had taken place and reiterated that the records are unlikely to be found. The Head of Information Governance/Data Protection Officer had provided advice on this, and CRD would liaise regarding next steps. FB stated that this required Executive consideration with regards to the level of risk.

Resolved: Essence update would be presented to Risk Management Forum.

Community and Mental Health Division
SQAC received the Community & Mental Health Report.
KB referred to the challenge within EPPR ability to audit and sought clarity regarding this.
SQAC noted that the challenge related to the ability to check records e.g. the need to find out when the last risk assessment was reviewed for each case and how many cases have up-to-date risk assessments, as well as for care plans. All professionals in the Trust should be able to see care plans and risk assessments and should either be able to access the details or just know that these documents exist to ensure that they are aware of any important information. Currently Expanse/Meditech does not support this level of scrutiny, resulting in the Division have developed

work arounds where possible, however these take time and often involve a degree of manual process.

Resolved: SQAC received and **NOTED** the Divisional Assurance Reports.

---- *Safe* ----

24/25/262 Patient Safety Strategy update

JR introduced the report detailing the work undertaken during February 2025 by the Patient Safety Programme Board (PSPB) and drew attention to the following key highlights:-

- Workstream 1 - Safety metrics remain on trajectory with continuous improvement noted in 5% reduction in low and above harms and an increase noted in the reporting of incident.
- Sepsis treatment – noted a positive increase in the % compliance of inpatients receiving antibiotics within 60 minutes
- Category 2 pressure ulcers had reduced with two consecutive months of 0 pressure ulcers
- Workstream 13 - Neonatal Newborn Screening – work related to roll out of blood spot screening had been completed and Patient Safety Strategy Board had accepted a closure business report
- Annual Reports are being requested to be presented at Patient Safety Strategy Board going forward for oversight of metrics, and would be reported into the neonatal steering group at Liverpool Women's NHS Foundation Trust, with next steps to involve training of additional staff and developing oversight document
- Due to workload and capacity a number of reports were deferred until March 2025
- HMRG report was presented, noting 90% of HMRG primary reviews are being completed within a four month target for quarter 3.

Challenges:

- Newborn screening – challenges were noted regarding babies being screened within the time frames recommended by NHSE and challenges regarding improvement relating to the quality of blood spot samples.
- Learning from patient safety incidents at the time of reporting In phases was not set up to capture the data required to provide assurance regarding compliance with national PSIRF standards, however this had now been actioned and completed in Inphase, to capture the relevant details, this would be subject to a six month dip sample audit undertaken by the patient safety team
- Medical Devices – there is an ongoing issue to achieve and maintain high levels of training competencies in relation to several medical devices, there had been commitment from learning and development and the educators to increase compliance via a skills day for all staff

ABA referred to the Deteriorating patient workstream and sought clarity when this workstream would be presented to the Patient Safety Board. JR confirmed this is included in the 25/26 Patient Safety Strategy Workplan which is being approved at Patient Safety Strategy Board on 27.3.25. JR confirmed that the Patient Safety Strategy Board and Terms of Reference are also being presented to SQAC at April 2025 meeting.

FB stated it would be helpful to have more time allocated on this item at the next meeting.

Resolved: SQAC received and **NOTED** the Patient Safety Strategy update

24/25/263 IPC Quarterly Report

BL presented the IPC Quarterly report and provided an overview of the work of the IPC Champions Group, and the Antimicrobial Resistance Steering Group.

- Environmental Cleanliness Group is reestablished and is being chaired by the Director of Nursing.
- BL advised on the Bacteraemia Surveillance and seasonal variations, and steering group working with staff groups and IPC proactively working with water safety colleagues
- BL advised that since January 2024,UKHSA alerted Trusts regarding a sharp increase in C Difficile cases across the UK, with high levels in the North West. BL advised on learning from PIRs for staff to isolate based on symptoms and sending samples earlier. C Difficile cases in Q3 mainly affected oncology and some case of patients admitted in the same room, despite the room being cleaned there was a risk for the next patient using the same cubicle in Oncology, this had been shared with Oncology colleagues and patients are now tested earlier and isolated earlier.
- 1 positive measles case reported in Q3, no significant contacts were identified following exposure.
- Band 7 Data Scientist Apprenticeship successfully recruited,and Band 6 IPC Specialist Practitioner post approved and advertised, and is due to commence in October 2025.

KB referred to AMR and stated that she had attended a QAR previously which highlighted ongoing work regarding delabelling, and stated that there was a suggestion that there was not any funding. KB sought clarity whether AMR has the right resources and the right funding or whether there is requirement for a deep dive. LB stated that there are a lot of people who are mis diagnosed with allergies and that it is important to identify those patients who are allergic. BL stated that she is presenting an update at Patient Safety Strategy Board on 27.3.25 as support is required from the Trust to continue this model.

DH alluded to the research aspect and referred to the excellent trainee (CP) and advised that he is applying for a locum role in the trust, and should CP be the successful candidate whether some aspects could be incorporated into his role. DH stated from a research perspective there is little to do as colleagues know relabelling is effective and that the underpinning work is present and just required roll out to clinical services.

GM requested BL view of the Trust resilience and the ability to scale up a Trust response in any area of infection. BL advised that the workforce is competent, staff are enthusiastic who want to work and want to have a data driven programme that serves the hospital. BL advised on the importance of recruiting the right people and providing opportunities for staff to flourish.

Resolved: SQAC received and **NOTED** the IPC Quarterly Report

24/25/264 Quarter 3 Mortality Report

JG presented the Q3 Mortality Report, detailing the work of the Hospital Mortality Review Group (HMRG) and Q3 mortality data, including a review of statical analysis.

JG advised that she had previously highlighted that the mortality rate was higher than expected, however during Autum/December 2024 the Trust had the lowest rate of deaths recorded in a number of years and advised on the change of the recording process and presenting of data from 2021 which resulted in a rise in figures reported, as previously children/young people that died in ED were not included in the figures and ED deaths were recorded separately.

- HMRG performance had continued to improve in Q4
- Commonest diagnostic themes consistent throughout the years are underlying congenital conditions and the SUDI. Recurrent themes are withdrawal and death inevitable
- No concerning trends with the learning disability cases noted and a deep dive is due within the next Mortality report
- Nationally the Trust had to report deaths over 4 years of age, there is discussion nationally to decrease this age
- Prehospital issues remain an issue – colleagues are working with NWAS to address this
- Medical Examiner process had scrutinised 72 deaths, 3 incidents within this quarter, 2 of which related to access issues due to cyber-attacks and 1 was a mild deviation of process
- There had been 2 avoidable deaths relating to external factors
- PICU deaths remain in the safe zone
- Neonatal deaths in 2024 - 84% of these cases are congenital, surgical cases are predominantly Necrotising enterocolitis which is very common premature complication and require children to come to Alder Hey to be assessed. 84% of the cases required palliating following assessment
- Learning-HMRG colleagues are continuing to receive increased requests for meetings with families. There had been considerable learning this quarter from coroners cases.
- Future plans include closer links with other paediatric hospitals regarding mortality; adapt according to feedback when appropriate and closer working links with safeguarding teams/CDOP

FB welcomed the learning disability deep dive update within the next Mortality report. FB referred to cases where the early release of the body is required for faith burials and queried whether this is in a satisfactory position. JG advised that there had only been 1 case where the family had raised that this had been slightly delayed, and on review the body could not have been released any quicker.

ABA referred to the neonatal deaths and stated that he is interested in exploring, the pre-natal diagnosis for some of the congenital abnormalities and stated if these could be diagnosed prenatally, whether the advice given is accurate, and whether there is a relationship between prenatal diagnosis and palliation and whether this affects mortality rates.

ABA referred to Necrotising enterocolitis and sought clarity whether there is an algorithm determining whether a child is salvageable or not and whether this algorithm is applied.

JG referred to the Necrotising children and whether it is appropriate for families to be given unrealistic hope, and advised that on review of cases the extreme prems may start off in good condition and have

deterioration on route or on arrival. JG advised that the if the Surgical team did not take the opportunity to review these patients, this would be poor decision making. JG stated that the Surgical team are happy with the decision making. JG plans to undertake a deep dive of all of the neonatal deaths over the last 3 years.
JG referred to Antenatal diagnosis and stated that there is a great deal of counselling undertaken and parental decisions, as families still want operations to be undertaken/proceeding where outcomes are not going to be ideal. JG stated that the majority of cases works very well.
RP stated that decision making and viability is definitely being considered.
JG referred to external benchmarking which is vital but has limitations, and referred to the benefits of peer reviews, to ensure that there is no bias.

JG referred to the congenital diaphragmatic hernias and the need to explore between neonatologist and paediatric surgical teams' given the complexities. JG advised on the need to align colleagues to provide substantive answer.
FB stated that there could potentially be some audits undertaken and that it would be helpful to receive updates in future Mortality reports.
Resolved: SQAC received and **NOTED** the Quarter 3 Mortality Report

----- *Effective* ----

24/25/265 Clinical Effectiveness & Outcomes Group Chairs Highlight report

JR presented the Clinical Effectiveness & Outcomes Group Chairs highlight report from the meeting that took place in February 2025

Highlights:

- Divisions had commenced in providing feedback from clinical audits on a monthly basis
- Acknowledgement of continued compliance with NICE guidance
- Continuing improvement noted with oversight and learning from clinical audits
- LNP Policies/guidelines task and finish group is progressing with review and streamlining of Alder Hey/Liverpool Women's Foundation Trust documents across the LNP
- Professional nurse advocate numbers continue to increase
- Several successes noted from QARs despite challenges faced by teams/staff

Area for escalation to SQAC

- With the exception of the Clinical Research Division, all of the Divisions continue to be below 90% compliance for Policies, Guidelines, other documents, work is ongoing to address
- A new member of staff has been in post for 1 month and is undertaking a data cleanse of DMS and revalidation of any policies, with an anticipated improved position in April 2025.

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

24/25/266 Liverpool Neonatal Partnership Monthly Update

SON introduced the Liverpool Neonatal Partnership update report and highlighted the following key points:

Highlights:

- KPIs for HR metrics noted a reduction in sickness. PDR and mandatory training compliance is on trajectory
- Staff turnover is showing a decreasing trend
- Parent consultation had slightly decreased, with targeted work to address
- Nurse Qualified in Specialties working across both sites, although data shows a reduction in compliance for 1C, this is due to an influx of new staff and had diluted the number of staff working on the neonatal unit, those babies who require that level of nursing receive this.

Challenges:

- Colleagues are working with power BI teams to display charts and displaying data that had been previously requested by SQAC and LNP – timescale to complete is June 2025
- Parental consultation and the Retinopathy of prematurity screening, there is narrative for those babies who had a delay in screening, however no babies were missed
- Incident and risks – there is a good reporting culture with 1 new risk – AHPs not meeting BAPM Standards for the new specification for AHP working in neonatal units, there is a business case being formulated

- Following an offer of appointment for Speech & Language Therapist, applicant had withdrawn their application, SON is working with the network and also the Associate Chief Nurses for Community & Medicine Divisions regarding supporting a possible Band 7 post, with some support. SON would provide an update within April report.

Resolved: FB advised that she has minor queries regarding a number of the statistics and that she would address this offline, with a view to agreeing the content of what is included in future reports for 2025/26, and to enable agreement of the frequency of the reports for 25/26.
Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership update report.

24/25/267 Quarterly Clinical Research Division Report

DH presented the Quarterly Divisional report which is being presented to SQAC and to the Futures Committee, which detailed the performance of the Clinical Research Division from 1st September – 31st December 2024

Highlights:

- There had been 194 studies, with 100 different principal investigators across the Trust
- Commercial income currently remains ahead of target
- Successful award of C&M-wide NIHR Commercial Research Delivery Centre (hosted by UHLG) with Alder Hey as the paediatric lead
- There had been issues regarding the configuration of the MRI scanner resulting in difficulties for research quality scan, issues had now been addressed, and colleagues are looking for research studies to develop the portfolio in this area
- Mobile research unit had been delivered on 28th October 2024, significant engagement with wider community engagement noted. DH advised that the unit is not limited to Research
- A successful Clinical Research Division wellbeing week was held in November 2024
- DH advised that NIHR are insistent that the Trust have to recruit to 90% time and target for the studies that the CRD recruit to. There are weekly meetings held at operational level in CRD to review studies, and achieving time and target is increasing and improving.

Resolved: SQAC received and **NOTED** the Quarterly Clinical Research Division report

24/25/268 EDS22 Annual update

FB advised that AD was unable to attend today's meeting as originally planned to present the EDS22 Annual Update.

FB advised that the report, covers work across other committees and covers workforce, health and wellbeing and would also be reviewed by the People Committee. FB stated that the report includes the reviews over three services within Domain 1. FB stated that SQAC would receive the EDS22 report in the future and sought any feedback from the committee.

KB referred to the health inequalities aspect and any liaison with R Isba team. FB stated that she plans to meet with AD to understand how the assessment had been undertaken, and what plans would originate from them, and how they would align with other teams, as this could not be delivered by one team in isolation.

Resolved: FB requested any comments or feedback to be shared with FB offline. FB stated if the report is annual the assumption would be is that three different services would be selected next year.
Resolved: ES requested whether FBs offline discussion could be fed back to the EDI steering Group and the responses to be shared with SQAC. ES stated it would also be helpful to include G Dallas in discussions. FB agreed that it would be helpful for SQAC to receive feedback following discussions.
Resolved: The Committee received and **NOTED** the EDS22 Annual update

24/25/269 CQC Inspection of nuclear medicine - learning

The Committee received the CQC Inspection of nuclear medicine – learning which detailed an overview of specific reflections, national standards review and recommendations and proposed next steps
ES advised on next steps to consider the mechanisms for disseminating some of the wider learning points across the organisation.

ES stated that the Trust is currently in a semi unannounced CQC inspection, and advised that all of the processes had been fully put in place for this ongoing CAMHS CQC inspection.

ES advised on an action required by ES with the operations manager from CQC regarding some of the messages received at the Trust and the department, from the inspectors regarding how low key the approach was, and subsequently resulted in a formal process regarding an Improvement Notice, with learning for both organisations.
ES informed the committee that the Director of Nursing and the Governance Manager are undertaking work for different specialties and services who have additional regulations to ensure all have the same manual and all are using the same approach to their own self assessments.
FB questioned how the Trust would know whether the actions had been followed up i.e. half day per quarter needed to ensure that people have time to update and the SLA is being updated annually. ES stated that those are different aspects and consulting the Chief Medical Officer regarding the 'art of the possible' and for a further offline discussion with the Division of Medicine regarding how they ensure this works in relation to this area for routine focus on policies/procedures etc. ES stated that she had not yet met with the Chief Medical Officer to discuss this.
ES stated that the Division of Medicine Management Team would incorporate an annual review of SLA in a structured way, which should also be the same for any department that has an external agreement in place with another organisation.
Resolved: SQAC welcomed an update report with action plan at June 2025 meeting
Resolved: SQAC received and **NOTED** the CQC Inspection of nuclear medicine – learning

24/25/270 Board Assurance Framework

ES presented the Board Assurance Framework and advised that the access risk is going to take on a different tone regarding the elective cap. ES advised that there is work required regarding how QIA process is incorporated into a number of the BAF risks controls in relation to both controls and assurance and potential gaps. ES advised that SQAC would see subtle differences in the next round of BAF reports.ES advised on the importance of a forward look into 25/26 in terms of main threats to patient safety.

FB referred to risk 1.6 - Impact of ADHD Medication shortages on Children, Young People, which had been allocated to Trust Board, and suggested that this risk be reviewed to align to SQAC. ES stated that this would be incorporate into the workplan for the end of year review of the BAF.
Resolved: the Committee received and **NOTED** the Board Assurance Framework

24/25/271 Quality Assurance Rounds Report and Annual Report

JR presented the Quality Assurance Rounds Report and Annual Report which detailed oversight of themes and associated risks identified following the Quality Assurance Rounds undertaken during the reporting period 1st September 2024-28th February 2025 and the overall findings from Quality Assurance Rounds completed over the last 12 months (February 24-February 25)

For the reporting period September 2024-February 2025

- 17 Quality Assurance Rounds were held, 2 were cancelled and had been rescheduled
- Agreement had been made in April 2024 to trial a hybrid approach. From the 17 QARs, 4 were undertaken face to face and 13 via teams. JR provided an overview of survey findings, and advised that there was limited feedback provided to support any future developments, JR would revisit this with the team to consider how this can be done in a different way.

Challenges:

- Recruitment and workforce
- Service delivery issues due to lack of capacity, mainly due to workforce
- IT network limitations
- National drugs shortages

Highlights:

- Despite the challenges several successes were noted, including a reduction of long waiting lists to 0 for 65 RTT in paediatric dentistry. ED continued to achieve all of their key ED targets, the achievement of 0 60 week wait targets through management of the waiting list and appointments in ENT and discharge rate of 62% following the development of an opt in and opt out programme for ENT service.
- Appointment of youth worker in the diabetes service had created a positive effect

- Complaint from a young person regarding her experience at the Rainbow SARC centre had resulted in the creation and introduction of Bella bags which are now given to every child or young person that attends the Rainbow SARC centre and includes high quality personal care items
- A key feature of the QAR is to support the front line teams to further understand risk management and in 24/25 a new Risk management module was developed and delivered to staff regarding the basics of risk management. This commenced face to face in June 2024 with several sessions delivered between July 2024 – November 2024, this would continue to be provided as and when required.

Quality Assurance Rounds Annual Report

- 32 QARs were undertaken during February 2024-February 2025
- Findings were similar to the 6 monthly report – mainly workforce, service issue, delivery due to capacity, lack of finance and IT concerns, those themes are reflective of the current open risk outlined in the report with a score of 12 and over on the risk register.
- Despite the challenges staff go above and beyond, noting excellent teamwork and improved resilience. Improved reporting of incident themes and strong leadership and support with MDTs, with positive feedback from FFT surveys.
- JR advised on next steps to explore a process of triangulation of QAR findings with those from the fortnightly quality rounds and the revised ward and accreditation process. JR stated that service level QAR summary updates are required in future reports, and that Risk Management Forum would continue to monitor and provide assurance. JR stated that there is a need to re-evaluate the impact of the transfer from teams to face to face undertaken and revisit the feedback process.

FB advised that the face to face QAR's had been relatively limited and sought feedback from the Committee as to whether there are any overall reflections whether QAR's are meeting objectives. JR stated that it is extremely difficult to source a meeting room, and advised on the difficulty regarding NEDS travelling, as most face to face QARs were held on a very busy Trust Board days.
FB advised that this would be reviewed separately with NEDs, and stated it was good to see the themes and onward management of risks.
ES referred to the reference regarding risks in Risk Management Forum and stated that this could be timetabled more regularly in the year and reported back to SQAC.
ES stated that face to face QAR's are beneficial, and colleagues need to continue to work on the logistical challenges to increase face to face QAR'S throughout the year.
Resolved: SQAC received and **NOTED** the Quality Assurance Rounds Report and Annual Report

24/25/272 Ward Accreditation and Annual Report

JM presented the Ward Accreditation and Annual Report, which detailed an overview of the methodology/changes/improvements to the Ward Accreditation process/outcomes/themes and learning and next steps. JM shared some key highlights as follows and provided an update on next steps:-

- Since resuming the Ward Accreditation programme in December 2024, 10 out of the 24 Ward/Department Accreditation had been undertaken, with a further 2 assessments scheduled prior to this meeting, outcomes are not yet known. The remaining Ward Accreditations are due to be completed by June 2025.
- From the 10 completed Ward Accreditation - 5 wards passed the mandatory checklists, and 5 Wards incurred at least 1 fail on the day
- Of the 10 assessments conducted since December 2024, the outcome had been shared with 6 teams. Of these 6, subsequent to the ward resolving any mandatory checklist fail, 5 wards and departments have been awarded Silver and Good and one ward had been awarded Bronze and Requires Improvement
- Several themes identified and shared with teams to share learning and improve the experience and safety of our children, young people and families. These are across the 5 Key Questions but predominantly in Safe domain and include: Staff awareness of incidents and learning at local level. Several excellent examples of sharing have been shared and observed such as incident boards, newsletters and confirmation of discussion at Safety Huddles however a number of staff are able to articulate - Safeguarding assessment not documented as undertaken on Meditech on admission - Staff not aware of the legal obligations of the Trust in relation to the Duty of Candour -Staff compliant with Mental Health Act training however are not able to describe the principles of the Mental Health - Estimated day of discharge (EDD) not

documented - Cannulas bandaged -Parents and carers not asked how they would like to be addressed (Trust has launched the “Call me” initiative)

JM advised that once all of the wards and departments had been fully assessed that a full review of the Ward Accreditation Programme and assessment criteria in collaboration with relevant senior leaders would take place to ensure all relative departments are included in the programme. JM advised on next steps.

FB stated that she is pleased to see the Ward Accreditation report developing and that on review of the report in 12 months’ time the insightful observation and change would be reviewed.
ABA referred to the sad death of a patient on ward 4A in 2024, and noted that Ward 4A received required improvement and queried whether there is some analysis on this score. RP stated that there is an action plan that aligns to this, and stated that part of the assessment process that requires review is that if there are any mandatory elements that are failed on the day, that there would be an alert for the senior nursing team to resolve this immediately and that this had not happened in this case. RP stated that when colleagues reassessed the 10 safety criteria, had been addressed. RP stated that there are some changes planned regarding 4A in terms of functionality, increased dependency care beds, patient flow, plus a full review of 4A to enable a clear improvement plan, with clear leadership support to help drive improvements.
ABA sought clarity regarding whether there would be a ward based dashboard developed to enable continuous feedback on performance, as opposed to a yearly review. RP stated that specialties are keen to have a dashboard to ensure continual oversight.
VG stated it would be helpful to know whether the Trust is consistent with other organisations or whether the Trust is an outlier.
Resolved: PW & JM to explore with colleagues whether a ward based dashboard could be developed to ensure continuous feedback on performance. PW stated that he is keen to work with JM regarding how processes could be improved.
Resolved: SQAC received and **NOTED** the Ward Accreditation and Annual Report

---- *Well Led* ----

24/25/273 **Arjo Bath Cleaning SOP**
Resolved: SQAC **RATIFIED** Arjo Bath Cleaning SOP

---- *Any Other Business* ----

24/25/274 No further business was raised.

---- *Board Assurance* ----

24/25/275 The key assurances and highlights report was presented to the Board meeting held on 6th March 2025.

Date and Time of Next Meeting: 30th April 2025 at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	**Alder Hey AI Strategy**
Report of:	**Kate Warriner, Chief Transformation and Digital Officer**
Paper Prepared by:	**Kate Warriner, Chief Transformation and Digital Officer**

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

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the Long Term Plan	12
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	16

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

Empowering Every Day Lives at Alder Hey through Artificial Intelligence

1. Introduction

The Alder Hey AI Strategy (Appendix 1) outlines a comprehensive plan to integrate artificial intelligence (AI) into everyday lives at Alder Hey Children's NHS Foundation Trust. This strategy aims to enhance patient care, empower staff, and transform paediatric outcomes through innovative AI solutions. The report seeks board approval for the implementation of this strategy.

2. Vision and Context

Alder Hey envisions a future where AI seamlessly enhances the experiences of patients, families, and staff. Building on the Living Hospital concept, the strategy leverages AI to improve operational and clinical processes. The vision for 2030 is to create "A Healthier, Happier, Fairer Future for Children and Young People," driven by the needs and feedback of children and their families.

3. Strategic Themes

The strategy focuses on four key themes:

- **Enhancing Children and Young People Centred Care**: Elevating the experience of children, young people, and families through personalised care and communication
- **Empowering Alder Hey Colleagues**: Freeing up time for staff through intelligent automation, AI assistants, and smarter workflows
- **Transforming Outcomes for Children and Young People**: Delivering precision care through AI-optimised pathways, predictive analytics, and remote monitoring tools
- **Revolutionising Diagnostics**: Accelerating speed and accuracy in paediatric diagnosis with cutting-edge innovation

4. Key Components

To realise this vision, the strategy includes several key components:

- **AI Education & Workforce Development**: Providing targeted training and resources to equip staff with the knowledge to use AI tools safely and effectively
- **AI Governance & Ethics**: Implementing a governance framework to ensure compliance with regulatory requirements and ethical guidelines
- **AI Infrastructure & Data Architecture**: Developing a scalable and interoperable AI infrastructure to support multimodal data integration and advanced analytics
- **AI Project Development & Implementation**: Identifying and prioritising AI projects that focus on improving patient outcomes, operational efficiency, and staff well-being

5. Progress to Date

Progress has been made in a number of key proof of concept areas as part of the Digital, Data and AI Transformation Collaborative including progress with ambient scribe deployment, Microsoft copilot trial and AI Coding planned for May 2025.

6. Implementation and Partnerships

To turn the AI strategy into reality, Alder Hey will focus on building strong partnerships and launching key initiatives.

This includes hosting an AI Summit, establishing a Clinical/Multidisciplinary Teams (MDT) Group, leveraging data intelligence, and collaborating with digital, data, and AI experts and partners.

7. Investment and Benefits Realisation

A comprehensive investment plan will be developed to cover the necessary resources for delivering the strategy. The AI strategy is designed to deliver significant benefits, including more time for direct clinical care, financial sustainability, improved patient care and safety, enhanced staff and patient experience, reduction in waiting lists, and attracting investment.

8. Conclusion

The Alder Hey AI Strategy 2030 positions Alder Hey to lead the way in paediatric AI innovation, delivering tangible benefits to children, young people, and families, empowering staff, and influencing the healthcare landscape to be more caring, effective, and equitable for every child.

The Board of Directors is asked to approve the AI Strategy and note the next steps in terms of resource planning and benefits realisation.

VISION 2030

Outstanding care and experience

Collaborate for children & young people

Revolutionise care

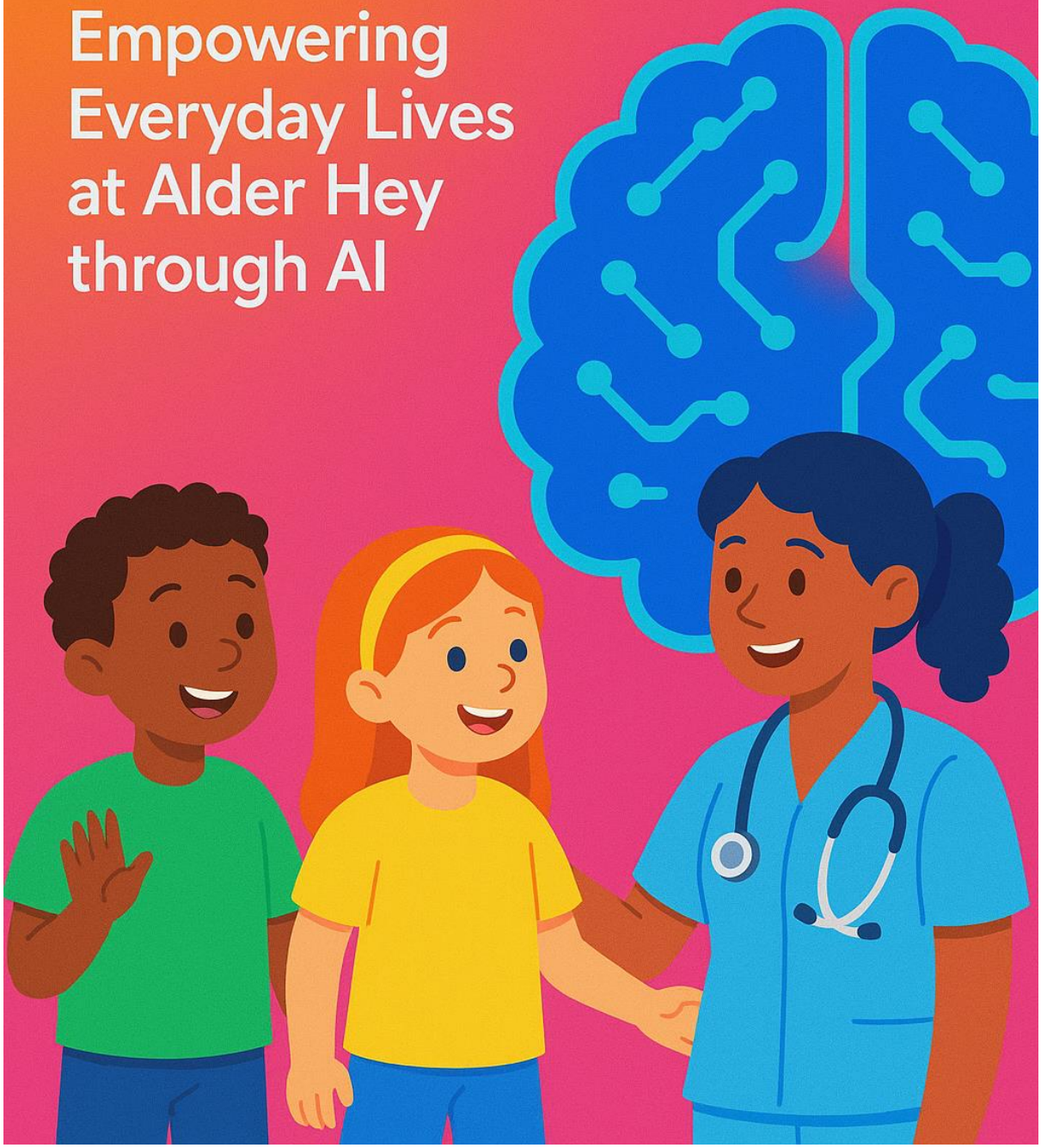
Support our people

Pioneering breakthroughs

NHS
Alder Hey Children's
NHS Foundation Trust

Alder Hey AI Strategy

Empowering Everyday Lives at Alder Hey through AI



Contents

Empowering Everyday Lives at Alder Hey through AI

1. Our Vision

At Alder Hey, we envision a future where Artificial Intelligence (AI) seamlessly enhances the everyday experiences of patients, families and staff. Since pioneering the Living Hospital concept with an AI driven chatbot for patient and family guidance, we have closely explored AI's potential to enhance operational and clinical processes, developing several predictive analytics tools along the way.

We believe the infusion of AI tools will enrich both the experience of staff and families as well as unlock the potential for more data driven personalised care. Through this integration, we will foster a world where technology empowers people to focus on what matters most, delivering compassionate, world class care at every step.

We aim to strategically integrate 'Alder Hey AI Agents' into the healthcare ecosystem to support children, young people and families navigating complex care journeys, as well as empowering clinicians and operational staff with data driven insights, all while acknowledging the unique complexity of healthcare data and adapting our implementation as the technology rapidly evolves.

2. Context

The world today is increasingly driven by technology. Many children are now familiar with using digital devices before they can even read or write. As AI and other technological advancements progress rapidly, their integration into our daily lives is accelerating, particularly in sectors like retail and industry.

At Alder Hey, our vision for 2030 is to create "A Healthier, Happier, Fairer Future for Children and Young People." This vision is deeply rooted in the needs of children and young people, shaped by the invaluable feedback they and their families have shared about their lived experiences and what truly matters to them.

Their message is clear: they need us to "Get Me Well," "Personalize My Care," "Improve My Life Chances," and "Bring Me the Future." These insights form the foundation of our Vision 2030 strategy, guiding us in how we can make a meaningful impact both within Alder Hey and in collaboration with our partners across the health and care system.

As we look ahead, the challenges facing the NHS require a transformative shift in how healthcare is delivered. The government has highlighted three key priorities: shifting care from hospitals to the community, transitioning from analogue to digital, and focusing on prevention over treatment.

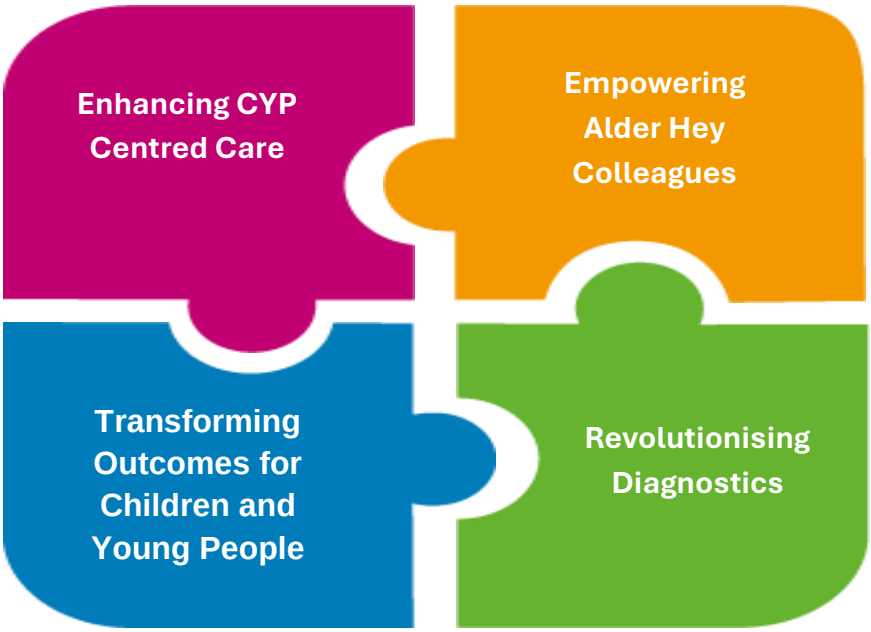
The shift from 'analogue to digital' is central to transforming services, driving new models of care, and improving productivity and efficiency. This is a critical element of the NHS's 10 Year Plan, and AI will undoubtedly play a significant role in this transformation. As a pioneering, forward thinking organization, we are determined to lead the way in adopting AI and emerging technologies. To achieve this, we must

remain agile and proactive in scouting and deploying innovative solutions as we continue to transform Alder Hey for the future.

3. Ambitions, Outcomes and Themes

To drive this transformation, our strategy builds on our experience and focuses on four key themes:

1) **Enhancing Children and Young People Centred Care:** elevating the experience of children, young people and families
2) **Empowering Alder Hey Colleagues:** freeing up time for patient and non patient facing Alder Hey staff through intelligent automation, AI assistants and smarter workflows
3) **Transforming Outcomes for Children and Young People:** delivering precision care through AI optimised pathways, predictive analytics and remote monitoring tools
4) **Revolutionise Diagnostics:** accelerating speed and accuracy in paediatric diagnosis with cutting edge innovation



4. Key components:

Realising this vision requires a strong foundation to ensure safe, effective and sustainable AI adoption across the following key components:

4.1 AI Education & Workforce Development

- Provide targeted training and resources to equip staff with the knowledge to safely and effectively use emerging AI tools in clinical and operational settings
- Enhance understanding of AI methodologies, including benefits and risks, to build confidence and trust in AI augmented workflows

- Foster a culture of AI literacy to enable clinicians, managers and support staff to recognise AI opportunities and understand the data requirements for AI driven solutions
- Promote interdisciplinary collaboration between clinicians, researchers, data scientists and digital teams to improve AI adoption and integration in healthcare

4.2 AI Governance & Ethics

- Implement a governance framework to ensure AI applications comply with regulatory requirements and ethical guidelines
- Establish robust machine learning processes to ensure deployed solutions meet performance, clinical safety and regulatory standards
- Develop a structured approval and oversight process of AI projects to ensure prioritisation of resources, maximisation of benefit and minimisation of risks (including bias) through clinical safety assessments. Where possible, this will be incorporated into current processes
- Foster public and patient trust through transparent policies, explainability initiatives and mechanisms for reporting concerns in AI driven processes. We will keep an inventory of tools and developments and engage with public through our engagement methods
- Develop clear risk management strategies, including regular audits and robust cybersecurity practices, to safeguard patient data and maintain system integrity.

4.3 AI Infrastructure & Data Architecture

- Develop a scalable and interoperable AI infrastructure to support multimodal data integration and advanced analytics. This will start with the migration of the existing data warehouse infrastructure to a secure cloud platform but scale to wider data assets.
- Facilitate a shift from a documentation centric data collection approach to a structured, AI ready data ecosystem that supports real time decision making
- Ensure seamless access to high quality data is available to clinical teams, researchers, and external entities with appropriate governance safeguards (e.g. deidentification and synthetic data)
- Access will be supported by the implementation of a Secure Data Environment integrating with the cloud-based data platform

4.4 AI Project Development & Implementation

- Identify and prioritise AI projects that focus on improving patient outcomes, operational efficiency and staff well being
- Implement rigorous evaluation frameworks to measure the clinical and economic impact of AI projects, ensuring alignment with NHS service priorities
- Develop clear pathways for AI adoption, from proof of concept to live deployment, with defined success metrics and user feedback loops
- Establish champions in clinical teams that can ensure clinical validation and address challenges in AI implementation

5. Strategic Initiatives

Across our key themes, we have highlighted the following strategic initiatives, which will naturally evolve in response to emerging opportunities, technological advancements, and the changing needs of our patients and staff.

5.1 Enhancing Children & Young People Centred Care: elevating the experience of children, young people and families

We will leverage AI to improve the experience of children, young people, and their families/carers throughout the healthcare journey by personalising care and enhancing communication.

Strategic Initiatives:

- **Children & Young People Facing Virtual Assistants:** Develop AI powered virtual assistants for children, young people and families/carers to guide them through more personalised routine care including appointment scheduling, post care guidance, medication reminders and symptom checking, helping parents to manage care at home and enhance preventative health.
- **Predictive Models for Early Intervention:** Utilise real world data and predictive analytics to detect early signs of paediatric conditions (e.g. developmental disorders, mental health support) and recommend timely interventions / resources that can improve long term outcomes.

5.2 Empowering Alder Hey Colleagues: freeing up time for patient and non patient facing Alder Hey staff through intelligent automation, AI assistants and smarter workflows

We will enhance the work experience and efficiency of healthcare professionals allowing them to focus more on patient care and less on administrative tasks.

Strategic Initiatives:

- **AI Powered Documentation:** Utilise ambient AI for speech to text transcription and summarisation of real time consultations / meetings, reducing time spent on notetaking and accurately capturing diagnostic and procedural codes.
- **AI Assistants:** Using personal AI Assistants to support and enhance day to day tasks
- **Automated Scheduling:** Optimise shift and rota planning tasks that maximise skill mix, minimise inefficiencies and prioritise staff wellbeing.
- **Intelligent Ordering and Task Management:** Streamline clinical workflows by automating investigation requests and tracking of results to ensure efficient and timely follow ups.
- **Clinical Decision Support Systems (CDSS):** Provide real time decision support, offering data driven insights on treatment protocols/guidelines, tailored to patient specific data.

- **Creation of an Alder Hey large language model:** Fine tune a local LLM to harness organisational data assets securely and fuel Retrieval Augment Generation (RAG) and Agentic AI developments.
- **AI Insights Agent:** Develop an 'insights agent' that can obtain data, perform analytics and find content in documents to support staff productivity
- **EPR Transformation:** use of AI tools on top of the EPR and other key systems to revolutionise interaction with our systems, improving user experience

5.3 Transforming Outcomes for Children and Young People: delivering precision care through AI optimised pathways, predictive analytics and remote monitoring tools

We will use AI to optimise clinical pathways and improve health outcomes for children and young people through precision diagnostics, treatment, and personalised care pathways.

Strategic Initiatives:

- **AI Optimized Care Pathways:** Streamline and optimise clinical pathways by training models that help identify inefficiencies and improve patient flow whilst maintaining or elevating outcomes
- **Predictive Analytics for Patient Outcomes:** Train machine learning models using actionable real time health data to optimise on clinically important outcomes such as deterioration, complications or readmissions, allowing targeted early intervention
- Utilise children and young people engagement with digital / AI tools such as chatbots to generate a patient reported outcome dataset
- **Remote Monitoring:** Implement AI powered remote monitoring tools that can track key health metrics in children with chronic conditions (e.g. diabetes, asthma) or those recovering from surgery. Facilitate interaction with clinicians remotely (e.g. telemedicine) to ensure timely care without unnecessary hospital visits
- **AI in AH Centres of Excellence:** Utilise cutting edge developments in data analytics such as detecting subtle changes in vital signs or laboratory values to predict and alert clinicians to issues before they become critical, thereby improving survival rates and reducing complications.

5.4 Revolutionise Diagnostics: accelerating speed and accuracy in paediatric diagnosis with pioneering innovations.

We will harness AI advancements to drive innovation in paediatric diagnostics, enabling faster, more accurate, and less invasive diagnostic methods. While significant progress is being made across various adult subspecialties, paediatrics often lags due to smaller patient cohorts, propensity to rare diseases and increased aversion to risk when dealing with children. We will continue to advocate for greater investment and pioneering approaches that ensures equitable access to cutting edge diagnostic technologies in children.

Strategic Initiatives:

- **Medical Imaging:** Develop and implement AI driven medical imaging solutions, ensuring accuracy and reliability through rigorously curated, high quality, and representative training data that reflects the diversity and unique anatomical variations of children
- **Rare diseases:** Utilise real world data from the electronic health record to facilitate the identification of rare diseases that may be missed across multiple consultations
- **Genomics:** Leverage the burgeoning field of genomics to facilitate early diagnosis and tailored treatment plans including pharmacogenetics
- **Wearables:** Harness data from wearable devices (e.g. smartwatches, biosensors) to enable continuous, real time monitoring of children's vital signs, reducing the reliance on intermittent spot checks and enabling earlier detection of conditions such as seizures, respiratory problems, heart abnormalities
- **Diagnoses:** Testing AI capability in diagnosing conditions such as neurodevelopmental conditions and congenital heart disease through echocardiography tools in foetal medicine

6. How will we make this a reality?

To turn our AI strategy into reality, we will focus on building strong partnerships and launching key initiatives that align with our vision. Our approach includes the following critical steps:

6.1 Strategic Partnerships:

We are positioning ourselves as leaders in paediatric healthcare, with a key focus on innovation and AI integration to meet the needs of children and young people. Our role is multifaceted: as experts in paediatric care, we will act as problem finders, identifying key challenges in healthcare, and as agile implementers, swiftly adopting and deploying solutions that improve care and outcomes for the young people we serve.

At Alder Hey, we are committed to being pioneers in AI and emerging technologies, working to lead the way in the healthcare transformation outlined by the NHS's vision for the future. This transformation requires moving care from hospitals into the community, transitioning from analogue to digital systems, and emphasizing prevention over treatment. Our ambition is to place AI at the core of these efforts, driving improvements in efficiency, productivity, and personalised care delivery.

However, we recognise that this journey cannot be undertaken alone. Collaboration is essential to our strategy. We will actively forge partnerships with industry leaders, academic institutions, and healthcare organizations to co-develop AI solutions tailored to the unique needs of paediatric healthcare. This approach will allow us to benefit from the latest technological advancements while contributing our expertise as paediatric specialists. These partnerships, both national and international, will foster an exchange of knowledge across sectors, ensuring that we have access to cutting edge AI expertise and tools to shape the future of healthcare.

We envision close collaboration with universities to tie in their research capabilities and academic strengths. By partnering with experts in this field, we will be able to

blend our clinical expertise with groundbreaking innovations emerging from academia. This integration of expertise will accelerate our ability to deliver practical, scalable solutions that directly address the challenges faced by children and young people in the healthcare system.

Recognising this is moving at a rapid pace, we will look to partner with those who see our value, implement early, at low cost to enable entry, gaining value as products develop.

6.2 AI Summit:

We will host an AI Summit, bringing together healthcare professionals, AI specialists, and key stakeholders from various fields to focus on paediatric opportunities. This summit will provide a platform for discussions on emerging trends, successful case studies, and the practical application of AI in healthcare. It will also act as a launchpad for innovative projects and partnerships.

6.3 Clinical/Multidisciplinary Teams (MDT) Group

A dedicated Clinical/MDT Group will be established to guide the sociotechnical integration of AI solutions in healthcare. This group will work closely with frontline clinicians to ensure AI technologies meet the real needs of healthcare teams and children, young people, families and carers, integrating effectively into workflows. Their role will also involve overseeing the implementation of AI driven improvements in clinical pathways. The group will include Children and Young People representatives.

6.4 Data

Data is at the heart of our AI strategy, serving as the foundation for innovation and transformation in paediatric care. By leveraging a robust data intelligence platform through databricks, we can unlock the full potential of our data to drive advanced analytics, machine learning, and AI driven insights. This will enable us to integrate, process, and analyse vast amounts of structured and unstructured data in real time, ensuring a seamless flow of information across systems. This unified data environment supports our ability to personalise care, enhance operational efficiency, and make data driven decisions that directly benefit children and young people.

As we continue to harness the power of AI, data will play a pivotal role in scaling our efforts, enabling agile development, collaboration, and deployment of AI solutions that improve health outcomes. By underpinning our AI strategy with a platform that prioritizes data intelligence, we ensure that Alder Hey remains at the forefront of healthcare innovation, delivering cutting edge care that meets the evolving needs of patients and the healthcare system.

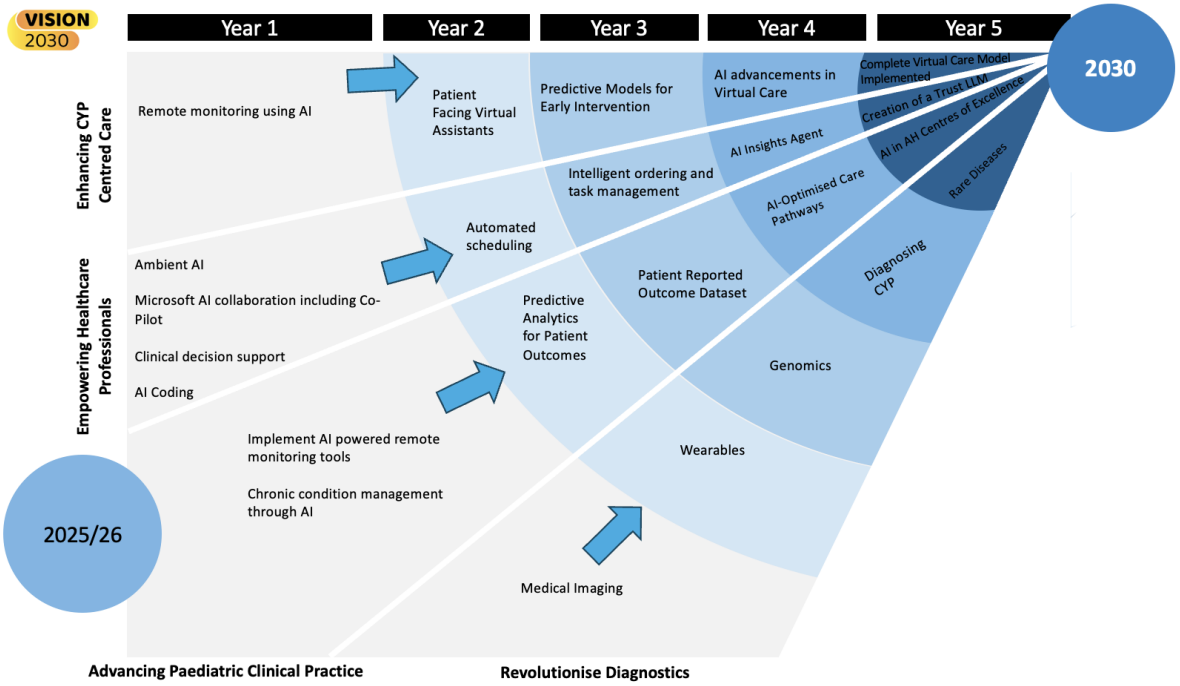
6.5 Digital, Data and AI Collaborative

This work will sit as part of the broader digital, data and AI transformation collaborative. Working together with a team of digital, data, and AI experts, this approach will enable

us to harness the collective expertise of diverse partners to drive innovation and promote sustainable change across the organization.

6.6 Roadmap

To keep us on track, we will establish a clear programme of work with defined milestones and timelines. This program will cover AI integration in various healthcare services, training for staff, and continuous evaluation of AI's impact. A detailed roadmap will ensure that all phases of implementation are aligned with our goals and set for timely completion. An outline of this plan at a macro level is summarised below.



6.8 Investment and Resource

A comprehensive investment plan for the delivery of the strategy will be developed. The investment will cover the necessary resources to deliver on the strategy, including infrastructure, staff training, and project implementation. It is imperative that the right resources and skills are deployed to meet the ambitions outlined.

7 Benefits Realisation with Estimated Impact

Our AI strategy is designed to deliver significant benefits across several key areas. By quantifying these improvements, we can measure success and refine our approach as needed.

- **More Time for Direct Clinical Care:** Estimated impact: A 20-30% reduction in administrative tasks for clinicians through AI automation, allowing for up to 10-15% more direct clinical interaction time. This could equate to 4-6 additional hours per week for each clinician to focus on clinical care

- **Financial Sustainability:** Estimated impact: AI driven efficiencies could lead to cost savings or increased productivity of 5-15% annually
- **Improved Patient Care and Safety:** Estimated impact: AI enhanced diagnostic tools and predictive analytics could lead to a 15-20% improvement in diagnostic accuracy, reducing medical errors and potentially preventing 100-200 adverse events annually.
- **Enhanced Staff and Patient Experience:** Estimated impact: AI powered tools will streamline workflows, leading to a 25% reduction in clinician burnout and improving overall job satisfaction. For patients, this could result in a 10-15% increase in satisfaction scores, driven by shorter wait times and more personalised care.
- **Reduction in Waiting Lists:** Estimated impact: AI optimised scheduling and resource allocation could reduce waiting times by 15-20%
- **Self Service Data and Cloud Based Data Analytics Platform:** Estimated impact: A centralized data warehouse will allow staff to access insights in real time, improving decision making. This could lead to a 30-40% reduction in time spent on manual data gathering and a 50% faster response to data requests.
- **Attracting Investment:** Estimated impact: By positioning ourselves as an AI leader in healthcare, we anticipate attracting £5-10 million in external investments over the next 3-5 years to further scale AI initiatives.
- **Profile, Reputation, and Leadership in AI:** Estimated impact: Our involvement in the Digital, Data, and AI Collaborative will elevate our profile, leading to new strategic partnerships over the next 2 years and further positioning us as a regional and national leader in AI driven healthcare innovation.

By defining clear metrics and setting specific goals, we can ensure that our AI strategy not only delivers on its promises but continues to evolve and generate meaningful impact across the healthcare ecosystem.

8 So What…… A day in the life in the Future….

Through this strategy, we are envisioning a future where healthcare is transformed for our children, young people, and colleagues. Just as no one could have predicted how the iPhone would revolutionize the way we live and connect, we are now imagining a world where healthcare evolves in ways once thought impossible.

This part of the strategy highlights the 'art of the possible,' offering a glimpse into the future we can create together.

8.1 Imagine the future for our Children and Young People

Ayesha and Rhys's Future……

In this future vision, Alder Hey's Community Paediatrics team leverages AI to improve the diagnosis and ongoing support of children with autism spectrum disorders (ASD) and mental health conditions.

When 7 year old Ayesha first showed signs of ASD, her parents used Alder Hey's AI supported platform "Link" to document patterns in her behaviour and development at home and school. Link's structured reports helped the paediatric team recognise key indicators, accelerating the diagnostic process and providing tailored advice early in her care journey.

Now diagnosed, Ayesha continues to receive ongoing support through Link. The AI system gently alerts her parents and teachers when activities may require adjustment to better accommodate her sensory sensitivities and social communication needs, ensuring she feels supported and included.

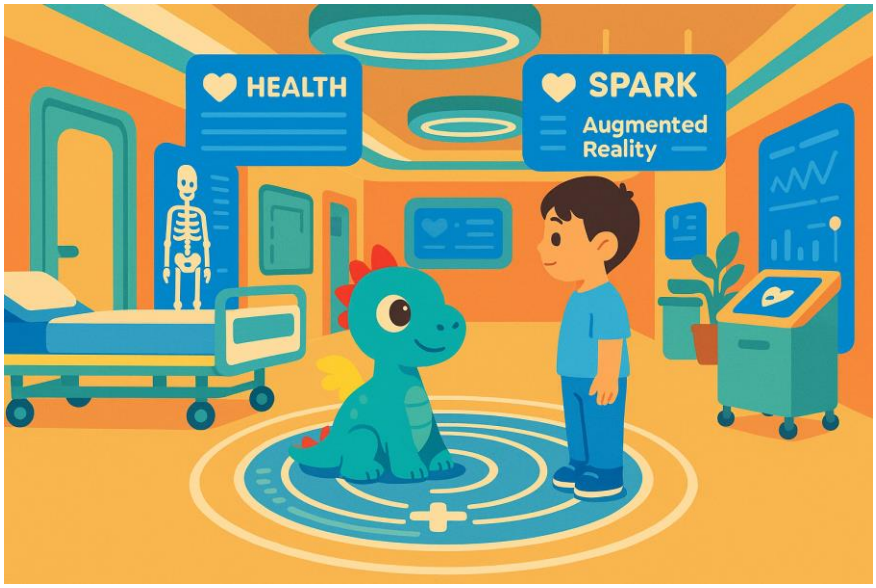
Or consider Rhys, a 12 year old experiencing anxiety, which was identified early through Alder Hey's mental health screening tool "Lumina," by analysing patterns in his emotional wellbeing reported by his parents and teachers. After diagnosis, Lumina continues to offer personalised coping strategies, alerting Rhys and his

support team when upcoming events or changes in routine might require additional support or preparation.

By blending timely diagnosis with proactive, personalised ongoing support, Alder Hey's AI enhanced community paediatric care helps children like Ayesha and Rhys navigate daily life successfully, empowering their families and caregivers at every step.

Leo's Future….

In this imaginative future, Leo is a patient at Alder Hey, one of the most innovative paediatric hospitals in the world, known for its pioneering use of AI and cutting edge technologies. Alder Hey has transformed healthcare into a child friendly, interactive experience where even complex treatments feel like a magical adventure.



Leo, a lively 6 year old with Type 1 diabetes, wakes up each morning greeted by his cheerful AI companion, "Spark," a friendly dragon who helps manage his health in a fun and imaginative way. Spark quietly checks Leo's overnight glucose levels using a comfy wearable sensor, gently reassuring him and discreetly updating his parents.

During school, Spark is always by Leo's side, tucked neatly into his backpack. Throughout the day, Spark playfully reminds Leo when it's snack time or insulin check, making each interaction feel more like an exciting game than a healthcare task. Teachers and the school nurse receive gentle alerts, ensuring Leo's safety without interrupting his play and learning.

Instead of regular hospital visits, Leo meets with his healthcare team virtually, supported by Spark. His doctor reviews Leo's health data, giving friendly, personalised advice that helps Leo and his parents feel confident managing his condition at home.

When Leo visits the hospital for special appointments, Spark helps transform the environment into a thrilling augmented reality adventure, turning the corridors into jungles or magical lands, ensuring Leo feels calm and excited. Friendly AI powered robotic nurses support the clinical staff, turning routine checks into fun interactions.

At bedtime, Spark helps Leo wind down with magical bedtime stories. As Leo sleeps, his smart pyjamas keep an eye on his health, ensuring quick responses to any overnight fluctuations.

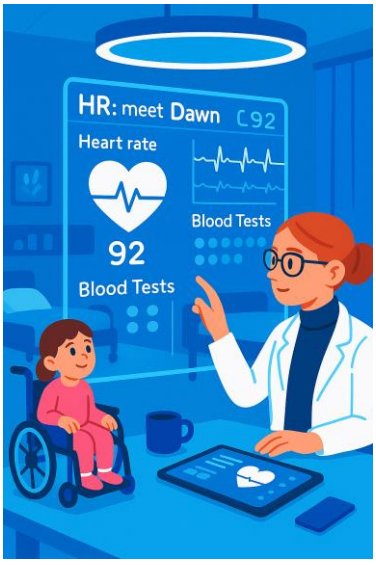
With Spark and his healthcare team's innovative AI support, Leo enjoys an adventurous, playful childhood, where managing his diabetes is seamlessly woven into his everyday life, empowering him to thrive.

8.2 Imagine the future for our Staff

Imagine a bustling children's hospital like **Alder Hey**, where advanced AI technology has seamlessly integrated into the daily operations. Healthcare workers now partner with **AI assistants** like **Oli**, a friendly, multi-functional AI designed to enhance patient care and streamline workflows.

8.2.1 Imagine the future for our Clinical Staff

Imagine the future for our Clinical Staff



Dr. Emma starts her day at the children's hospital assisted by "Ask Oli," an AI powered information assistant. Over her morning coffee, she says, "Oli, summarise my ward round patients". Oli instantly compiles key details from the medical history and monitoring trends over the past 24 hrs, helping Emma prioritise her workload.

During rounds, Emma notices an unusual facial rash on one of her patients and asks, "Oli, give me a structured list for possible causes of a malar rash, including

suggested baseline investigations". Oli searches a database of curated medical literature and provides a summary for Emma to consider next steps.

Later that day Emma considers the results for her patients and requests Oli to perform "a deep dive on studies looking at the diagnostic criteria for paediatric Lupus". Emma uses this summarised information to facilitate discussion with a rheumatologist, capturing this discussion seamlessly through ambient AI in the medical record.

At the end of the day, Emma asks Oli to summarise patient notes and highlight any significant observations, ensuring clear documentation for review and handover to on call staff.

By providing efficient information retrieval and summaries, Oli helps Emma streamline her workflow, while retaining full responsibility for clinical interpretation and decision making.

8.2.2 Imagine the future for our Support Staff

In a future where AI seamlessly enhances healthcare, administrative roles at Alder Hey Children's NHS Foundation Trust have evolved dramatically. Administrative workers, often the unsung heroes of hospital operations, now collaborate with intelligent AI systems that revolutionise every aspect of their daily work, making the hospital run like a well oiled machine.

A Day in the Life of Sophie

Sophie, an administrative assistant at Alder Hey, begins her day supported by "Pip," an AI powered information assistant. She starts by asking, "Pip, summarise today's day case surgery appointments and highlight any scheduling conflicts." Pip quickly

compiles the day's surgical schedule, identifying overlaps or potential delays based on overnight developments.

When managing hospital resources, Sophie queries, “Pip, what's the current availability of surgical beds?” Pip retrieves real time bed availability data, allowing Sophie to effectively manage and allocate beds for incoming surgical patients.

During staff rostering, Sophie learns a nurse has called in sick. She asks, “Pip, show me available nurses qualified for today's shift.” Pip immediately provides a list of available staff, enabling Sophie to quickly arrange cover.

Later, a parent calls needing clarification about medication changes discussed in a recent clinic visit. Sophie asks, “Pip, find the clinic letter from the recent visit.” Pip rapidly retrieves the relevant letter, enabling Sophie to quickly discuss the query with the on call clinical team and provide a prompt, clear response to the parent.

At day's end, Sophie requests, “Pip, generate a daily operational report summarising today's surgery schedules, staffing changes, and bed usage.” Pip compiles comprehensive summaries, streamlining Sophie’s administrative tasks and preparing her effectively for the following day.

Pip’s ability to rapidly access and summarise crucial information empowers Sophie to efficiently handle administrative tasks and maintain smooth communication with patients, families, and clinical staff.

10. Conclusion

Alder Hey's AI Strategy 2030 outlines a bold vision: to harness the power of artificial intelligence in a way that truly transforms children's healthcare for the better. By strengthening partnerships in a smart, autonomous way, we gain the capabilities to innovate faster. By establishing rigorous data governance, we unlock insights responsibly and sustainably. By leading on ethical AI, we ensure that progress never comes at the expense of our values. By investing in our workforce, we build the human foundation needed for technological change. By modernizing governance and focusing on long term outcomes, we keep the strategy on course to deliver real impact. By setting ambitious targets, we challenge ourselves to achieve what was once unimaginable. And through it all, by championing a children first approach, we make sure that every step forward is a step forward for young patients everywhere.

This strategy is not a static document but a living roadmap. As we implement these initiatives, we will learn and adapt – celebrating milestones (for example, when a new AI tool saves a life or significantly improves a service) and honestly confronting obstacles (such as the need for cultural change or technical hurdles) with a problem solving mindset. The structures put in place will keep the Board and stakeholders informed and engaged, ensuring accountability at each stage. We will also keep aligning our AI efforts with the wider Trust Strategy and Vision 2030, so that technology serves the overarching mission of Alder Hey rather than becoming a goal in itself.

By 2030, Alder Hey will not only have improved the care for the children who walk through our doors, but will have influenced paediatric care well beyond our walls – through the innovations we pioneer, the standards we set, and the knowledge we share.

In summary, this AI Strategy positions Alder Hey to **lead the way in paediatric AI innovation**: delivering tangible benefits to children, young people and families, empowering our staff, and influencing the healthcare landscape to be more caring, effective, and equitable for every child. Through delivery of this strategy we are confident that Alder Hey will achieve its ambition of creating a healthier, happier, fairer future through the magical application of artificial intelligence empowering everyday lives at Alder Hey.

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	People Plan Strategic Update
Report of:	Chief People Officer
Paper Prepared by:	Melissa Swindell, CPO

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 No.	Risk Description	Score
BAF2.3/86/LLE	Failure to successfully embed Workforce Equality, Diversity and Inclusion across the organisation	12
BAF2.1/95/KLE	Failure to maintain a sustainable workforce which impacts on the Trusts ability to deliver high quality care for children and young people	12
BAF 2.2/127/ME	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	9

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

1. 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. Priority actions:

One Alder Hey & Thriving

Inclusion & belonging:

The EDI Steering Group met on 17th March 2025, and focused on the following areas:

Gender Pay Gap Report:

- There has been a reduction in the mean pay gap from 27% to 25% and the median pay gap from 19% to 18%. The multifactorial reasons behind the pay gap and ongoing efforts to promote flexible working and inclusive behaviour were considered and associated actions agreed.

EDS 2022 Report:

- An overview of the EDS 2022 report was presented, summarizing the progress made in various domains, including services provided, workforce health and well-being, and inclusive leadership. The positive impact of the report was highlighted as were the ongoing efforts to build an inclusive culture.

Sexual Safety Charter:

- The Steering Group discussed the prevalence of sexual misconduct in the NHS and the steps being taken to address it, including the creation of an action plan and the implementation of new tools from NHS England. Next steps agreed focused on bringing further information to the People Committee along with evidence against the assurance framework, and training implementation.

Staff Networks Updates:

- **ACE Network**: The Chair provided updates on neurodiversity celebration week, the stoma toilet initiative, and concerns about discriminatory behaviour.
- **REACH Network**: The Chair discussed the reciprocal reverse mentoring programme and leadership initiatives

- **Armed Forces Network**: the Chair shared updates on various initiatives, including the VE 80 street party and recruitment events

Zero Tolerance Policy:

- The Steering Group considered the Safe and Respectful Behaviour Policy, which combines the previous Zero Tolerance and Discriminatory Behaviour policies. The new policy focuses on creating a positive and supportive environment for staff and includes training and resources for implementation.

Values:

- A refreshed set of values were presented to and endorsed by the Board in April 2025. These are: Compassion, Courage, Commitment and Community. As agreed at the Board meeting, a plan is being developed to engage with colleagues across the organisation to identify and agree the way in which these values will be expressed and how an aligned behavioural framework will be created. This work will be undertaken during Q1, with a view to going live with the new values in Q2.

Thriving Leaders framework:

- The Thriving Leaders working group continues to develop and review the 8 core workstreams below whilst awaiting the outcome of NHS England's development of a new Management and Leadership Framework, starting with a set of Standards and Competencies which are due to be finalised by Summer 2025.

    - Strong Foundations
    - Management Essentials
    - Clinical Leadership role
    - Leadership Induction
    - BAME Aspiring Leaders Programme
    - Operational Leader Programme
    - Consultant Induction
    - Leadership Faculty

Thriving Teams:

- A draft Thriving Teams Index has been developed using staff survey team-level data as a starting point. Teams have been clustered according to their People Promise scores on the staff survey into three categories of: Thriving, Struggling and Suffering.
- After consultation with divisional leads and execs, a briefing paper will be taken to the People Committee regarding the further development of uses of the Index.
- A working group is due to meet in May to establish wider metrics outside of staff survey data that can be utilised to enhance our ability to identify and predict teams that may need support.

Thriving Staff Index:

- The Thriving Staff Index, a tool developed to encourage staff to take a few moments to reflect on how they are feeling on a regular basis and encourage them to seek support if needed is in its final development stages and will be ready to be rolled out by the end of April 25 along with a two-layered evaluation process as described in an update paper

presented to the People Committee in March 2025. The tool will also provide the Trust with a regular sense of how staff are feeling utilising the same categories of Thriving, Struggling and Suffering seen in the Thriving Teams Index.

Professional Development / The Development Hub

- A refreshed approach to Performance and Development Review (PDR) was approved at the People Committee in March 2025 and has now been launched across the Trust, with associated training and guidance documents. The new framework promotes the use of a coaching style of conversation to encourage a focus on performance, wellbeing, development and future career goals within the PDR conversation.

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 are taking 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.

Workforce Planning

- The annual planning round has now completed and HR and finance colleagues continue to work closely with colleagues in the clinical transformational collaboratives to ensure long term workforce planning is captured in all transformation programmes.

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	Freedom to Speak Up – Progress Update Report
Report of:	FTSU Guardian
Paper Prepared by:	FTSU Guardian

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	FTSU Board reports from September 2016 onwards
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☐
Resource Implications:	

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

1. Purpose

The purpose of this paper is to provide the Board with a summary of the activities of the FTSU team for 2024/25 including the Q4 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 annual Activity

The tables below are taken from the National Guardian's Office portal, for submitted data (the only exception being Q4 data 2025 as this has only recently been submitted however the data is correct), the data demonstrates a slight increase in staff using FTSU to raise concerns, however during Q1 and Q3, where we can see a decline in reporting numbers, can, in part, be attributed to the FTSUG being on annual leave and therefore not visible, with the appointment of the Deputy FTSUG, we would expect the reporting numbers to remain similar each quarter, however these trends will be reviewed, to understand any challenges staff may encounter in raising concerns.

Based on data reviewed from the NGO portal and looking at the Northwest, Alder Hey is reporting some of the highest number of cases, which may indicate the confidence staff have in raising concerns through this route.

2023/2024

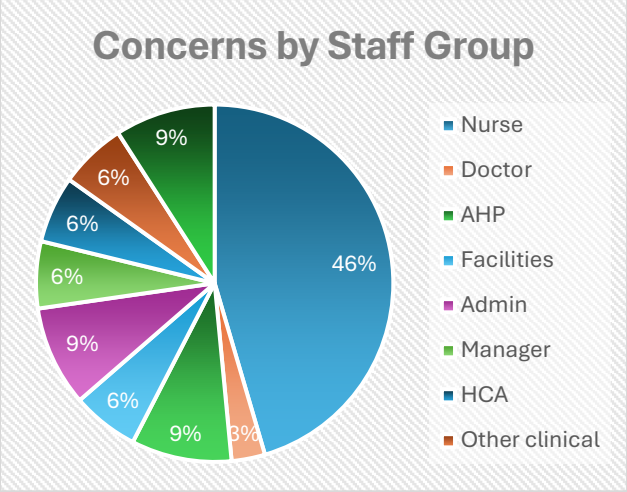
Alder Hey Children's NHS Foundation Trust	Q1 2023/2024	Northwest	28
Alder Hey Children's NHS Foundation Trust	Q2 2023/2024	Northwest	27
Alder Hey Children's NHS Foundation Trust	Q3 2023/2024	Northwest	32
Alder Hey Children's NHS Foundation Trust	Q4 2023/2024	Northwest	25
		TOTAL	112

2024/2025

Alder Hey Children's NHS Foundation Trust	Q1 2024/2025	Northwest	24
Alder Hey Children's NHS Foundation Trust	Q2 2024/2025	Northwest	40
Alder Hey Children's NHS Foundation Trust	Q3 2024/2025	Northwest	19
Alder Hey Children's NHS Foundation Trust	Q4 2024/2025	Northwest	36
		TOTAL	119

Of the 119 cases reported in 2024/2025, 53 are closed and 66 are open. Of the 30 that are open pre Q4 data, 25 are relating to 3 cases, 1 of which is due to close (12 staff members) and the remaining 2 cases (13 staff members) are active but with an agreed approach to address concerns. The remaining 5 cases are currently awaiting closure conversation. Please refer to Q4 data below for remaining open cases.

4. Q4/ 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)]

Table 1

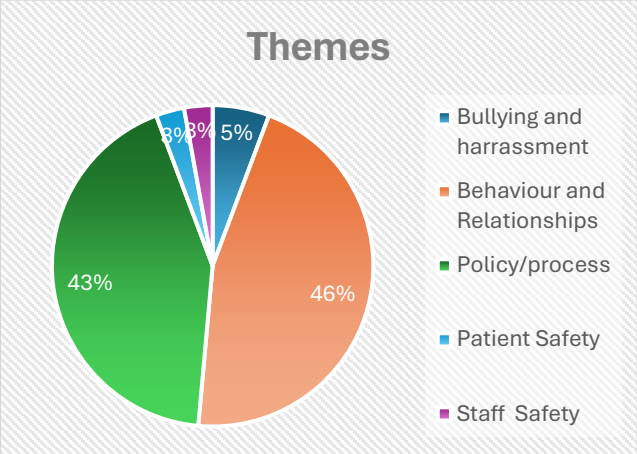


Table 2

Q4 Cases remaining Open 29, Closed 7.
Cases reported anonymously 13

Of the 29 cases open, 14 are pending closure following final closure meeting or email correspondence to confirm agreement with the decision to close, the remaining 15 cases are all complex active cases, requiring increased support and sensitivity.

As indicated in the Table 2, the highest number of concerns is behaviour and relationships, this would also include those relating to bullying and harassment. In the majority of these cases, the reporter references that inappropriate communication, lack of adherence to Trust values and poor leadership styles, are the primary reasons for the breakdown in relationships, there have also been claims of sexual harassment and inappropriate language reported. It should be noted that in a high proportion of these cases, the individual's psychological safety is also potentially compromised with the possibility of impacting their cognitive ability to perform, which could have a direct or indirect impact on patient safety.

In relation to policy/process, the highest number of reported cases are in relation to the adoption of the Sickness Policy, with a lack of understanding relating to reasonable adjustments, and when these may apply, there have also been concerns raised regarding the Flexible Working Policy and the process of review to ensure the request remains valid.

The patient safety cases do remain open however this is due to closure communication not being completed, assurance has been sought from the managers responsible for these patients, that the issue raised has been addressed and mitigation in place.

Feedback from those cases closed can be viewed below;

https://forms.office.com/Pages/DesignPageV2.aspx?subpage=design&FormId=G888R1c5sE6Cur6KaqH2Sri2S89zA4NJtHQSSVjh0UBUQktJNk5OWUNCN01YUVNOWjlSTkVQSFBDMC4u&Token=f741342afb374643a0770a39aa055290

5. Staff Survey results 2024

Question	Response 2023	Response 2024	National Best	Average results	Worst results
Q20a I would feel secure raising concerns about unsafe clinical practice.	77.51%	79.71%	79.71%	70.44%	60.03%
Q20b I am confident that my organisation would address my concern.	66.91%	68.85%	68.85%	55.91%	40.42%
Q25e I feel safe to speak up about anything that concerns me in this organisation	70.22%	70.04%	72.15%	60.29%	43.46%
Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.	60.17%	61.53%	63.63%	48.23%	29.95%

Of the 4 questions we have seen a positive increase, with 2 attaining the national best and all being significantly above average, Q25e saw a slight decrease, however the national picture, 72.15%, also saw a decrease from 2023, which was 73.98%. That said the focus remains on ensuring all staff feel safe to speak up about concerns and understanding what the barriers to speaking up may be, and to also confirm to staff that their concern will be addressed.

Following the publication of the 2024 staff survey results, there have been requests from other organisations to meet with the Guardian to understand how FTSU is adopted within Alder Hey and to share learning.

6. Freedom to Speak Up Visibility Programme

The FTSU visibility programme continues across the organisation and with support from Racheal Lea, Chief Finance Officer, there is a plan to include our Staff Network Chairs, which it is hoped will help reduce some of the barriers staff may have in raising concerns. Please see attached A4

FTSU NETWORK CHAIR COLLABORATION A4

The programme is being well received in those areas attended and with the addition of the CEO, Executives and NEDS, staff are recognizing the commitment being made to the FTSU service and with this, comes a growth in trust that FTSU is a safe space to raise concerns, that acts upon the concerns raised and makes changes to mitigate similar issues occurring in the future. Attached we can see the areas visited.

FTSU WALKABOUT SUMMARY 2025

7. Freedom to Speak Up App

The primary driver for the development of this app was to provide a platform for staff to raise concerns anonymously, as to date this had not been available, although those staff who had wished to remain anonymous had been protected by the FTSUG. Without this option it has been difficult to determine whether the absence of this route may have been a significant barrier for staff wishing to raise concerns, therefore it is hoped that the app will now eliminate this barrier.

Whilst anonymity is an important aspect of this app, it is also hoped that it can allow staff to see progress of their concern, provide prompts to those that the concern has been escalated to, generate reports, identify themes and trends, collate data in the format required when reporting to the National Guardian's Office and finally create a way in which reported detriment can be monitored post closure on a 3,6,9 and 12 month basis. To the best of our knowledge there is not another system available that provides these functions, therefore it is hope that this will potentially generate income by sharing with other trusts. Interest in the app has already been received, this will be further explored.

The app was launched in its current simple form on the 23/4/25, this could not have been achieved with Jacob Moore from the Innovation hub and Joe Fitzpatrick Internal Communications manager and FTSU Champion, this work is truly appreciated. The link for the app is below.

here

8. Freedom to Speak Up Champions/Deputy FTSU Guardian

The Deputy FTSU guardian role is due to be advertised among the existing group of Champions via an 'expression of interest'; the role will initially be for one day per week to be accommodated within the individual's existing hours with the support of their line manager. The appointment of the successful candidate will support the Guardian in the development and implementation of an effective and innovative approach to speaking up and assist in promoting learning and continuous improvement and amplify the voices of individuals, groups/networks to support the speaking up culture.

This additional capacity to the service will support a review of our FTSU Champions and the valuable role they provide to FTSU and the organisation. Currently we have 20 FTSU Champions, with varying degrees of commitment, there are a variety of reasons for this, for which a greater understanding is required. The review will aid in this understanding and therefore enhance the service, the deputy will lead on this valuable project.

Recently the FTSUG met with Dr Chris Turner , one of the co-founders of Civility Saves Lives, the main driver for this request to meet was gain further insight in to the 2nd Messenger, a system created by an American Doctor, Gerry Hickson, which uses a 2nd messenger (trained in this work) to have a peer-peer conversation with an individual, where an allegation of poor behaviours has been made. The messenger will demonstrate compassion for both victim and perpetrator, have no judgment and will reframe the conversation, by assuming that they (perpetrator) didn't intend to land it badly, this allows us to then step away from the desire to punish. Considering this I have recently met with the lead for the SALS Pals, Sarah Robertson, and we are looking at how we may develop this method by using the FTSU Champions and the SALS Pals to be the 2nd Messenger.

9. Training

Speak Up training is now mandatory and is currently compliant at 98.19%, there has been limited feedback from staff regarding this training which is positive, however in light of this and as a requirement of the Trust, the FTSUG is scheduled to meet with the Head of OD Darren Shaw, to look at how we can evaluate this training to ensure staff receive the information required about FTSU and the service it offers.

Kerry Turner
April 2025

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	**Freedom To Speak Up Review Tool for Boards**
Report of:	**Chief Corporate Affairs Officer**
Paper Prepared by:	Chief Corporate Affairs Officer

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The report provides a snapshot of Alder Hey's FTSU arrangements against the various parameters set out in the National Guardian's Office review and planning tool, together with suggested areas for improvement.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	None identified at present

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
BAF 2.2	Organisational culture	9

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

National Guardian
Freedom to Speak Up

NHS
Alder Hey Children's
NHS Foundation Trust

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes

Enter summarised commentary to support your score.

The FTSU Guardian is a full time post directly line managed by the Executive lead. The NED lead meets with the FTSUG and Exec lead as a triumvirate on a monthly basis to ensure line of sight of all key issues of concern. In addition the FTSUG also has monthly one to one meetings with the Chief Nurse and Chief Executive. Quarterly formal reports to the Board have been in place for a number of years and have continued to develop to reflect themes and lessons learned. In addition, quarterly reports are submitted to the People Committee. The FTSUG also produces an annual report on the activities of the service – this will be the second year for this. Speaking up arrangements are kept under review to continue to ensure they reflect best practice and guidance from the NGO.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Finalise recruitment of Deputy Guardian

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I am confident that the board displays behaviours that help, rather than hinder, speaking up	Yes
I effectively monitor progress in board-level engagement with the speaking-up agenda	Yes
I challenge the board to develop and improve its speaking-up arrangements	Yes
I am confident that our guardian(s) is recruited through an open selection process	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am involved in overseeing investigations that relate to the board	N/A to date
I provide effective support to our guardian(s)	Yes

Enter summarised evidence to support your score.

The NED lead meets on a monthly basis with the FTSUG and Executive lead in order to receive updates on concerns raised, any trends, national or local developments and future plans. The NED lead has continued to focus on information provided to the board on a quarterly basis to improve transparency in terms of process whilst maintaining confidentiality. The NED lead has been proactive in raising the profile of her role through communication mechanisms such as 'Ask the Execs' and this has resulted in some members of staff seeking direct access to her as the NED lead. She has had direct oversight of one investigation (not relating to the board) and has been satisfied with the process surrounding this. The NED lead is committed to championing speaking up at Board level and to demonstrate this externally through attendance at relevant national or system events.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 As chair of the Audit Committee, ensure that the actions from the MIAA audit are tracked.

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	Yes
We regularly and clearly articulate our vision for speaking up	Yes
We can evidence how we demonstrate that we welcome speaking up	Yes
We can evidence how we have communicated that we will not accept detriment	Yes
We are confident that we have clear processes for identifying and addressing detriment	Yes
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	Yes
We regularly discuss speaking-up matters in detail	Yes

Enter summarised evidence to support your score.

In 2023/24 the Board approved an FTSU strategy position statement in support of the Trust's Vision 2030 and underpinning People Strategy. The Board also approved the FTSUG's proposal to include the national Speaking Up training module as mandatory training for all staff. Compliance rates with this training are now above 90% across the organisation. The Trust has had in place an annual Speaking Up week for a number of years and the Guardian has a well-publicised programme of visibility visits to all areas of the organisation including community locations. During the last 12 months members of the Board have been accompanying the Guardian on these visits in order to reinforce key messages with regard to speaking up principles at Alder Hey including unacceptable behaviours that should not be tolerated by staff. The visibility programme cycle will continue in the current year to ensure organisation wide coverage; include board member attendance across the year. The FTSUG and NED lead participated in the 'Ask the Execs' broadcast to staff to raise awareness of the processes after the civil unrest which took place in 2024; it is intended to repeat this event at least annually. The Guardian was an influential figure in the development of the Trust's Respect at Work policy and signposts staff to this and other routes as appropriate. Our most recent staff survey results demonstrate the Trust's continued progress in this area.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1 Invite FTSU Champion team to a Board meeting at least annually to broaden collective knowledge and understanding and invite feedback	
Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes
Enter summarised evidence to support your score. A central pillar of the Trust's People Strategy is to ensure we foster a culture and environment in which all of our staff can thrive and develop. The adoption of a Just and Restorative culture is part of that development and is woven through key aspects of our work including the Patient Safety strategy, delivered via the Patient Safety board. FTSU is a recognised tool in the patient safety strategy and the Guardian regularly spends time with teams in order to support individuals who have experienced safety incidents and need support through the learning process. The Guardian has developed strong relationships with the chairs of the staff networks and has worked in partnership with them on specific cases. In the last year a Thriving Teams MDT approach has been established which includes the FTSUG alongside colleagues from the SALS team and HR colleagues. This has proved an effective means of triangulating information with regard to teams who need extra support.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue to develop the FTSU data set and triangulation with other information sources such as SALS, incidents and concerns raised through other routes.	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Yes
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	No
Enter summarised evidence to support your score. The Board took the decision to create a full time Guardian role in 2023. A formal part time Deputy role is to be appointed within Q1 of this year. This will enable a refocus on the recruitment and retention of Champions as a cohesive team representing all areas of the Trust.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Complete Deputy FTSUG recruitment process.	
2 Consider succession plan for Guardian role over the next 12 months including increasing the pool of Champions.	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	Yes
Enter summarised evidence to support your score. The national Speaking Up policy was adopted by Alder Hey in September 2022 which was in advance of the mandated deadline. Alder Hey has a centralised Document Management System which contains all policies, accessible on the Trust intranet. In addition, a managers' guide to handling concerns raised by staff was developed as a companion to the policy which contained a variety of helpful examples and scenarios.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Ensure the policy is referenced routinely in FTSU communications plans.	
2 FTSUG to signpost to policy at induction sessions.	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	Yes
We have an annual plan to raise the profile of Freedom to Speak Up	Yes
We tell positive stories about speaking up and the changes it can bring	Yes
We measure the effectiveness of our communications strategy for Freedom to Speak Up	No

Enter summarised evidence to support your score.

The Trust's internal communications manager has worked closely with the Guardian from the beginning of her tenure and they have developed a rolling comms plan that has included the development of visual collateral such as banners and lanyards, through to the annual Speaking Up Week in October which over time has used mechanisms such as pledges by senior leaders in relation to speaking up. The Guardian has also supported colleagues to bring their experiences to board meetings through the 'Staff Story' slot. Whilst we have not to date developed any effectiveness metrics per se, the year on year improvement in staff survey results relating to the raising concerns questions demonstrate steady improvement and places us as a high scoring organisation in this regard.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Consider a methodology for measuring the impact of FTSU comms other than the annual staff survey metrics.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes
Our HR and OD teams measure the impact of speaking-up training	No
Enter summarised evidence to support your score. The organisational compliance rate with the NGO speaking up training module currently stands at 98%. The Guardian has a specific session with new starters at each corporate induction.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 The Guardian to engage with the Head of Learning and Development to consider how the Speaking Up training module can be evaluated.	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	Yes
We have enabled managers to respond to speaking-up matters in a timely way	Yes
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	Yes
Enter summarised evidence to support your score. The Guardian works with managers as required when issues are raised in their area. There have been notable examples of positive and productive joint working in the last 12 months.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Guardian to consider specific learning sessions for managers following visibility activities.	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes

Enter summarised evidence to support your score.

The Guardian is a key member of all organisational forums that focus on staff wellbeing, enabling her to undertake horizon scanning for potential hotspots as issues arise in particular services for example. This now includes the Thriving Teams MDT meeting. One key source of data (anonymised) is the SALS service. The Guardian has developed a close working relationship with the SALS team since it was put in place in 2020; the lead for SALS is also leading the development of the Trust's cultural programme.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Continue to refine data sources, analysis and triangulation as part of board assurance and learning.

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes
We use this information to add to our Freedom to Speak Up improvement plan	Yes
We share the good practice we have generated both internally and externally to enable others to learn	Yes

Enter summarised evidence to support your score.

The FTSUG analyses the case studies published by the NGO to ensure that any learning that can be derived for Alder Hey is assimilated. The Guardian also draws learning from network events that can be adopted by the Trust and similarly has regularly offered her time to guardians in other organisations who have expressed an interest in the Alder Hey approach. Following the publication of this year's staff survey results other organisations are reaching out to the FTSUG to seek advice.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Consider formalising the dissemination of learning from elsewhere through an annual report eg to the People Committee.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes
Our guardian(s) has been trained and registered with the National Guardian Office	Yes
Enter summarised evidence to support your score. The Guardian has been in post since 2018 having been recruited through an open internal process. She subsequently undertook NGO training and remains registered as Alder Hey's Guardian.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 N/A	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	Yes
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes

Enter summarised evidence to support your score.

There is a long-standing robust management support structure in place the FTSUG. She reports to the Executive lead, including monthly one to one meetings, as well as a monthly meeting with both the Executive and NED lead jointly and has open access to the Executive lead at other times to discuss specific cases. She also meets on a monthly basis with the Chief Nurse, who is her professional lead as well as with the Chief Executive. She has standing open access to meet with the Trust Chair on request. The Guardian has an annual PDR with the Executive lead with agreed performance objectives and development opportunities identified. She is able to access emotional support/clinical supervision from the Associate Director of Organisational Development. The FTSUG routinely reports the Trust's data to the NGO in accordance with stipulated requirements.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 As above the formal Deputy arrangements need to be finalised.

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	Yes
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	Yes
Enter summarised evidence to support your score. The FTSUG keeps a detailed confidential database on which she documents each case. As part of the closure process of each case, individuals are asked about their experience and whether they would use the service again. This information is summarised for the quarterly board assurance report in addition to the number of open cases and the length of time they have been open; any delays in closing cases are documented with the reason for the delay. A bespoke FTSU App that enables fully anonymous reporting has just been launched and will be evaluated during the course of the next 12 months.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider more proactive board endorsement of FTSU activities through Speaking Up week.	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	Yes
We know who isn't speaking up and why	No
We are confident that our Freedom to Speak Up champions are clear on their role	Yes
We have evaluated the impact of actions taken to reduce barriers?	No

Enter summarised evidence to support your score.

Whilst the Trust scores well on staff survey metrics relating to raising concerns, it is understood that there is scope for improvement and a better insight into the factors that enable and disable staff from speaking up. Work has been done to identify barriers such as professional boundaries, geographical location, confidentiality etc. and the development of the team of Champions has aimed to address these by actively recruiting Champions from all parts of the organisation both in terms of service and structure but also in terms of characteristics and background. The FTSUG has been working closely with the staff networks to gain a better understanding of any barriers for particular groups and take steps to address them. This work will develop further in the coming year and form part of the quarterly board report.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Consider targeted work to identify groups or individuals who may be reluctant to use speaking up mechanisms.

2 Develop a methodology to assess changes in appetite to raise concerns among staff groups identified and contributing factors.

Statements about detriment	**Score 1–5 or yes/no**
We have carried out work to understand what detriment for speaking up looks and feels like	Yes
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	Yes
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes
Enter summarised evidence to support your score. The FTSUG considers the issue of detriment specifically with each member of staff who raises a concern. She follows up with individuals after the concern has been closed to ensure that no detriment has arisen. This is reflected in the board report which is overseen by the Executive and NED leads.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Review the questions in relation to detriment and consider supplementary information as appropriate.	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	No
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	No
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	No
Our improvement plan is up to date and on track	No
Enter summarised evidence to support your score. We do not currently have a standalone FTSU strategy, having taken the view that speaking up must rather be an integral part of our overarching People Strategy. We developed a position statement in support of the People Strategy which can be developed into an improvement plan but again this must align to the work that is currently underway in relation to the Trust's cultural evolution and revised values. The short survey that was undertaken during 2024 to seek the views of staff with regard to the accessibility and effectiveness of FTSU is a good platform on which to build; it is intended to run the survey on an annual basis to track progress.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider the development of an FTSU improvement plan	
2 Consider appropriate metrics to evaluate improvement	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	No
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	No
Our speaking-up arrangements have been evaluated within the last two years	Yes
Enter summarised evidence to support your score. Our speaking up arrangements were formally audited during 2023/24 by MIAA and substantial assurance obtained with regard to the process. The scope of the review included policies and procedures, staff and training, actions taken as a result of concerns and lesson learning.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Consider structured evaluation of staff attitudes to speaking up out with of the annual staff survey.	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	Yes
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	Yes
Enter summarised evidence to support your score. The quarterly board assurance report has developed significantly over time and last year underwent some structural changes suggested by the NED lead. Periodically the standard report has been supplemented by case studies and self-assessments which can be built into the workplan at intervals during the year. The annual report to the board reflects the totality of FTSU activity over the previous 12 months.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue to refine the quarterly report to include the areas identified in this assessment with oversight from the NED lead.	
2 Continue to develop the formal annual report on FTSU activity as referenced above.	

Erica Saunders
Chief Corporate Affairs Officer/Executive lead for FTSU
April 2025

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	Discussion Paper to support the assessment of Going Concern for 2024/25 Annual accounts
Report of:	Finance
Paper Prepared by:	Emily Kirkpatrick

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:	Nil

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

A review of the Trusts going concern status has been undertaken in the preparation of the 2024/25 accounts.

Given the strong liquidity status of the trust, it's overall cash position, and its status in terms of draft plan submitted for 25/26, it is proposed that the Trust does meet the criteria for the 2024/25 accounts and associated financial statements to be prepared on a Going Concerns basis.

The Audit and Risk Committee reviewed this proposal in April 2025 and support this view.

On this basis the Trust Board are asked to support and recommend that the 2024/25 annual accounts and associated financial statements should be prepared on a going concern basis and to formally minute that they consider it appropriate for the Trust to prepare its 2024/25 financial statements on this basis.

2. Background and current state

The Trust is compliant with the Department of Health and Social Care (DHSC) guidelines preparing the 2024/25 financial accounts on a going concern basis. Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption, a Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading. A key consideration of going concern is that the Trust has the cash resources to meet its obligations as they fall due for the foreseeable future. For these purposes, 'foreseeable future' is considered to be twelve months from the date of signing of the annual accounts.

International Accounting Standard 1 – presentation of financial statements (IAS 1) requires the Trust directors to assess and satisfy themselves that it is appropriate to prepare financial statements on a going concern basis. The 2024/25 DHSC Group Accounting Manual (GAM) sets out the interpretation of going concern in the public sector context.

<u>Directors' assessment of going concern</u>
The specific factors that the Directors should consider in respect of their assessment of going concern are:

- Financial conditions
- Operating conditions
- Other conditions such as serious non-compliance with regulatory or statutory requirements

Having considered the above the Trust directors have a reasonable expectation that the Trust will remain in operation for the foreseeable future. The Trust has a proven track record of consistently meeting the performance and control totals set by the regulator and over the last 5 years has delivered within these targets often making significant surpluses to support the sustainability of the Trust.

As a specialist provider of children's services, the Trust is commissioned to provide services across the North West Region and nationally for highly specialised services and it is expected

that NHS funding will flow from commissioners, at similar levels to that previously provided for all of these specialist services. There remains a firm requirement to still provide the services.

The Trust currently has a significant level of its own cash resource available demonstrating strong liquidity (£53.7m as at 31st March 2025).

In 25/26 there will again be a 'blended' approach to funding in England. In England the exact mechanism for payment is still under consultation. It was initially indicated there would be a cap on over performance on elective variable payments (against national ERF targets). However, it now seems likely the cap will be removed, but will be replaced with far closer scrutiny of over performance against plan for ERF variable activity, with Commissioners having the ability to implement an activity management plan to bring activity back to affordable levels, which is likely to act in a similar way to a cap. Most high-cost drugs and devices remain pass-through.

Wales are expected to adopt a similar approach as to that in England. Isle of Man and Northern Ireland will be full PBR across all activity points of delivery.

Based on the updated funding arrangements, and planned activity for 2025/26, initial draft plans have been submitted to the ICS and NHSE with a planned control total with a surplus of £3.4m. Whilst these are still yet to be approved, it is expected this will be achieved prior to the anticipated sign-off of the 2024/25 financial statements in June.

As such the Trust board can take assurance that it is reasonable to expect that the 2025/26 funding levels will be maintained based upon these plans as the actual income streams are not expected to be materially different. Arrangements beyond 2025/26 are yet to be confirmed and the Trust assumes similar arrangements to those in place for 2025/26 will be adopted.

The Trust has calculated a number of liquidity ratios based upon its forecasted closing Statement of Financial Position as at 31st March 2025 as follows;

Quick Ratio	Cash & Receivables Current Liabilities	86,234	/	(63,277)	1.36
Current Ratio	Current Assets Current Liabilities	90,909	/	(63,277)	1.44

Generally the higher the ratios are the greater the margin of safety
An ideal ratio is considered to be between 1 & 1.5

The Trust has also completed a scenario analysis to assess operational liquidity for the next 18 months to September 2026 and consider what level of cash the Trust could close H2 26/27 with, expressed as a percentage of current levels and this is shown in Appendix A.

The outcome of this analysis demonstrates that in all scenarios, the level of cash available at the end of next financial year is likely to remain significant therefore all examples fully support the Directors assessment that a Going Concern basis should be adopted.

3. Conclusion

The Trust Directors have a reasonable expectation that Alder Hey Children's NHS Foundation Trust will have adequate resources to continue in operational existence for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements. **On this basis the Trust Board are asked to support and recommend that the 2024/25 annual accounts and associated financial statements should be prepared on a going concern basis and to formally minute that they consider it appropriate for the Trust to prepare its 2024/25 financial statements on this basis. It should be noted the Audit and Risk Committee have reviewed the contents of this paper and support the view that the accounts and associated financial statements should be prepared on a going concerns basis.**

Appendix A – Liquidity Scenario Analysis

Going Concern Liquidity Scenario Testing for 25/26 & H1 26/27 - 30th September 2026						
	Base Case		Upside Case - Capital Restraint		Downside Case - CIP not delivered	
	£'000	£'000	£'000	£'000	£'000	£'000
Bank & cash balance per 31st March (Draft Close)		**53,711**		**53,711**		**53,711**
Trust Operations 25/26 :						
Draft Planned Income (exc non cash)	443,369		443,369		443,369	
Draft Planned Expenditure (exc non cash)	(449,589)		(449,589)		(449,589)	
Draft CIP Target	22,748		22,748		22,748	
Draft Plan Capital Expenditure April 25 - March 26	(16,759)		(16,759)		(16,759)	
		(231)		(231)		(231)
Downsides:						
CIP Not delivered @ 50%						(11,374)
Mitigations:						
Capital restraint 25/26 - uncommitted capital spend				2,500		
Projected Cash Balance 31/3/26		**53,480**		**55,980**		**42,106**
Trust Operations H1 26/27:						
Projected Planned Income (3% Growth)	228,335		228,335		228,335	
Projected Planned Expenditure (Incl Inflation)	(231,538)		(231,538)		(231,538)	
CIP Target - H1	11,715		11,715		11,715	
Indicative Capital Expenditure April - September 25	(4,460)		(4,460)		(4,460)	
		4,052		4,052		4,052
Downsides:						
CIP Not delivered						(5,858)
Mitigations:						
Capital restraint 26/27 - 1/3rd of indicative capital spend				1,472		
Projected Cash Balance 30/9/26		**57,532**		**61,504**		**40,300**
% of current cash balance		**107%**		**115%**		**75%**

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	**Chair's Report from ARC meeting, 17th April 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	Minutes from the meeting on 17th January 2025
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 Corporate Services
- Board Assurance Framework (Detailed review of risks 1.5, 1.6 and 3.5)
- Risk Management Forum Update including Chair's Report and Minutes from the most recent meeting
- Corporate Risk Register
- Trust Risk Management Report
- Risk Horizon Scanning Discussion
- Update on the roll out of Risk Appetites and Tolerances in CAMHS
- Draft Head of Internal Audit Opinion for 24/25
- Final Internal Audit Plan for 25/26 **(Approved)** – See Appendix 2
- Internal Audit Charter **(Approved)**
- Internal Audit Progress Report, including the outcomes of audits of Risk Management (Substantial Assurance), Assurance Framework (Met Requirements), PSIRF (Substantial Assurance), Workforce Planning (Substantial Assurance) and Safeguarding (Substantial Assurance) – See Appendix 1
- Internal Audit Follow Up of Previously Agreed Recommendations Report
- Anti-Fraud Services Annual Report for 24/25
- Anti-Fraud Services Annual Plan for 25/26 **(Approved)**
- Annual Governance Statement **(Approved)**
- External Audit Planning Report and Fees for 24/25 Audit
- External Audit Project Plan
- Update on Interim External Audit work
- Details of treatment of specific accounting transactions, ahead of the year end audit
- Statement of Going Concern **(Endorsed)**
- Annual Assurance Report for 24/25 and Forward Plan for 25/26 for:
    - Data Quality
    - Cyber Security
    - Compliance with the Data Protection Act
    - Compliance with the Freedom of Information Act
    - Project Assurance
- Outcome of the review of the effectiveness of the Anti-Fraud Service, Internal and External Audit
- Waiver Activity Report
- Gifts & Hospitality Register

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

Benchmarking information provided by Health Procurement Liverpool to the January 2025 meeting showed that the Trust is an outlier across the C&M region for requesting significantly more waivers of Standing Financial Instructions - specifically waiver tender and quotation requirements and also specifically those requested retrospectively. A further report was received to this meeting which showed some reduction in numbers, but there still remains significant scope to improve. ARC will continue to monitor the position.

4. Positive highlights of note

There are number of items to bring to Board's attention:

- The Head of Internal Audit Opinion provided substantial assurance *"substantial assurance can be given that there is a good system of internal control designed to meeting the organisation's objectives, and that controls are generally being applied consistently".*
- The first internal audit of PSIRF was undertaken resulting in Substantial Assurance with only 1 Medium and 1 Low recommendations. This is a great outcome given the significant process change and thanks were expressed to Chris Talbot and Jackie Rooney in leading this across the Trust.
- The Internal Audit Annual Plan for 25/26 was approved, and 3 audits were left unallocated at this stage to enable the Plan to respond to changes in, and requirements of, the external environment. An audit of Financial Grip and Control is included in the Plan to review the implementation of recent and expected financial controls required by the C&M ICB.
- The roll out of the Board approved Risk Appetites and Tolerances has begun with CAMHS volunteering to be the first Division to implement them. Feedback and learning areas were provided by the Chief Corporate Affairs Officer and CAMHS representatives are to present their experiences to the July meeting.
- It was agreed that a deep dive of Cybersecurity and Lessons Learned from the iDigital Partnership will be presented to the July meeting.
- The Committee undertook its first detailed effectiveness review of the Anti-Fraud Service. No fundamental weaknesses were identified and a small number of enhancements have been requested of MIAA.

5. Issues for other committees

Board is to **note** that ARC endorsed the Statement of Going Concern and the Annual Governance Statement for presentation to, and approval by, Board.

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	Met Requirements	Board
Risk Management Core Controls	Substantial	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
PSIRF	Substantial	SQAC
Safeguarding	Substantial	SQAC
Equality, Diversity & Inclusiveness	Moderate	People Committee
e-roster	Moderate	SQAC
Workforce Planning	Substantial	People Committee
Cyber Assessment Framework		FTPC

Appendix 2 – 2025/26 Internal Audit Plan

Audit	Assurance Outcome	May be of interest to…
Assurance Framework Opinion		Board
Conflicts of Interest		Board
Governance of the Gender Development Service		Board & SQAC
Key Financial Controls		FTPC
Asset Processes		FTPC
Financial Measures (Grip & Control)		FTPC
People review (audit area to be determined)		People Committee
Clinical Audit		SQAC
Theatre Management		SQAC
Data Security & Protection Toolkit		FTPC
Cyber review (audit area to be determined)		FTPC
Placeholder (unallocated)		Tbc
Placeholder (unallocated)		Tbc

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 16th January 2025 via Teams**

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	Interim Chief Finance Officer	(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	Chief Corporate Affairs Officer	(ES)
	Mr. D. Spiller	Senior Manager, Ernst & Young	(DS)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
	* Risk items only		
Observing:	Mr. L. Stark	Trust Governor	(LS)
	Mr. R. Tabb	Appointed Governor	(RT)
Item 24/25/106	Dr. U. Das	Director of Medicine	(UD)
Item 24/25/117	Mr. P. White	Chief Nursing Information Officer	(PW)
Item 24/25/119	Ms. K. Toothill	Health Procurement Liverpool	(KT)
Apologies:	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)

24/25/102 Introductions and Apologies

The Chair welcomed everyone to the meeting especially two of the Trust's governors; Lachlan Stark and Rob Tabb who were observing the meeting. The Chair advised of the papers that are to be taken as read with questions only, and the substantive papers that will instigate a more in-depth discussion. Reference was made to agenda item 24/25/127 which is to be discussed with the core membership of the Committee in private and, at that point, observers will be asked to leave the meeting.

24/25/103 Declarations of Interest

Non-Executive Director (NED), Gerald Meehan, declared that he is the Independent Chair of Liverpool's Children's Services Improvement Board.

24/25/104 Minutes from the Meeting held on 10th October 2024

Resolved:

The minutes from the meeting held on the 10.10.24 were agreed pending the following amendment:

- Minute 24/25/89 should include narrative to advise that a Clinical Governance Audit will replace the ICB Expenditure Controls review in the Internal Audit Plan.

24/25/105 Matters Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

For noting
The Committee received an update on a number of risks relating to finance/risk and it was agreed to close them, as per the two papers submitted to advise of the progress made against these actions.

Action 23/24/97.1: *Risk Tolerance and Appetite (Meetings to be widened to develop a risk appetite and tolerances for advocacy and JG to be invited)* – It was agreed to defer this action to July so that a more in-depth update can be provided following the commencement of work relating to neighbourhoods/communities and the Trust's role in that space which should lead to the crystallisation of what needs to be done from a risk appetite and tolerance perspective.
ACTION TO REMAIN OPEN

Action 24/25/10:1 *2023/24 Annual Report on Risk Management (Conversation to take place with the Chief People Officer and the Director of the Academy to escalate the Committee's request for Risk Management Training Programme to be included on the list of mandatory training)* – A report is to be submitted to the Education Committee in February as December's meeting was not quorate. It was agreed to update the Chair of ARC on the outcome of the proposal once the meeting has taken place and to provide ARC with an update in April.
ACTION TO REMAIN OPEN

Action 24/25/14.3*: Internal Audit Plan 2024/25* (*Discuss the approach for the audit of Clinical Governance audit (Internal Audit and/or Clinical Audit)* – Following a discussion with the Chair of the Safety and Quality Assurance Committee (SQAC) it has been confirmed that this area of work will be reported via SQAC. Components of the audit have commenced, and a report is to be submitted to SQAC in April 2025. **ACTION CLOSED**

Action 24/25/89.1: *Internal Audit Progress Report DSPT – Include the recommendations from the assessment against the National Data Guardian Standards, in the Internal Follow-up Report)* – The recommendations have been included in the Internal Follow-up Report and are to be followed up by the AFS. It was reported that DSPT assessments are undergoing significant changes and there is a requirement for an action plan to be implemented with management responses required to recommendations. **ACTION CLOSED**

Action 24/25/89.2: *Internal Audit Progress Report (Discuss the possibility of including the NHSE system investigation and intervention review recommendations in the Internal Audit Follow Up Process to enable ARC to monitor the actions that arise from the audit)* – The Finance, Transformation and Performance Committee (FTPC) is overseeing the combined action plan which is submitted on a quarterly basis. An update will be provided to ARC in the event actions fall behind agreed deadlines or a concern is raised.
ACTION CLOSED

Action 24/25/98.1: *Financial Governance Policy (Discussion to take place with the Chair of FTPC to gain approval re the increase in business case approval limits to £250k, as detailed*

in the Financial Governance Policy) – This action has been addressed via the amendments made to the Corporate Governance Manual. **ACTION CLOSED**

24/25/106 Update on the Risk Management Process within Division of Medicine

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

- Category themes of current risks.
- The process for new risks.
- The process for approved risks.
- Risk actions.
- Actions taken since the last Medicine Division update to the Risk Management Forum.
- Priorities;
    - Risk Managers will be encouraged to attend the Trust's risk management training.
    - A Medicine Division governance SharePoint site has been developed to allow ease of sharing guidance and training resources for risk management.
    - Risk reviews and actions data to be provided to each Care Group on a monthly basis to allow oversight and ownership by the Care Groups. Care Groups to review the data during monthly governance meetings.
- Challenges;
    - Reduction in Governance Team hours requires a review of current workloads.
    - InPhase reporting to be developed when corporate role is in place.

Positive feedback was provided by MIAA and the Associate Director of Nursing and Governance in terms of the outcome of the Risk Management Review and the amount of work that has been undertaken by the Division to improve their risk management processes. It was also pointed out that the risk management training that the Governance Leads are using mirrors that of the Trust wide training.

Reference was made to the reduction in the Governance Team hours that was highlighted in the presentation, and it was queried as to whether this will impact the great strides that the Division has made. It was confirmed that the Team will be impacted as will training and education, but the Division are sighted on this and will review it on a regular basis.

The Chair felt that the new processes that the Division has implemented are excellent and queried as to whether there are any areas of best practice that other Divisions could learn from. It was pointed out that the Committee doesn't provide a template for the submission of presentations, but it was felt that the Divisions provide relevant information and there is an opportunity to ask questions. The Chair asked Non-Executive Director colleagues if they were comfortable with this approach, of which they confirmed they were.

The Chair offered thanks for the presentation and the improvements that the Division has made.

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

24/25/107 Board Assurance Framework

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

- The BAF risks monitored by SQAC have been scrutinised in great detail with a number of substantive papers submitted to the Committee on the whole array of risks that sit underneath BAF risk 1.1 *(Inability to deliver safe and high-quality services).*
- The risks relating to the shortage of ADHD medication and mental health have also had had their own focus in many committees, as have internal strategically focussed risks.
- There has been an increase in score during November to 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)* appertaining to cyber security.
- In terms of the 2025/26 financial year there will be a number of adjustments made to BAF risk scores to reflect the gain in focus/volatility of external risks and the changing shape of the Liverpool health economy, for example, system working, partnership working and finance, all of which could affect the delivery of the Trust's 2030 Strategy. JR drew attention to the impact that the workforce efficiency risks are having on decision making, staff, morale, and the work that the Trust is undertaking on culture and reiterated the point about increasing the presence of external risks on the BAF.

The Chair queried as to whether a future deep dive into health inequality should be scheduled as there doesn't seem to be any risks included on the BAF or Corporate Risk Register relating to this area of work. ES agreed to liaise with the Chief Strategy and Partnerships Officer, Dani Jones, regarding this matter. GM advised that Professor Chris Bentley has done a lot of work on health inequalities from a community perspective and felt that it would be beneficial for a meeting to take place. Following discussion, GM agreed to facilitate a meeting between the Trust's Consultant in Paediatric Public Medicine; Rachel Isba, and Professor Chris Bentley. It was also pointed out that Ian Sinha, Consultant in Respiratory, has also undertaken similar work in health inequalities.

24/25/107.1 Action: ES
24/25/107.2 Action: GM

Reference was made to BAF risk 3.4 *(Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments)* and the action that relates to mitigating the tariff funding for patients with complex health issues. A question was raised and responded to about the barriers in reaching a conclusion on this matter. Following discussion, it was agreed to re-look at the narrative to make sure the action required is still appropriate.

24/25/107.3 Action: RL

The Chair informed the Committee of the suggestion that has been made to review specific BAF risks in greater detail during ARC meetings to ensure all risks have an airing throughout the course of the year. It was agreed to discuss this suggestion further in terms of having a process/structure in place to do this.

24/25/107.4 Action: ES/KB

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

24/25/108 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 13.12.24. Attention was drawn to the following points:

- In terms of the Corporate Risk Register (CRR) there are two high risks overdue review. This provides assurance that the vast majority of high-risk scores are being reviewed on a regular basis. It was confirmed that action has been taken to follow up on the two overdue risks.
- Reference was made to risk 253 *(lack of access to sufficient training and education to complete the requirements of the GRID programme resulting in removal of GRID trainee posts)* and it was confirmed that meetings have been arranged to discuss solutions to the issue with the current GRID trainees. Short, medium and long-term actions have also been agreed to help reduce this risk in the future. The Committee was advised that the General Medical Council (GMC) is also looking into this matter.
- Risk 2650 (*absence of out of hours cover in the laboratory*) – It was reported that the Division of Medicine has undertaken a huge amount of work and implemented a number of actions to mitigate this risk which was scored at 25. The Committee was informed that the on-call rota will be more resilient by the end of the month as the result of the inclusion of two additional colleagues following completion of their training.
- There is a theme around insufficient capital funding to replace core equipment due to the constraints on the Capital Programme. A plan is in the process of being devised to address these risks, which will include raising awareness across the Divisions. The Medical Equipment Manager is undertaking a piece of stratifying with the Medical Equipment Group to formulate a plan to address the replacement of high-risk equipment despite the pressures on the Financial Programme. It has also been agreed to expedite an action around replacing an x-ray kit on an urgent basis.
- *Learning and Best Practice* - It was reported that the Division of Medicine has made great progress in reducing their high risks and it has been agreed to share the methodology used to do this with the Divisions.

The Chair felt that the RMF continues to provide assurance to ARC and drew attention to the learning environment of the Forum. The Chair referred to the risk relating to out of hours cover for the laboratory and asked as to whether the mitigation of two additional staff will make the service safe. The Committee was advised that there is an expectation that the likelihood of this risk will reduce due to the mitigations in place, but it was pointed out that the service hasn't reached maximum resilience as there are still a number of staff being trained who will join the rota in due course. JRO reported that as of the 15.1.25 the score for this risk has been reduced to 20.

The Chair felt that the rationale for the long-standing risks is really helpful but asked if narrative could be included in the report to indicate as to whether the mitigations are within the organisation's control/out of the organisation's control.

24/25/108.1 Action: JRO

Corporate Risk Register

The Committee received the CRR for the reporting period from the 1.9.24 to the 30.11.24.

Resolved:
ARC noted the RMF update, the CRR and the approved RMF minutes from the meeting held on the 23.9.24.

24/25/109 Trust Risk Management Report
Resolved:
ARC received and noted the content of the Trust Risk Management Report, and the level of assurance provided in the report for the period from the 1.9.24 to the 30.11.24.

The Chair felt that real progress has been made in terms of risks/actions overdue but pointed out that the risks without an action plan remain static compared to the position in the previous report. It was confirmed that this remains an area of focus to ensure effective plans are in place to mitigate risk to their target level.

24/25/110 Risk Appetite and Tolerances Roll Out

An overview was provided of the meeting that took place with the Community Division in December regarding risk appetite and tolerances which has resulted in the Division undertaking a review of the risks on their register and the wording of their risks. It was acknowledged that some scores have been updated since the last meeting with a small number having increased. It was reported that there is a theme emerging in other places around risks sitting under the workforce theme that might be more of a service issue. A lot of these risks are Trust wide and cross cutting. Linked to this, the Division is going to undertake a piece of work to see where their workforce risks meet patient safety risks.

One of the Division's concerns was around having a system in place to have oversight of risks that are removed from the risk register once they have been closed in line with their tolerance. The Team was advised that the risk doesn't have to be closed as long as there is a rationale in place. The Division is going to have further discussions regarding this matter, look at a process for having consistency in the scoring of risks, and think about how workforce risks can be closed without being transcribed and transferred into patient safety risks. A further meeting will take place in six weeks to discuss the progress that has been made.

In terms of rolling out risk appetite and tolerances the next steps will be to identify a further two services to participate in the pilot, possibly Digital and Nursing & Quality. A report will also be submitted to the RMF in March 2025 to provide an update on the work that has taken place, with a recommendation that select papers submitted to the Forum have a section on risk appetite.

The Committee was informed of the discussion that took place with Non-Executive Directors that sit on the Futures Committee. It was reported that progress has been made in terms of understanding the categorisation of the Committee's risks and sub-categories in respect to the way they are split. There has also been substantial headway with regard to the differentials between the financial risk in the sub-category and commercial risks. Given the external environment at the present time further discussion is required to determine whether risk appetite should be lowered in order to be more circumspect.

The Chair recognised the work that has been undertaken by ES, JP and JRO with all of the Assurance Committees. It was pointed out that it has taken an extended period in which to roll this area of work out, but it has been beneficial as it has enabled staff to understand risk appetite and tolerances, reflect, and then progress with the work that is required. The Chair asked for her thanks to be relayed to the Community Division for participating in the pilot.

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

For noting
AB left the meeting due to the risk element of the agenda concluding.

24/25/111 Draft Internal Audit Plan for 2025/26

The Committee received a briefing note that set out the context for the production of the Trust's draft Internal Audit Plan for 2025/26. It was reported that there are a number of annual mandated/core reviews that have to be part of the Plan; Assurance Framework and Data Security and Protection Toolkit reviews. Risk Management, Key Financial Controls, and a Cyber review also form part of the Plan due to the importance of these systems to the operation of the Trust. It was reported that conversations have taken place with the Trust's Executives who identified a number of potential audits; financial measures, constraints, asset processes, people, governance for the Gender Service, temporary spend, bank/agency overtime, and waiting lists.

Discussions have also taken place with ARC NEDs who highlighted additional areas for review; Document Management Service (DMS), clinical audit, theatre management systems, and use of single tenders. The Committee was advised that Conflicts of Interest is reviewed on a three-year basis and therefore has been included in the Plan as it is due to be audited in 2025/26.

Reference was made to the potential audit that has been identified for financial measures, constraints and variable spend. It was felt that this could be done using the Trust's previous Key Financial Controls, action plan, and scope to see if it picks up the measures. Following discussion, it was agreed to look at the scope to see if it covers what is required and is within the allotted days.

24/25/111.1 Action: RL

The Chair explained that the Internal Audit Plan for 2025/26 is already full and expressed concerns about the Plan not having any manoeuvrability to respond in year if required. The Chair requested that two audits be postponed giving the plan more flexibility (*DMS/Single Tender*).

The Chair drew attention to the placeholder on the plan for a people related audit and advised that there might be potential for a review of the leavers process due to an issue that has arisen relating to staff lease vehicles, and the disciplinary process as this has been subject to a rewrite and roll out.

A query was raised about the potential for an audit to be undertaken on record keeping for Sefton CAMHS. It was reported that this matter has been raised with management who advised that this isn't a priority at the present time in light of the internal learning review that is

due to commence. GM felt that it would be beneficial from a safety perspective to audit management oversight in CAMHS to determine how decisions are made. In response to GM's comment ES suggested that strengthening the Terms of Reference for the internal learning review would address this matter and agreed to liaise with the Chief Nurse and the Director of Community and Mental Health to explore this.

24/25/111.2 Action: ES

The Chair pointed out that the Committee reviewed the size of the Internal Audit Plan twelve months ago and it was agreed to increase the allotted days from 190 to 225, although benchmarking indicated that it should have been 235. In light of discussions during the meeting, a question was raised about whether the Trust should increase its days as per the benchmarking figure. RL felt that given the financial constraints that are being experienced the Trust should remain within its current allocation of 225 days and review the matter again in two years' time.

Following discussion, the Committee approved the 2025/26 draft Internal Audit Plan with the caveat that the DMS and Single Tender reviews be transferred to the reserve list. The Chair advised that the Trust is keen to commence the Plan in April 2025 and asked that auditees be made aware of the importance of reviews taking place on the agreed date. MIAA confirmed that the final version of the Plan will be submitted to the Committee in April, and thanks were offered to everyone who engaged to develop the Plan.

Resolved:
ARC approved the draft Internal Audit Plan for 2025/26.

24/25/112 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 October 2024 to December 2024. The following points were highlighted:

- There have been three reports finalised in this reporting period;
  - Equality, Diversity and Inclusion (EDI) – Moderate Assurance.
  - Key Financial Controls – Substantial Assurance.
  - E-Roster – Moderate Assurance

It was pointed out that this is the first time that EDI and E-Roster have been reviewed and it was felt that a moderate outcome was really positive.

Questions were raised and responded to about whether the E-Roster system has been fully embraced by the Trust, how clear will this be when followed up, and the timescale for the cleansing exercise of the system.

MIAA provided an update on the status of the Plan and offered assurance that the work will be completed by the year end in time for the submission of the Internal Audit Opinion to the Committee.

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

24/25/113 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 October 2024 and December 2024. The following points were highlighted:

- Of the 15 recommendations which have fallen due in this reporting period, nine have been confirmed as implemented or superseded.
- Six recommendations are partially implemented. One of the recommendations relating to medical devices remains in progress and a further extension to the implementation date has been requested to March 2025. Two of the Freedom to Speak Up recommendations are partially implemented with an extension request to April 2025. Three of the Cyber Assessment Framework recommendations are partially implemented with an extension request to March 2025.

The Chair provided rationale as to why the requests for extensions should be approved. It was pointed out that the extension date might need to be reviewed for the two FTSU recommendations depending on the date that the InPhase Developer commences in post as he will be assisting with the development of the FTSU modules that the Trust is wanting to implement. MIAA agreed to feedback to the respective individuals on the outcome of their request for an extension.

Resolved:
ARC received and noted the content of the Internal Audit Follow Up Report and approved the requested implementation deadline extensions.

24/25/114 Anti-Fraud Services Progress Update

The Committee received the Anti-Fraud Progress Report for the reporting period from the 4.10.24 to 6.1.25 .

It was reported that the 'Failure to Prevent Fraud Offence' will be implemented on the 1.9.25. The Home Office has released guidance which recognises that NHS bodies already comply with NHS Counter Fraud (CF) Standards, but it will be necessary for NHS organisations to comply with the new legislation. The NHS Counter Fraud Authority (CFA) has advised that they will provide support to NHS organisations to understand the impact of the new offence and will work with their colleagues in the Home Office to do this.

The Chair referred to the proactive exercises (local/national) that were carried over from 2023/24 and queried the reason for this. A response was provided, and it was confirmed that the report is now in draft stage and that there will be no local or national proactive exercises carried forward into next year as they will all have been completed.

The Chair drew attention to the referrals relating to conflicts of interest and timesheet fraud and asked as to whether an internal review had been undertaken to identify any gaps in controls and whether there has been a tightening of controls since. It was reported that the Trust investigated both incidents and has provided MIAA with the final report and accompanying evidence. MIAA will review all documentation and provide an update on both investigations in the next progress report. The Chair felt that it would be beneficial if the local and national exercises could be separated in the report with assurance provided on the outcomes of actions following a referral.

24/25/114.1 Action: VM

A discussion took place in relation to a referral that was received via the NHSCFA relating to recruitment concerns of roles created in a specified area of the Trust over the last few years with no advertisement. It was confirmed that this investigation is ongoing but it was felt that it would be beneficial to liaise with the Freedom To Speak Up Guardian (FTSUG), Kerry Turner, to see if there a reason why this concern was raised externally rather than internally.

24/25/114.2 Action: KB/ES

Resolved:
ARC received and noted the Anti-Fraud Progress Report for the reporting period from the 4.10.24 to the 6.1.25.

24/25/115 Briefing on the issue relating to a member of staff being in possession of a lease vehicle nine months after leaving the organisation

The Committee was briefed on an issue that related to an employee of the Trust who had previously left the organisation but where the process for termination of the lease car had failed to be implemented effectively resulting in an outstanding debt being owed.

An outline of the circumstances was provided that led to this event and also the actions that have been taken to mitigate against future events occurring; **1.** Monthly reconciliations have been implemented to review lease contract employment status to ensure that the Trust has captured those that haven't been highlighted. **2.** Quarterly reconciliations of fleet cars on the road v payments now takes place. **3.** The Trust has also engaged with ELFS due to the process failing in this instance in terms of ELFS notifying the Trust when an employee who has a salary sacrifice leaves. **4.** Another measure is being explored in respect to including a tick box on the leavers/termination form to call attention to those who have a salary sacrifice.

It was reported that in September 2024 the member of staff returned to work for Alder Hey on a substantive contract and, through discussions with the individual, a repayment plan has been agreed which, after taking into account the individual's circumstances, payment will be taken over the next 40 months. It has also been made clear to the individual that if employment were to cease, the amount owed would be automatically deducted from their final salary payment.

It was queried as to why this individual did not inform the relevant department/s of the changes to his substantive employment with the Trust, and a question was raised about the onus of individuals in this situation. The Committee was advised that when this individual returned to Alder Hey via NHSP his salary remained in place, albeit for a different amount, and when this question was raised, he advised that he didn't realise that payment hadn't been taken due to his monthly salary being variable. It was reported that when an employee agrees to a lease car contract, the terms and conditions state clearly that if there is a change to employment status during the lease term, a termination fee will apply which is the employee's responsibility to settle. It is also the employee's responsibility to notify NHS Fleet Solutions to arrange collection of the car once employment has ended and payment for the car has ceased.

VM advised that a discussion had taken place with a member of the Finance Team on a previous occasion regarding a recommendation appertaining to recruitment checks *'if it becomes apparent that somebody has worked at the Trust before, whether they have*

declared it or not, then include that within the checks made via Finance to see if there are any outstanding debts'. It was queried as to whether this has been actioned, and if so, include lease cars as part of the recruitment check. RL agreed to check as to whether this recommendation has been actioned.

24/25/115.1 Action: RL

Resolved:
ARC noted the contents of the report and the actions that have been taken to mitigate future occurrences.

24/25/116 Capital Improvement Plan Update

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.

In prior years external audit existence testing has picked up a small number of items where the assets were recorded on the Fixed Asset Register (FAR), but they were found to have been disposed of. This precipitated a piece of work within Finance and Capital Teams to review items on the FAR to gain assurance that it remains valid to hold a value on the Register.

The Chair asked as to whether a complete check has been undertaken on each asset and if not, will the work be finalised by the 31.3.25? The Committee was advised that this work is ongoing and has been completed for medical equipment and IT assets, with the 'other category' assets review in progress. It was confirmed that this review will be completed ahead of the year end.

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

24/25/117 InPhase Programme (Phase 2) Update

The Committee received an update on the implementation of Phase 2 for the continued development, optimisation and support of the InPhase Risk and Incident Management system. Attention was drawn to the following:

- Eleven modules have been procured and developed, with the majority having gone live.
- An InPhase System Development Lead has been appointed and is due to commence in post on the 3.3.25. The creation of new modules and portals will be explored once the Developer is established in their role.
- It was reported that the core system is safe and that the Trust has maintained a stable system. The ultimate goals of the system are to provide greater data for safety and quality metrics and interoperability between different modules.
- Phase 2 has been split into three core themes for oversight; deployment, optimisation and relationships which are being tracked by the InPhase Board.
- A user survey has been undertaken which received good feedback. This will feed into the development pieces going forward. In respect to relationships, a meeting took place with the InPhase Account Manager and a number of goals and expectations have been agreed for 2025 to ensure that the Trust is in a position to progress its plans.

- There have been challenges developing the FTSU module, with some of the core issues relating to accessibility of data. It was reported that before any further developments can be made it is imperative that the system is completely secure and that only the FTSUG can access the information. There is also a lot of focus on the Nursing Audit Module with a number of rapid developments being undertaken to transition core audits from Tendable into InPhase.
- 17,000 incidents have been reported on the system since it went live. This is an accomplishment in terms of the positive reporting culture within the organisation, the amount of learning that has come from these incidents, and the continued engagement from staff at all levels across the organisation with the InPhase system.

The Chair pointed out that development has been delayed due to the lack of an internal development resource but, despite that, progress has been made. It was suggested that the InPhase Project Board should give some thought about having InPhase Champions so that the organisation isn't solely reliant on one person. It was agreed to discuss this suggestion with the InPhase Project Board.

24/25/117.1 Action: PW

It was also pointed out that it would be beneficial if the staff networks could be included as part of the FTSU module as this is another source where the Trust is encouraging staff to raise incidents and concerns.

24/25/117.2 Action: PW

It was agreed to provide a further update on InPhase in September 2025.

24/25/117.3 Action: PW

Resolved:
ARC received an update on Phase 2 of the InPhase Programme

24/25/118 CIO Quarterly Updates for Data Protection and Freedom of Information
Resolved:
ARC received and noted the:

- Data Protection update for Q3.
- Freedom of Information update for Q3.

24/25/119 Update on Changes to the Procurement Act 2023

The Committee received a report that provided an overview of the key changes of the Procurement Act 2023 (PA23) , and the key areas that will require review and approval from Audit Committees in relation to potential changes to Standing Financial Instructions (SFIs), waiver documentation and procurement policies.

Notices are required for all public sector contracts over £12k to alert the market that there is a contract in place for that value of spend. The Procurement Team is required to put in place an internal process to ensure that Notices are published for all contracts with a value of more than £12k. Following a piece of work that was undertaken to determine whether the Trust should reduce its SFI limit from £20k to £12k, it was found that this would detract Procurement from some of the more strategic high value contracts, therefore it was recommended that the Trust should leave the limit in the SFI's at £20,000 for competitive quotations but implement new internal processes for the Operational Services Team to ensure expenditure and Notices are published in line with the requirements for spend between £12,000 and £19,999 and £20,000 and £49,999.

The Chair queried as to whether Health Procurement Liverpool (HPL) will provide an update on the impact of this change. It was confirmed that a report will be submitted to the Committee in six months' time.

It was pointed out that the Trust's level of retrospective requisitions (waivers) is higher than other trusts therefore it is important to bring these two areas of work together to ensure HPL are aware when a Transparency Notice is required.

For noting
ARC supported the recommendation made in the report on page 7.

The Committee was advised that consideration needs to be given to updating the Trust's Waiver Form to reflect the new reason codes for entering into a direct award or awarding a contract to a particular supplier without competition.

The Chair asked for the next Waiver Report to show which waivers are supported by HPL, and to track the retrospective waivers in order to gauge impact.

24/25/119.1 Action: KT (via EK)

For noting
ARC agreed the action to update the Trust's Wavier Form to reflect the justifications set out in the new Procurement Act for single tender action and for this to be reflected with the Trust's SFI document, as detailed in page 9 of the report.

The Committee was informed that the Trust's SFIs will need to be updated to ensure any reference to the current Public Contract Regulations (PCR) is removed and updated to reflect the requirements of the Procurement Act 2023. Coupled with that is the update to the Procurement and Tendering Policy.

For noting
ARC agreed for the 1. Trust's SFIs and Scheme of Reservation and Delegation (SORD) to be updated to ensure the requirements of PA23 are detailed. 2. Procurement and Tendering Policy to be updated to reflect the new processes/
procedures and to provide guidance for colleagues across the organisation.

MEAT versus MAT – It was reported that under PCR, a contract award should be based on the most economically advantageous tender (MEAT), whereas PA23 moves to awarding the most advantageous tender (MAT). HPL has advised that trusts should be assessing cost and quality as part of its procurement process and only in exceptional circumstances where there is a pre-agreed strategy would cost be dropped. It would also need to be signed off by the organisation.

For noting
ARC approved the recommendation to leave price as a key factor of the tender evaluation process and guidance as part of the Trusts Procurement and Tendering Policy, however noting the option to remove this on a case-by-case basis.

Resolved:
ARC noted the update on the changes to the Procurement Act 2023 and approved the recommendations made by HPL.

24/25/120 HPL's report on Procurement Workstreams and Subsequent Procurement Action Plan

As part of a drive to deliver greater efficiency in year, FTPC and the Sustainability Delivery Group (SDG) commissioned HPL to conduct a deep dive into procurement activity as part of the Trust's Sprint Programme designed to drive out further savings in year. HPL were asked to review current practices and raise recommendations for improvements, as well as compare Alder Hey's performance with other trusts serviced by HPL to benchmark performance.

An overview of the findings/next steps were shared with the Committee, and it was reported that there's an action tracker in place that is being overseen by FTPC and SDG. The Chair asked members if they required any additional assurance in relation to this ongoing work. It was pointed out that ARC receives a report on waivers and is able to challenge in the event of a downturn in performance, but it was asked that an update on the progress of the procurement action tracker be included in FTPC's 2024/25 Annual Report.

24/25/120.1 Action: RL

The Chair felt that progress has been made as a result of the work that has been undertaken, and that the Trust should start to see a reduction in waivers.

Resolved:
ARC noted the contents of the report and the proposed ongoing reporting against the procurement action tracker to both SDG and FTPC.

24/25/121 Review of the Audit and Risk Committee Terms of Reference, Work Plan, and Schedule of Meetings for 2025/26

In accordance with good practice, ARC regularly reviews its Terms of Reference (ToR) and Work Plan. This year, the Meeting Schedule has also been reviewed to include an additional meeting because in 2024/25 the agenda for each meeting was full leaving little time for wider debate and horizon scanning. Attention was drawn to the following points:

- ToR to be reviewed annually rather than on a six-monthly basis.
- Meetings are to take place in September and December (replacing the current October meeting).
- Ernst and Young to produce an Interim Report on the audit, and in conjunction with the Finance Team provide greater detail on the planned work in terms of when information is required from the Trust and when an EY junior/senior review happens. It was confirmed that the submission of the Interim Report will be for information/comment purposes only and not for approval.

The Committee was advised of the change of the named NED lead for EPPR from ARC Chair to SQAC Chair and it was queried as to whether the Annual Report for EPPR should now be submitted SQAC with assurance provided to ARC via SQAC's Annual Report. The Committee confirmed their agreement to the change in reporting.

Reference was made to the Work Plan, and it was pointed out that April's meeting is too quick of a turnaround for the Risk Management Annual Report and the Clinical/Non-Clinical Annual Report to be submitted to the Committee. It was agreed to update the Work Plan to reflect a June submission for both reports.

24/25/121.1 Action: KMC

Resolved:
The Committee confirmed their approval of the updated ToR, Work Plan, and Meeting Schedule.

24/25/122 Audit and Risk Committee Effectiveness

Since the completion of the last full assessment there are two new ARC Members as well as new Attendees therefore it was felt that it was timely to undertake a full self-assessment of the Committee's effectiveness. All Members and Attendees (including external Attendees) of the Committee were invited to complete the questionnaires. The Committee was provided with an overview of the outcome of the evaluation questionnaires and a discussion ensued to determine and approve the required actions, as detailed in section 3.2 of the report. The following points were raised:

- *External Inspection Reports (Committee is asked to consider whether it needs to review external inspection reports, or if these are being adequately considered by other Committees)* – It was reported that a piece of work is being undertaken which is focussing on areas of the organisation that are subject to additional scrutiny from a regulatory body, in order to ensure that the Trust has full oversight of all external visits. ES agreed to submit an update once the work has been concluded to enable ARC to consider whether there any additional external reports that need to be reviewed by the Committee.

24/25/122.1 Action: ES

- *Third Party Assurance (Committee is asked to consider if there are any third-party service providers for which assurance is required)* – A discussion took place about whether the Committee should be receiving Third Party Assurance from its providers. It was pointed out that it would be difficult to capture assurance from all providers, but it was felt that it is important to receive assurance from organisations who provide critical business systems to Alder Hey. Reference was made to Mersey Care, Mitie, and the SPV in terms of ARC receiving Third Party Assurance from these companies. It was agreed to discuss this matter further outside of the meeting.

24/25/122.2 Action: KB/ES/RL

The Chair queried as to whether the Trust should be receiving Third Party Assurance from HPL. MIAA confirmed that this should be the case therefore it was agreed to liaise with HPL to request a report going forward.

24/25/122.3 Action: RL/EK

- *Relationship between ARC and the RMF (Committee is asked to consider and discuss how the relationship with the RMF should improve)* - As no comments were provided as to what might be improved, the Chair advised that this issue will be closed unless any comments/views are received.
- *The Committee is asked to consider how it minimises the potential of straying into management of risks* – A specific agenda item has been included on the ARC Work Plan relating to horizon scanning and risk anticipation to ensure the Committee addresses more strategic elements. The Chair also asked that Members and Attendees flag within meetings if it is felt that discussions are straying into management of risks rather than oversight.
- *Committee to understand if there are actions required for late or missing assurances* – The comment received was unclear as to whether an action was required. The Chair advised that this issue will be closed unless any comments/views are received.

- *The Committee is asked to agree what information is needed from Clinical Audit and/or SQAC in relation to the effectiveness of Clinical Audit to discharge its duties in relation to Clinical Audit*) – ARC is overall responsible for overseeing the effectiveness of Clinical Audit, but oversight is provided by SQAC, as per the SQAC ToR. SQAC provides assurance as to the effectiveness of Clinical Audit via its Annual Report. It was reported that JRO is undertaking a piece of work to review the format of Clinical Audit reports using a Brilliant Basics approach. Therefore, rather than having a debate during the meeting it was agreed that JRO, as part of the review of the reporting, will look at how best to report to SQAC and ARC, and submit a proposal.

24/25/122.4 **Action: JRO**

Resolved:
ARC approved the actions in section 3.1 of the report. As per the discussions relating to section 3.2 of the report, the Chair agreed to incorporate the agreed actions into an action plan and track it going forward.

24/26/123 Review of the Effectiveness of; Internal Audit, External Audit, and Counter Fraud Service

The Committee was provided with a suggested questionnaire for reviewing the effectiveness of the Counter Fraud Service (CFS) as well as a single question for a "light touch" review of Internal (IA) and External Audit (EA), of which both have been slightly updated since originally presented in April 2024. Whilst questionnaires to review the effectiveness of IA and EA are easily sourced publicly and from peer organisations, no such questionnaires were found for CFS therefore a questionnaire has been drafted using questions adapted from the IA and EA questionnaires and by reference to the work undertaken by CFS as referenced in its 2024/25 Annual Plan.

The Committee confirmed its approval of the proposed CFS questionnaire and did not request for any changes to be made.

Resolved:
ARC approved the proposed CFS questionnaire.

24/25/124 Accounting Policies; including Update to Corporate Governance Manual – Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD)

The Committee received a report advising of key accounting issues which may arise during the preparation of the Trust's Annual Accounts and to inform of the accounting policies adopted in the preparation of the Annual Accounts. The following points were highlighted:

Accounting Policies

- *Valuation of Work in Progress (Capital)* - Certificates are to be provided by Quantity Surveyors as close to the 31.03.25 as possible for all major capital projects to ensure an accurate valuation of work is completed for the year end accounts. Where assets have been purchased but have not yet been received on site, Vesting Certificates will be supplied which will demonstrate ownership by the Trust.
- *PFI Capital Payments* - As per the 2023/24 accounts a payment was made to the SPV under the contractual variation process for the Elective Hub. Work has continued on this project throughout 2024/25 with the intention that all work

would be completed by 31.03.25, however due to building and structural issues outside of the Trust's control, delays have been incurred which poses a risk to the works being fully completed as intended. Early discussions with the auditors indicate this is unlikely to cause an issue in the 2024/25 accounts.

The Chair raised a number of questions that were responded to positively about whether the Trust has commissioned independent surveyors to undertake valuations, whether it is likely there will be any material/value issues, and if there are any foreseen areas of the audit that may be problematic.

Reference was made to the large piece of IFRS16 work that was undertaken as part of the 2023/24 audit and it was queried as to whether this process is now a standard element of the audit that won't incur any additional fees. DS explained the reason behind the additional fees in 2023/24.

Corporate Governance Manual

Given the 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 portfolios over recent times, an in-depth review of the Corporate Governance Manual has been completed. The following key points were highlighted:

- There has been an update to 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 may be subject to change ahead of Board approval, as SDG have requested further information from HPL around the number of contracts that are likely to require approving at each approval level. If the volumes of contracts are deemed to be too high by SDG an alternative approach may be taken, for example, approval outside of meeting, with retrospective reporting to relevant committee on a quarterly basis.
- Procurement limits for requisitions have been updated to simplify governance processes 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.
- A section has been included 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. 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.

The Chair thanked EK and the team for the work that has taken place to update the Corporate Governance Manual. It was requested that the Committee be provided with an overview of any changes following the six-month review of the amendments to the document. In terms of communicating the changes to the organisation it was reported that this information will be updated on the Finance page on the intranet and briefing sessions will take place via Divisional/Corporate Service Collaborative meetings.

24/25/124.5 Action: EK

Resolved:
ARC approved the amendments made to the Trust's Corporate Governance Manual and recommended that the document progress to Board for final approval.

24/25/125 Any Other Business

There was none to discuss.

24/25/126 Meeting Review and Forward Look to the Next Meeting

The Chair offered to provide a debrief to the Trust's governors who were observing January's meeting, if required.

Date and Time of the Next Meeting: Thursday 17th April 2025, 2:00pm-5:00pm, Room 14.

Finance, Transformation and Performance Committee
Confirmed Minutes of the meeting held on Tuesday 25th March, 1pm on Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive Director	(SA)
	Dame Jo Williams	Non-Executive Director	(JW)
	John Grinnell	CEO	(JG)
	Adam Bateman	Chief Operating Officer	(AB)
	Rachel Lea	Interim Chief Finance Officer	(RL)
	Melissa Swindell	Chief People Officer	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Pauline Brown	Director of Nursing	(PB)
	John Chester	Director of Research & Innovation	(JC)
	Amanda Graham	Executive Assistant (notes)	(AG)
	Dani Jones	Chief Strategy & Partnerships Officer	(DJ)
	Emily Kirkpatrick	Deputy Director of Finance	(EK)
	Andy McColl	Deputy Director of Finance	(AMC)
	Natalie Palin	Associate Director Transformation	(NP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Gary Wadeson	Associate Finance Director	(GW)

24/25/177 Apologies
Apologies were noted from:

Nathan Askew	Chief Nursing Officer	(NA)

24/25/178 Minutes from the meeting held 24th February 2025.
The minutes were approved as a true and accurate record of the meeting.

24/25/179 Matters Arising & Action Log
The action log is to be reviewed outside the meeting due to time constraints.

24/25/180 Declarations of Interest
There were no declarations of interest.

24/25/181 Top 5 Risks
RL presented an overview of the top Five risks:

1. **Immediate financial performance including system position**
   Ek advised that work on Year End was now underway. (System position discussed within Annual Plan item).

2. **Capital Programme**
   RL gave a brief overview of year-end capital forecasts, potential overspending, and management strategies and also confirmed a £1.4m capital award for PV installations.

3. **Efficiency Programme**
   Concerns were raised about sustainable transformation efforts and achieving CIP targets through growth or cost reduction. Focus to be on reducing pay costs early in the year to avoid lagged impacts on financial performance.

a. Updates were given on Mars applications (currently 58) and identifying opportunities for reduction in headcount by reviewing management costs, non-clinical, bank & agency.
b. Challenges in balancing workforce reductions with operational needs were discussed, covering zero bank & O/T in non-patient facing & nursing bank expenditure.
c. Further cost-reduction options were discussed including a package around facilities; a review of 90% non-patient facing expenditure limits; and medicine optimisation (switches & wholly owned subsidiary options).

4. Benefits realisation, governance and prioritisation of change programme to 2030

NP gave a brief presentation on transformational programs, highlighting the need for robust benefit realization plans.
Concern was raised over the pace and specificity of collaborative plans to achieve CIP targets, along with the sustainability of some transformation programmes, emphasizing the need for achievable benefit realization and alignment of objectives.

5. The Campus & Park developments

Updates were given on key projects and discussion on asset write-offs. Neo-Natal and Alder Park build projects were reviewed with issues flagged in relation to valuation accuracy.

24/25/182 Finance Report

Month 11 Financial Position

EK gave an overview of the financial position as at M11, noting the following:

- Currently off plan by £0.4m, including funding of £0.5m that has been received towards the pay award gap
- Divisional slippage due to non-pay pressures, ERF and confirmation of values around central income including the Spec Comm top-up. Deterioration offset by extra funding from ICB, some Rev to Cap distribution, and mitigations from the Financial Improvement Programme (FIP) including review of commercial income and improvements within Corporate & Community Divisions
- Balance sheet review continues
- ICB have been advised that the remaining gap can only be closed by resolving several issues

RL noted that given what is known about next year and dependent upon the final position, a review will be undertaken on any risk going into next year.

Resolved:
FTPC received and noted the M11 Finance report.

24/25/183 Month 11 Integrated Performance Report

The report was included within the pack; AB gave a brief overview, highlighting the following points:

- Expecting that by year end the 52WW number will have reduced from 800+ to ~314
- Spinal surgery, ENT & Dental have all reduced their waiting times
- ED performance has been very good over the year, with the department at 4th in the top ten best performing EDs in the country and expecting to receive a share of a capital incentive (value tbc).

- Proposal to establish first same day emergency care (SDEC) facility for children in the country below the new NICU – this will be brought to a future meeting for full discussion as it is asking for more investment and currently will cost more than savings. More benefits and higher risk appetite for reducing ward capacity are being worked on.

24/25/183.1 AB to bring SDEC proposal to May meeting for discussion & approval
Action: AB

Resolved:
FTPC received and noted the M11 Integrated Performance report.

24/25/184 **Annual Plan**

JG noted that the current situation was very finely balanced, with submissions due in within 24 hours. It is recognised that the Board will need to review the Plan but with the figures only just being shared it maybe best to caveat them ahead of the Extraordinary Board session to give the scrutiny required in the quickly changing environment.

RL presented slides and gave a brief update, noting that it was a very live, fluid position but there should be enough to give detail & assurance to the Board. Discussion took place regarding any remaining system gap and allocation across providers based on risk share in comparison to the control total set at the start of the planning process.
JK asked whether discretionary drug spend is to be capped, or that there is an assumption of no inflation; RL responded that the assumption is that inflation won't be above the national tariff; there is now a Medicines Optimisation workstream to manage and keep spend within inflation assumptions.

JW noted some concern regarding chargeable capital expenditure, EK noted that this will need to be confirmed capital spend.

JK questioned the accuracy of forecasting in the Divisional plans when comparing the Annual plan to M12 position.

AMC commented that historically there has been growth from business development and income generation; the opportunity to deliver CIP through NHS contract income has been curbed so CIP must be achieved by cost reduction, in particular pay reduction. However ,while pay reduction changes are being made now, the impact won't show until later in the year.

Also, another key risk is the agreement in principle to move to standard premium rates across the ICB due to the impact on delivery of service delivery and access. Finally ,a challenge was noted in relation to workforce plans across the ICB.

JW noted a risk regarding future pay award and funding. JK asked whether it is fully funded in the current plan. RL responded that assumption currently pay award cost is in line with funding until further detail is known.

Resolved:
FTPC received and noted the Annual Planning update.

24/25/185 **Board Assurance Framework**

ES noted that the BAF update was within the meeting pack and there was nothing specific to be raised; however a meeting is due to take place with RL to review all risks in light of today's discussions.

Resolved:
FTPC received and noted the risks recorded within the Board Assurance Framework.

24/25/186 Any Other Business

- **Debt write-off paper** – this paper was circulated by email after the meeting for virtual approval.

Resolved:
FTPC received and approved the Debt Write-off paper virtually.

24/25/187 Review of Meeting

The Chair noted how useful it had been to review the Annual Plan content which gives an understanding of everything being down and how it is brought together; it was also noted that the discussion around growth & funding was important.

Date and Time of Next Meeting:
Monday 28th April, 1pm, VEC room, Innovation Hub (F2F Divisional updates)

24/25 FTPC Key Risks – Month 12 Position

Alder Hey Children's NHS

	Initial Risk	Initial RAG	Latest Position	RAG M12
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 12 position reported £1.5m surplus to plan in month and a £3.3m surplus to plan for the year. In month Corporate were off plan largely due to non-pay pressures. Despite the trust having signalled to the ICB at M11 significant risks to the delivery of the £3.3m target (c£1m), a number of mitigations materialised in M12 which supported the achievement of the £3.3m plan. The mitigations were specifically around additional ERF income, procurement rebate, review of SPV deductions due, and further balance sheet opportunities.	Green
Capital Programme	Limited CDEL allocation in 24/25 Significant capital investment required, and prioritisation required.	Medium	Month 12 Capital position reported in line with external forecast for the year (e.g. in line with expectations from NHSE/ICB). As at M11 the trust were internally reporting a risk of forecast overspend of circa £1.5m. This was mitigated due to reduced in year spend on Neo (circa £1m lower that forecast), Alder Park (circa £0.2m) lower than forecast, and lower spend on a number of smaller schemes. The impact of lower 24/25 spend has been included in the plans that are progressing for 25/26.	Medium (due to impact on 25/26 plan)
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	In-year CIP has been achieved in full at M12. Recurrent CIP achieved for the year is £13.9m (green schemes) and remains 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

Proposed risks – 25/26

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG
Immediate financial performance Trust and system position (revenue and capital)	Challenging 24/25 revenue plan for AH with rev to cap stretch included. Risk increased costs and inability to deliver activity plan and/or deliver on ambitious CIP programme. 24/25 Capital plan is constrained by CDEL available in the system, and AH plan is contingent on securing £1.8m UEC Funding. Risk of increasing costs in Neo and limited availability of funding for new capital requirements/medical equipment. System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High
Efficiency Programme development and delivery	Plan assumes delivery of £22.7m recurrent savings. Highest level set in any one year. Delivery contingent on both BAU and transformation savings	High
Productivity and benchmarking	National focus on productivity and benchmarking to drive down costs. Efficiency programme contingent on driving up productivity in order to reduce costs (recognising that ERF is likely to be capped)	Medium
Transformation including benefits realisation, governance and prioritisation of change programme to 2030	New benefits realisation framework launched to ensure delivery of benefits across all programmes.	Medium
Campus	Complex campus programme across multi sites, with several key buildings opening in year (Neo/Alderpark).	Medium

OUR PLAN
INSPIRED BY CHILDREN

BOARD OF DIRECTORS

Thursday, 1st May 2025

Paper Title:	**Board Assurance Framework (BAF) Report March 2025**
Report of:	Erica Saunders, Chief Corporate Affairs Officer
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 March 2025.					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	Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.	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 given the current operating environment	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 15th April 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 RL	Building and infrastructure defects that could affect quality and provision of services	FT&P	4x3	2x3
1.4 LC	Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.	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 given the current operating environment	FT&P	**4x4**	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 March 2025 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  This risks and controls have been reviewed as stetted. The risk 1.1 will be undergoing a large scale review following submission of the annual plan and in the context of the changing landscape.

- ***Lack of visibility at Board level across the Gender Service (LC).***
  BAF risk reviewed and actions are up to date.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  Continuing to see patchy improvement of medication availability but still no real consistency, so still under monitoring. Full review needed for the end of April.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  The trust achieved the national access targets that were set at the start of 24/25.
  Zero patients waiting over 65 weeks - achieved
  278 patients waiting over 52 weeks - exceeded, ended the year on 241
  78% 4 hour ED performance - exceeded, ended the year on 79.6.

  By achieving and exceeding these targets we are gradually reducing waiting times. Over the next 12 months the trust will aim to increase the number of patients waiting <18 weeks by 5% and have no more than 1% of the RTT waiting list waiting over 52 weeks for treatment.

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***
  Meetings with Project Co-partners and execs over corroded pipework have taken place to discuss the future repair/replacement of the affected areas. Th trust have received further correspondence on the matter and are taking advice on next steps. Exec representatives are aware of the issue and involved in discussions with Project Co Directors.

  Out-of-range water temperatures continue to be monitored, and local mitigations are in place such as filters on water outlets. New updates and proposals recently discussed at water safety group. Review being undertaken by new Mitie director and changes to the AE/AP for water are awaited.

  Water safety group meetings held alongside operational groups to monitor progress.

  Internal AH staff pipework meetings have also taken place.

  Dosing system is now on hold due to improved controls.

- ***Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services. (LC).***
  BAF risk reviewed and updated version to include digital issues. Control added regarding use of BI dashboards to help manage open caseload. An action has been added regarding task & finish Expanse group, and training for administrative staff.

The ROMS action as been closed as completed and new action added regarding improving compliance. All other actions on 1.4 are updated/in date.

- ***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 - actions on track and aligned to priorities set out in the people plan 2030. Workforce plan (numbers) submitted for the year to match the financial submission, with divisional people plans outlined as part of annual planning. Financial challenge and plans reviewed through workforce efficiencies and decision document through to tactical command. Sickness target adjusted from April 2025 to 4.5% (2% short term; 2.5% long term).

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).***
  Risk reviewed. All actions reviewed and updates made to actions relating to Data insights (to reflect progress in the Thriving Staff Index) and Values following approval of new Trust values at Board. No change to risk rating.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risks reviewed and actions are on track. Progress is being made. The Head of EDI will commence fulltime at the Trust as of the 1st May 2025.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk Reviewed. No change to score. Phase 3 remains on target for completion Dec 2025.

- ***Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (KW).***
  The increased financial targets present a heightened risk to the achievement of the 2030 Vision, as quantified financial benefits have not yet been fully validated. Until greater specificity is established around confidence and achievability, this remains a key risk. To support delivery, five Collaborative 3 programmes have been established, with SRO roles assigned to each of the Divisional Directors. As of March/April, each collaborative has been asked to produce updated financial forecasts to support the assessment of potential benefits and delivery risk. In parallel, a Transformation Programme Board is being established to provide oversight and governance, ensuring alignment with strategic priorities and financial targets.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***
  No change to risk score. Risk reviewed but following draft plan submissions for 25/26 and emerging changes, the BAF risk will be reviewed and updated in full once known. Actions currently in here remain on track.

- ***System working to deliver 2030 Strategy (DJ).***
  Continued strategic engagement with CYP system continues as well as close monitoring of the evolving national landscape in light of NHSE reforms and the forthcoming 10-year plan but no change to the overall score.

- ***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. 3 outstanding actions remain which include recruitment of the Futures comms post, the development of a Futures comms strategy (delayed by not having someone in post) and sign off of the IZ funding agreement. Overall review of risk underway in line with updated targets for new financial year. Score remains 9.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***
  Risk reviewed score remains at same level. Recruitment of key roles still in progress but expected to be completed in April. Workforce and cost reduction plans to be developed and presented to Execs in the same month. Plans being finalised for EPR development including Business Case to support the transition to the next version of AlderCare. AI Strategy supported at Futures Committee and supporting Digital and Data strategy to be reviewed by relevant committees in April.

5. Corporate risks (15+) linked to BAF Risks (as at 14th April 2025)

There are currently 22 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
2450	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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post.	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
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
027	Fragility of Inherited Metabolic Disease Service (IMD)	3x5	Medicine	2.1	Jun 2023	Dec 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
298	ED Reception Support ***(NEW)***	4x4	Medicine		Dec 2024	Feb 2025
271	Safeguarding Nursing Team Capacity	5x3	Community	2.1	Nov 2024	Nov 2024
288	CAMHS Planned Safeguarding Supervision	3x5	Community	2.1	Nov 2024	Nov 2024
341	Named Doctor for Children in Care ***(NEW)***	4x4	Community		Apr 2025	Apr 2025
335	Radiology Report Addendums are not visible on Meditech ***(NEW)***	3x5	Medicine	4.2	Mar 2025	Mar 2025
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
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)						
	None					
1.4 Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services. (3x5=15)						

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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=16)						
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
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
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	1.1	Apr 2023	June 2024
2100	Risk of inability to provide safe staffing levels due to absence.	4x4	Business Support	1.1	Jan 2020	*Apr 2023
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post.	4x4	Medicine	1.2	Feb 2023	Oct 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	1.1	May 2022	Oct 2024
271	Safeguarding Nursing Team Capacity	5x3	Community	1.1	Nov 2024	Nov 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
288	CAMHS Planned Safeguarding Supervision	3x5	Community	1.1	Nov 2024	Nov 2024
027	Fragility of Inherited Metabolic Disease Service (IMD)	3x5	Medicine	1.2	Jun 2023	Dec 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
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 (4x2=8)						
	None					
3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (4x4=16)						
	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
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						

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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 (4x4=16)						
229	PIMP end-of-life server which is no longer supported by the supplier	4x4	Business Support		Jul 2024	Sep 2024
292	Inappropriate sharing of demographics ***(NEW)***	5x3	Business Support		Dec 2024	Dec 2024
335	Radiology Report Addendums are not visible on Meditech ***(NEW)***	3x5	Medicine	1.1	Mar 2025	Mar 2025

* 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, Chief Corporate Affairs Officer

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

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..

Apr 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	April 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.
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

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.

Apr 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	April 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	30/06/2025
Maintain UEC Standards	The UEC Standards have previously being recovered to be achieving in line with national targets. The following actions are to be delivered to maintain achievement throughout Winter 2024/25: 1. Maximise utilisation of the expanded capacity delivered withi the Paediatric UTC. 2. Working with system partners to deliver measures to prevent unnecessary attendance to ED 3. Reviewing pathways and assessment working to ensure admission avoidance is being maximized where possible through PAU and Virtual Ward 4. Reviewing internal processes for capacity and flow management to ensure optimal utilisation and effective escalation 5. Supporting staff health and wellbeing through the roll out of the vaccination programme and proactive sickness management 6. Planning for 2025/26 through the business case for expanding the ground floor urgent and emergency services, designing the Same Day Emergency Care Pathways to avoid future admission, promotion of the RSV vaccine and system working	31/03/2025

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		Rachel Lea

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

Apr 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	April 2025 Due Date	Action Update
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	30/11/2025	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.

Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.

Risk Number	Strategic Objectives
1.4	Outstanding care and experience

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

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

Description

Since 2020 there has been a significant increase in demand for Specialist Mental Health Services at Alder Hey, which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours, there has also been an increase in the clinical urgency of referrals received.

This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.

Apr 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 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; 2) Challenges with visibility of clinical risk and safeguarding information via the electronic patient record (EPR) to enable services to safely manage clinical risk and need without workarounds

Action	Description	April 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.	30/09/2025	
Meditech Expanse – Task and Finish Group	Task and finish group commenced to review EPR changes required following CQC inspection.	03/04/2025	
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/05/2025	
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	
Administration training	Training needs analysis to be completed following issues identified w/c 24 Feb 2025 within admin teams issues with booking and scheduling of appointments, validation and closure of activity training needs analysis and training plan to be arranged in conjunction with clinical systems training team and validation team	31/05/2025	
ROMS collection and reporting	Improve recording and reporting of routine outcome measures	30/06/2025	

Lack of visibility at Board level across the Gender Service

Risk Number	Strategic Objectives
1.5	Outstanding Care and experience

CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
Safe Effective Responsive		Lisa Cooper	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.

Apr 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	April 2025 Due Date	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.

Apr 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	April 2025 Action Update
Risk 236 - Action 1	Engagement with suppliers to increase knowledge and seek support.	30/06/2025	Work with suppliers and feedback from local pharmacies and parents/carers appears to suggest that supplies are starting to come through more consistently in the past couple of weeks. This remains patchy but is showing signs of some improvement.
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.	09/09/2025	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	08/07/2025	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

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

Apr 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 intranet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Apprenticeship Strategy implemented	Annual update to PC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to 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	April 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	A 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

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.

Apr 2025	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports Bi-monthly reporting to PC
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PC (agendas and minutes)
Values and Behaviours Framework	Stored on Trust Intranet and accessible for staff
People Pulse results to People and Wellbeing Committee quarterly	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 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 PC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC bi-monthly
Regular Schwartz Rounds in place	Steering Group established
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to PC
Alignment of staff safety and patient safety work via developing safety culture training and developing Restorative Just & Learning culture strategy	Patient Safety Board minutes
Monthly Thriving Teams MDT established comprising all corporate support functions who work with teams. Chaired by Associate Director of Organisational Development and enables shared thinking about teams in need of support and joint working where indicated.	

Gaps in Controls / Assurance

- lack of embedded safety culture across the organisation
- lack of understanding about a just and restorative culture approach
- lack of consistent compassionate leadership
- Inconsistent application of Trust values and behavioural framework
- insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas
- insufficient OD resource available to fully address all culture tensions and challenges when they arise

Action	Description	April 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.	30/09/2025	Clinical leads work to be progressed in conjunction with Directors of People and Transformation to align next steps with overall transformation programme and workforce efficiencies. Inintial meeting planned for 9th April to agree next steps and align work to broader leadership and management review. .
Values and behavioural and implementation	New values and behavioural framework to be developed and . embedded across the organisation	31/07/2025	New values (Compassion, Courage, Commitment, Community) agreed at Trust Board on 3rd April. Full implementation plan to be developed and values working group to be established to progress this.
Safety culture programme	Safety culture programme of work to be agreed and developed with the Patient Safety leads and Chief People Officer to reflect need for an integrated safety culture including both patient safety as staff safety as key to an adaptive safety culture. Safety culture training to be developed and implemented with teams as part of this wider programme to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors	01/05/2025	Meeting with Patient Safety Lead to agree draft Safety Culture decision socument and to review safety culture data from staff survey. Agreed he will arrange a meeting to discuss and agree with CMO/CNO/CPO. Safety Culture training proposal Being recosted to be resubmitted for approval as a key part of the wider programme of work. No further progress with this action. Proposal still with Execs and resource to be agreed for the delivery of the training. Meeting held to loo at integration of safety culture training and STAT programme running in theatres. Further meeting to be arranged by Patient Safety Lea to be confirmed.
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	30/05/2025	February AEH workshop cancelled and rearranged for 30th April 2025. Second AEH workshop to be held on 12th February with HR team with a view to a 3rd workshop to be held with HR and staffside to be coordinated by the Deputy CPO.
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	Action parked in view of current financial situation. To be reinstated at a leter date.
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.	03/09/2025	Thriving staff index complete and to be implemented at the end of April. Initial period of evaluation post impementation to assess effectivemness of the tool and enable measure to be adapted if needed. Thriving Teams Index still in development requiring further discussion with CPO and CEO.

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

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

Apr 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	Mandatory EDI Training for all staff. current compliance above Trust target of 90%.
Head of EDI (0.6wte) in post. joint post with Clatterbridge Cancer Centre.	
Actions taken in response to Gender Pay Gap	
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 PC
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 PC.
NHS England Improvement Plan supported by Trust Board, and associated actions into action plan	NHSE EDI Improvement Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 3 of delivery, continues to include a focus on inclusive leadership
EDI Steering Group established - Chaired by NED	Minutes reported into PC
actions taken in response to the Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to EDS22	Reported to People 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	April 2025 Due Date	Action Update
1. Multi-factoral issues spanning training and education	Education and training programme launched. Conversations underway to implement EDI training as mandatory	31/03/2025	
2. Sufficient EDI resources to support the EDI agenda	Business case for additional resource to be developed.	31/03/2025	
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.

Mar 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	March 2025 Due Date	Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	30/11/2025	Meetings will continue with LCC until full legal agreement of transfer of Park to the Council.
Adoption of the SWALE by United Utilities	Engaged with planning consultants to assist with planning requirements.	09/05/2024	
Funding availability and potential market inflation	Continual monitoring of market inflation	30/04/2025	Regular updates continue to be provided to RABD and Trust Board as appropriate
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	30/04/2025	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves: 1) Vacate 3SM & move staff to former police station and other (Summer 2024) 2) Vacate Histopathology and mover staff to alternative accommodation (Winter 2025)	28/02/2025	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell
Weather conditions causing potential delays	Dry season now upon us – all works now in accordance with revised programme and on target.	30/11/2024	

Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment.

Risk Number	Strategic Objectives
3.2	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	8	Finance, Transformation & Performance Committee

Description

Risk of failure to: continue to deliver the ambitions of Vision 2030 given multiple competing demands of the system coupled with variable capacity, balancing short-term versus long-term decision making on priorities and investment.

Apr 2025

Control Description	Control Assurance Internal
Portfolio Board	Benefits tracker
Executive sponsor roles within the programme	
Transformational collaboratives with Divisional SROs	Programme assurance framework
Operational Plan incorporates Vision 2030 deliverables (2025/26)	Operational Plan
Executive Portfolios all incorporate elements of Vision 2030 delivery	
Reports to Board and FTPC	
Assurance and support mechanism framework for transformational collaboratives	

Gaps in Controls / Assurance

1. Shift of focus to meet demands
2. Failure to develop capacity for delivery
3. Failure to build capacity and skills within our workforce to deliver 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	April 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	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.

Apr 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	Due Date	April 2025 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	23/24 Capital Plan submitted un final plan. Due to changes in CDEL limits for the future years, further work is ongoing the next 3 years including a review with each capital lead. This work will be compete and presented to Exec Team early June and reported back through FTP and TB once full risk is known.
Devolved specialist commissioning	3. Regular reporting to strategic execs and assurance to FTP and Trust Board Financial Analysis required to understand risk	31/03/2025	
High risk recurrent Efficiency programme	6. transformation efficiency schemes now in place and monitored through Sustainability 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.	30/09/2024	Annual planning process complete and bridge completed by division. However further delays to the completion of LTFM and the productivity work has resulted in this not being completed in the time-frame initially set. This will form part of the 2030 financial strategy to be completed in Q2.

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

Risk Rating		
Actual	Target	Assurance Committee
16	9	Trust Strategy Board

Description

Risk of inability to control execution of 2030 Vision due to system complexities, constantly evolving statutory environment, new Government and operational planning guidance.

Risk of failure to secure sign up from partners to engage in a new Strategy for CYP given the wider NHS context and competing priorities.

Potential failure to land our 2030 Strategy with key partners within the wider system impacting on our reputation and long-term sustainability.

Risk of poor relationships and strategic connection at Place, leading to mis-alignment of priorities and inability to execute Vision 2030.

Risk of lack of focus on CYP agenda in febrile system environment; leading to lack of pace, resource and investment.

Apr 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	April 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	Ongoing influencing of Commissioning Plans – CYP strategic commissioning plan in development via CYP Committee with ICB – March 25
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	Horizon and policy scanning ongoing – presentation at Dec 24 Trust Board, and within monthly Board 'CYP System' item Jan/Feb/Mar 25
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

Risk Rating		
Actual	Target	Assurance Committee
9	6	Futures Committee

Description

Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships – which would delay new discoveries.

Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities.

Risk of exposure to ethical challenges and national and international reputational risks.

Apr 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	April 2025 Due Date	Action Update
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	IZ award supported by Futures Committee and Trust Board – awaiting final sign-off of agreement with LCR Combined Authority
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	Comms post interviews delayed until and of April due to large number of applications
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	Interviews delayed until late April due to large number of applications.

Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families

Risk Number	Strategic Objectives
4.2	Revolutionise Care

CQC Domains	Linked Risks	Owner
		Kate Warriner

Risk Rating		
Actual	Target	Assurance Committee
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.

Apr 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	April 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	