BOARD OF DIRECTORS PUBLIC MEETING
Thursday 6th March 2025, commencing at 12:30
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
Lunch (12:00pm-12:30pm)							
1.	**24/25/327**	**12:30 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**24/25/328**	**12:31 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**24/25/329**	**12:32 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **6th February 2025.**	**D**	Read enclosure
4.	**24/25/330**	**12:34 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**24/25/331**	**12:35 (10 mins)**	**Chair's/Chief Executive's Update.**	Chair/ J. Grinnell	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**24/25/332**	**12:45 (10 mins)**	**Vision 2030 Strategy Progress Update.**	K. Warriner	To receive an update on the deployment of Vision 2030.	**A**	Verbal
7.	**24/25/333**	**12:55 (10 mins)**	**C&M System Wide Issues Update.**	D. Jones	To receive an update on the current position.	**N**	Presentation
Operational Issues							
8.	**24/25/334**	**13:05 (15 mins)**	**Integrated Operational Plan, 2025/26.**	A. Bateman	To receive and approve the final version of the Trust's Integrated Operational Plan for 2025/26.	**D**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
9.	**24/25/335**	**13:20 (40 mins)**	**Evidence of Our Performance:** • **Flash Report, M11.** • **Integrated Performance Report for M10, 2023/24:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.**	A. Bateman N. Askew A. Bateman A. Bateman M. Swindell D. Jones R. Lea Divisional Directors	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A**	Read report
Unrivalled Experience							
10.	**24/25/336**	**14:00 (10 mins)**	**Patient and Carer Equality Framework.**	J. Grinnell	To receive a briefing note on the Patient and Carer Equality Framework.	**N**	Read report
11.	**24/25/337**	**14:10 (5 mins)**	**Patient Safety Response Plan, 2025/26.**	N. Askew	To receive the Patient Safety Response Plan, 2025/26.	**D**	Read report
12.	**24/25/338**	**14:15 (10 mins)**	**Brilliant Basics Update.**	N. Askew	To receive an update on the current position.	**A**	Read report
13.	**24/25/339**	**14:25 (10 mins)**	**PALS and Complaints, Q3.**	N. Askew	To receive the PALS and Complaints Report for Q3, 2024/25.	**A**	Read report
14.	**24/25/340**	**14:35 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 19.2.25.** - **Approved minutes from the meeting held on the 22.1.25.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 22.1.25.	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Supporting our People							
15.	**24/25/341**	**14:40 (15 mins)**	**People Plan Highlight Report.**	M. Swindell	To receive an update on KPIs and actions.	**A**	Read report
Strong Foundations (Board Assurance)							
16.	**24/25/342**	**14:55 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's Highlight Report from the meeting held on the 24.2.25.** - **Approved minutes from the meeting held on the 27.1.25.** - **2024/25 Top Key Risks, (M10).**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 27.1.25, and to receive an update on the top key risks for 2024/25.	**A**	Read enclosures
17.	**24/25/343**	**15:00 (5 mins)**	**Board Assurance Framework Report; including:** • **Corporate Risk Register.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
Unrivalled Experience							
18.	**24/25/344**	**15:05 (10 mins)**	**DIPC Report, Q3.**	B. Larru	To receive the DIPC report for Q3, 2024/25.	**A**	Read report
Items for Information							
19.	**24/25/345**	**15:15 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
20.	**24/25/346**	**15:19 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 3rd April 2025, 9:00am, LT4, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal wasn't used in February.

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M10, 2024/25	R. Lea

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 6th February 2025 at 9:00**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer/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)
	Ms. C. Lee	ACOO for Division of Surgery	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/304	Ms. L. Boggan	Head of ASD Services	(LB)
Item 24/25/304	Ms. R. Greer	Assoc. COO – Community and MH Services	(RG)
Item 24/25/304	Ms. K. Holian	Programme Manager	(KH)
Item 24/25/304	Ms. H. Massey	Community and MH Services	(HM)
Item 24/25/310	Mrs. K. Turner	FTSUG	(KT)
Apologies:	Ms. B. Pettorini	Director of Surgery	(BP)

Patient Story

The Chair welcomed Jackie Wotten (Senior Supervisor/Link Worker Support) from Citizens' Advice Liverpool, who had been invited to attend February's Board to present a Family Wellbeing Hub case study and to describe the impact that the intervention had on the family.

The Family Wellbeing Hub is a new initiative that the Trust has rolled out to help a number of parents through social prescribing. Alder Hey has worked in collaboration with Citizens' Advice Liverpool and a number of teams across the hospital. Meetings have also been scheduled in February with the Respiratory Team, Allied Health Professionals, and Bronchiolitis Champions. A case study has also been presented to the Charity.

Jackie provided an overview of a case study that related to a young couple from out of area who were staying with the Trust for a few weeks as their baby was having heart surgery. The parents mentioned their concerns to concierge staff about not being able to afford to stay at Alder Hey so a member of staff offered to contact the Wellbeing Hub to see if they could help. Jackie met with the family who presented with a number of financial issues that they needed

support with. The service completed a debt assessment on behalf of the couple which was the most pressing action as the bailiffs were due to call at the family home within a seven-day period. A benefit claim had been submitted by the parents for child disability allowance, which can take up to 20 weeks, and they hadn't received a response. Due to family's circumstances the service was able to address this matter on their behalf, as well as the large amount of deductions that were being taken from their Universal Credit benefit for an advance payment. The family visited the Wellbeing Hub the following day and advised that a hold had been placed on all actions for a 28-day period and that they had received confirmation of their award in respect to the child disability allowance claim that they had submitted. It was reported that the service also helped with a whole host of small interventions that benefited this family. Jackie pointed out that as a result of one conversation with a member of staff the service has been able to help this family to address their financial difficulties.

As the service is new, Jackie asked the parents if they would mind providing feedback. Mum advised that the service has helped her family through the most horrendous period in their lives and offered thanks. Mum pointed out that this service is helping families with their financial difficulties which enables parents to concentrate on their sick child. Jackie felt that this case study is a really good example of the power of conversation.

On behalf of the Board, the Chair thanked Jackie for attending Board and sharing this family's story which had a positive outcome. The Chair felt that the Family Wellbeing Hub is a super initiative and pointed out that Alder Hey was transforming the life of a child, but the service has transformed the life of the parents so that they can focus on their child. The Chair queried as to whether the services is seeing people on a regular basis. It was confirmed that it is and that nobody is turned away. It was reported that staff are understanding the premise behind the initiative and are directing parents to the service.

24/25/294 Welcome and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received. Congratulations were offered to Adam Bateman on his appointment as the Trust's new Deputy Chief Executive Officer.

24/25/295 Declarations of Interest

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

24/25/296 Minutes of the previous meeting held on 9th January 2025.

Resolved:

The minutes from the meeting held on the 9.1.25 were agreed as an accurate record of the meeting.

24/25/297 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 24/25/142.1: *Campus update (Provide an update on the resolution for the sprinkler system in the Under-Croft car park)* – An update has been included in February's report on the Campus. **ACTION CLOSED**

Action 24/25/181.2: *Autumn and Winter Emergency Response Plan, 2024/25 (National debate on the Healthier Together App - Set time aside to think about whether the Trust should continue with its established symptom checker which is to be promoted and further developed this winter, or whether Alder Hey should link in with the national initiative 'Healthier Together' and the options available)* – Work is underway to enable a decision to be made. Discussions have also taken place with national teams to see if the apps can be combined. **ACTION CLOSED**

Action 24/25/183.1: *Campus update (Board discussion to take place on a partnership strategy for the Campus and the options available)* – An update has been included in February's report on the Campus. **ACTION CLOSED**

24/25/298 Chair's and CEO's Update

The Board was advised that a meeting took place between the Chair of the Cheshire and Merseyside (C&M) Integrated Care Board (ICB), Raj Jain, Dame Jo Williams, David Flory and Rosie Cooper to discuss how Alder Hey, LUFT, and Mersey Care can work better in collaboration. A further meeting of the Chairs will take place in March and a session has been scheduled for the CEOs of each organisation to meet w/c 10.2.25 to look at a way forward.

It was reported that the Chairs from Cheshire and Merseyside providers met on the 5.2.25. The majority of the meeting focussed on finance, and the group received a presentation on health inequality from the ICB's Medical Director and Public Health Director which raised questions about whether the right data is being used to tackle this area of work. In terms of finances, it was felt that there is a lack of long-term focus as energy is being channelled into addressing end of year challenges and the forthcoming financial year.

The Chair informed the Board of the visit that the Trust received from the Brathay Trust. The Brathay Trust is a charity that is dedicated to improving the life chances of young people through outdoor education. It was reported that the outcome of the visit was really positive and the Trust's Chief Nurse, Nathan Askew (NA), has agreed to visit Brathay's dedicated centre in the Lake District.

John Grinnell (JG) made reference to February's agenda and felt that it captured the items that are currently dominating the Trust's time and effort. JG informed the Board that the current financial environment is extremely challenging with swathes of NHS meetings taking place at national, regional and ICB level. it was pointed out that there is a large amount of work that needs to be done before the end of the financial year.

In terms of progressing the CYP agenda, an Exec to Exec meeting took place on the 23.1.25 with Liverpool City Council. It was a positive meeting and both teams felt that more can be done for CYP via collaboration. It has been agreed to schedule quarterly Exec to Exec meetings going forward. The Trust is also meeting with the ICB on 10.2.25 and is looking to put forward a number of proposals to help drive the children and young people's (CYP's) agenda.

JG provided an overview of the positive feedback that has been received following a number of visits, meetings and events that took place recently; visit to the Gender service by NHSE, meeting with Hitachi Services, CQC engagement session, and 'CYP Mental Health Week'.

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

24/25/299 System Alignment and Partnerships

The Board received a presentation that provided an update on system alignment and partnerships. It was pointed out that NHSE is requesting ICBs to explicitly reflect the needs of CYP in their local planning and funding allocations. From the Trust's perspective it is important to raise awareness of the CYP agenda to ensure CYP are included in plans and receive investments, and provide evidence that it is delivering on the three shifts; hospital to community, sickness to prevention, and analogue to digital.

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

- 2025/26 priorities and operational planning guidance for the NHS;
  - Reduce waiting times for planned care.
  - Improve Accident and Emergency (A&E) wait and ambulance response times.
  - Improve access to GPs and Dental services.
  - Improve access to Mental Health services with a focus on CYP.

  Wins for CYP;
  - ICB and provider boards to consider this year's and the medium-term plans for all groups and explicitly CYP.
  - Improve access to CYP Mental Health services, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019.
  - Reduce inequalities in line with the Core 20PLUS5 approach for adults and CYP.
- Enabling change and system leadership.
  Systems will need to;
  - Develop Neighbourhood Health Service models.
  - Live within their financial means.
  - Prioritise safety and quality.
- Vision 2030 deliverables in Q1/2 2025/26, partnerships and systems;
  - A CYP Neighbourhood Model event is taking place on the 28.2.25 to identify a small number of neighbourhoods to test, learn and evaluate the model.
  - An Exec to Exec meeting has been scheduled in February with the ICB to discuss the CYP agenda and mandates/commitments.

A discussion took place around the investment that will be required to comply with key priorities in 2025/26, the NHS 10 Year Health Plan, Vision 2030 and business as usual. It was pointed out that time will need to be set aside to look at do ability and prioritisation as there are no resources available to undertake work outside of the plan.

For noting
In order to have a greater understanding of concerns, and advocacy in terms of gaining support from people, it was felt that it would be helpful to have a breakdown of the challenges around resources, partnerships, systems, and ways of working, as the organisation moves forward.

A question was raised about whether targets will be set as part of the expansion

of Virtual Wards. It was reported that there is not a lot of information on Virtual Wards in the guidance as the emphasis is on elective. The Board was advised that the Trust has set internal targets for Virtual Ward, and it was pointed out that there are signs that there might be some investment for this area of work.

The Chair offered thanks for the update and acknowledged that the Trust's forward thinking has aligned the organisation's strategy with the NHS 10 Year Health Plan. Going forward there will be challenges in terms of capacity and money, therefore in the event the Trust receives funding from other sources careful thought will need to be given about how it is used.

Resolved:
The Board noted the update on system alignment and partnerships.

24/25/300 Transformation Programme Update

The Board was provided with an update on the progress that has been made in delivering the current Vision 2030 Transformation Programme. The following points were highlighted:

- It was reported that this year's programme continues to progress with Martha's Rule having been successful piloted in December 2024 and the Lyrebird Ambient AI deployment in progress. One of the key programmes is the establishment of the Family Wellbeing Hub.
- Four cross-cutting collaboratives have been established to deliver the next phase of Vision 2030 which are aligned with the organisation's strategic priorities. It was reported that there is an emerging opportunity for a fifth cross-cutting collaborative in digital, data and Artificial Intelligence (AI).
- Work is being undertaken to look at key areas of risk to ensure there is integration for the next phase of Vision 2030. A number of transformation collaboratives have been established which are hosted by the Divisions, together with cross-cutting work for example, Fit for the Future.

Resolved:
The Board noted the 2030 Transformation Programme update.

24/25/301 2025/26 Annual Plan Update

The Board was provided with a briefing on the Trust's emerging annual plan for 2025/26 which is in the process of being concluded. A full written version of the plan will be submitted to the Finance, Transformation and Performance Committee (FTPC) on the 24.2.25 for scrutiny, and the Trust Board on the 6.3.25 for review ahead of submission on the 19.3.25. A number of slides were shared that provided information on the following areas:

- Timeline and review process.
- The Trust's emerging plan;
  - National priorities and assessment of deliverability.
  - Plan on a page.
  - Financial framework;
    - Financial planning in C&M has not yet been concluded, and there are a large number of income allocations not yet known.

  - The Trust has a draft indicative plan in place using internal assumptions and likely income, but this will be subject to change over the coming weeks.
  - There is a national target-balance, however, the ICB has set a £3.4m surplus as a target for Alder Hey.
  - The latest draft plan is a £4.9m deficit. Further work is required over the next ten days to lay out the parameters as the organisation goes into the planning round, whilst determining as to what will enable the Trust to breakeven.
- Workforce;
  - Overall reduction by March 2026 of 146 WTE (-3%) after accounting for known areas such as growth, TUPE transfers, and impact of cost improvement schemes.
  - A workforce efficiency group has been established to drive down bank and agency costs.
  - Targets have been set for all budget holders, with a 5% reduction required in Corporate Services by March 2025.
  - A number of workforce reductions have been assigned to CIP but there is still further work to be undertaken.
- Risks and challenges.

The Chair felt that the briefing was really clear but pointed out that financial sustainability is going to be an issue in the coming years therefore it is imperative to have a longer-term view going forward. It was agreed to add this to the risk profile.

24/25/301.1 Action: RL

A discussion took place about workforce modelling, WTE reductions and actual cost savings. It was suggested that the Trust should focus on clinical productivity and not use productivity gains to take cost out, for example, does the Trust want to reduce waiting times in a marked way or shrink the workforce and have a waiting time that is acceptable. It was felt that the Trust would benefit from having an agile workforce that can support services across services that have a greater clinical need in comparison to other departments where pressures are manageable.

A question was raised about whether the Trust is going to ask staff to share their ideas on how to save money. It was reported that a broader programme is in the process of being implemented via events, conversations, and e-mails. It was reported that discussions have already taken place with staff and as a result twenty e-mails have been received suggesting how the Trust can save money.

John Grinnell informed the Board of the importance of progressing growth, being clear about the choices the organisation makes in terms of productivity, decisions not to invest, keeping waiting list discussions live, and having an effective communications approach for staff. It was also pointed out that it is important not to lose the ability to make decisions on the areas of work that the Trust wishes to progress.

Resolved:
The Board noted the briefing on the 2025/26 Annual Plan.

24/25/302 Evidence of Our Performance

Flash Report, M10

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

- There were two C-Diff hospital onset healthcare associated infections reported in M10.
- The Trust has seen an increase in sickness absence figures in M10 to 6.17%. It was reported that there are some quite complex issues that people are dealing with that aren't work related.
- Diagnostics achieved 95% performance for the third consecutive month.
- The 4-hour ED target was achieved in M10.
- *RTT:* There are 310 patients waiting over 52 weeks for treatment. Figures are continuing to decrease but there are challenges in Dentistry and ENT.
- *Performance Challenges:* Target for clinic letters - discussions are taking place with the Divisions regarding this matter and the Trust is also looking to scale up Lyrebird to help achieve this standard.
- Was Not Brought (WNB) continues to be above the Trust's target and has increased from 9% to 10% in month. Pilots are underway to help address this matter, and appointments have been relocated into community settings to make access more convenient for patients. It was reported that Ophthalmology has the second highest WNB figures therefore the Trust is looking at alternative ways to change the way it invites patients to appointments and provide an opportunity to enable families to take responsibility of their appointments.

A suggestion was made about having productivity measures for the innovative solutions that the Trust is implementing in order to gauge the savings that are being made. It was agreed to look into this suggestion.

24/25/302.1 Action: AB

Integrated Performance Report for M9, 2023/24

The Board received the Integrated Performance Report (IPR) for Month 9. An update was provided on the following areas of the IPR:

Outstanding Care and Experience – Safe and Caring

- A device related Category 3 pressure ulcer was reported in M9. This was investigated and then reviewed by a PSIRI panel.
- Bank usage has reduced by 30% in December 2024. This is a 43% reduction in comparison to December 2023.

Pioneering Breakthroughs

- *3rd MRI Scanner* – The Trust has commenced use of the 3rd MRI scanner for patient activity; with Manchester having invested in 100 scans, and the C-GULL Study investing in 700 scans for neonates. An improvement plan has been implemented and work is taking place to look at how the Trust will address the mobilisation of studies.

Collaborating

- There is to be a focus on patient ethnicity and capturing that data in the clinical system.

Financial Sustainability: Well Led

- Divisional forecasts have deteriorated in M9 by a further £2m compared to M8 due to challenges within the Division of Surgery and income.
- The Trust is forecasting to achieve a £3.3m surplus, with a risk adjusted forecast to the ICB of £2.2m (*off plan due to pay award*).
- M10 position was £1.7m surplus and £0.6m surplus YTD which was off plan due to pay award. £0.2m of benefits that were assumed for future months were used to achieve this position

Community and Mental Health Division

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

Division of Medicine

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

Division of Surgery

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

Resolved:
The Board noted the Flash Report for M10 and the IPR for Month 9.

24/25/303 Alder Hey in the Park Campus Development Update

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

- *Neonatal Unit and Emergency Floor* – Progress is being made with the construction of the building and the issue relating to water compliance has been resolved. The Trust is liaising with Project Co regarding the increased SPV costs, and a cost/programme update is to be presented to the Finance, Transformation Performance Committee (FTPC) on the 24.2.25.
- *Catkin and Sunflower House;*
  - Mediation has commenced to try and reach a conclusion on the commercial settlement with the contractor.
  - *Car Park* – It has been agreed that parking facilities will be made available at the side of the Catkin Centre rather than using the Undercroft car park.
- *Master Site Planning* – A refresh of the Master Site Plan is underway to reflect emerging developments.
- *Claire House Opportunity* – It has been agreed not to progress this opportunity as the scale of the project is too big.

Resolved:
The Board noted the Campus development update.

24/25/304 Neurodiversity Transformation Plan

It was reported that there has been a significant increase in demand for assessment for ASD and ADHD over the last 4 years which has impacted on waiting times. A deep dive took place into ASD and ADHD assessment pathways and the Board received a presentation on the outcome, the next steps, and the support required. A number of slides were shared that provided information on the following areas:

- ASD and ADHD pathway since 2020 *(several changes have been implemented to the pathways since 2020*).
- ASD Peer coaching model.
- ASD and ADHD digital, research and innovation
- Sensory Environment project.
- ADHD medication.
- Commissioning arrangements/activity.
- ASD and ADHD pathway monitoring.
- Waiting times, risk register, transformation programme.
- Clinical model development.
- Pilot of new joint assessment pathway *(it was reported that feedback from families has been positive).*
- Alder Hey's Neurodevelopmental pathway principles.
- Workstreams; Digital and Innovation, Capacity and Demand, Workforce and Education.
- Overview of the transformed Neurodevelopmental pathway roadmap.
- C&M ICB Neurodiversity Programme approach *(the Trust has dovetailed the work that it commenced previously, into the ICBs programme*).
- CYP Neurodiversity Programme structure.
- Empowerment, early help and ongoing support.
- Programme forward plan; 4, 8 and 12 weeks.
- ADHD, C&M Places *(CYP 0-18 diagnosed prevalence by year, 2020 to 2024).*
- C&M waiting times (*significant challenge in comparing data*).
- Next steps and support;
  - Engagement with commissioners in agreeing a sustainable funded model for assessment and treatment, this includes pre and post diagnostic support.
  - Support for any changes in commissioning requirements, e.g. use of 'Right to Choose' frameworks.
  - Acknowledgement of the complexity of service/improvements achieved.
  - Support for workforce growth needed e.g. vacancy approvals.
  - Corporate support to facilitate delivery of improvement actions e.g. Procurement, Digital, Research and Innovation.
  - Acknowledgement that the Division has the skills, experience and leadership to continue to transform the service in partnership with CYP and families.

The Chair offered thanks for the update and felt that Board members should set time aside to read the presentation in greater detail due to the amount of information included in the slides. A number of questions were raised and responded to about whether research on demand management has been undertaken, whether the Trust is capturing data in respect to the amount of people waiting for these services; is there evidence to support the escalation in demand, and what does the pathway look like for CYP transitioning into adult services?

A discussion took place about modelling, how the Trust will model expected prevalence going forward, and the profiling tool that has been adapted for two early adopter sites in C&M; Halton and Wirral (*Portsmouth model*).

A query was also raised about the Trust's approach for the oversight of risk for CYP who are awaiting a diagnosis. It was reported that there is an open-door

policy to enable patients to report any changes. Advice will be offered, and the patient will be re-stratified via the use of a profiling tool. If required, the patient will be offered an earlier appointment. It was confirmed that there are lots of processes in place to ensure nobody is overlooked. Following a conversation, it was agreed that the Safety and Quality Assurance Committee (SQAC) will monitor the progress of the Neurodiversity Transformation Programme going forward and an update will be submitted to the Trust Board in December 2025.

24/25/304.1 Action: LC

For noting
SQAC will monitor the progress of the Neurodiversity Transformation Programme going forward.

Resolved:
The Board noted the outcome of the deep dive into ASD/ADHD Assessment pathways and noted the next steps and support required.

24/25/305 Network Approach for the Gender Service – Briefing

The Board received an update regarding the development of the National CYP Gender Service Provider Network and National MDT. The following points were highlighted:

- The Chair of the National Provider Network and National Multi-Disciplinary Team (MDT) has been appointed and will commence in both posts on the 1.2.25.
- The formal commencement of the network will take place on the 1.2.25.
- The National MDT is established and ready to receive referrals. It is a vital part of the network/services, as it is the only mandated route for referrals into Endocrinology and the puberty suppressing hormone research trial.
- Work is taking place to establish a national provider collaborative.

Resolved:
The Board noted the content of the network approach for the Gender Service

24/25/306 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 18.12.24 were submitted to the Board for information and assurance purposes.

During January's meeting the committee received a deep dive into the declining compliance with in-date policies, guidelines and patient information leaflets held on the Data Management System (DMS), and was provided with an update from each of the Divisions regarding the current challenges. The committee has asked for a report to be submitted during February's meeting detailing the actions that have been implemented, together with a forward view. It was confirmed that SQAC will continue to monitor this area of work until it is fully assured that this issue has been resolved.

Resolved:
The Board noted the approved minutes from the meeting held on the 18.12.24.

24/25/307 Liverpool Neonatal Board (LNP) – Chair's Report to Trust Board

The Board received an update on the outcome of the LNP Board meeting that took place on the 20.1.25. The following points were highlighted:

- The LNP Board discussed water safety and potential implications for the new unit. It was agreed that immediate decisions on how to proceed need to be made due to the significant risk that this presents in terms of unit design, delivery timeframes and cost. The LNP Board was assured that these discussions are being progressed at pace, with all key stakeholders engaged in the process.
- The alignment of key HR policies and procedures was previously highlighted as a potential issue and was discussed at a recent Exec to Exec meeting. A meeting has been scheduled for the 7.2.25 between Executive colleagues from both organisations and the LNP's Senior Leadership Team to share the recommendations agreed at the previous meeting and to discuss the next phase of the partnership process/ leadership team.
- The LNP has successfully recruited to the Speech and Language Therapy vacancy.
- It was reported that collaborative work has commenced on culture.

Reference was made to the concern that was raised formally by Morgan Sindall in regard to programme delays and it was queried as to whether a decision is being made on this matter via the LNP. It was reported that a delay to the programme occurred prior to the Trust receiving the water report and was contested with the SPV. In terms of the water related issue, a resolution has now been found.

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

24/25/308 People Plan Highlight Report

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

24/25/309 People Committee

The approved minutes from the meeting held on the 13.11.24 were submitted to the Board for information and assurance purposes.

During January's meeting there was a focus on the People Plan and the 2024 Staff Survey. A discussion also took place about the impact that the Workforce Efficiency Programme will have on staff morale, and the approach that needs to be taken in respect to staff communications. It was reported that PDRs remain a focal point in terms of completion by the end of Q4.

Resolved:
The Board noted the approved minutes from the meeting held on the 13.11.24

24/25/310 Freedom To Speak Up (FTSU) Update

The Board was provided with a summary of the activities of the FTSU service for Q3 and an outline of the actions planned for the coming period. The following points were highlighted:

- It was reported that there are 6 cases that remain open related to inappropriate behaviour/relationships, and not 5 as advised in the report.
- There was a total of 19 cases reported in Q3 and 16 in Q4. A review took place to determine the reason for the reduction in the number of cases in Q4 and it was felt that this was due to leave over the Christmas period. This will be mitigated going forward with the appointment of a deputy FTSUG.
- Further work is required in terms of lessons learnt and the sharing of this information Trust wide. It was reported that a conversation is to take place with the Associate Director of Organisational Development, Jo Potier, to understand how lessons learnt can align with work that she is undertaking.
- A review of the recommendations made by MIAA was undertaken in January 2025 which demonstrated that 3 of the 5 recommendations have been implemented. The two recommendations that are partially implemented relate to the logging of FTSU concerns on the InPhase system and the appointment of a deputy FTSUG. Work is ongoing to fully implement these two outstanding recommendations, as detailed in the report.
- The FTSU visibility programme continues, with FTSU walkabouts being well received by staff. Non-Executive Directors and members of the Executive Team participate in the walkabouts which demonstrates to staff the Board's commitment to the FTSU principles. Work is also underway in association with the Network Chairs to develop a collaborative safe space for all staff. Part of this remit will include attendance at FTSU walkabouts by Network Chairs.
- As of the 18.12.24, 97.23% of staff had completed the Speak Up training module.

For noting
The Chair asked as to whether a communication can be circulated Trust wide to advise staff of the process once an FTSU referral has been submitted, and it was suggested undertaking a piece of work with teams who don't feel safe enough to speak up.

Resolved:
The Board noted the FTSU update for Q3.

24/25/311 Update to Corporate Governance Manual

The Board received a paper that reflects the output of the annual review of the Trust's Corporate Governance Manual. It was reported that given the increased scrutiny on grip and control of expenditure at a national and regional level, the 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 amendments to the Corporate Governance Manual were approved by the Audit and Risk Committee on the 16.1.25, and attention was drawn to the key changes, as detailed in section one of the report.

Resolved:
The Board approved the changes to the Corporate Governance Manual and agreed the proposed next steps.

24/25/312 Audit and Risk Committee

The approved minutes from the meeting held on the 10.10.24 were submitted to the Board for information and assurance purposes.

Resolved:
The Board received and noted the Chair's Highlight Report from January's meeting and the approved minutes from the meeting held on the 10.10.24

24/25/313 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 16.12.24 were submitted to the Board for information and assurance purposes.

2024/25 Top Key Risks (M9)

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

Resolved:
The Board noted the approved minutes from the meeting held on the 16.12.24 and the update on the Committee's top key risks in M9.

24/25/314 Board Assurance Framework Report (BAF)

The Board was provided with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 13 principal risks aligned to the Trust's strategic objectives. The following points were highlighted

- Time is being set aside to enable risk owners to review and update their respective risks ahead of the new financial year, particularly in the context of the challenges discussed earlier in the meeting in relation to the external environment and its potential impact on CYP.
- A discussion is to take place to agree what BAF risk 4.1 will look like going forward and to determine whether the Futures Committee will have five top risks, similar to FTPC, that they will monitor on a regular basis during committee meetings.

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

24/25/315 Any Other Business

There was none to discuss.

24/25/316 Review of the Meeting

The Chair thanked everyone for their contributions during the meeting. It was felt that the Board had had a productive conversation about the financial challenges facing the Trust at the end of the current financial year and moving into 2025/26. In respect to the neurodiversity issues raised and discussed, it was pointed out that

the Trust needs to support the Community and Mental Health Division to address this area of work but as a Board it is also necessary to understand the risks.

Date and Time of Next Meeting: Thursday 6.3.25 at 12:30pm, 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 March 2025							
9.1.25	24/25/273.1	Integrated Performance Report	*Support Our People* - Establish a systematic methodology to bring all aspects of the Workforce WTE plan together; including MARS, spans of control, reset points and communications for staff and the system.	M. Swindell	6.3.25	On track Mar-25	
9.1.25	24/25/274.1	Tuberculosis Positive Case Update	Formally lodge the Trust's concerns with the respective occupational health provider about the delay in being notified of the positive TB case.	M. Swindell	6.3.25	On track Mar-25	
9.1.25	24/25/280.1	2024 Staff Survey	•Look at the possibility of making it mandatory for PDRs to take place in person rather than virtually. •Look at the correlation between positive feedback from staff following their appraisal and managers who manage large numbers of staff. •Review the cultural element of the Trust's plan via an autonomous culture lens taking into account that this area needs performance at the heart of it. •Use trends to display changes to enable staff to look back and compare data. •Look at the trends/themes of feedback from staff on lower bands in the organisation.	M. Swindell	6.3.25	On track Mar-25	**27.2.25** - An update will be provided during March's meeting.
6.2.25	24/25/301.1	2025/26 Annual Plan Update	Risk profile to include a longer-term view of financial sustainability.	R. Lea	6.3.25	On track Mar-25	
6.2.25	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.	A Bateman	6.3.25	On track Mar-25	
Actions for April 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	Apr-25	
Actions for June 2025							
6.6.24	24/25/83.1	2023/24 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement	Covering report sheet to be more specific to identify actions that are important versus business as usual.	A. Bass	Jun-25	On track Jun-25	
Actions for September 2025							
5.9.24	24/25/149.1	Wellbeing Guardian Dashboard	Integrate Freedom To Speak Up in the next iteration of the Wellbeing Guardian Report.	J. Revill	Sep-25	On track Sep-25	

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
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							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
5.9.24	24/25/142.1	Alder Hey in the Park Campus Development Update	Provide an update on the resolution for the sprinkler system in the Under-Croft car park.	D. Powell	5.12.24	Closed	**27.9.24** - This item will be included on November's Board agenda. **3.10.24** - This action has been deferred to December as further work is required before an update can be submitted to the Board. **28.11.24** - This action has been deferred to January. **3.12.24** - A report on the resolution of the sprinkler system in the Under-Croft car park will be submitted to the Board in February following approval of the proposal by the FTPC. **31.1.25** - An update will be provided in February. **6.2.25** - An update has been included in February's report on the Campus. **ACTION CLOSED**
3.10.24	24/25/181.2	Alder Hey – Autumn and Winter Emergency Response Plan, 2024/25	*National debate on the Healthier Together App* - Set time aside to think about whether the Trust should continue with its established symptom checker which is to be promoted and further developed this winter, or whether Alder Hey should link in with the national initiative 'Healthier Together' and the options available.	A. Bateman	6.2.25	Closed	**6.2.25** - Work is underway to enable a decision to be made. Discussions have also taken place with national teams to see if the apps can be combined. **ACTION CLOSED**
3.10.24	24/25/183.1	Alder Hey in the Park Campus Development Update	Board discussion to take place on a partnership strategy for the Campus and the options available.	D. Powell	9.1.25	Closed	**3.12.24** - A workshop is taking place at the end of January to discuss site planning opportunities. An update will be provided in February. **6.2.25** - An update has been included in February's report on the Campus. **ACTION CLOSED**
9.1.25	24/25/273.3	Integrated Performance Report	Review the generation of income for the new MRI scanner and provide an update to the Board.	R. Lea	6.3.25	Closed	**6.2.25** - The Trust has commenced to use the 3rd MRI scanner for patient activity; with Manchester having invested in 100 scans, and the Seagull Study investing in 700 scans for neonates. An improvement plan has been implemented and work is taking place to look at how the Trust will address the immobilisation of studies. **ACTION CLOSED**
9.1.25	24/25/274.1	Mortality Report, Q2	It was felt that the proposed new law to legalise assisted dying for over-18s will raise concerns for young people and attention was drawn to the importance of determining what this will mean for the Trust. It was agreed to flag this to the Children's Health Alliance (CHA).	D. Jones	6.3.25	Closed	**27.2.25** - This action has been addressed. **ACTION CLOSED**

9.1.25	24/25/279.1	LNP Board – Chair's Report to Trust Board	*LNP* - Provide an update on the on the outcome of the proposal for governance, policy and leadership arrangements once it has been discussed at the next Exec to Exec meeting with the Liverpool Women's Hospital (LWH).	A. Bass	6.3.25	Closed	**6.2.25** - A meeting has been scheduled for the 7.2.25 between Executive colleagues from both organisations and the LNP's Senior Leadership Team to share the recommendations agreed at the previous meeting and to discuss the next phase of the partnership process/leadership team. An pdate on the outcome of the session will be incuded in the next LNP Chair's report. **ACTION CLOSED**

BOARD OF DIRECTORS
Thursday, 6th March 2025

Paper Title:	**Integrated Operational Plan, 2025/26**
Report of:	**Chief Operating Officer**
Paper Prepared by:	Acting Head of Performance

Purpose of Paper:	Decision Assurance Information Regulation	x ☐ ☐ ☐
Action/Decision Required:	To note To approve	x ☐
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**	x x **x** **x** **x** **x**
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

NHS England have asked all Trust Boards to be assured that:

- The operational plan for 2025/26 is an accurate reflection of the shared 2030 vision and strategy of the Trust Board.
- The operational plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and
- All plans described and activity and finance figures quoted in the plan have been developed in accordance with the national planning guidance, specifically:

  - National priorities: The Board has systematically reviewed and assured itself that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26.
  - Local prioritisation decisions: The Board has reviewed its existing quality and finance governance arrangements and put in place a robust clinically led process to support local prioritisation decisions.
  - Delivery planning: The Board has assured itself of the deliverability of its plans and identified mitigating actions to address key delivery challenges and risks.

Confirmation that the Integrated Operational Plan for 2025-26 is approval on behalf of the Board of Directors by:

Role: Chair **Name:** Dame Jo Williams	**Signature:**
Role: Chief Executive Officer **Name:** John Grinnell	**Signature:**
Role: Interim Chief Financial Officer **Name:** Rachel Lea	**Signature:**

Integrated Operational Plan

2025-26

Contents

1. Executive Summary

1.1 Overall Plan

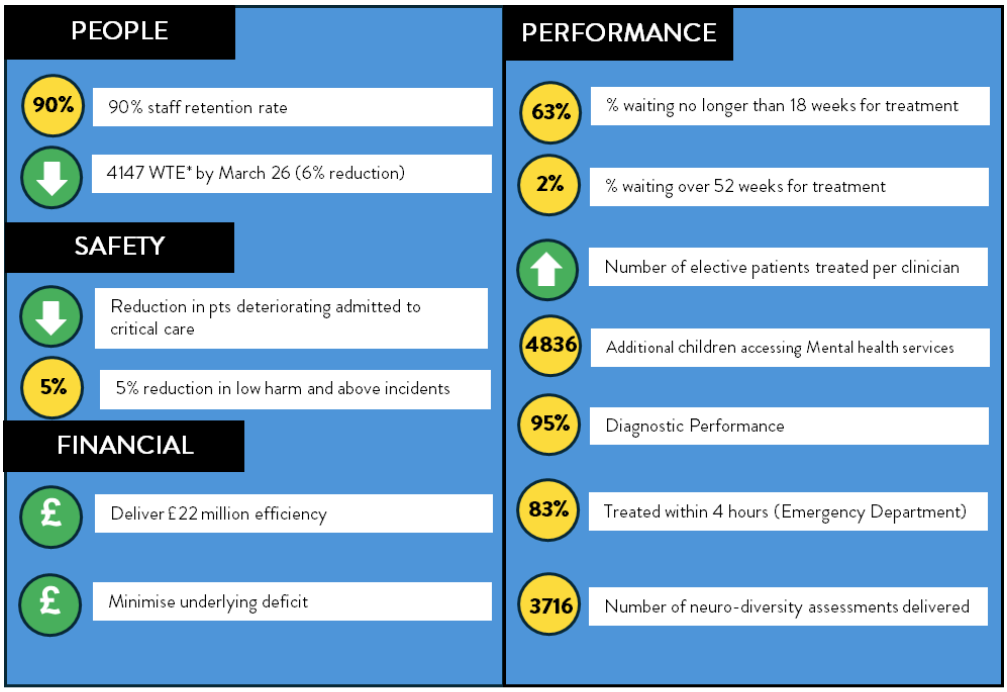
The 2025-26 Integrated Operational Plan sets out our priorities for the year ahead, guided by our 2030 Vision and the needs of children, young people and their families (CYPF). It is underpinned by the integration of our plans for patient safety and quality, performance, workforce, transformation and financial sustainability.

Our 2025- 26 Integrated Operational Plan has four priority areas of delivery:

i. **Patient safety**: reduce preventable harm, support safe care and act on learning through a just and restorative culture.
ii. **Transforming key clinical services and support services:** we will offer, with our partners, new services in neighbourhoods; open the first paediatric same day emergency care centre (SDEC) in England; and improve access to elective care through more efficient service models. We will modernise our support services, harnessing data and AI solutions to reduce burden and improve staff experience.
iii. **Securing financial sustainability:** through a new financial improvement programme.
iv. **Grow the future:** our local, national and global partnerships will grow our reach, positively impacting the health and wellbeing of more CYPF. Our commercial and academic collaborations will accelerate discoveries in research, innovation, digital and education. Through our Green Plan we will reduce carbon emissions and improve public health.

1.2 Annual Plan – At a Glance

We expect the plan to change the size and shape of our workforce, to meet key performance standards, an improvement in patient safety and a challenging financial improvement programme.



*Substantive / Bank / Agency / Doctors in training

1.3 Patient safety and quality

The Quality Strategy for the year will focus on three key areas: a learning organisation, excellent outcomes and outstanding experience. Our ambitions for safe patient care include enhanced care to children who deteriorate with a subsequent reduction in unplanned admissions to critical care. We also have improvement goals and programmes relating to safe follow-up care, medication safety and enhancing clinical documentation.

1.4 Performance

We expect to meet, and in many cases exceed, all national performance standards. This includes treating 83% of C&YP within 4 hours of arrival (above the 78% target); delivering time to treatment standards cancer care; waiting times for diagnostic tests; and improving the number of CYPFs treated within 18 weeks to 63%, an increase of 5 percentage points. Due to the cap in NHS income for elective care, we are not predicting to be able to meet the standard of having less than 1% of patients on a waiting list waiting over 52 weeks for treatment.

In mental health services we plan to expand service access, supporting an additional 4,836 CYPF above 2024-25 planned levels (which was set at 40,044 C&YP). Similarly, in neuro-diversity pathways, we will increase capacity, supporting more than 3,700 C&YP to receive an assessment.

1.5 People

Our people plan has five areas of focus: firstly, supporting colleagues to thrive by providing a psychologically safe culture and learning environment; secondly, improving productivity; thirdly, strengthening leadership; fourthly, ensuring diverse and accessible recruitment; fifthly, developing a workforce ready for the future with support to use the latest digital and AI tools to reduce administrative burden.

We expect the size of our workforce to decrease by 6%, from 4,415 WTE in March 2025 to 4,147 WTE by March 2026. This change will be driven by modernised corporate and support service models, and expenditure levels limited to 90% of expenditure levels in 2022.

1.6 Transformation

Year 2 of the Vision 2030 transformation programme will be advanced through five cross-cutting collaboratives.

The collaborative model builds on the principles of experience-led and needs-driven transformation, ensuring that every initiative prioritises outcomes for CYPF, and our workforce. By bringing together expertise, resources, and leadership from across divisions, the collaboratives will transforming key clinical and support services: we will offer, with our partners, new services in neighbourhoods; open the first paediatric same day emergency care centre (SDEC) in England; and improve access to elective care through more efficient service models. We will modernise our support services, harnessing data and AI solutions to reduce burden and improve staff experience.

1.7 Finance

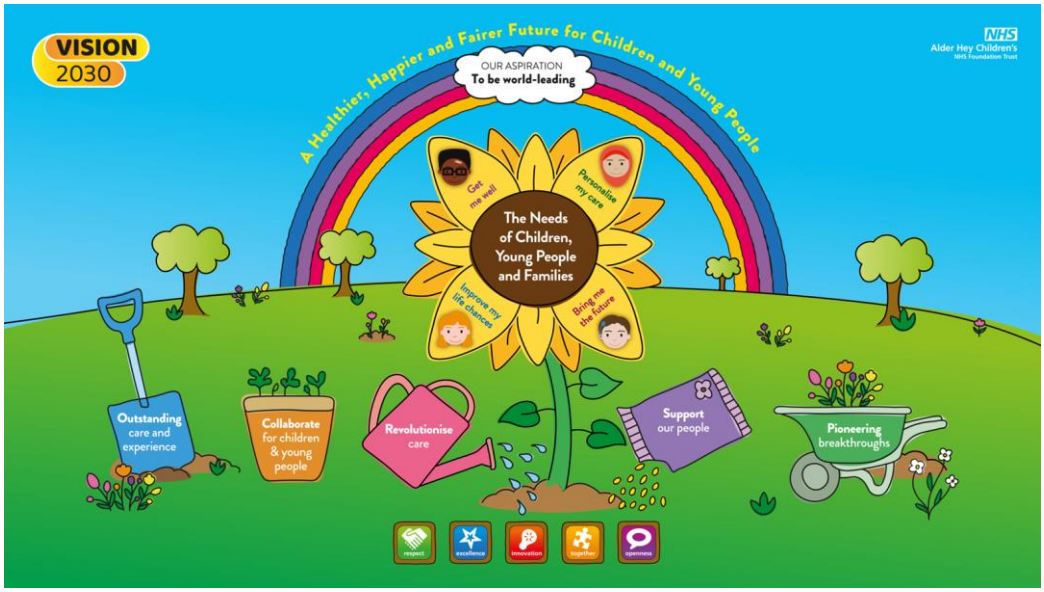
To meet our commitment to the ICB system, and secure financial sustainability our financial framework for the year will be underpinned by the following:

- **Minimise underlying deficit**. Draft indicative plan using internal assumptions and likely income is £1.7m deficit, however, this is subject to change over coming weeks as financial planning in C&M is not yet concluded and a high number of income allocations not yet known. National target is to achieve financial balance however ICB has set Alder Hey target at £3.4m surplus.
- **Maximise our income**, noting ongoing discussions regarding introduction of ERF Cap which is expected to limit growth and put greater focus on productivity and cost reduction.
- **Recurrent Efficiency savings of £22m**, with greater focus on benefit realisation from transformational schemes (£10m), aligned to the Trust Strategic Programme.
- **Capital Development Expenditure Limits:** in 2025-26 will continue to be managed through the ICS at system level, with an allocated spend limit for each provider. The level has not yet been set at the time of publication of this plan.

2. Context

2.1 Vision 2030

Alder Hey Children's vision is for a 'healthier, happier and fairer future for Children and Young People'. 2025-26 is year 2 of our 7-year transformation programme, designed to meet the current and future needs of children, young people and families.



2.2 Reflecting on 2024-2025

Our people, in collaboration with our partners, have worked tirelessly to meet the needs of CYPF. Below we summarise the key achievements of the previous year against our Vision 2030 strategic goals:

Vision 2030 Strategic Goal	Key achievements
	• A 'Warm Welcome' training package for our staff developed with our CYPF • Launched the Children, Young People and Families Charter & Children and Young People's Promises • Friends and Family Test and CYPF Information leaflets have been developed to be available in over 40 languages • A new state-of-the-art and pioneering virtual hospital tour was created and made available to patients and visitors. • Martha's Rule service established, supporting families to access a second clinical opinion and raise concerns. • Strengthened patient safety , by embedding the Patient Safety Incident Framework and securing the support of C&YP as Patient Safety Partners • Maintained top quartile performance of incident reporting nationally • The quality of our catering service was recognised for excellence nationally. • Our security services team won a national award for service excellence.
	• The Alder Hey Youth Forum helped shape the design and plans for the new Elective Hub, which will open in 2025. • A new Wellbeing Hub was launched October 24 to provides poverty proofing and social prescribing support for all CYP&F accessing Alder Hey Services. It is provided through a collaboration with Citizens Advice Liverpool and Health Junction CIC, funded by the Alder Hey Charity. • New partnerships have been established by the Alder Hey Academy to support Young People from across the region achieve their potential. including over £200k of social value delivered 24/25 by the widening participation team alone

	• NHSE-funded vaccination pilot delivered more than 200 vaccines to date. • Alder Hey is a Phase 1 adopter of the Cheshire & Merseyside Prevention Pledge, now a core component of Schedule 2N of the NHS Standard Contract and the Trust is delivering against all 13 prevention commitments set out. • Alder Hey's 'Mini Mouthcare Matters' programme (an oral health improvement programme) has provided education to 250 C&YP and issued 1,200 individual oral hygiene packs.
	• Received national recognition from NHSE for improving the experience and engagement of our colleagues in all seven elements of the People Promise. • Outstanding staff survey results, with 75% of our colleagues recommending Alder Hey as place to work • Launched equality, diversity and inclusion training by co-designing a new training programmes with staff networks • Co-developed and issued our *Anti-Racism Statement and Commitment* • Staff networks further embedded into organisational improvements and have collaborated with HR to ensure inclusive policies and practices. • Shortlisted for National HMPA Awards for Workforce Decision Intelligence with partners Strasys • Sustained an improvement on turnover position, averaging 10.5% • Reduced vacancy position to 3% vacancies across the Trust • Launched a new programme of induction for new consultants
	• Improving elective waiting times for C&YP, with a 50% reduction in the number of CYPF waiting over 52 weeks for treatment. • Growing our elective services to treat more C&YP, with the number of patients treated at 116% of 2019-20 levels. • Ranked the second best Type 1 Emergency Department in England by the timeliness of urgent & emergency care. • Meeting all national cancer access standards.

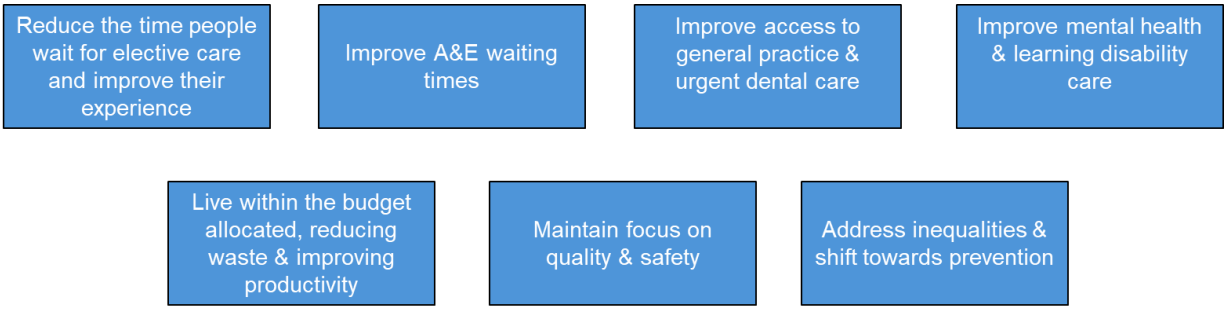
	• 100% of initial health assessments completed within statutory timescales. • Transformation work in theatres is supporting higher rates of day surgery and more multi-procedure operations, reducing the number of general anaesthetics C&YP. • Growing the virtual ward service to support more C&YP to receive care at home and leave hospital sooner. • In Neurosurgery, the Laser Interstitial Thermal Therapy is providing new treatment to improve outcomes for C&YP with epilepsy.
	• Liverpool Institute for Child Health and Well-being was opened by the Secretary of State for Health, a major collaboration between the Trust, The University of Liverpool and The Alder Hey Charity. • Alder Hey academic clinicians were major contributors to two successful LIFEArc grants totalling well over £10m in cystic fibrosis and rare kidney diseases. • Subject to formal ratification, the Innovation team has been awarded £4m by the Liverpool City Region Combined Authority (LCR-CA) to host a Paediatric Innovation Zone (POIZ), from April 2025. • Agreed a multi-year collaboration with the Hartree Centre, part of Science & Technology Facilities Council, to exploit emerging Quantum technologies applications in healthcare. • In collaboration Wavelength Leadership to provide corporate innovation training with consumer companies such as EDF, Astra Zeneca, Eli Lilly, All Saints, BUPA, Nuffield Health. • Funded by the National Institute for Healthcare Research the new third MRI scanner is operational and leading new medical imaging research. • Formed a new pioneering collaboration with an AI start-up to use Generative AI to provide patient letters in real-time and reduce administrative burden for staff. • Mobile Research Unit mini-bus now taking research out into the community • Continuing strong portfolio of clinical research trials and high levels of patient participation in research studies.

	• Thriving Research Ambassador and Parent Champion schemes in the community

2.3 National priorities & operating guidance

The NHS Confederation summary of the NHS 2025-26 plan states that the operating guidance sets a path for reform through development of neighbourhood health services models to prevent admissions and improve access to care. It also asks systems to improve productivity to balance system budgets and improve quality and safety of services, particularly maternity and neonatal services.

The national priorities are to:



2.4 Strategic Environment

Achieving Alder Hey's Vision 2030 relies on deep collaboration with our partners in the communities we serve. In an evolving health and social care landscape, a shared commitment to children and young people needs to be at the heart of an integrated system that works beyond traditional boundaries.

As part of Cheshire & Merseyside's Integrated Care System (ICS), Alder Hey is physically based in Liverpool Place, but our impact extends far beyond. We deliver services across multiple C&M Places, the North West Region, Isle of Man, North Wales, nationally and globally.

The strategic NHS context: a leadership role for CYP

The current NHS environment is defined by:	Within this complex landscape, Alder Hey plays a leadership role, championing CYPF within our system. Through strong partnerships and shared programmes, we work collaboratively to set and achieve joint objectives, ensuring that children and young people remain at the centre of decision making.
• A shift to integrated and community-based care • A focus on reducing health inequalities • Waiting list reduction and backlog recovery • Digital transformation • Financial and workforce constraints	

Strategic Partnerships: Transforming CYPF Health and Care

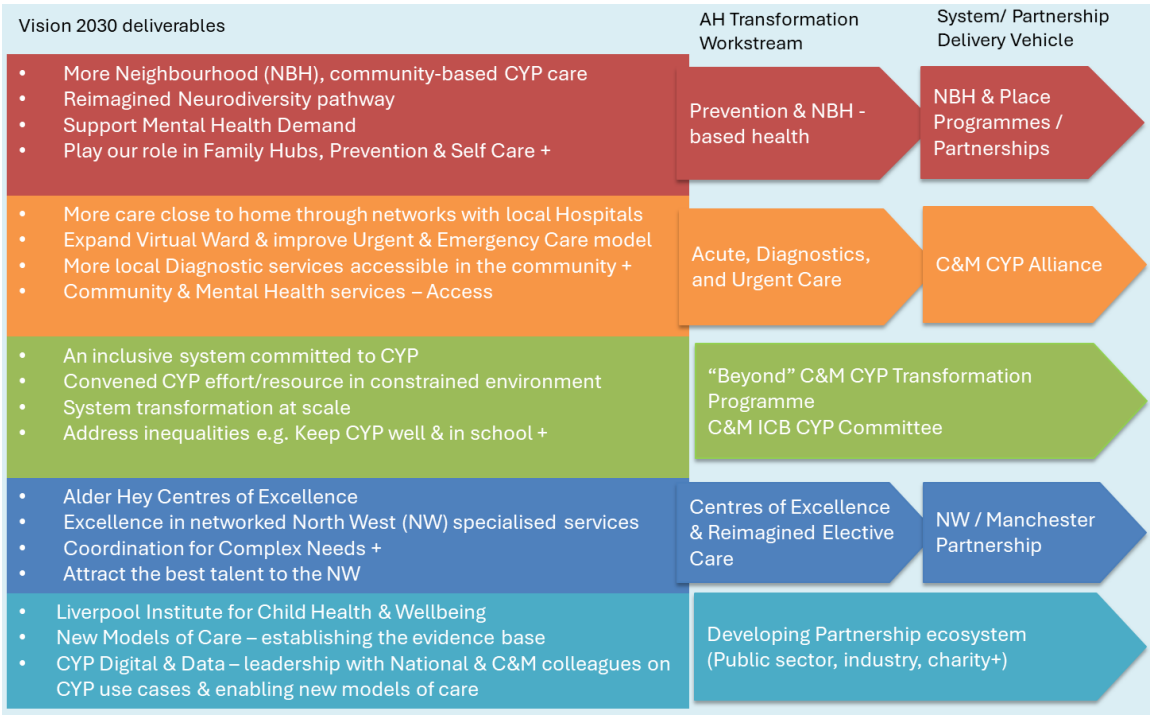
Our partnerships address critical challenges in CYPF health and care, influence strategic decisions, optimise resource allocation, and drive innovation. By connecting expertise across networks, we improve outcomes, experience, and system efficiency. Key partnerships include:

Place Partnerships	Collaborating with local communities in Liverpool, Sefton, and Knowsley to deliver local population-based care.
Cheshire & Merseyside	Driving CYP transformation through the "Beyond" Programme and NHS delivery through the "C&M CYP Alliance".
North West	Strengthening specialist services through the North West Paediatric Partnership Board (NWPPB), co-led with Manchester Foundation Trust / Royal Manchester Children's Hospital (RMCH).
Global	Expanding Alder Hey's reach through philanthropic and business partnerships worldwide.
Futures	Advancing research and innovation, including the establishment of the Liverpool Institute for Child Health & Wellbeing in collaboration with the University of Liverpool. Developing the partnership ecosystem including public sector, charity and industry. Leading digital and data developments for CYP nationally and enabling new models of care.

Looking Ahead: The Role of Partnerships in 2025-26 and Beyond

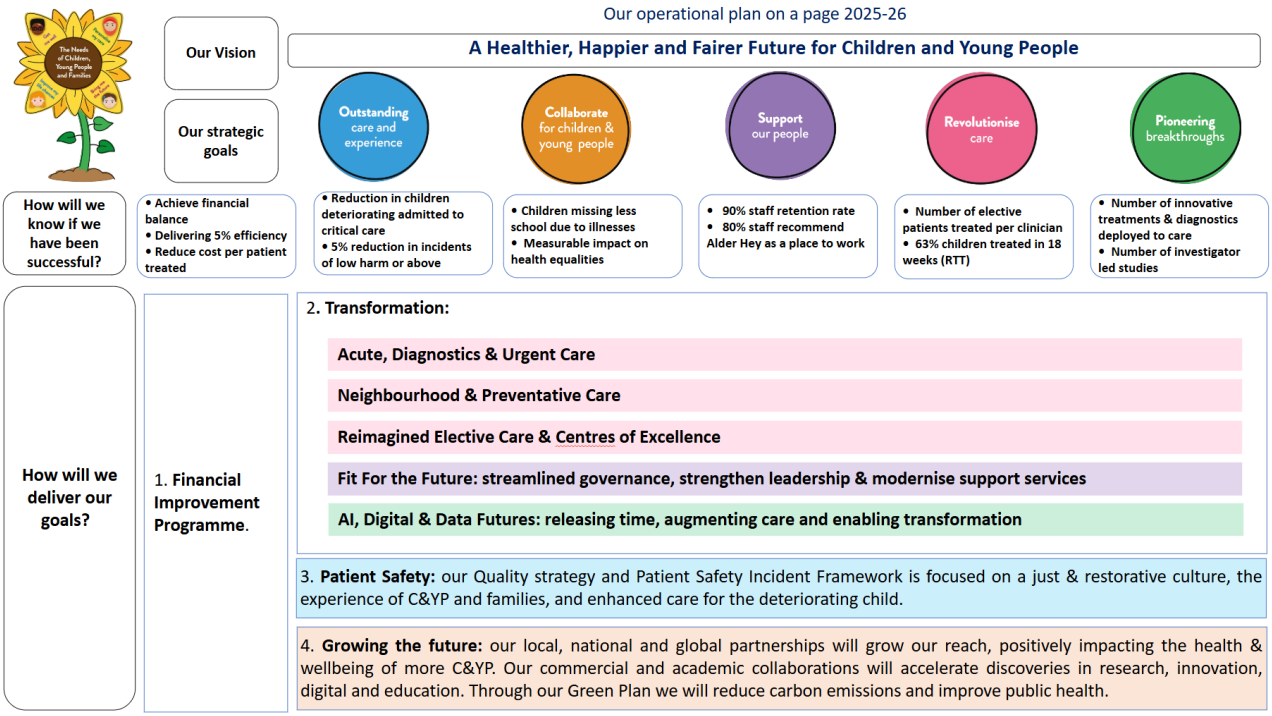
In 2025-26, our partnerships will remain essential to delivering our annual plan and long-term strategy. Every aspect of our work will be shaped by the relationships we have built and our ability to collaborate effectively for the benefit of children and young people.

Alder Hey is not just part of the system—we are leading the way in shaping its future, ensuring that every child and young person receives the care, support, and opportunities they deserve.



3. Our Integrated 2025-26 Annual Plan

3.1 Our Plan on a Page



Our plan has four priority areas of delivery:

i. **Patient safety**: reduce preventable harm, support safe care and act on learning through a just and restorative culture.
ii. **Transforming key clinical services and support services:** we will offer, with our partners, new services in neighbourhoods; open the first paediatric same day emergency care centre; and improve access to elective care through more efficient service models. We will modernise our support services, harnessing data and AI solutions to reduce burden and improve staff experience.
iii. **Securing financial sustainability** through a new financial improvement programme.
iv. **Grow the future:** our local, national and global partnerships will grow our reach, positively impacting the health and wellbeing of more CYPF. Our commercial and academic collaborations will accelerate discoveries in research, innovation, digital and education. Through our Green Plan we will reduce carbon emissions and improve public health.

3.2 Patient Safety & Quality

In 2025, we will launch the Quality Strategy which builds on the work of our ambitious Vision 2030 and underpins the main vision of delivering a happier, healthier and fairer future for CYPF. Fundamentally, this strategy will require a focus on three key areas:

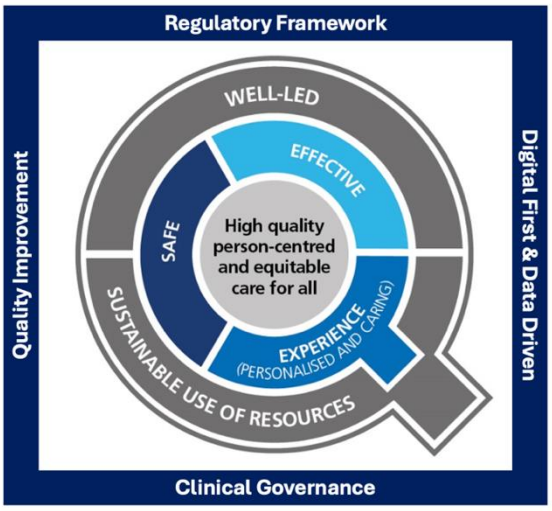
A learning Organisation
Ensuring that when things do go wrong, we understand all the factors that were involved, and to use this learning to change practice for the future. To ensure that we maximise our learning from where things go right, and ensuring good practice is celebrated and shared across all areas of the organisation. We are supporting the development of a just, restorative and learning culture across our organisation which will support our teams to learn from things that consistently go well, as well as when things go wrong.

Excellent Outcomes
Ensuring our CYPF excellent clinical outcomes, as well as meeting their own Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS). We will use our outcomes data to benchmark nationally and where possible internationally and use the data to drive improvements in care.

Outstanding Experience
Ensuring that all our CYPF experience a warm welcome. We will minimise the impact of healthcare on their lives and maximising a positive experience of our care. We will keep the voices of our CYPF at the heart of everything we do.

This strategy signals the embedding of continuous improvement into all our quality work through our Brilliant Basics Quality Improvement Programme.

Our framework is based on the Darzi-based definition of healthcare quality, with the domains of Safe, Effective, and Outstanding Experience (Caring & Responsive).



In practice this means our teams will deliver care that is:

Safe	Delivered in a way that minimises things going wrong, maximises things going right and seeks to reduce risk. CYPF will be empowered and supported to make safe choices, and we will protect them from harm, neglect and abuse. We will be a learning organisation and will ensure when things do go wrong, we take steps to improve.

Effective	Informed by latest knowledge, best evidence, research, guidelines, and training. We will seek to continually improve based on research evidence, outcomes and clinical audit.
Outstanding Experience	We will revise our approach to ensure that we are meeting the needs of our CYPF by being an experience led, needs driven organisation. Our evidence-based care will be delivered with compassion, maintain people's dignity and ensure choice at all opportunities. We will uphold our trauma informed promises to CYPF, providing maximum support in our interactions. We will ensure that CYPF are listened to, see and heard.

Local Patient Safety Priorities 2025-26 : Our data driven Patient Safety Incident Response Plan (PSIRP) sets out our areas of local focus and is agreed in collaboration with key stakeholders each year. The local patient safety areas of focus for 2025-26 are:

- Incidents relating to the recognition and escalation of the deteriorating patient
- Incidents relating to delay and/or lost to follow up appointments/treatment
- Incidents relating to medication safety - ***Omission/ delay of critical medications***
- Incidents relating to documentation – ***consent & medical record keeping***
- Incidents relating to digital systems access, configuration and process compliance

In addition to local patient safety priorities, two additional patient safety improvement priorities have been set for 2025-26:

- *To improve safety culture through enhancing levels of psychological safety and civility across the Trust*
- *To improve how we identify and share learning across the Trust*

The following metrics will be used to monitor our progress for the current financial year 2025-26:

- ***Number of incidents rated low harm and above (Physical and/or Psychological) per thousand bed days***: an indicator which should demonstrate a downward trend or remain within the top quartile of comparator organisations. The objective 2025/26 plan is a 5% reduction on 2024-25.
- ***Number of incidents rated no harm per thousand bed days***: an indicator which should demonstrate an upward trend or remain within the top quartile of comparator organisations. The objective 2025-26 plan is a 5% increase on 2024-25.
- ***A new metric, focused on the Prevention, Intervention, Escalation and Response (PIER_ framework for patient deterioration will be developed and confirmed in Q1)***

3.3 Performance

The table provided below is an assessment of the deliverability of the national operational priorities for 2025-26:

Priority	Measure	Current	25/26 National Target	Assessment to deliver	25/26 Internal target
Reduce the time people wait for elective care	% of patients waiting no longer than 18 weeks for treatment	60%	63%		63%
	% of patients waiting no longer than 18 weeks for a first appointment	63%	67%		67%
	Reduce the proportion of patients waiting over 52 weeks	1.4%	1%		2%
	Improve performance against the headline 62 day cancer standard	98%	75%		98%
	Improve performance against the 28-day cancer faster diagnosis standard	98%	80%		98%
Improve ED waiting times	Improve A&E waiting times to treat patients within 4 hours	83%	78%		83%
Live within the budget, reducing waste & improving productivity	Deliver a balanced financial position for 2025/26	£2.3m	£3.4m		(£1m)
	Reduce agency expenditure, with a minimum 30% reduction across the system	£1.3m	£0.9m		£0.5m
Improve mental health and learning disability care	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP compared to 2019	34,994	N/A		39,830

3.4 People

The workforce plan provides an overview of the changes between 2024-25 and 2025-26. Our workforce plan is based on the following assumptions and projected changes:

- Continued ability to attract and recruit, ensuring we have the right staff with the right skills in the right place at the right time, as well as supporting both internal moves, development and progression.
- Maintaining optimal staff turnover and reduce sickness absence to a revised 4.5% target. Enhance digital capabilities, with increased use of AI and Robotic Process Automation, to enhance workforce productivity.
- **The total workforce will decrease from 4,415 WTE (whole time equivalent) in March 2025 to 4,147 WTE by March 2026. This represents a reduction of 6%, 268 WTEs.**

The changes in WTE are driven by the following:

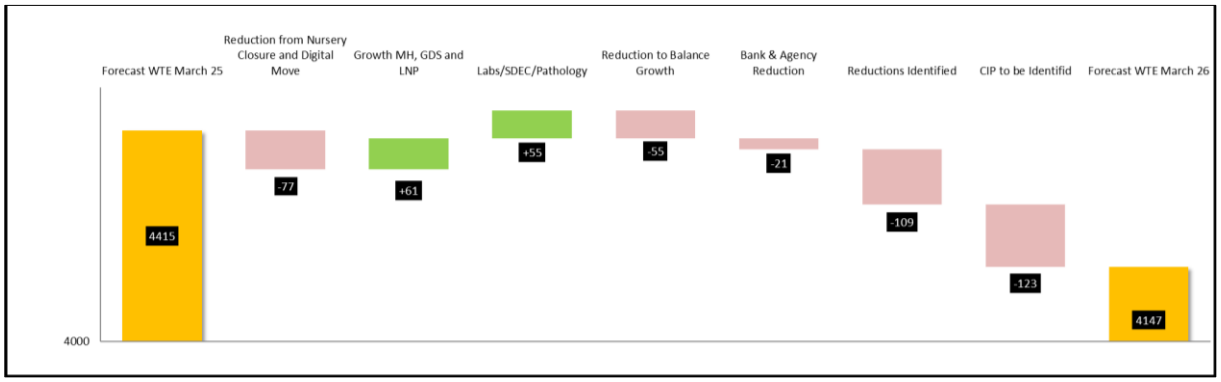
- **Productivity and cost improvement plans will reduce the number of WTEs by -252.42**. In total, we project a reduction -252.42 WTE Our low vacancy rate and controls on agency

expenditure will reduced Bank and Agency spend. Where there is additional growth beyond that outlined above, additional reduction will be required to meet this, as shown in the *WTE Movement from March 25 to March 26* graph below. The WTE *Reductions Identified* include -62 WTE of non-clinical workforce reductions, and a combination of reductions through turnover and in the number of supernumerary colleagues. The bank and agency reduction has associated plans from within the divisions. The remaining -123 WTE CIP is to be identified

- **Growth through service development will grow the WTE by 61 WTE:** in Community based Mental Health Services and the new regional Children & Young People's Gender Service will see an additional 56 WTE employed across the services, and the Liverpool Neonatal Partnership will increase by 5 WTE.

- **Change in service provision will reduce the WTE by - 77:** key service changes include the closure of the Trust Nursery (-22 WTE) and TUPE transfer of some iDigital services (-55 WTE).

Waterfall diagram: movement in WTEs from March 2025 to March 2026



3.5 Transformation

Our multi-year transformation programme is focused on two priorities: transforming clinical services to be sustainable and outstanding for C&YP and modernising our support services to reduce burden and empower our frontline teams. To achieve this, we will mobilise five transformation collaboratives, which will have multi-disciplinary teams driving the change.

Collaborative	Summary of Focus	Benefit and Outcome
Neighbourhood Preventative Care Models	**Aim:** Transform community-based care for CYPF to improve health outcomes, reduce inequalities, and increase system efficiency. **How**: Through family-centred multidisciplinary teams (MDTs), redesigning care to make it more	**Outcome**: CYPF receive care closer to home, reducing unnecessary hospital attendances. **Driver Measure**: CYPF receive timely, proactive, and preventative care closer to home, reducing health inequalities and the need for acute interventions

	accessible, preventative, and equitable. ***Key partners*** *(include): CYP & families, Place Partnerships (Liverpool, Sefton, Knowsley), NHS Trusts, Local Authorities, Public Health, Education, Voluntary/Community /Independent Sector +*	**Benefit:** Fewer CYPF requiring acute and emergency care, lower system costs through reduced demand, and improved long-term health outcomes driven by early intervention and prevention.
Acute, Diagnostics and Urgent Care	**Aim:** To create a world-class, integrated urgent and emergency care service for CYPF, ensuring rapid access to high-quality, safe, and family-centred care while enhancing operational efficiency and financial sustainability. **How:** Optimising the acute care model, same-day emergency care, and deteriorating patient management to create a seamless, high-performing urgent and emergency system. ***Key partners*** *(include): CYP & families, Primary Care Networks, CYP Alliance member Trusts (NHS), Place Partnerships +*	**Outcome:** More efficient, family-centred urgent and acute care, improving patient flow and reducing unnecessary admissions. **Driver Measure**: Increase in % of CYPF treated on the same day, reduction in unplanned admissions, and improved bed utilisation. **Benefit**: Optimised bed management aligned with demand and reduced pressure on inpatient services. (Bed closures)
Re-imagined Elective Care to create Centres of Excellence	**Aim:** Re-design of elective care pathways and develop future models of care to provide streamlined, accessible and equity of care for CYPF. **How:** Re-design of existing pathways with a strong focus on new technologies, virtual care and development of our workforce to support efficient pathways along with data-driven decision-making. ***Key partners*** *(include): CYP & families, C&M CYP Alliance member Trusts (NHS), Royal Manchester Children's Hospital ,3 x North West Integrated Care Boards +*	**Outcome:** CYPF experience seamless, equitable, and digitally enabled care. Ensuring timely access, clear & standardised pathways and a personalised approach that empowers them & their families **Driver Measure: %** Reduction in variation and improved standardisation & access to care across full elective pathways for CYP across the trust. **Benefit:** Optimisation of elective capacity for CYP which reduced waiting time, is digitally enabled and ensures efficient use of resources.
Fit for the Future	**Aim:** Build an inclusive and adaptable Alder Hey that continuously learns,	**Outcome:** A resilient, high-performing workforce with optimised structures that

	improves and is future ready. **How:** A systems approach to organisational design, focusing on vision and values, streamlined governance, right size workforce and modernised corporate services.	enhance efficiency, engagement, and long-term sustainability. **Driver Measure:** Staff Thriving Index (Staff survey results/proxy). **Benefit:** Right-sized non-clinical workforce streamlined management structures, and reduced reliance on temporary staffing.
AI, Digital and Data Futures	**Aim:** Empowering Everyday Lives at Alder Hey through AI, Digital & Data Futures **Focus:** To empower CYPF and staff through advancements in AI, Digital and Data, which will release time, augment care, and enable transformation of new discoveries. **How:** Broadening virtual care offers, driving data insight led care, advancing the use of AI and enhancing and optimising digital systems to improve CYPF care.	**Outcome:** Data-driven, insight-led care across all services and utilisation of new technologies to support efficiencies, empower CYPF and improve staff experience **Driver Measure:** CYPF and our people feedback, time saved, reduction in patient safety incidents and increase in data-driven clinical decision making **Benefit:** Improved our people and CYPF experience, efficiencies as a result of technology introduction across processes and improved patient safety and care

4 Finance

4.1 Activity Planning

Detailed, “bottom up” activity plans have been Divisionally led with support from the Finance team. Plans have been built by starting with the recurrent baseline plans and adjusting in light of 2024/25 Forecast Outturn (at M7), current run rates, and capacity required to meet waiting time targets.

We have costed all activity plans using average tariff prices from M4-8, to reflect the most up to date prices and depth of coding.

Elective Excess Bed Days can be subject to peaks resulting from children who have been in the hospital for many months. These plans have been set at specialty level based on 21 months of activity (since 1 April 2023) and adjusted for exceptional children.

The aggregated ERF activity and income plan is summarised in the table below:

POD	C&MH Activity	C&MH Income	Medicine Activity	Medicine Income	Surgery Activity	Surgery Income	Trust Wide Activity	Trust Wide Income
CHEMO			2,134	£ 862,136			2,134	£ 862,136
DC			12,875	£15,437,903	13,619	£18,505,178	26,494	£33,943,081
ELEC			1,654	£ 5,498,743	3,320	£28,372,942	4,974	£33,871,685
ELEXBD			1,318	£ 811,904	1,332	£ 772,077	2,650	£ 1,583,981
OPIMAG			16,241	£ 2,631,011	10,434	£ 1,189,476	26,675	£ 3,820,487
OPPROC			8,455	£ 1,608,472	21,083	£ 3,439,636	29,538	£ 5,048,108
OPNEW	8,186	£ 1,719,060	21,105	£ 5,314,802	36,104	£ 6,973,765	65,395	£14,007,627
OPNEW - CAM	2,654	£ -					2,654	£ -
OPNEW - ED			20,428	£ 4,289,880			20,428	£ 4,289,880
Total	**10,840**	**£ 1,719,060**	**84,210**	**£36,454,851**	**85,892**	**£59,253,074**	**180,942**	**£97,426,985**

This is pending final amendments to include:

- Business cases in Community Paediatrics and Neurodevelopmental pathways
- Business case in Radiology
- Potential reductions in plan resulting from contract risks and impact assessment of ERF Cap
- A review of cardiac capacity and the waiting list

The following table shows ERF activity (excluding ELEXBD) compared to forecast outturn, with 25/26 Draft greater than Forecast Outturn primarily due to high volume areas such as Outpatient and Outpatient Imaging.

Division	Recurrent Plan	Forecast Outturn (M7)	25/26 Draft
Community	**10,822**	**12,649**	**10,840**
Medicine	**79,547**	**80,262**	**82,892**
Surgery	**79,308**	**81,622**	**84,561**
Trust	**169,548**	**174,533**	**178,445**

4.2 Financial Overview

To meet our commitment to the ICB system and enable investment to deliver Vision 2030 we will deliver on our obligations to ensure financial sustainability, including:

- I&E position: minimise underlying deficit. Draft indicative plan using internal assumptions and likely income is £1.7m deficit, however, this is subject to change over coming weeks as financial planning in C&M is not yet concluded and a high number of income allocations not yet known. National target is to achieve financial balance however ICB has set Alder Hey target at £3.4m surplus.
- Income / ERF position: maximise our income, noting ongoing discussions regarding introduction of ERF Cap which is expected to limit growth and put greater focus on productivity and cost reduction
- Recurrent Efficiency savings of £22m, with greater focus on benefit realisation from transformational schemes (£10m), aligned to the Trust Strategic Programme.

- Capital spend (CDEL) (£TBC) in 2025/26 will continue to be managed through the ICS at system level with allocation of spend distributed to each provider.
- Continue investment in our campus and estate, with schemes including Neonatal Unit, Alder Park and Same Day Emergency Care (SDEC).

4.3 Income & Expenditure Plan

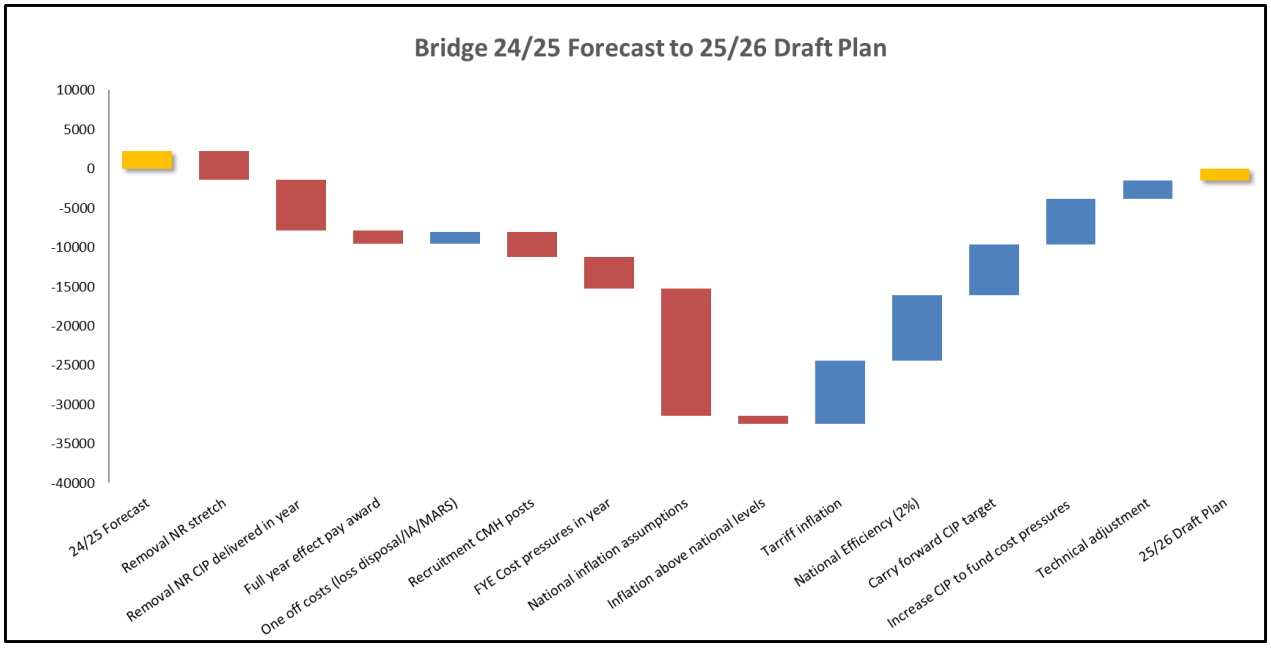
The following table summarises the proposed financial plan for 2025/26, compared to our performance in 2024/25. At the time of writing this report, discussions are continuing across the region as ICB financial position is in a significant deficit and therefore our budgetary plan is still provisional. Table may need to be updated, pending further adjustments:

Category	Area	Forecast @ M9 £'000	25/26 Annual Plan £'000	Movement £'000
Income	Block Payments	241,673	245,235	3,563
	C&V drugs	49,127	48,817	(310)
	C&V devices	8,420	8,414	(6)
	ERF	96,001	97,081	1,079
	Clinical Other	1,905	2,337	432
	Non-Clinical	38,075	35,840	(2,235)
	Total Income	**435,201**	**437,724**	**2,523**
Expenditure				
	Pay Costs	(273,065)	(289,396)	(16,330)
	Non-Pay	(133,295)	(126,391)	6,904
	Depreciation	(16,998)	(18,186)	(1,187)
	Other Technical Charges	(9,460)	(5,418)	4,043
	Total Expenditure	**(432,818)**	**(439,389)**	**(6,571)**
	Overall Position	**2,382**	**(1,665)**	**(4,048)**

The key principles that have been adopted in the development of the 2025/26 I&E plan include:

- Recurrent Block contract income levels rolled over from 2024/25 uplifted by inflation and growth as per national guidance.

- Activity based contract income broadly based on 2024/25 forecast outturn with a view to maximise income opportunities but whilst remining within the expected ERF cap.
- Pay award based on 4.7% as per the national guidance although this has not yet been awarded. This includes both the impact of pay award and National Insurance increase.
- 70% of legacy cost pressures funded within divisional budgets with the remaining expected to be mitigated through switch off or additional CIP and will be monitored through the Sustainability Deliver Group.
- A recurrent efficiency target for the year of £22m (c.5%), including carry forward from 2024/25 as identified non-recurrently.
- The 2025/26 position includes £5.2m technical adjustment in relation to PFI accounting (IFRS16 (provider accounting requirement) to UK GAAP (DHSC accounting requirement) which providers are required to include in plans

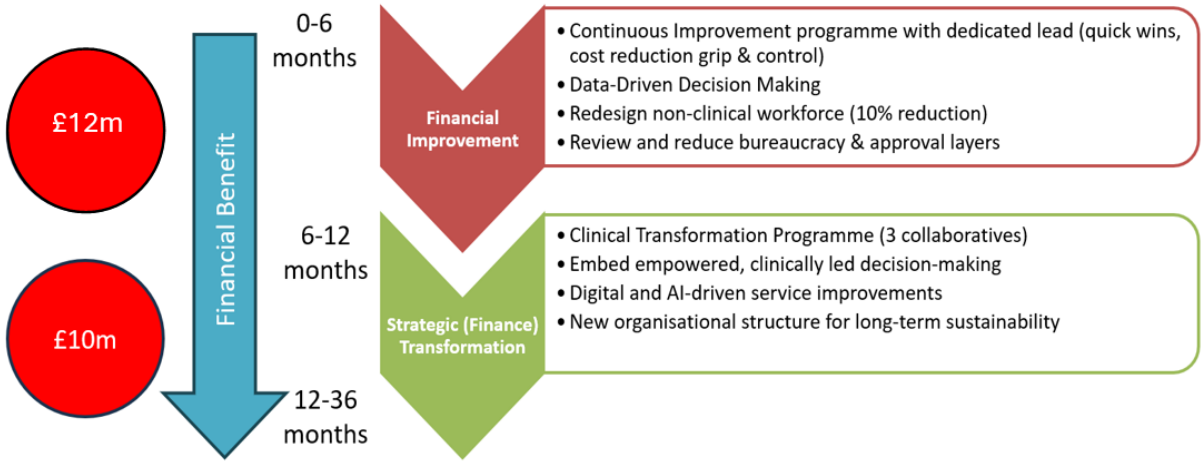


4.4 Efficiency Programme

To achieve a £1.7m deficit budget, we will be required to deliver an extremely challenged Efficiency Programme, with recurrent savings of £22m. This represents circa 5% of our current budget and includes carry forward from 2024/25 (as the savings were delivered non-recurrently). This re-iterates the importance of ensuring we collectively achieve the recurrent efficiency benefits in 2025/26 to remain financially sustainable – or we risk having even greater financial challenges in future years.

As this is such a large efficiency target, there will be greater focus on benefit realisation from transformational schemes (£10m), aligned to the Trust Strategic Programme. The remaining c. £12m will be delivered through a financial improvement workstream focusing on redesign of non-clinical

workforce, cost reduction and grip and control with support from central functions such as procurement, innovation, Finance etc.



To allocate the 2025/26 efficiency targets to divisions and departments, the following principles have been followed:

- Unachieved recurrent savings carried forward from 2024/25
- 2% of 2025/26 start point budgets, including
    - Requirement for 10% recurrent savings on non-clinical pay budgets
    - Opportunity arising from `financial improvement` (as above, this element may need to be moved as further details are worked up)
- Opportunity arising from strategic transformation (this element of the target may need to be moved as further details are worked up under SRO leadership)

	Financial Improvement Group: £12m			Strategic Transformation: £10m				
		2% of Operational Budgets						
Division	Recurrent Carry Forward (as at M9) £000's	Pay Savings (Non Clinical) ** £000's	Working Efficiently (inc Non Pay Savings) £000's	Prevention & Neighbourhood Based Health £000's	Acute, Diagnostics & Urgent Care £000's	Centres of Excellence £000's	Re-imagined Elective Care (OP& IP) £000's	Total £000's
Community & Mental Health	290	1,396	109					TBC
Medicine	1,731	681	1,547					TBC
Surgery	0	666	2,101	0	2,000	2,000	6,000	TBC
Futures (R&I / Global)	0	0	193					TBC
Corporate Teams*	520	2,709	0					TBC
Total	2,541	5,452	3,950	10,000				21,943

* Corporate team budgets are primarily non-clinical pay, therefore the £2.2m non clinical pay savings target is greater than 2% of total budget
** Pay Savings (Non Clinical) - expectation to deliver 50% of this target in year, and find non recurrent savings to offset slippage

Outline Proposal for £10m Benefit from Strategic Transformation

Collaborative	Proposed 25/26 Target	Opportunities
Prevention & Neighbourhood Based Care	£0m	Move a number of phlebotomy clinics out of hospital setting, to release OP capacity. Financial Benefit from this will need to be realised through OP Transformation below. Secure new investment in neighbourhood, public health and prevention services.
Acute, Diagnostic & Urgent Care	£2m	£0.5m PAU – through reduction of additional 8 beds, subject to bed modelling and timing of delivery. £0.5m SDEC – ambitious target, need detail modelling to confirm opportunity and timing of delivery. £0.5m Diagnostic – ensure these opportunities are not double counted with Medicine 2% CIP. £0.5m Unidentified – potential for growth in UTC attendances, but may be subject to ERF Cap.
Centres of Excellence	£2m	GIRFT / SLR Expand high value activity Grow nationally commissioned services
Reimagined Elective Care - Outpatients	£3-4m	• Robust triage of inappropriate referrals • More B&S processes (portal; letters) • Increase clinic utilisation through RPA and better scheduling through the Federated Data Platform. • Clinical productivity and reduced administration time from Ambient AI (Lyrebird) • Eliminate use of paper in OP pathways • Reduce out-of-hours clinics (WLI / overtime / premium costs)

Reimagined Elective Care – Day Case & IP	£2-3m	• GIRFT / SLR
		• Productive Theatre Group
		  ○ Elective Hub – utilise additional capacity
		  ○ Optimise Surgical Day Case volumes
		• MDU Productivity (Brilliant basics)

4.5 Capital Planning

The level of capital spend is controlled by a Capital Resource Limit (CDEL) set nationally by Treasury and then allocated to each ICS by way of a system CDEL envelope that must not be exceeded.

As a Foundation Trust, Alder Hey has previously had the autonomy to develop a capital plan that utilised internally generated cash with the approval of own Trust governance. The move to a system capital resource limit (CDEL) with allocations to each provider, removes this autonomy to ensure that the capital spend for the ICS is within the limits set nationally. The CDEL allocation is a 'permission to spend' our own cash reserves and not necessarily an additional cash allocation although, new national capital investments will take the form of new cash in addition to an increase in CDEL to spend it.

The table below sets out the summary of the capital requirements for 2025/26 based on a prioritisation process that in ongoing. Capital allocations for 2025/26 are yet to be confirmed and are subject to an ICB prioritisation exercise. Likely minimum funding available for 2025/26 will be £12.8m which will cover existing contractually committed schemes plus capital staff. Other projects will be prioritised as overall capital funding envelope becomes clearer.

Scheme	24/25 Plan TRUST CDEL	24/25 Plan Charity
Neonatal	9,132	4000
Alder Park	1,000	
Elective Hub	TBC	
CT scanner *		950
Total contractually committed	**10,132**	**4,950**
Capital staffing	1,650	
Medical equipment	2,000	TBC
Omnicell	805	
EPR data centre refresh	2,000	
Core data centre refresh	2,000	
Other digital	1,390	
Other campus	739	
H&S/PES/Innovation/Other	740	
Other capital priorities	**11,324**	**-**
Total	**21,456**	**4,950**

**Subject to charity board approval*

In addition to the above there are a number of projects that will be prioritised if funding should become available as set out below:

To bid for if funding became available		25/26 Trust CDEL
New Models of Care	Insight Unit	250
New Models of Care	Remote Monitoring	250
New Models of Care	Pharmacy Automation (Robot)	1,000
New Models of Care	Bed Management and Patient Flow	1,000
New Models of Care	Population Health	250
	Total	**2,750**

The capital management group will meet throughout the year to review any new requirements and monitor spend against the plan ensuring appropriate utilisation of the resources.

5. Risk & Governance

The Trust has a robust risk and governance system in place which underpins our overall control environment. This means that Alder Hey is well-placed to meet the challenges presented by the national and local landscape, as well as the opportunities we wish to pursue in line with our own ambitious strategy. That said, the current challenges must be acknowledged as unique in Alder Hey's history, and we must remain vigilant as an Anchor Institution for CYPF that we continue to advocate for ring-fenced resources in this vital area.

For the purposes of the delivery of the plans laid out above, we will keep the associated risks under review through our existing assurance functions at sub-board level, whilst instituting more flexible arrangements locally to track the risks emerging from the transformation collaboratives. This will be in the context of our agreed risk appetite and thresholds, which will be used as a touchstone by the board as we move forward.

The risks and key mitigations to the overall plans across the four key areas can be articulated as follows:

5.1 Safety and access

There is a risk that the constrained financial envelop will impact on our ability to deliver safe patient care.

We will mitigate this by:

- Ensuring there are robust and transparent mechanisms for assessing the quality impact of each and every decision 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.

5.2 People and culture

There is a risk that 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.

We will mitigate this by:

- Developing a strong communication strategy to reinforce our values and ensure that staff have accurate and transparent information that they can relate to their own circumstances.
- Working with individual teams to involve staff in service transformation and place them at the forefront of change programmes.

5.3 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.

We will mitigate this by:

- Developing an operating model that will improve productivity and efficiency.
- Increasing our data analytics and horizon scanning capability in support of this to ensure our resources are maximised and we are able to lever opportunities for growth through diverse routes.

5.4 Leadership and governance

***T**here is a risk that we do not provide appropriate support mechanisms required by the organisation to effectively meet the challenges we face.*

We will mitigate this by:

- 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, whilst maintaining robust assurance processes using our BB approach.

Appendices

Appendix 1: Divisional

Community & Mental Health Division	Measures of success	Outstanding care and excellence	Collaborate for children & young people	Support our people	Revolutionise care	Pioneering breakthroughs
Improvement in access to ND diagnostic assessment	Maximum waiting times to assessment	●	●	●	●	
Improved access to CYPF Mental Health	Impact of health inequalities & access	●				
Delivery of Eating Disorder Day Unit service and improved therapy space at Alder Park (part year – to open May 2025)	Unit opens Activity through DCU Reduction in admissions / LOS in acute beds	●				●
CQC Healthcheck - Mental Health Service	Completed review of service Development action plan	●		●		
Delivery of high quality outpatient service which is efficient, effective and responsive to children and young peoples needs	Increase in clinics/activity Increase in clinics delivered in community locations			●		
SARC accreditation	TBC	●	●			

Corporate Services	Measures of success	Outstanding care and excellence	Collaborate for children & young people	Support our people	Revolutionise care	Pioneering breakthroughs
Digital – Improvements to data warehouse	Staff reporting easier access to data and analysis			●		
Digital – device refresh	Decrease in service desk tickets related to old hardware			●		
HR – Increasing E-Roster Levels of Attainment	Maximise usage, workforce availability & productivity	●		●		
Finance – Process review of Financial Services	Improvement in BPPC target Improved debt recovery Streamlined service	●		●		
Estates & Facilities	TBC					

Division of Medicine	Measures of success	Outstanding care and excellence	Collaborate for children & young people	Support our people	Revolutionise care	Pioneering breakthroughs
Perinatal Pathology Hub development	NHSE hub commissioning model to commence	●	●	●	●	●
Oncology Care Closer to home	% CYPF to be treated at home or within the community	●	●		●	●
Stabilising services with National collaboration - Haematology -Neurology	Regional / National on-call rota's to commence		●	●	●	
Development of non-NHS income to ensure the financial sustainability of the Division	Non-NHS related income to grow by 25%	●			●	
Embed Trust wide Pharmacy strategy fit to serve CYPF now and for the future	3 new pharmacy models embedded within the Trust	●	●	●	●	●

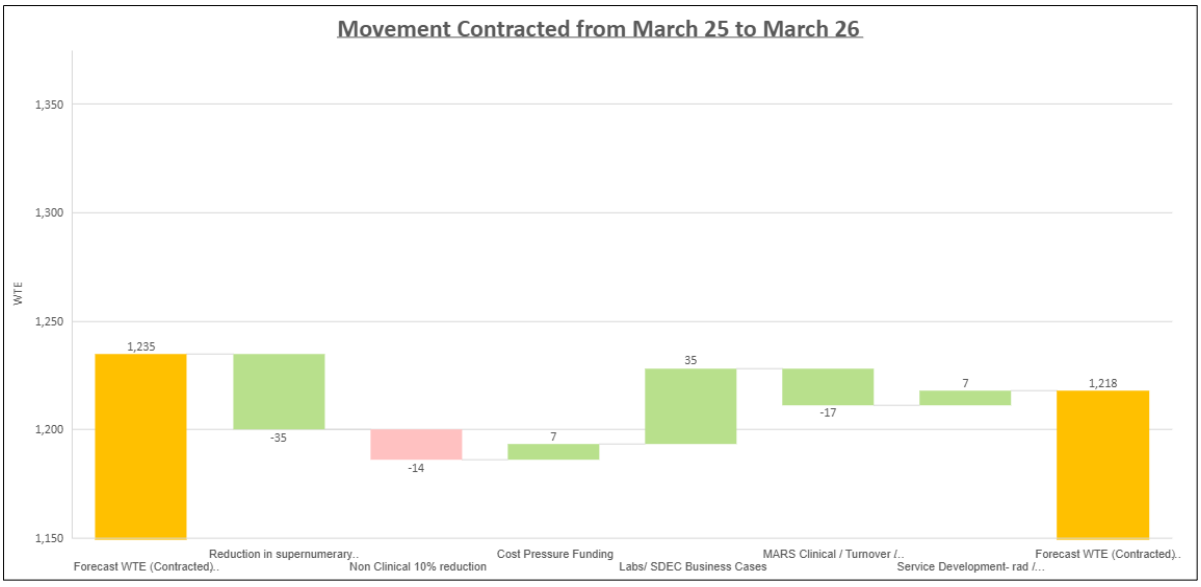
Clinical Research & Futures	Measures of success	Outstanding care and excellence	Collaborate for children & young people	Support our people	Revolutionise care	Pioneering breakthroughs
Discover and Grow - Secure external funding through grants and partnerships to support discovery of new knowledge and solutions	Driver - increase commercial and non-commercial income across Futures by 10% Secure 5 commercial partnerships with financial benefit (revenue share, royalties)				●	●
Develop - Attract and retain a diverse, R&I-informed workforce across all staff groups through capacity and capability building	Driver – increase number of staff benefitting from capacity and capability funding support 5 successful external fellowship applications		●	●		●
Discover and Transform - Ensure the Trust Change Collaboratives are R&I enabled to drive new knowledge and solutions locally, nationally and beyond	Driver – implement 10 innovative solutions to address problem statements Manual hours released through implementation of innovative solutions	●	●	●		
Underpinning priority - Maximise opportunities to learn from data to inform new discovery, build partnerships and share knowledge	Implementation of CRM system Trustwide Integration of R&I data capture systems with data warehouse and IPR				●	●
TBC						

Division of Surgery	Measures of success	Outstanding care and excellence	Collaborate for children & young people	Support our people	Revolutionise care	Pioneering breakthroughs
Implement a robust system for capturing clinical outcomes across the division	Improved clinical outcomes Increased research opportunities Reduced variation	●			●	●
Implementation of enhanced patient monitoring 'Etiometry' in Critical Care	Reduction in re-admissions Improved outcomes Reduced LOS	●	●		●	●
Theatres Digital Excellence programme: FDP, Emergency & Trauma system, implantable devices solution	Increase TT Utilisation Reduction in cancelled operations Paper free	●	●	●	●	
Critical Care Review of demand & capacity	Successfully support cot moves to NICU	●		●	●	
Future sustainability of Services: Cardiology, ENT, Dentistry	Sustainable delivery of access targets Sustainable & streamlined patient pathways	●	●	●	●	●

Appendix 2: Divisional Annual Plans – (Finance, Workforce & Activity)

2.1. Medicine Division

Description	Income £000's	Pay £000's	Non-Pay £000's	Total £000's	WTE
24/25 Budget (Rec & Non-Rec)	(78,985)	80,616	55,692	57,322	1204
24/25 M9 Forecast Outturn	(85,294)	83,429	64,468	62,604	1261
Variance (at M9)	6,308	(2,814)	(8,777)	(5,282)	-57
25/26 Rec Budget rolled forward	(79,135)	81,675	56,605	59,145	1205
25/26 CIP Target	(2,597)	(346)	(600)	(3,543)	
Cost Pressures				3,000	
Total Budget Required for 25/26	(81,732)	81,329	56,005	58,602	1205



Forecast WTE (Contracted) March 25	1,235
Reduction in supernumerary Nursing	-35
Non Clinical 10% reduction	-14
Cost Pressure Funding	7
Labs/ SDEC Business Cases	35
MARS Clinical / Turnover / Outsourcing	-17
Service Development - rad / perinatal pathology	7
Forecast WTE (Contracted) March 26	1,218

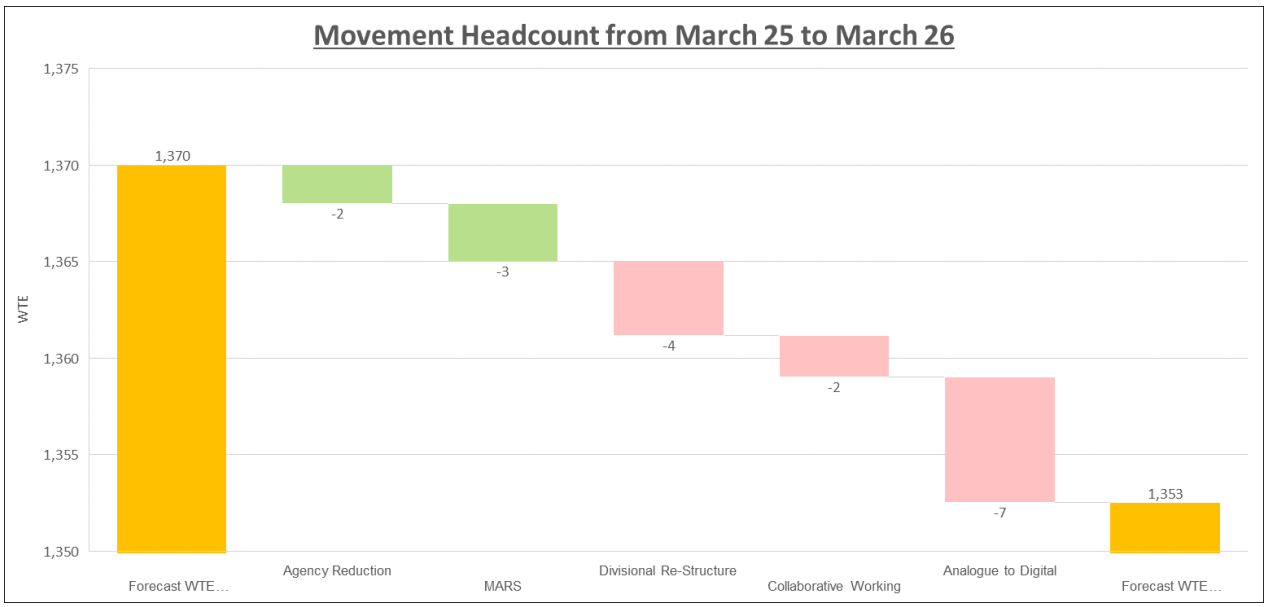
Proposed Budget 25/26	1,205

Point of Delivery	24/25 Start Activity Plan	24/25 CIP Recurrent FYE	2025/26 Growth & Productivity	2025/26 Activity Plan	2025/26 Activity £	M7	
						24/25 £ FOT @M7	24/25 £ FOT @M7
Chemotherapy	2,111		23	2,134	£862,135	2,105	£850,173
Daycases	11,597	896	382	12,875	£15,437,903	12,690	£15,725,304
EL Excess Bed Days				1,318	£811,904	1,386	£913,223
Elective	1,598	70	- 14	1,654	£5,498,743	1,618	£5,552,615
OP Imaging	15,173	628	440	16,241	£2,631,011	16,141	£2,574,679
OP Procedure - New	5,786	1,137	1,532	8,455	£1,608,472	7,443	£1,438,727
Outpatient New	40,051	500	982	41,533	£9,604,682	40,265	£9,145,534
Total ERF	**76,316**	**3,231**	**4,792**	**84,210**	**£36,454,850**	**81,648**	**£36,200,255**

24/25 Recurrent Plan	£35,224,896
Increase in 25/26	£1,229,954
Variance from M7 FOT	£254,595

2.2 Surgery Division

Description	Income £000's	Pay £000's	Non-Pay £000's	Total £000's
24/25 Budget (Recurrent & Non-Recurrent)	(67,915)	93,513	23,618	49,216
24/25 Forecast Outturn (at M9 23/24)	(72,776)	97,342	28,679	53,245
Variance (at M9)	4,861	(3,829)	(5,061)	(4,029)
25/26 Recurrent Budget Rolled Forward	(70,424)	95,270	24,485	49,331
24/25 CIP carried forward	1,352	(797)	(1,111)	(556)
25/26 CIP Target (TBC)		(541)	(1,709)	(2,250)
Cost Pressures		268	2,466	2,734
Total Budget required for 25/26	**(69,072)**	**94,200**	**24,131**	**49,259**

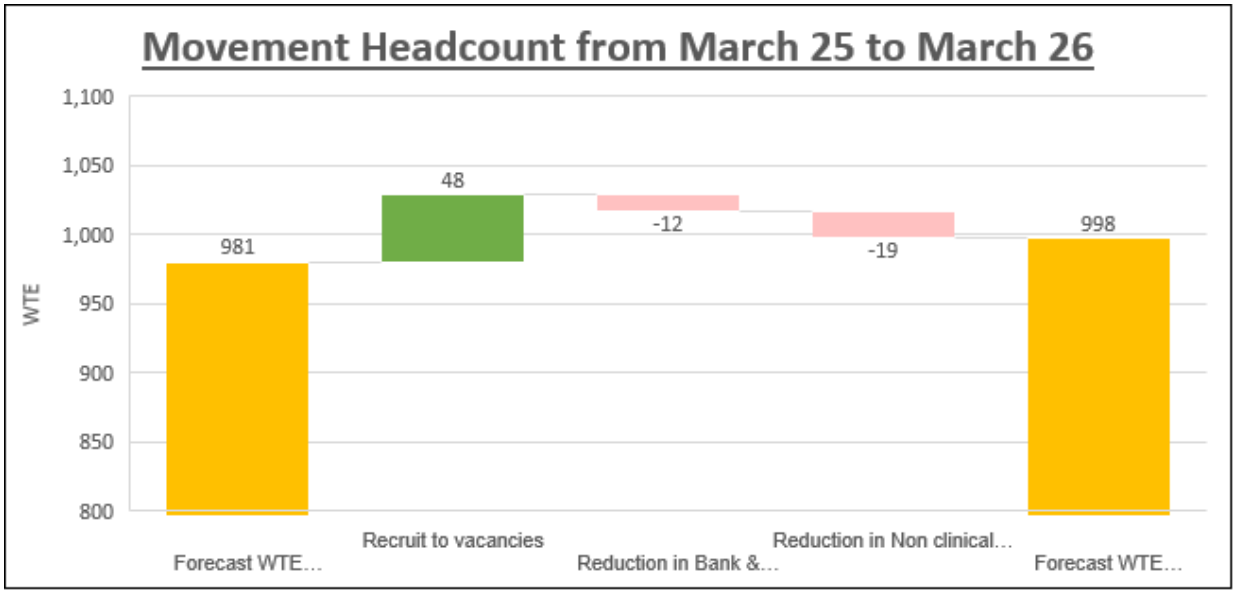


Surgery Activity Plan 25/26		Forecast 24/25 Activity	Forecast 24/25 (£000)	Revised Plan 25/26 Activity	Revised Plan 25/26 (£000)	Movement Activity	Movement (£000)
ERF	Daycases	12,856	18,597	13,619	18,505	763	-92
	EL Excess Bed Days	1,206	673	825	462	-381	-211
	Elective	3,265	27,962	3,320	28,373	55	411
	OP Imaging	8,753	973	10,434	1,189	1,681	217
	OP Procedure	20,854	3,435	21,083	3,440	229	4
	Outpatient New	35,894	6,907	36,104	6,974	210	67
Grand Total		**82,829**	**58,547**	**85,386**	**58,943**	**2,557**	**396**

2.3 Community & Mental Health Division

Description	Income £000's	Pay £000's	Non-Pay £000's	Total £000's	WTE
24/25 Budget (Rec & Non-Rec)	(3,881)	58,041	5,755	**59,915**	**1003**
24/25 M9 Forecast Outturn	(4,735)	54,125	6,318	**55,708**	**954**
Variance (at M9)	**854**	**3,916**	**(563)**	**4,207**	**49**
25/26 Rec Budget rolled forward	(3,881)	57,584	5,766	**59,468**	**1003**
25/26 CIP Target (New Target)	0	(937)	(287)	**(1,224)**	**(19.22)**
Cost Pressures	0	254	0	**254**	**0.73**
Total Budget Required for 25/26	**(3,881)**	**56,901**	**5,479**	**58,498**	**984.51**

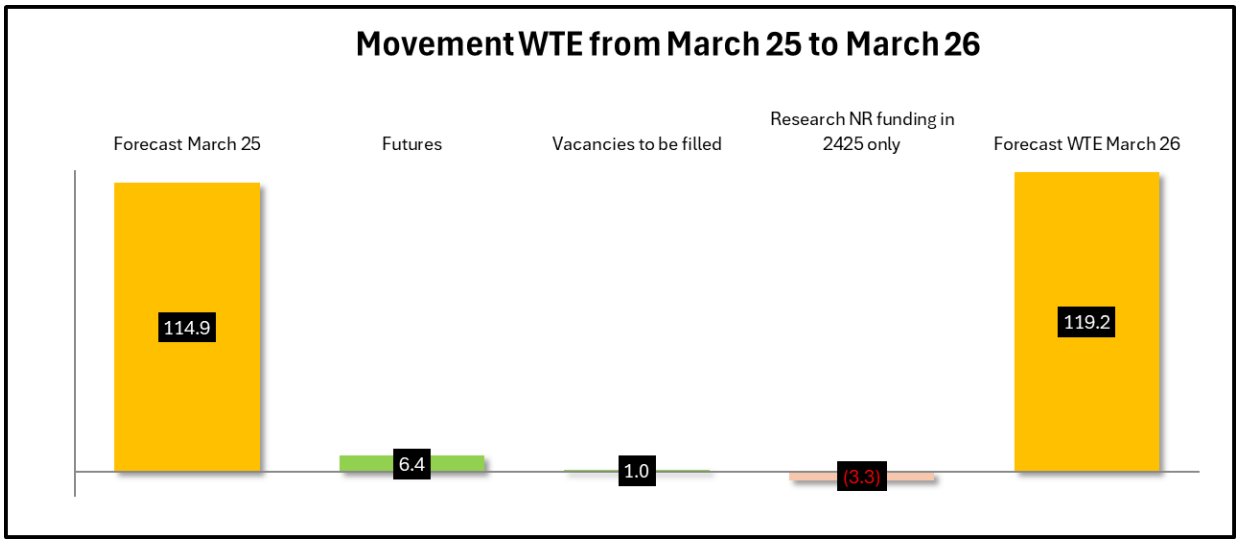
Point of Delivery	24/25 Start Activity Plan	24/25 CIP Recurrent FYE	Contract Variations	2025/26 Growth & Productivity *	2025/26 Activity Plan
OP New	9,812	1,028	0	691	11,531
OPFU	56,391	0	0	4,343	60,734
Total	**66,203**	**1,028**	**0**	**5,034**	**72,265**



2.4 Clinical Research & Futures

Description	Income £000's	Pay £000's	Non-Pay £000's	Total £000's	WTE
24/25 Budget (Rec & Non-Rec)	(9,632)	5,824	2,830	**(979)**	**101**
24/25 M9 Forecast Outturn	(9,146)	5,651	4,251	**755**	**107**
Variance (at M9)	**(486)**	**174**	**(1,421)**	**(1,734)**	**-6**
25/26 Rec Budget rolled forward	(9,607)	6,227	2,386	**(994)**	**119.02**
25/26 CIP Target	0	0	(157)	**(157)**	**0**

Cost Pressures	0	0	25	**25**	**0**
Total Budget Required for 25/26	**(9,607)**	**6,227**	**2,254**	**(1,126)**	**119.02**



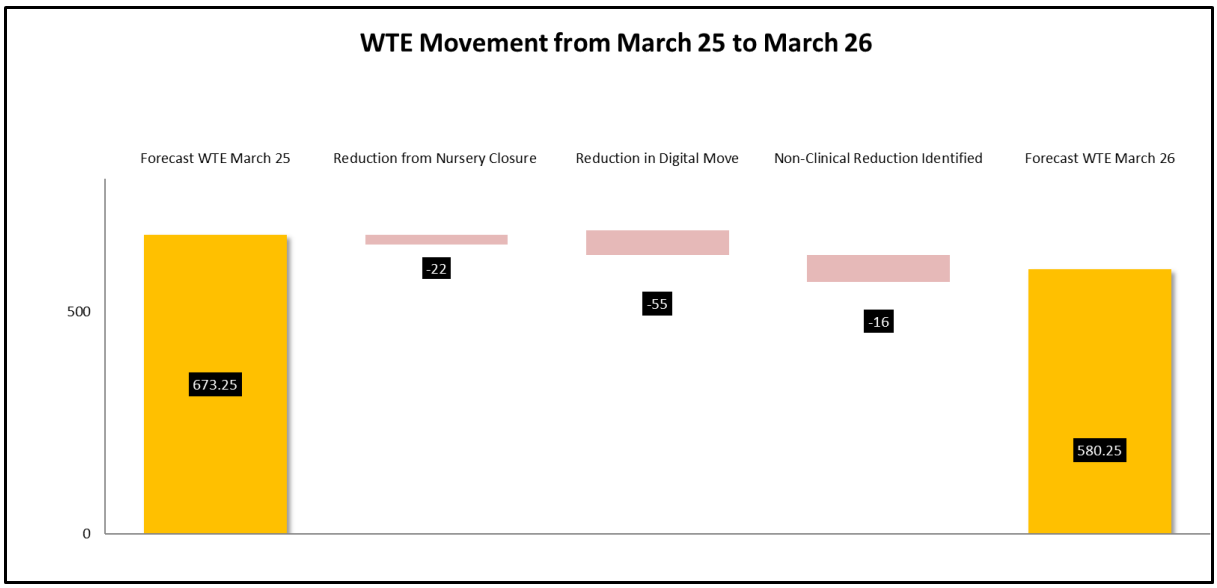
**Futures – 1.4 WTE converted from non-pay budget, 4 WTEs vacant at March 25, 1 WTE newly created offset by income target.*

2.5 Corporate

Description	Income £000's	Pay £000's	Non-Pay £000's	Total £000's	WTE
24/25 Budget (Rec & Non-Rec)	9,931	- 36,977	- 24,423	**- 51,469**	**720**
24/25 M9 Forecast Outturn	10,663	- 35,369	- 28,093	**- 52,798**	**632**
Variance (at M9)	**732**	**1,608**	**- 3,669**	**- 1,329**	**88**
25/26 Rec Budget rolled forward (exc carry forward CIP)	9,843	- 36,678	- 22,933	**- 49,768**	**683**
25/26 CIP Target (including carry forward)	75	2,288	360	**2,723**	**- 68.08**
Digital TUPE	- 5,200	3,158	2,232	**190**	**-63.13**
Cost Pressures	-	- 378	- 3,993	**- 4,371**	**2**
Total Budget Required for 25/26	**4,718**	**- 31,610**	**- 24,334**	**- 51,225**	**554**

The above is broken down by division as follows;

	ALDER HEY IN THE PARK	FACILITIES	STRATEGY	Corporate Other	N&Q	FINANCE	HR	DIGITAL	ACADEMY	Grand Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Sum of 2025 Budget	- 9,537	- 7,685	- 4,062	- 5,554	- 3,921	- 3,593	- 3,723	- 10,617	- 2,777	- 51,469
Sum of 2025 Forecast	- 9,610	- 8,099	- 4,002	- 6,060	- 3,926	- 3,064	- 3,987	- 10,946	- 3,104	- 52,798
Variance	**73**	**414**	**- 60**	**506**	**5**	**- 529**	**264**	**329**	**327**	**1,329**
25/26 Rec Budget rolled forward (exc carry forward CIP)	**- 9,666**	**- 7,781**	**- 3,060**	**- 5,273**	**- 3,987**	**- 3,734**	**- 3,948**	**- 10,083**	**- 2,234**	**- 49,767**
CIP including carry forward	98	800	101	533	377	265	432	-	116	2,723
Digital TUPE	-	-	-	-	-	-	-	190	-	190
Cost Pressures	- 1,061	- 332	-	- 422	- 58	-	- 129	- 2,041	- 328	- 4,371
	- 10,629	**- 7,313**	**- 2,959**	**- 5,162**	**- 3,669**	**- 3,469**	**- 3,645**	**- 11,934**	**- 2,446**	**- 51,225**



**The above waterfall does not include bank and agency use.*

Flash Report February 2025

Performance is subject to change

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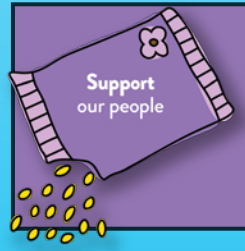
1	1	90.9%	3
Severe/Fatal Incidents/Never Events	Number of Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections

79.0%	310	109.6%	94%
ED: % Treated within 4 Hours	Number of RTT Patients waiting >52weeks	Elective Recovery Volume vs 19/20	Diagnostic Performance



+189	9.67%	80.2%	TBC%
Estimated Workforce Plan	Staff Turnover	%PDRs Completed	% Sickness

VISION 2030

HIGHLIGHT

Staff Turnover 2nd consecutive month under target (10%)

4 hour Emergency Department target achieved

Financial Sustainability

M11 position was £0.7m surplus and £1.3m surplus ytd which was off plan due to pay award. Activity levels were lower than forecast and non-pay costs higher than forecast resulting in £0.5m of benefits being brought forward to achieve this position.

Forecast to be finalised, but likely to show £3.3m surplus for the year, however risk adjusted forecast remains at £2.2m following another challenging month

CHALLENGES

WTE estimated to be +189 above plan although not the final position. Sickness position to be finalised.

x2 MSSA hopsital onset healthcare associated infections & x1 C.Diff Community onset.

Never Event/PSII

NHS
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Integrated Performance Report

Published: February 2025

VISION 2030

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

OUR ASPIRATION
To be world-leading

Our Journey
To 2030

Get me well

Personalise my care

The Needs of Children, Young People and Families

Improve my life chances

Bring me the future

Outstanding care and experience

Collaborate for children & young people

Revolutionise care

Support our people

Pioneering breakthroughs

respect | excellence | innovation | together | openness

Contents

VISION 2030

Our Journey To 2030

BRILLIANT BASICS

IPR Summary

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

Variation	Assurance: Achieving Target	Assurance: Inconsistently Achieving Target	Assurance: Not Achieving Target
Special Cause - Improvement	Liquidity, Mandatory Training, Category 3 & 4 Pressure Ulcers and Level 1 patient safety training are consistently achieving target with an improving trend	Incidents of harm, Severe/Fatal incidents, PSII's, 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 and MRSA are achieving targets with common cause variation.	Incidents no harm, F&F, Sepsis, PALS resolved, ED 4hr, WNB Rate, C.Diff, Sickness (Total) and risks within review date are inconsistently achieving target and are yet to evidence statistical improvement	Theatre Utilisation & Long-Term Sickness are not achieving targets and currently not demonstrating statistical improvement
Special Cause - Concern		Short Term Sickness is inconsistently achieving its target but demonstrating declining trend .	

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

- 65.3% of measured metrics have achieved target in the month of January 2025.

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

- We are consistently passing 19.6%* of our metrics.
- We are achieving 67.4% of our metrics inconsistently.
- We are not consistently achieving the target for 13% of our metrics. 0 are showing special cause of concern however 4 are showing special cause of improvement.

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

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

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

100% of patients in ED and 92% of inpatients requiring antibiotics for sepsis received them within 60 minutes which is a great improvement. The number of medication errors resulting in harm has been consistently lower than the target for the last 9 months (with the exception of one month). The data shows a sustained improvement since May 2024

Areas of Concern:

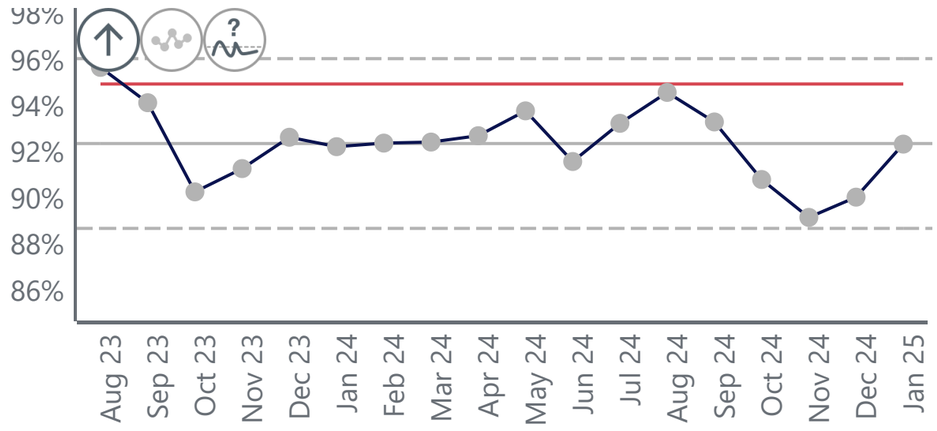
Continued fluctuation of patients who deteriorate on inpatient wards and need admission to critical care; a deep has been undertaken which includes findings and learning to take forward. The Response Team review all deteriorations requiring critical care admission using the preventability framework. The number of potential / predictable deteriorations remains low overall (14% in last 3 months)

Forward Look (with actions)

Divisional governance teams undertaking training in complaints management

F&F Test - % Recommend the Trust

Target: Statutory



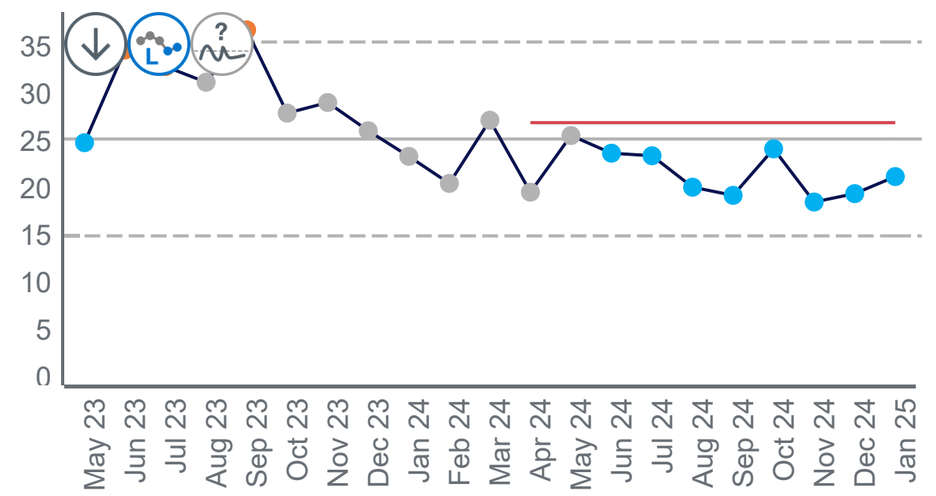
Technical Analysis:

Common cause variation has been observed with performance of 92% in January 2025. An increase from December performance of 90%. 2nd consecutive month with improvment since November 2024.

Actions:

92% of families who have responded shared that they would recommend the Trust. A Quality Ward Round has been undertaken to review the FFT questions asked; analysis and outcome of the findings underway

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



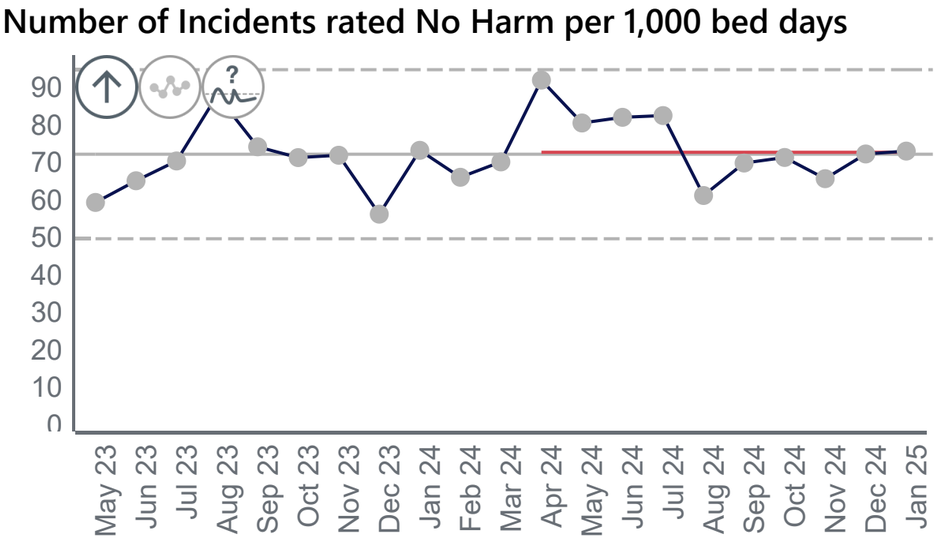
Technical Analysis:

Special cause variation of improving nature has been observed with performance of 21 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:

Number of incidents below the threshold which is positive whilst maintaining a culture of incident reporting within the Trust

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



Technical Analysis:

Common cause variation observed with 73 incidents of no harm per 1000 bed days, with a monthly average of 72. This includes 53 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:

Continued positive culture of reporting no harm and near miss incidents. "Good Catches" - near misses – recognised and the learning disseminated through the weekly Patient Safety Meeting and the bulletin published after the meeting

Integrated Performance Report | February 2025

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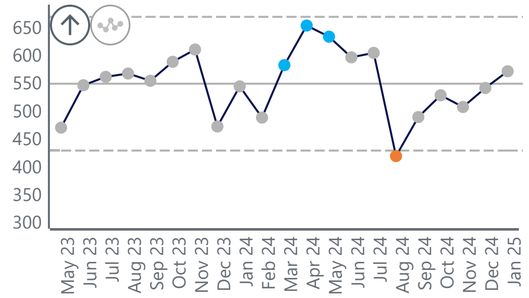
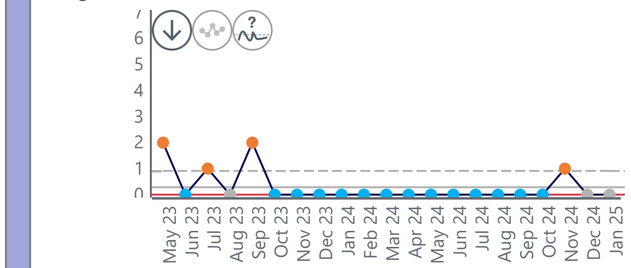
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



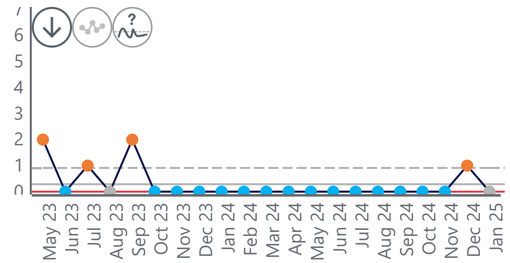
Severe or Fatal Incidents – Physical only

Target: Internal

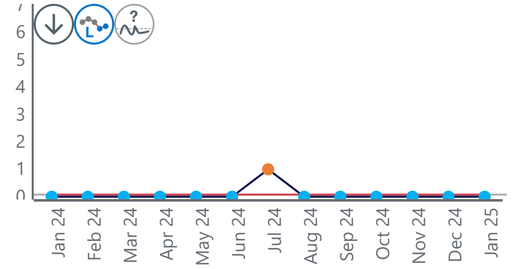


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

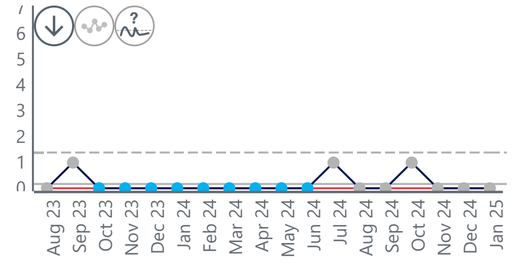


Number of PSIIs (Patient safety incident investigation) undertaken



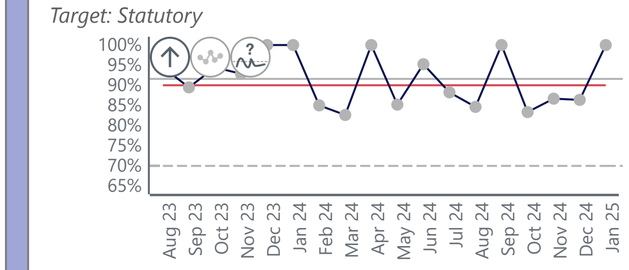
Number of Never Events

Target: Internal



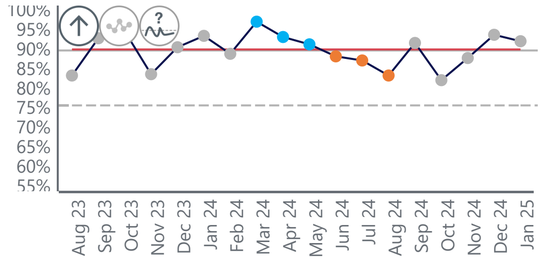
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

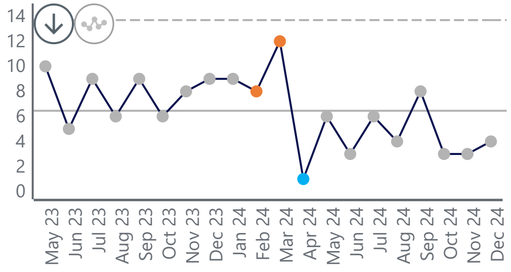


Sepsis % Patients receiving antibiotic within 60 mins for ED

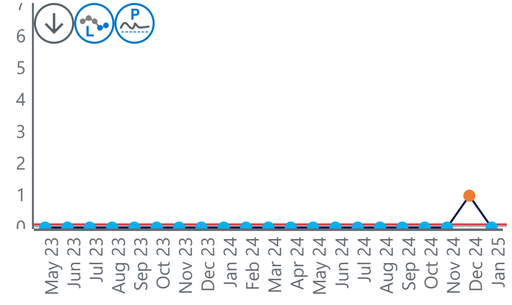
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

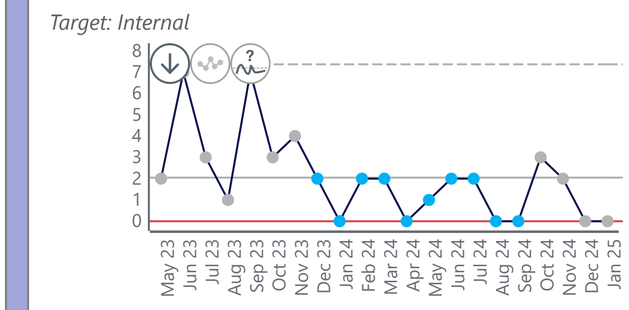


Pressure Ulcers Category 3 and 4

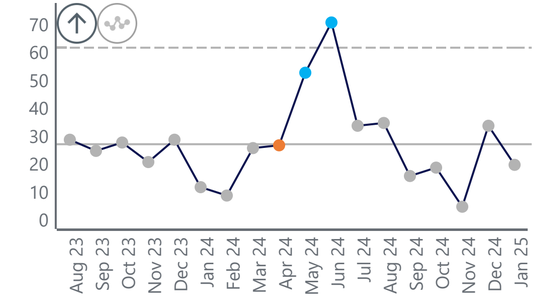


Pressure Ulcers Category 2

Target: Internal

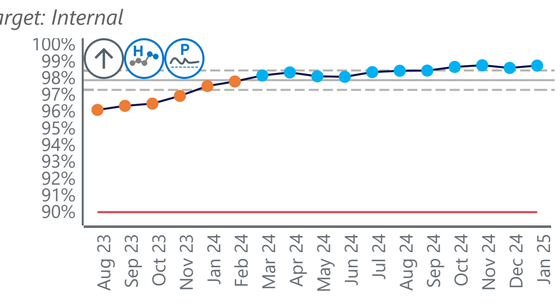


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



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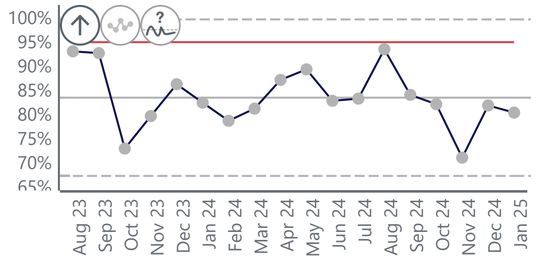
Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

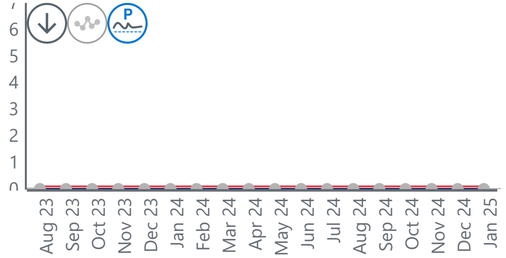
F&F ED - % Recommend the Trust

Target: Internal



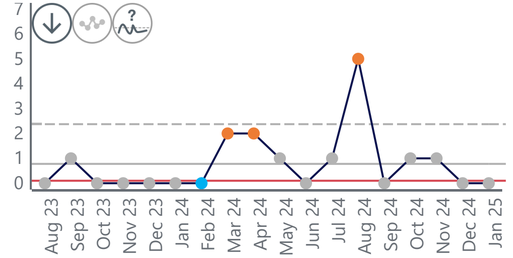
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



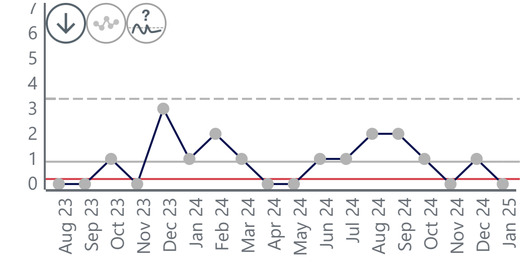
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



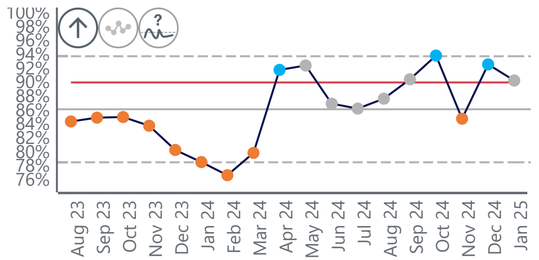
Hospital Acquired Organisms - MSSA

Target: Internal



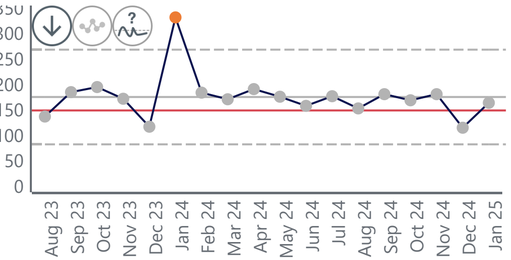
% PALS Resolved within 5 Days

Target: Internal



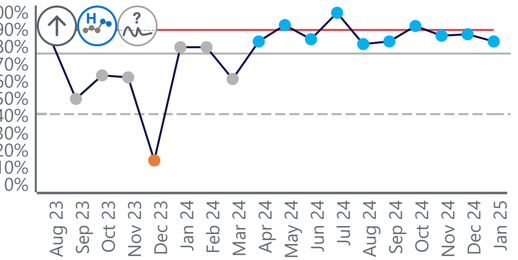
Number of PALs contacts

Target: Internal



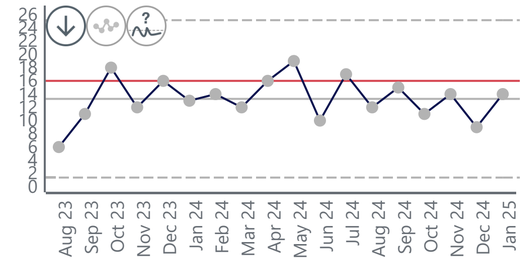
% Complaints Responded to within 25 working days

Target: Internal

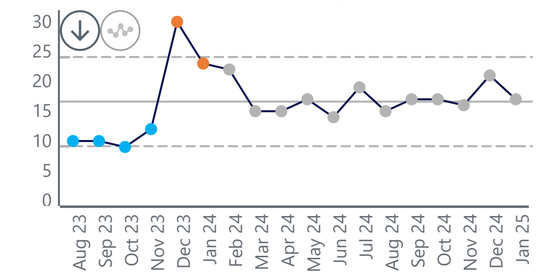


Number of formal complaints received

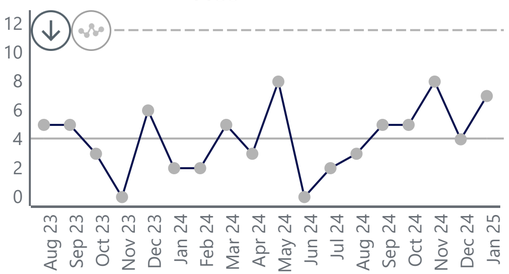
Target: Internal



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



Number of patients deteriorating from HDU admitted to PICU



Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

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

Highlights:

The trust continues to exceed the target of 107% DC & EL achieved in 2019/20, reaching 116% in January. YTD performance remains at DC - 102%, EL - 96%, OPN & OPROC – 103%. Maintained >95% DMO1 compliance for a third month. Maintained no patients waiting over 52 weeks in CAMHS and Community Paediatrics. IP Touchtime Utilisation achieved a YTD high of 84.87%.

Areas of Concern:

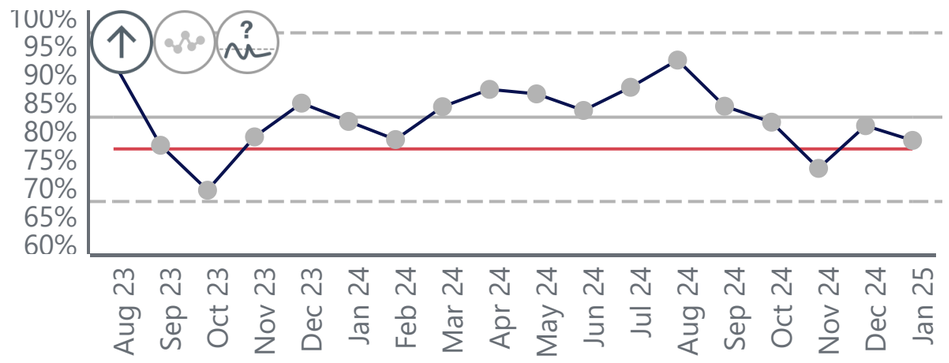
WNB rate continues to be above trust target. Despite a further reduction to overdue FU >2 years the current run rate does not achieve the target for end of March.

Forward Look (with actions)

DC Touchtime Utilisation continues to be a challenge. Four specialties are actively piloting increasing patients per theatre session.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

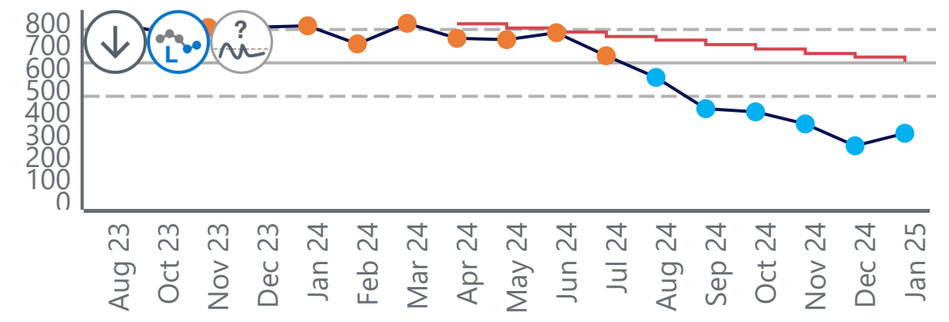
Trust achieved the national target (>77%) in January-25. Common cause variation has been observed with performance of 78.4%, a decrease from Dec-24 (81.1%). Jan-25 performance is -2.7% compared to Jan-24 (81.8%). Jan-25 seen 589 fewer attendances compared to Jan-24. Jan-25 had +1.7% greater ratio of Resus and Very Urgent patients compared to Jan-24. 2024/2025 performance to date is 83.3%

Actions:

Performance monitored weekly through Care Group Leadership/Winter Planning Meetings. Key actions: • Reporting on Clinically Ready to Proceed • Maximising use of primary care streaming within the UTC • Review of medium term workforce plan • Testing and roll out of new escalation plans

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

Target: Internal 24/25



Technical Analysis:

Demonstrating special cause variation of improving nature with number of patients waiting > 52 weeks at 310 for Jan 2025 against a trajectory of 630. Increase from Dec 2024 position of 254. Top 3 services with waiters >52 weeks: Dentistry (n= 147), Neurology (n=59) & ENT (n=33). Externally the trust target is to have under 575 breaches by March 2025 with an internal aim of 0 breaches.

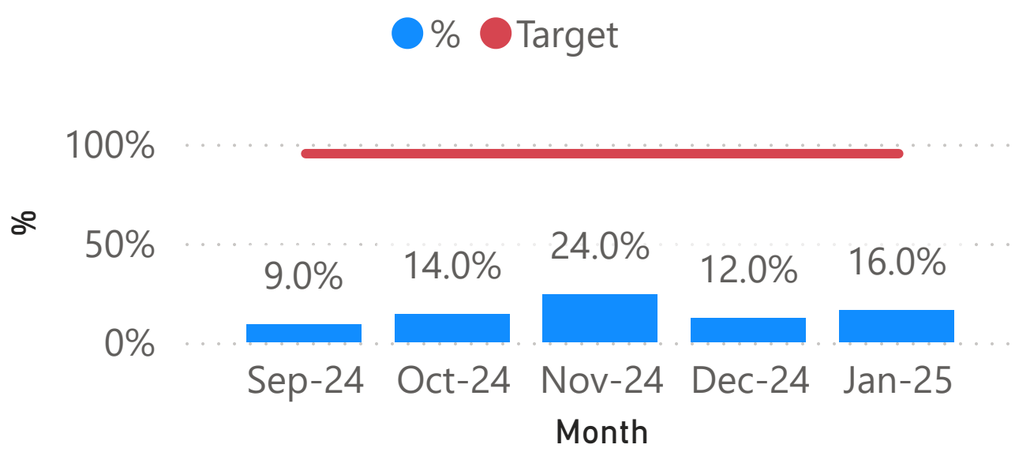
Actions:

The number of patients waiting >52 weeks increased in January. This is due to the seasonal peak of referrals increasing in comparison to December where demand reduces. The trust is continuing to work towards the stretch target of 278 patients waiting over 52 weeks by March 25.

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

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



Technical Analysis:

Performance at the end of January 2025 is
16% against a target of 95% which is an improvement from performance of 12% in December 2024. Insufficient data to assess previous years if any seasonality impact on performance.

Actions:

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

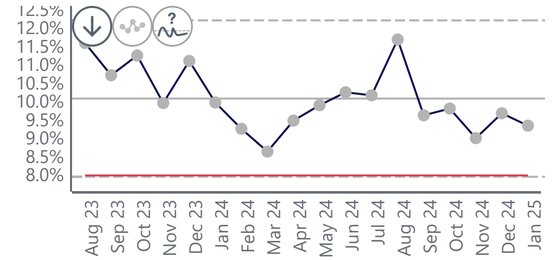
Integrated Performance Report | February 2025

NHS
Alder Hey Children's
NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

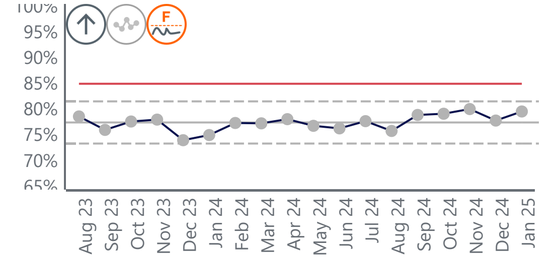
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

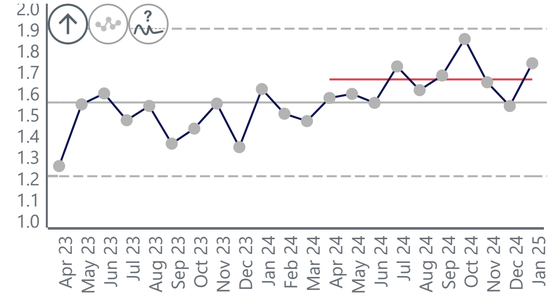


Theatre Utilisation (Capped Touch Time)

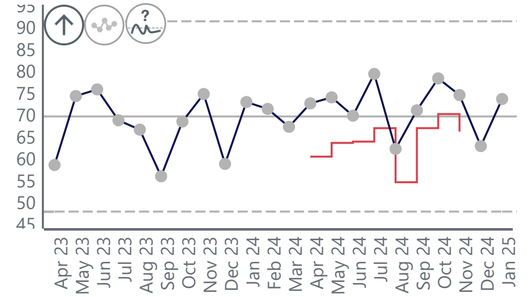
Target: Internal



Elective admissions (IP & DC) per clinical WTE

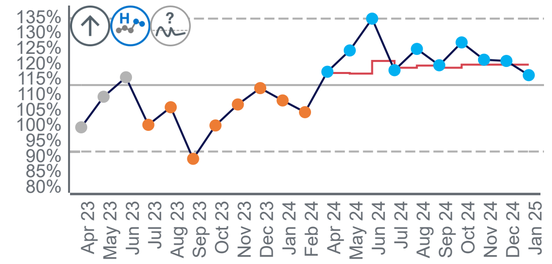


Outpatient attendances per Consultant WTE



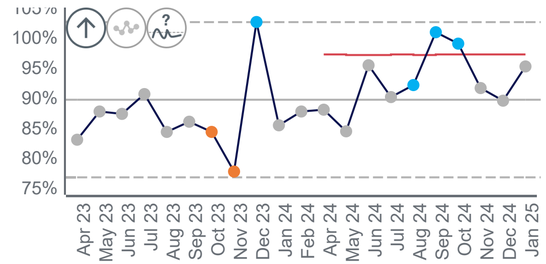
% Recovery for Daycase Discharges

Based on 19/20 baseline



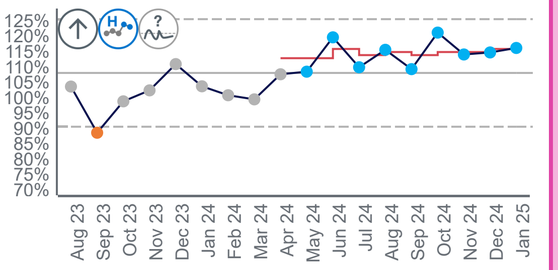
% Recovery for Elective Discharges

Based on 19/20 baseline



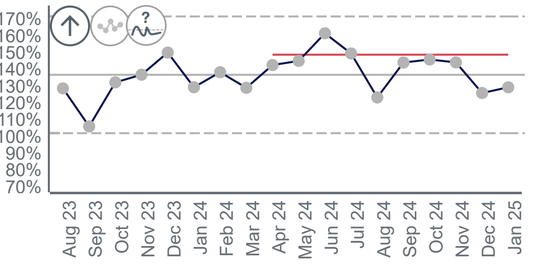
% Recovery for DC & Elec Activity Volume

Based on 19/20 baseline



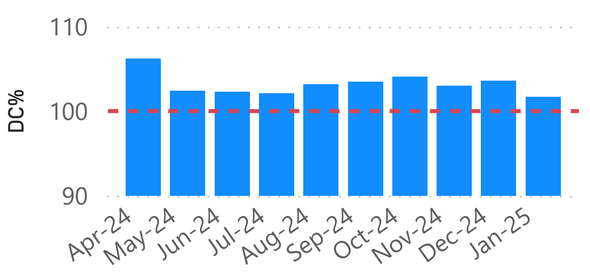
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline



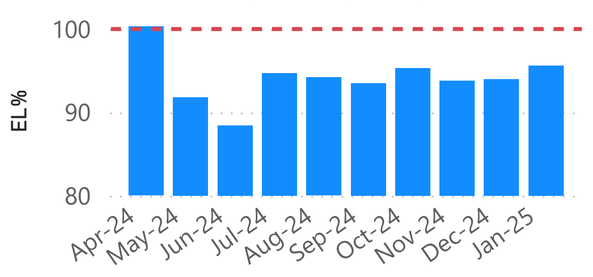
Daycase Activity vs Plan (YTD Position)

SLAM Performance (Volume)



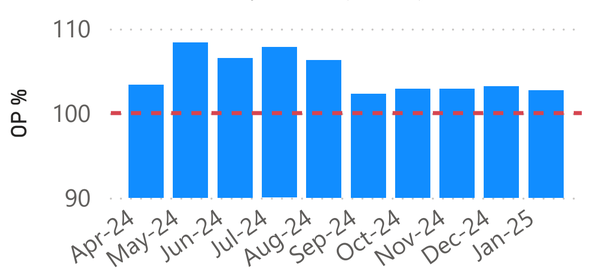
Elective Activity vs Plan (YTD Position)

SLAM Performance (Volume)

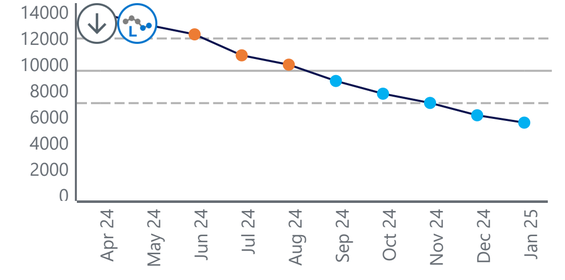


OP New & OPPROC Activity vs Plan (YTD Position)

SLAM Performance (Volume)



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

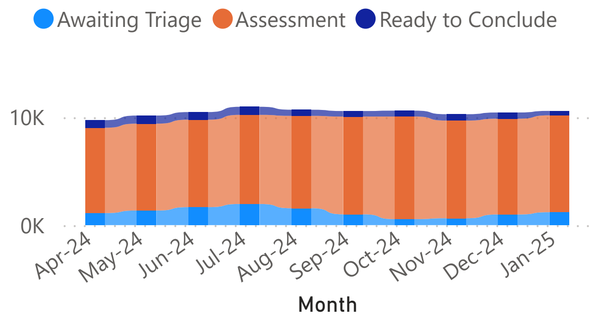


Integrated Performance Report | February 2025

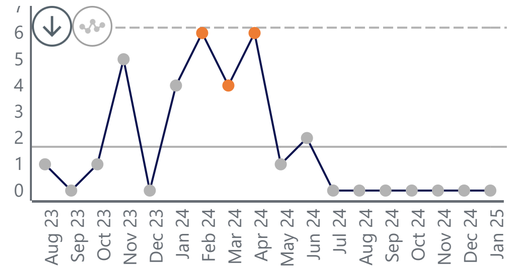
Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

ADHD/ASD Diagnosis Status

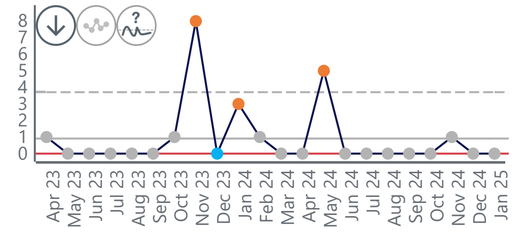


CAMHS: Number of children & young people waiting >52weeks



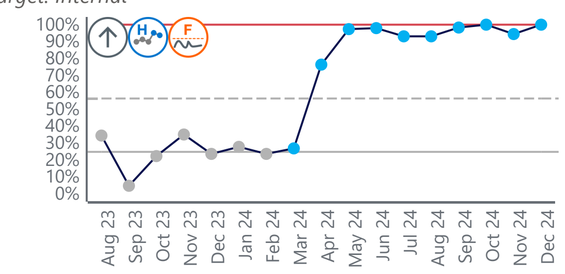
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



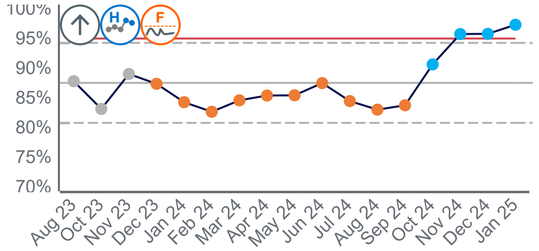
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



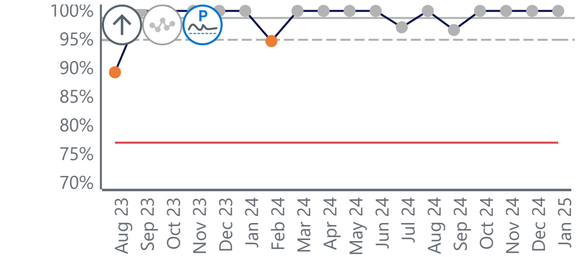
Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory



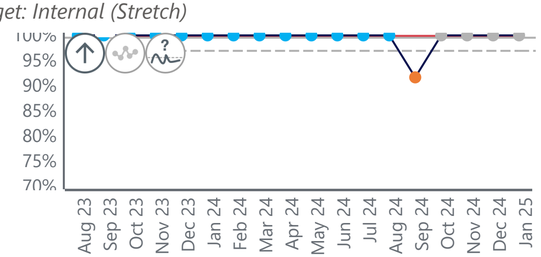
Cancer: Faster Diagnosis within 28 days

Target: Statutory



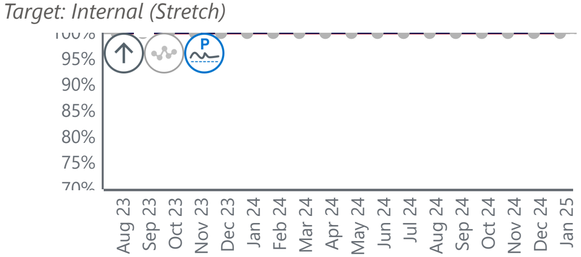
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

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%
- Turnover has reduced to below 10% for the first time this year (24/25)

Areas of Concern:

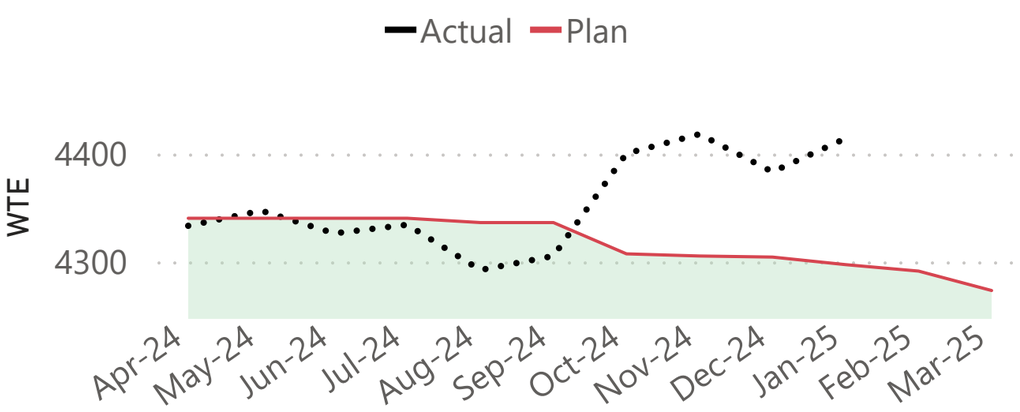
- Sickness absence levels are high, especially long-term absence, though lower than sickness levels in February 2024. A deep dive into sickness absence is being undertaken, reporting to People Committee in March 2025.
- Total workforce (WTE) is a challenging position, with the Trust highly unlikely to meet the initial plan by the end of March 2025. A revised forecast has been completed, and measures around additional spend being reviewed to impact WTE.

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.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

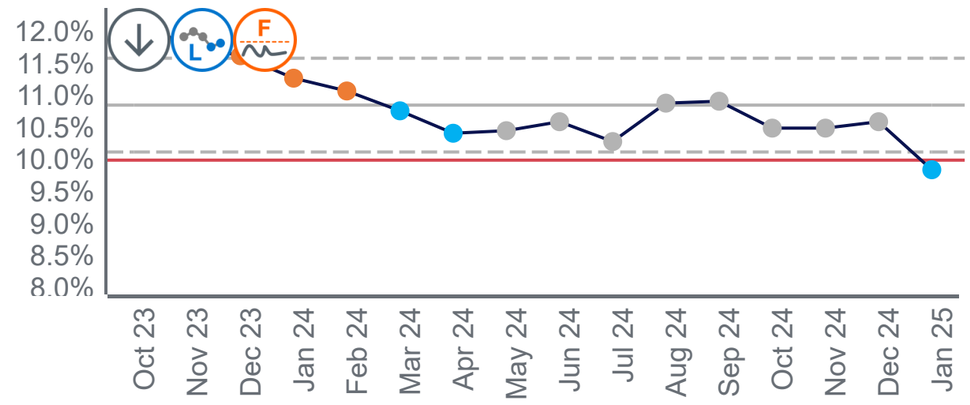
Total workforce for the end of January 2025 was 117 WTE above plan. Actual WTE was 4414 against a reduced plan of 4297. 24/25 year end plan is set at 4273.4 WTE.

Actions:

Total workforce (WTE) is a challenging position, with the Trust unlikely to meet the initial plan by the end of March 2025. A revised forecast has been completed, and measures around additional spend being reviewed to impact WTE.

Staff Turnover

Target: Internal



Technical Analysis:

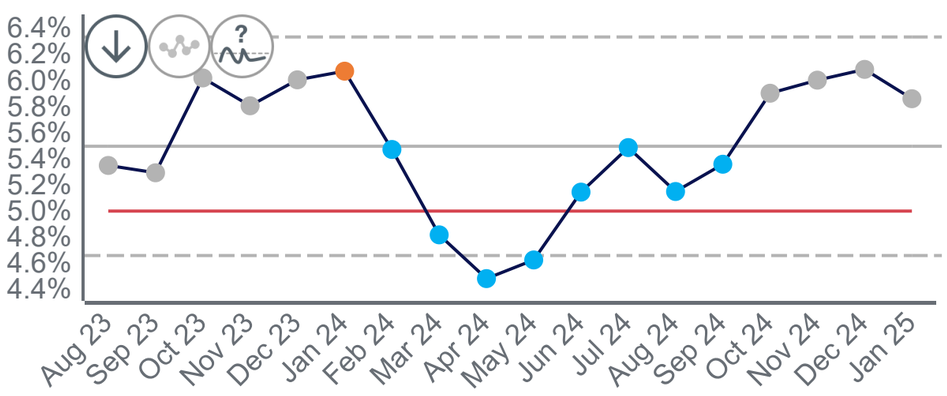
Staff Turnover is demonstrating special cause variation of improving nature with performance of 9.85% in January 2025.

Actions:

Staff turnover has reduced to below the 10% target for the first time this year (24/25).

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in January 2025 is 5.86% which is above the 5% target although slight decrease from December 2024 at 6.07%. January 2025 performance comprises STS at 2.26% and LTS at 3.60%. Still demonstrating common cause variation, 8th consecutive month above the target in 24/25.

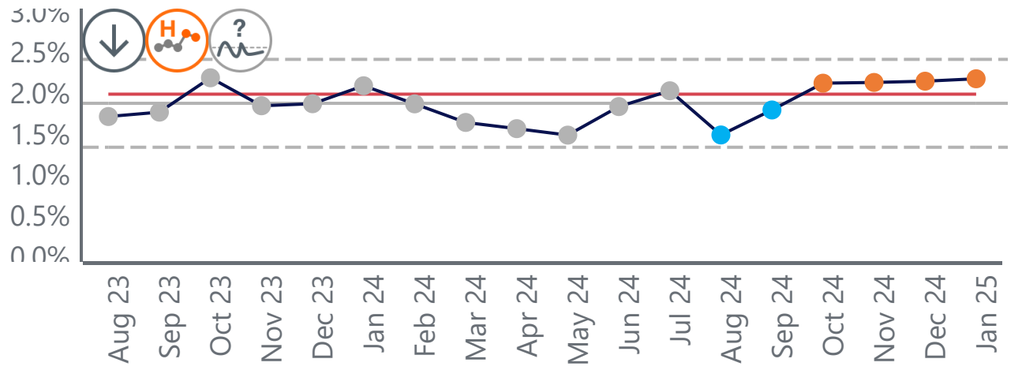
Actions:

Sickness absence levels are high, especially long-term absence, though lower than sickness levels in February 2024. A deep dive into sickness absence is being undertaken, reporting to People Committee in March 2025.

Supporting Our People - Watch Metrics

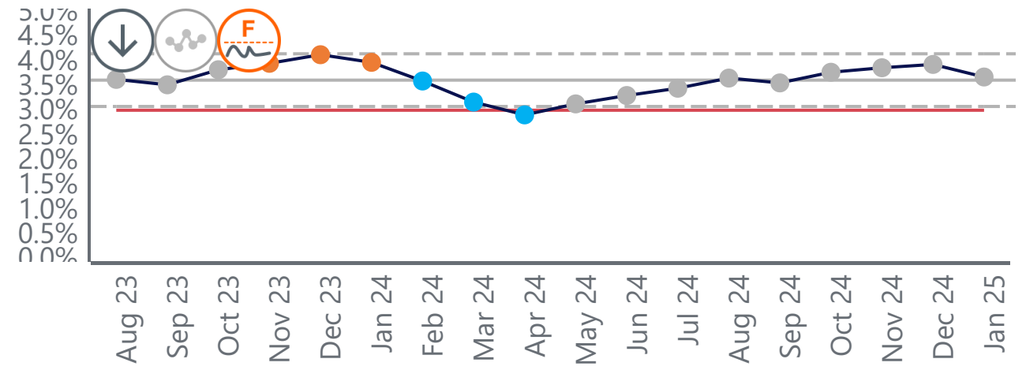
Short Term Sickness

Target: Internal



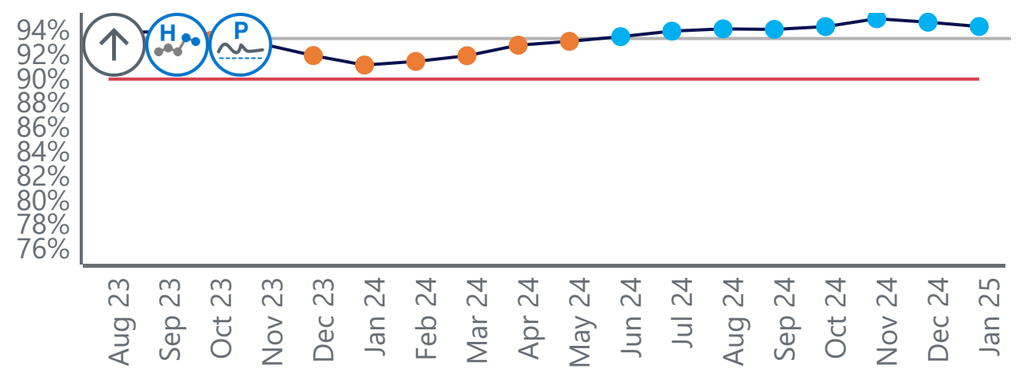
Long Term Sickness

Target: Internal



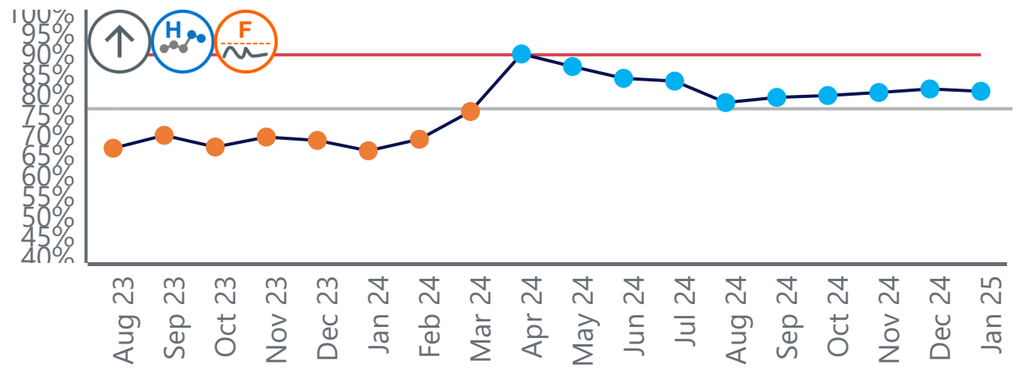
Mandatory Training

Target: Internal



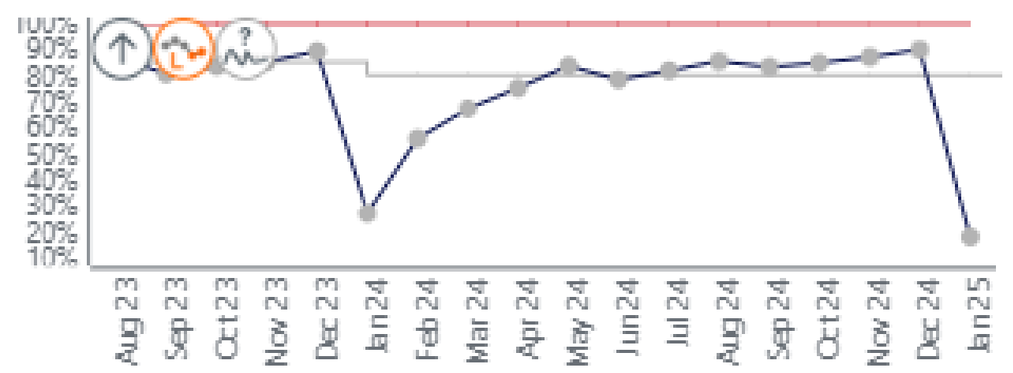
% PDRs Completed (Rolling 12 Months)

Target: Internal

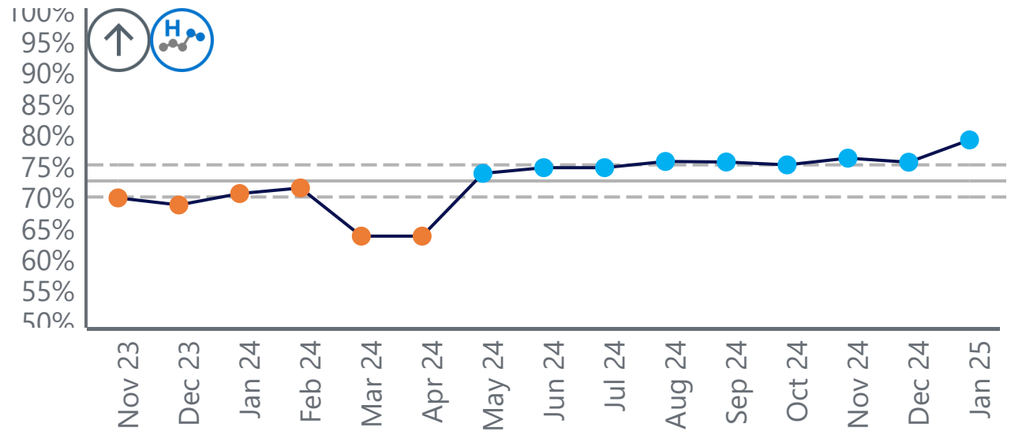


Medical Appraisal

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:

• Funding application to LCR Combined Authority for £4.1m (over 4 years) approved by external panel – awaiting internal panel decision on 20th Feb • Mobile Research Unit now in use for community engagement activities • Commercial research income remains ahead of target offsetting underachievement against MRI business case • Beccy Cummings established as new Futures Programme Manager (1 day per week) with replanning underway for 25/26 delivery • Futures Comms and Marketing Officer post advertised (closing on 14th Feb – funded through external research income)

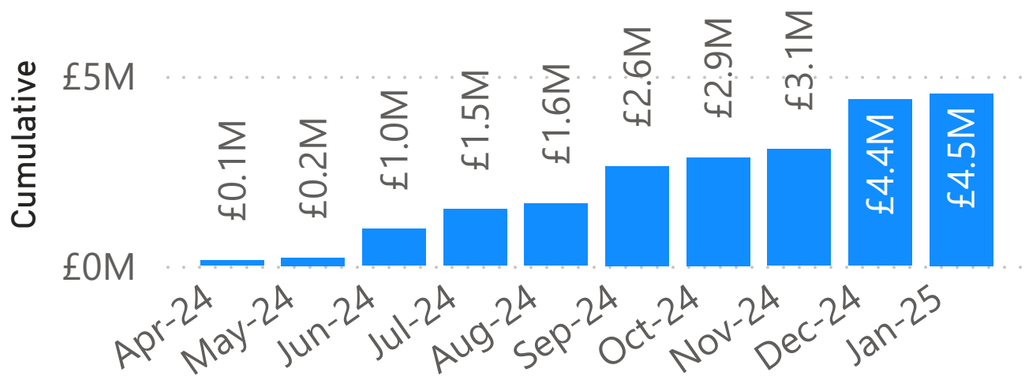
Areas of Concern:

• MRI not fully operational for research and pipeline of research activity not yet established – underachievement in 24/25 offset by increased commercial income. • Innovation external income target is underachieving with outstanding schemes unlikely to deliver in 24/25 - deep dive underway with finance team

Forward Look (with actions)

• Review of MRI business case underway to ensure clear roles and responsibilities for operational and pipeline activities with dedicated time secured • Full review of innovation income and expenditure underway to ensure breakeven position at year end • AH Charity application for ongoing support for Futures initiatives going to Charitable Spend Committee on 11th Feb

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



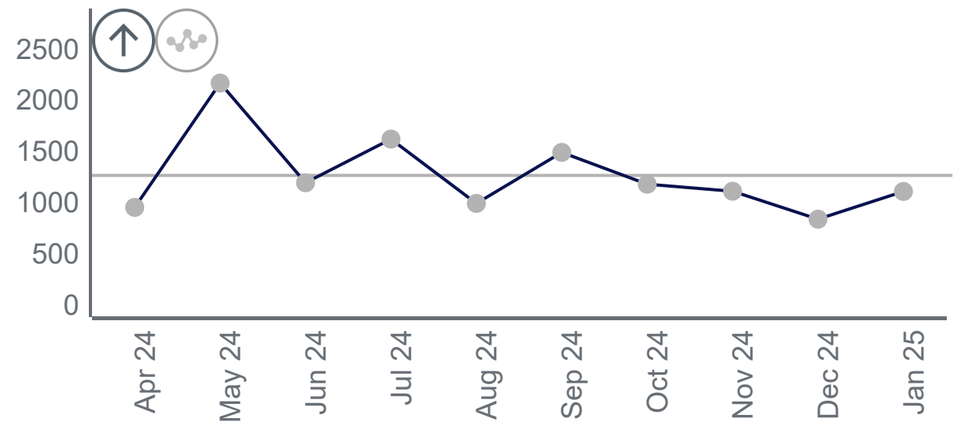
Technical Analysis:

Commercial and non-commercial income (cumulative)

Actions:

External funding applications ongoing

Manual hours saved through automation solutions - Monthly

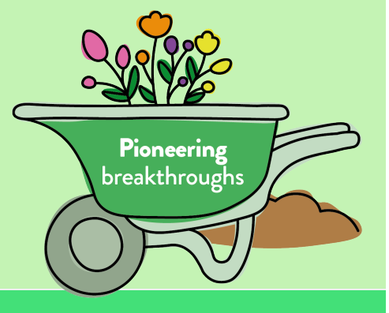


Technical Analysis:

Manual hours saved through RPA solutions

Actions:

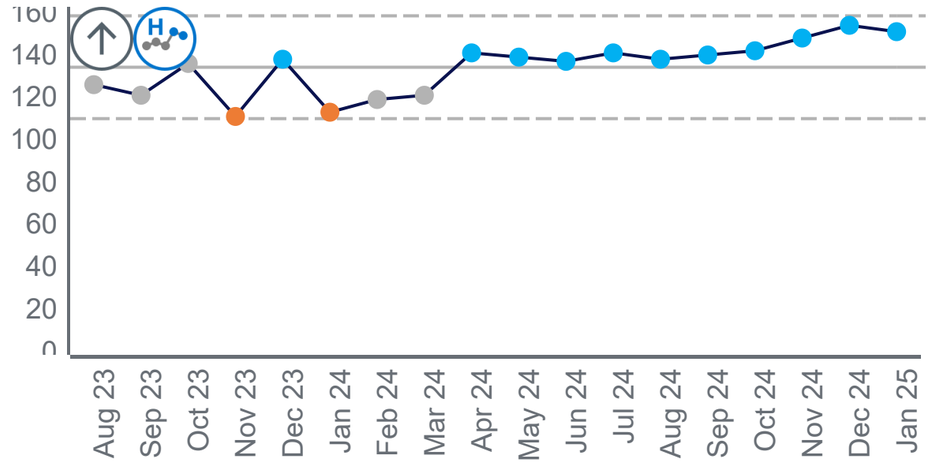
Review of pipeline to ensure delivery against business case underway for 25/26



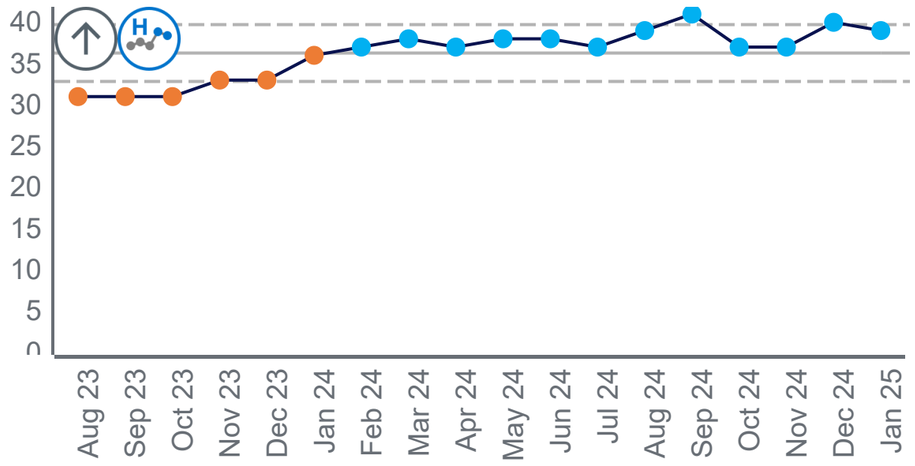
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

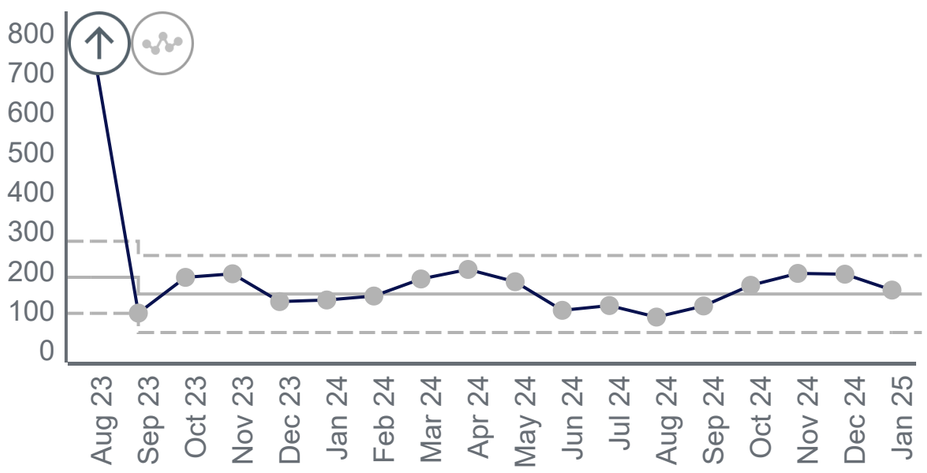
Number of Active (Open) Studies - Academic



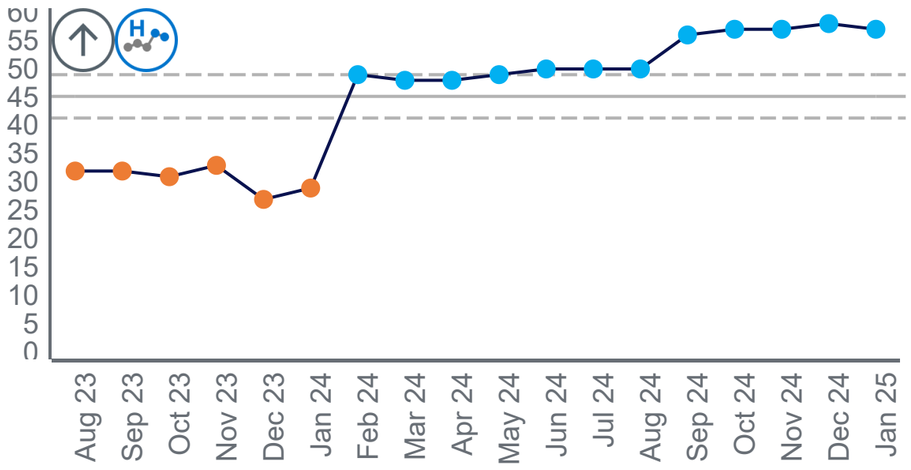
Number of Active (Open) Studies - Commercial

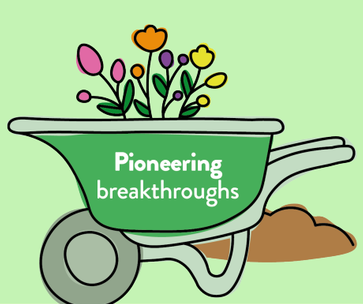


Number of Patients Recruited into Research Studies



Number of Chief Investigator led studies





Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

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

Highlights:

• Health Inequalities & Prevention: The ICB-funded vaping service live from January2025. Discussions underway to scope service provision for CYP with cocaine and ketamine addiction. On 20th January a 'drop-in' was held where families were encouraged to bring their CYP to Alder Hey for flu vaccination through the "flu fairies" programme.

• Wellbeing Hub: 50 referrals to date (n.b. one referral can equate to multiple social prescriptions). Service expanded to cover Endocrinology/cleft/CF/Renal/Complex Care Team. Parent Champion supporting newly diagnosed SEND CYP connected into the Hub. Bespoke Wellbeing Hub Signage in place outside PALs office

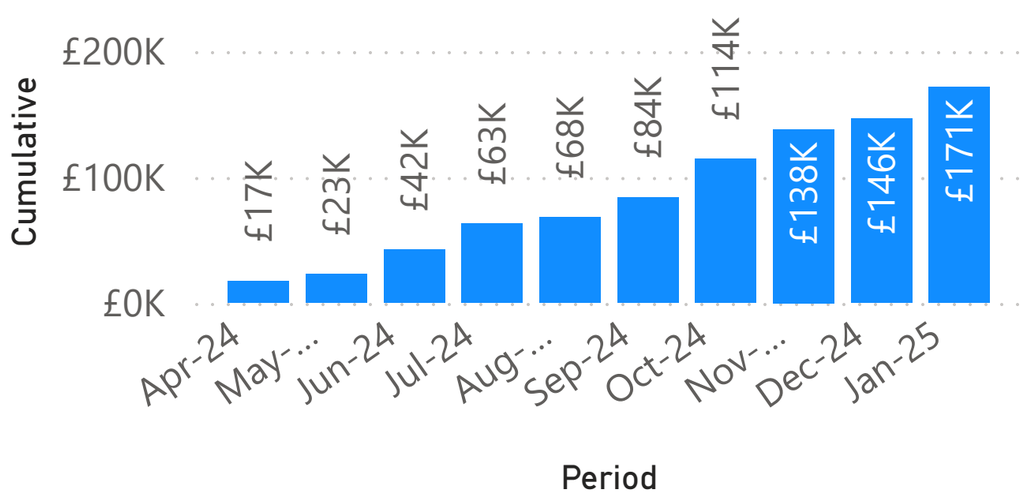
Areas of Concern:

Social value target for 2024/25 is £400,000, achievement by end of January 2025 is £171,447.45.

Forward Look (with actions)

Exploring opportunity of having wellbeing hub presence in Emergency Department. In discussion with local HEI about their providing a law clinic as an addition to the family wellbeing hub and also for staff.

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:

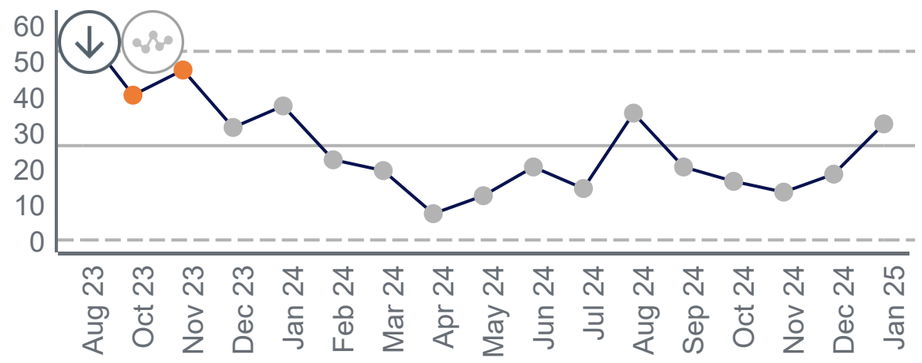
Exploring opportunities for Virtual Work experience. Conversations with current and future partners regarding collaboration opportunities and to further strengthen the Alder Hey offer. Careers event in Careers Connect, practice interview sessions requested by Broughton Hall. Met with Virtual School to support NEET and Care Experienced Young People. Delivered presentation about NHS careers and took part in Dragons Den experience at Crosby High School

Alder Hey Children's NHS Foundation Trust

Collaborate for CYP

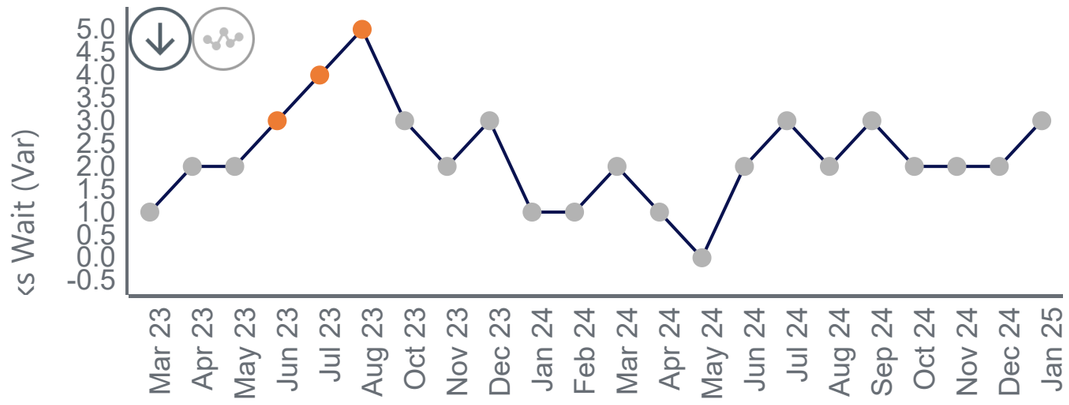
Oral Health: Number of children <10 years old waiting >52wks for tooth extraction

Sept-23 Unavailable

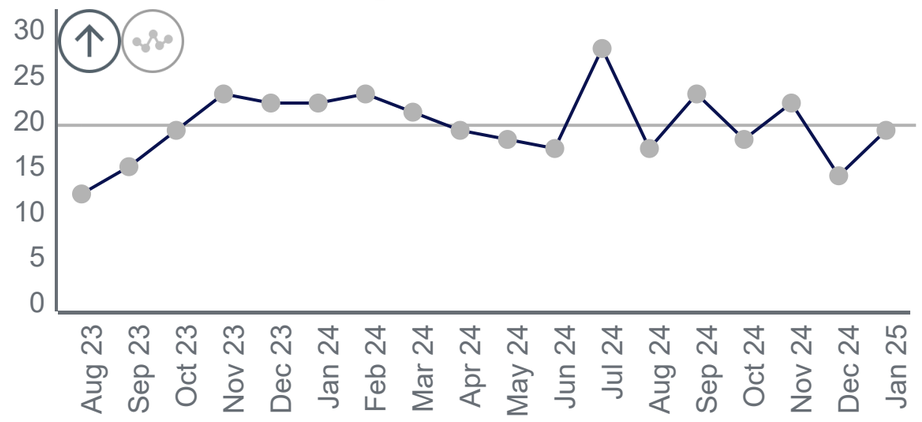


Median Waiting Time (RTT) - LD Waiters Variance (Wks) to Non-LD

Sept-23 Unavailable



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



Collaborate for children & young people

Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

Off plan by £0.86m YTD, due to pay award. Divisional forecasts have deteriorated by a further £0.6m compared to M9 due to challenges within Innovation and Medicine non pay. Forecasting to achieve £3.3m surplus, with a risk adjusted forecast of £2.2m (off plan by pay award). £19.1m CIP has been transacted in year, with £0.8m in progress/opportunity. Capital broadly on plan YTD however forecast is currently £1.3m overspent. Capital outturn in reality will range from under to over spent dependent on progress with major builds in the final months.

Areas of Concern:

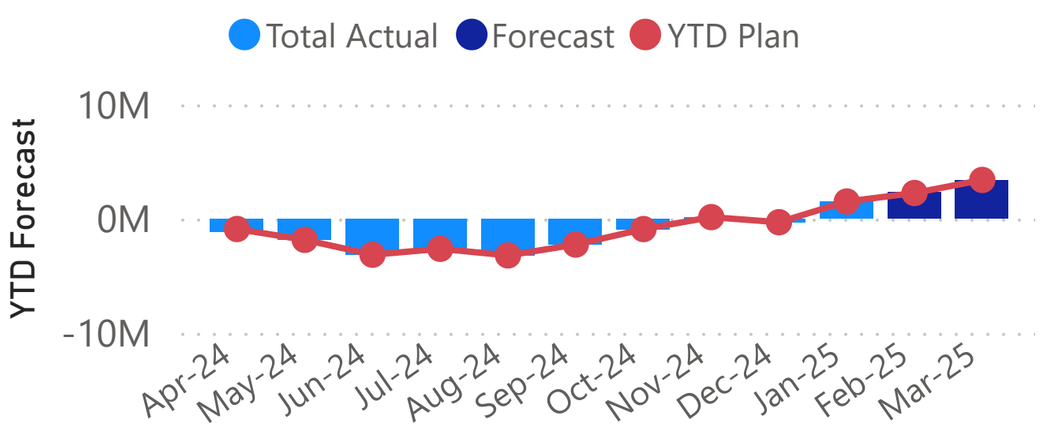
Recurrent CIP pressure of £6.1m not yet transacted. Divisional forecasts highlight significant financial and operational challenges 2 key areas being Innovation income and Medicine non pay. SDG meetings continue to focus on 4 key priorities (Workforce, Drugs, Coding and Activity). The capital allocation in year is tight and will be carefully managed over final quarter

Forward Look (with actions)

Continued focus on cost control and WTE plans with finance improvements in place being monitored through SDG. Continued focus on achievement of £19.9m CIP plan. Continued prioritisation of capital programme

I&E Year End Forecast

Target: Statutory



Technical Analysis:

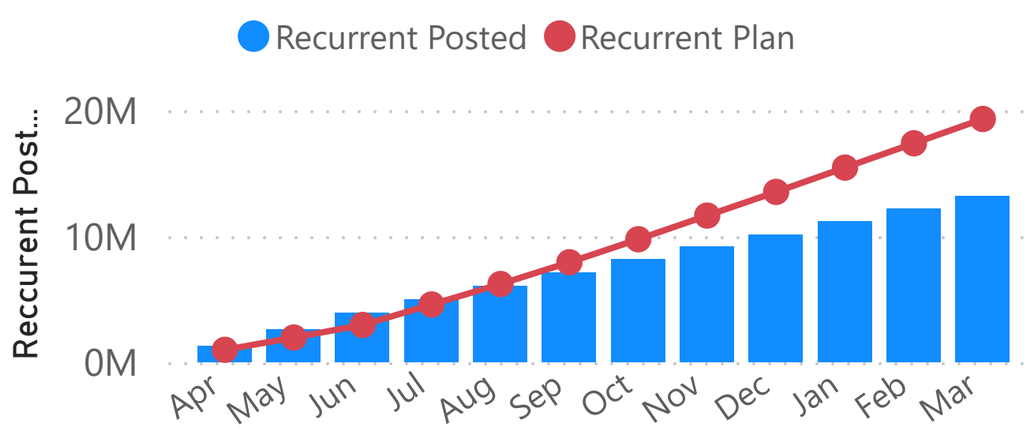
Current plan is £3.3m surplus (£1m pay award risk) however, M10 forecast continues to highlight significant challenge. Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

Actions:

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

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

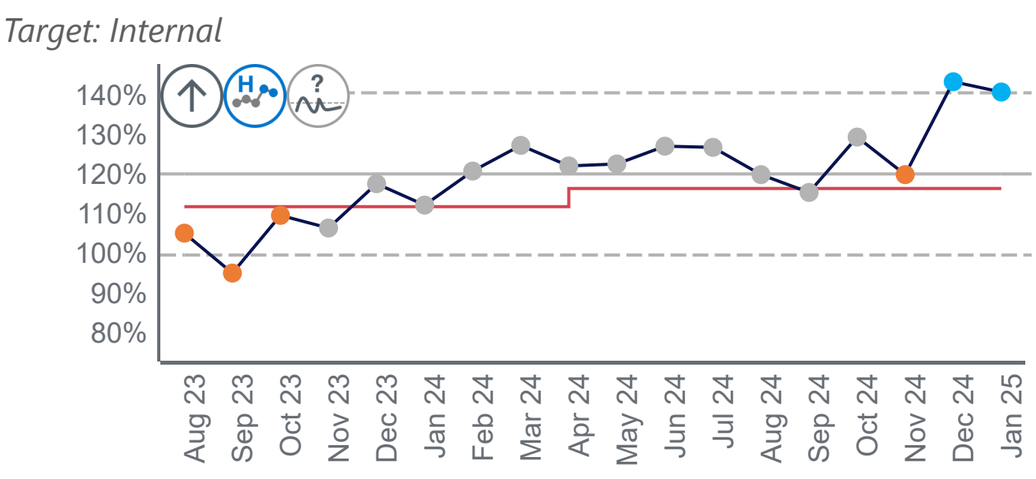
January performance estimated at 141%.

Actions:

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

% ERF Value (Income)

Target: Internal



Technical Analysis:

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

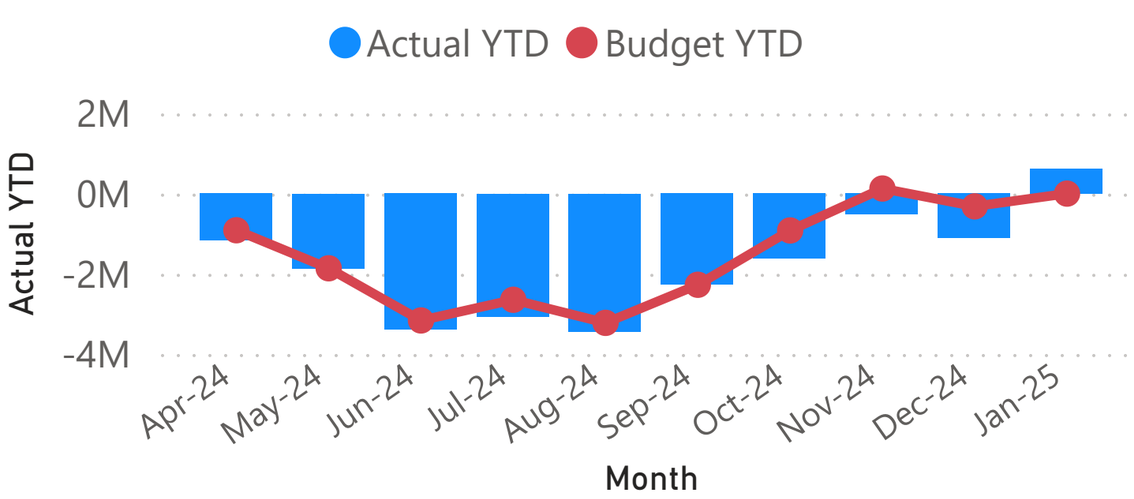
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

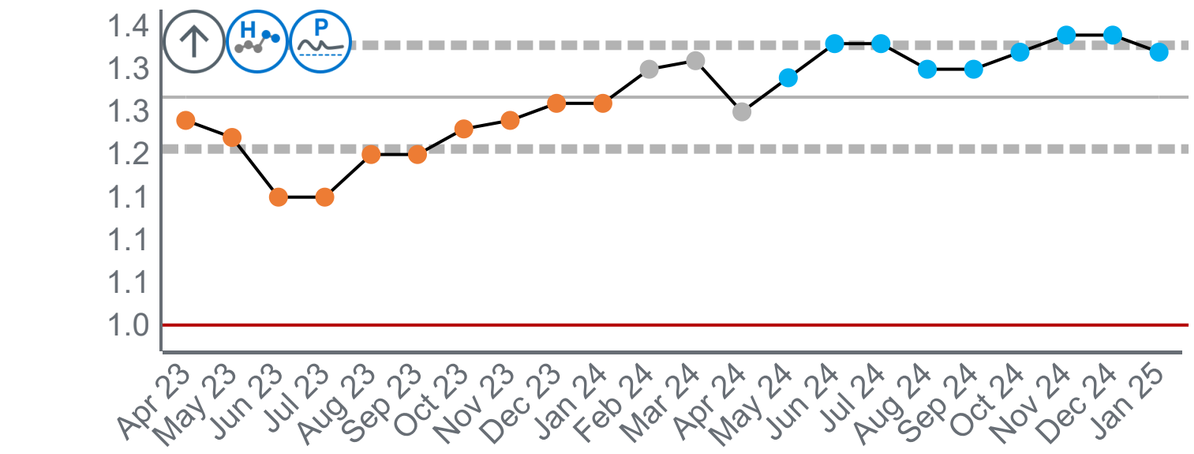
I&E distance from target (cumulative YTD)

Target: Internal

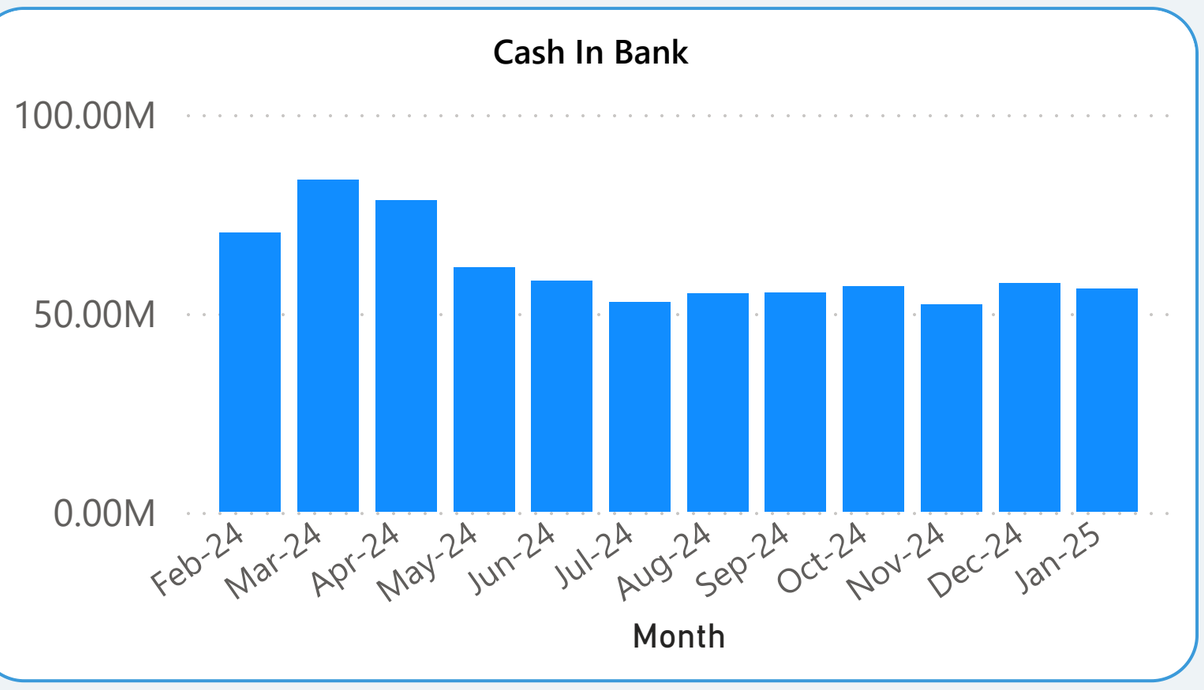


Liquidity

Target: Internal



Cash In Bank



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Positive engagement with teams at risk oversight meetings. Review of corporate risks aligned to nursing and quality reviewed and realigned to relevant risk owners as relevant. Oversight of risk process for surgery division presented at Decembers RMF-work has enabled no risks overdue or without actions updated. Meeting held with NEDs/Director Futures Committee to set risk appetite tolerances.

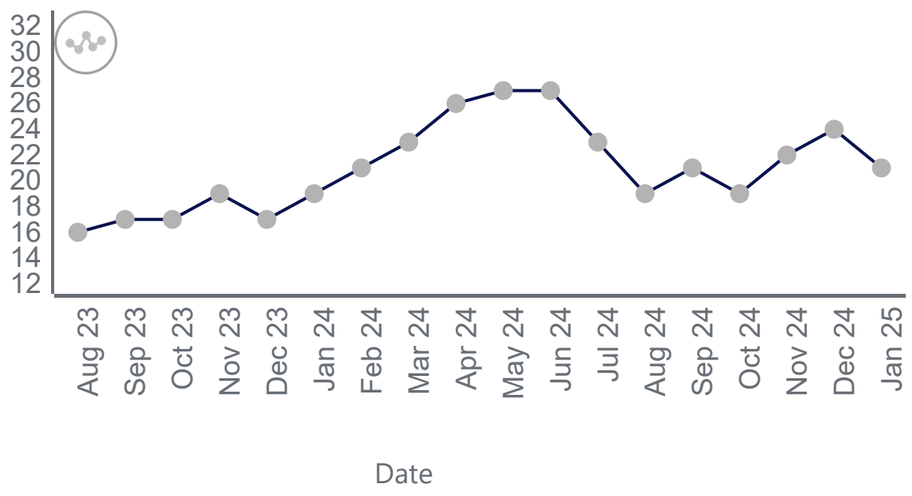
Areas of Concern:

None of note

Forward Look (with actions)

Meeting with C&MH division to test out use of risk appetite across divisions with feedback due at RMF Feb 25

Number of High Risks (scored 15 and above)



Technical Analysis:

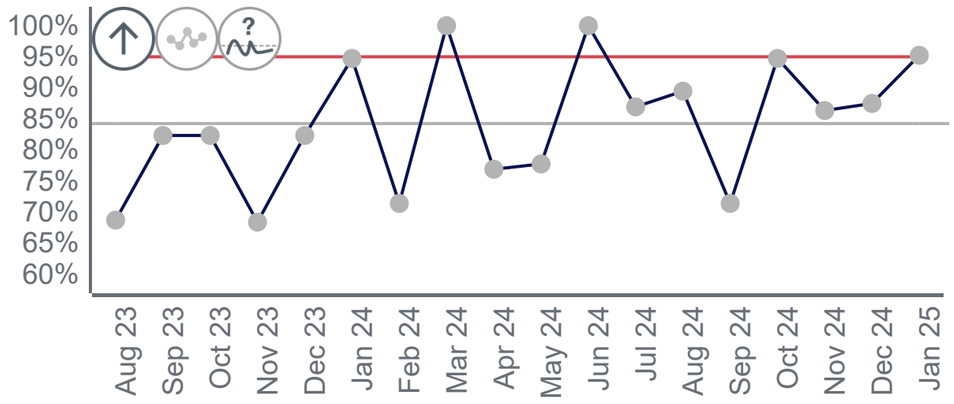
21 high risks on risk register as of end January 2025: a decrease of 3 from the previous reporting period.

Actions:

Risks themed as follows: • Quality – Safety = 9 risks • Workforce – Sustainability = 6 risks • Compliance & Regulatory = 4 risks • Reputation = 1 risk • Financial – Investment = 1 risk

% of High Risks within review date

Target: Internal



Technical Analysis:

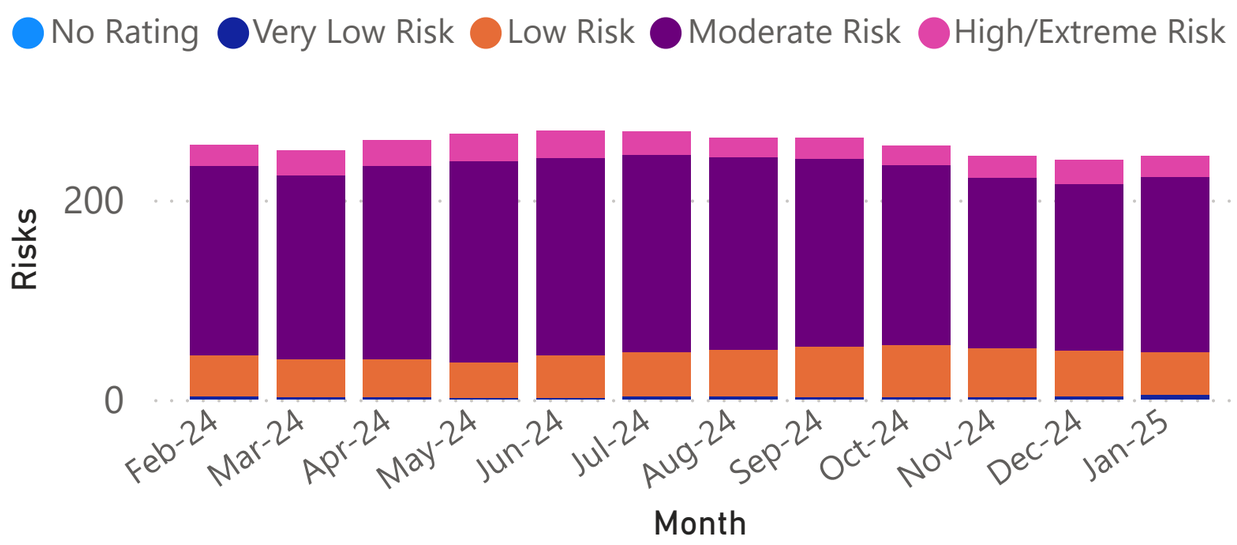
95.2% (20/21) high risks within expected review date.
Risk watch metric: 28.6% of high risks with actions past expected date of completion (6 / 21 high risks with actions past expected date of completion)

Actions:

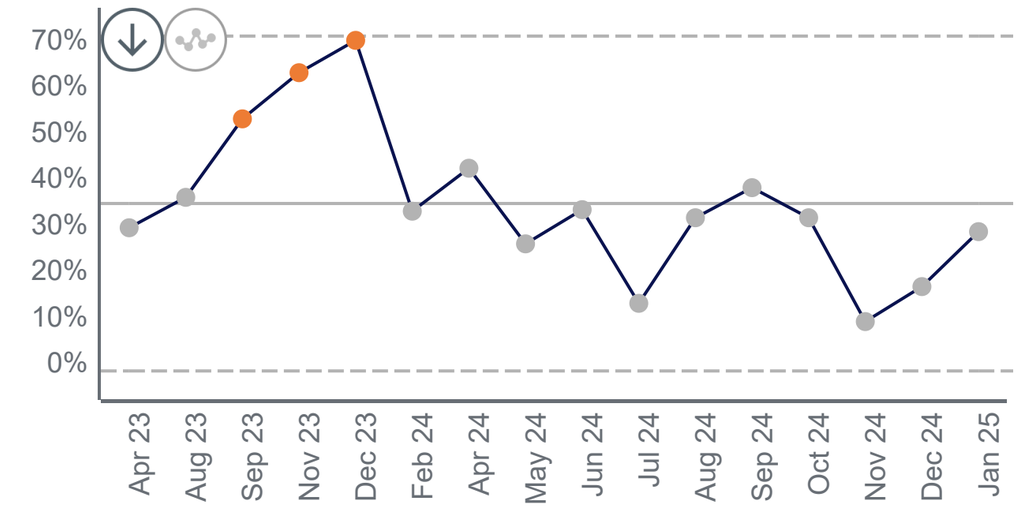
The 1 overdue risk has now been updated.

Well Led - Risk Management

Trust Risk Profile



% of high risks with actions past expected date of completion



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

- Outpatient Fracture / Dermatology work completed January 2025 – new clinic schedule started January 2025
- Improvement in WNB rate (11%)
- Improvement in all friends and family measures
- 100% Initial Health Assessments completed within 20 days of receiving referral
- Reduction in sickness absence rates (6%) with improvement in long term sickness
- Mandatory training compliance remains above Trust target (96%)
- No children and young people waiting over 52 weeks for CAMHS, community paediatrics and therapies.
- Sustained improvement in RTT for SALT (98%) and Dietetics (95%)
- First virtual ward away day held in January 2025 with positive feedback from internal and external colleagues

Areas of Concern

- 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
- Reduction in routine RTT for Eating Disorder team (77%) although on target for February 2025 (7 breaches)
- Continued challenges with ADHD medication shortage which is impacting on waiting times for the diagnostic pathway
- Sunflower House Meditech development work – go live delayed due to clinical demands. On track for March 2025.

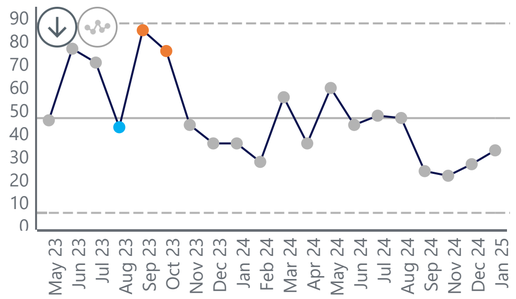
Forward Look (with actions)

- Contract awarded for external ADHD assessments – capacity due to start March 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 planned sign off March 2025
- Pilot of digital H&W scales to continue with planned analysis and review
- First OPD team away day planned for 21 February 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.

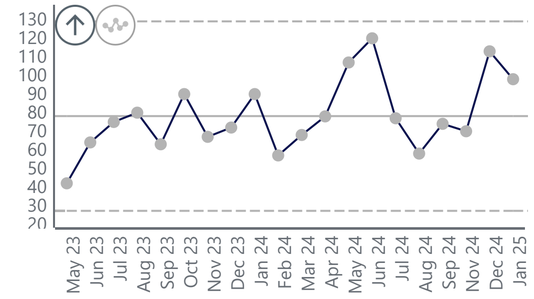
NHS
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

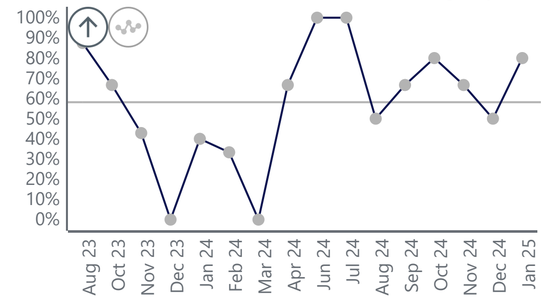
Patient Safety Incidents rated Low Harm & Above



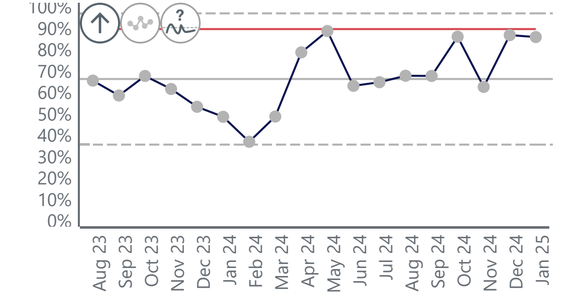
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

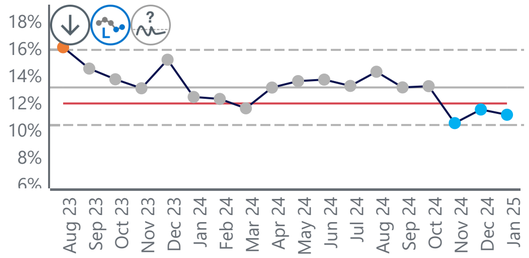


% PALS Resolved within 5 Days

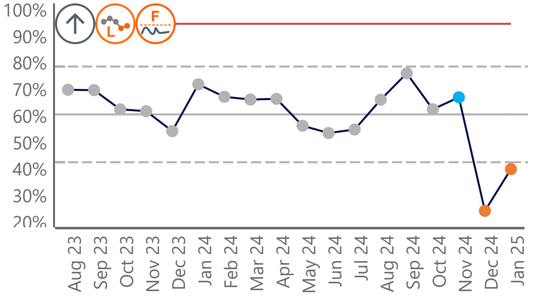


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

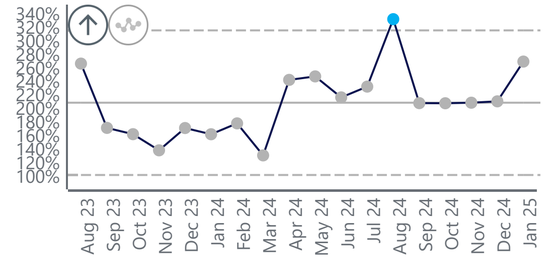


% of Clinical Letters completed within 10 Days

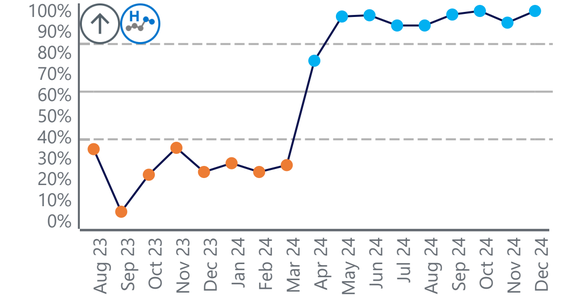


% Recovery for OP New & OPPROC Activity Volume

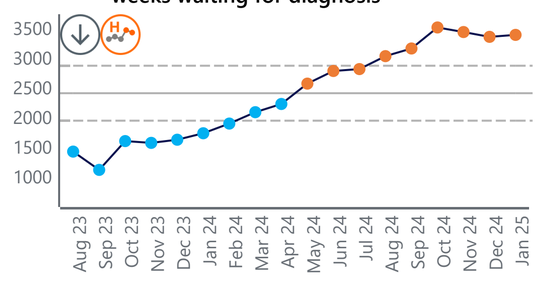
Based on 19/20 baseline



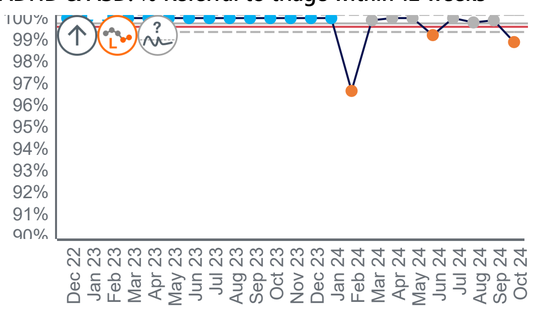
IHA: % complete within 20 days of referral to Alder Hey



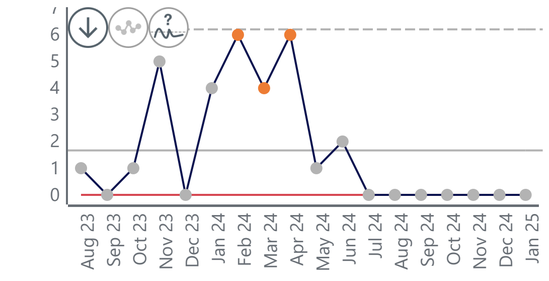
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



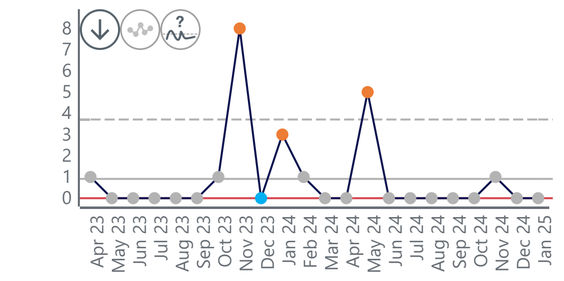
ADHD & ASD: % Referral to triage within 12 weeks



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



Number of Paediatric Community Patients waiting >52 weeks

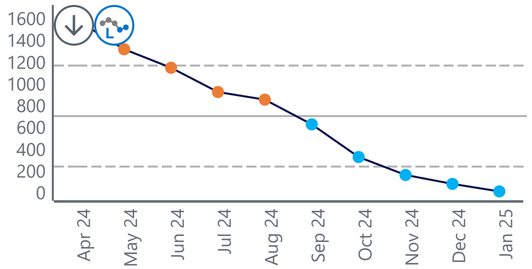


Integrated Performance Report | February 2025

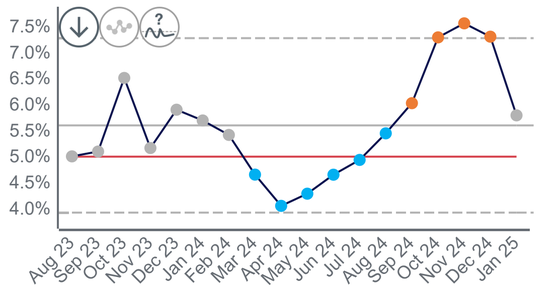
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

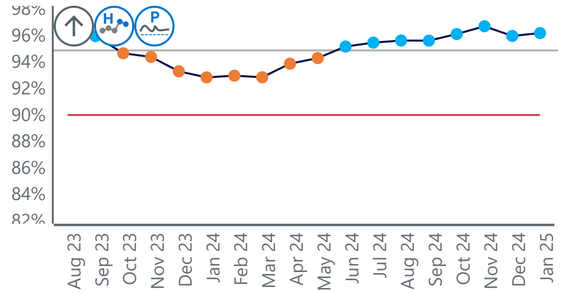
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



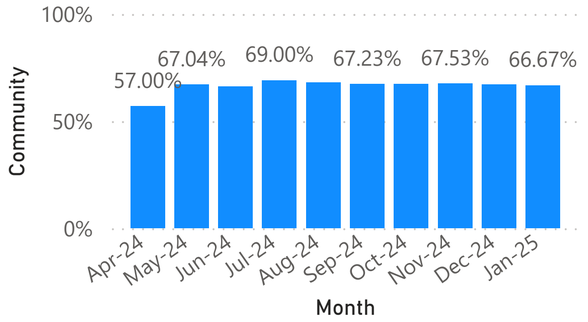
Sickness Absence (Total)



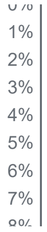
Mandatory Training



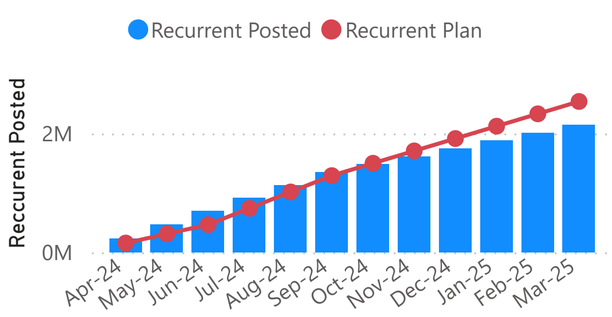
Workforce Stability



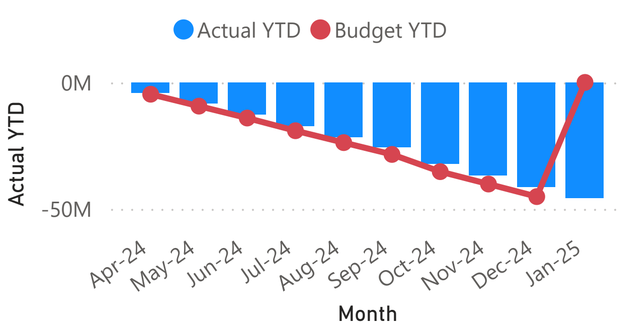
Staff Turnover



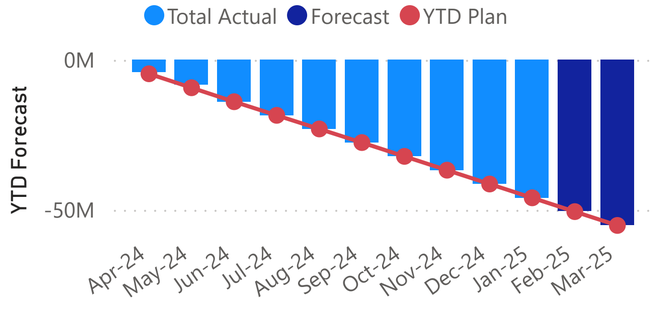
Recurrent Efficiency Plans Delivered (Forecast)



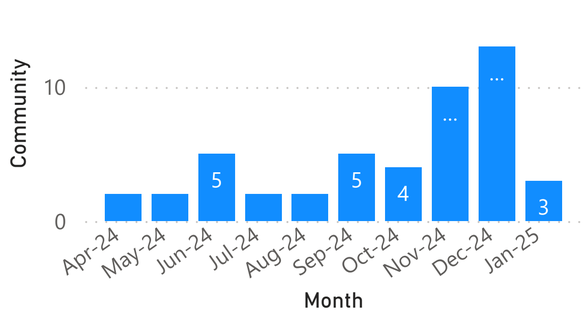
I&E distance from target (cumulative YTD)



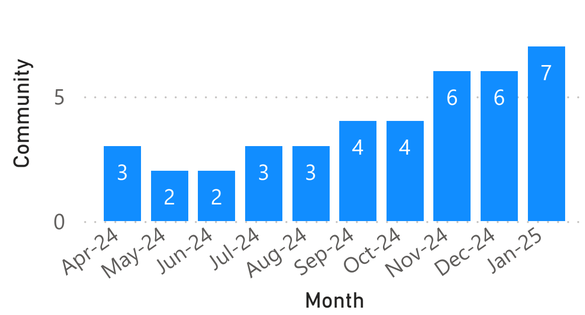
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Sepsis compliance achieved within ED for the second consecutive month
• Sepsis compliance for the ward achieved 100%
• 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
• Improvement in median time to triage within ED
• Reduction in volume of clinic cancellations within 6 weeks
• Only 2 CYP waiting over 65 weeks for treatment
• Third consecutive month noting an increase in CYP treated within 18 weeks
• Continued reduction in children waiting over 52 weeks for treatment; however, primary area of concern being neurology for March 2025 target
• DM01 target maintained 95% compliance for the third consecutive month
• Continued reduction in children waiting over 2 years for follow up care
• Achieved 90% PDRs completed for staff in B7 roles and above, now moving focus to remaining staff within the division
• Maintained high performance in mandatory training compliance
• Successfully relocated the ED waiting area into radiology & the atrium to facilitate the capital development works

Areas of Concern

• 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
• Increase incidents of minor harm or above occurring, all under review by the governance team
• Increase sickness absence noted with worsening short & long term sickness (7%)
• Challenging financial position, owing to reduction in forecast income anticipated and increase in non-pay spend, resulted in worsening end of year forecast position
• Despite achieving operational CIP targets within year and matching the CIP posted for 2023/24 a challenge remains in delivering the transformational and recurrent CIP allocation
• Medical appraisals to be scheduled for the coming year to ensure compliance
• Acute bed capacity challenges remain during peak times during January owing to reduction in bed base and demand in admissions
• Reduction in activity against plans for Elective activity, partly associated with change in recording for ED activity, all of which should retrospectively be inputted to recover the position

Forward Look (with actions)

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

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

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

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

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

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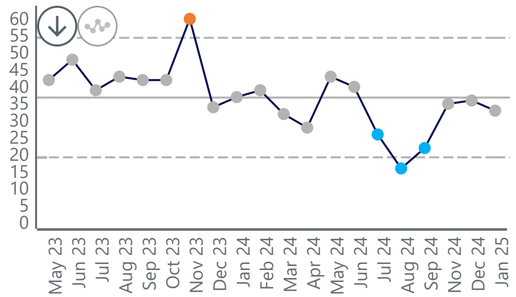
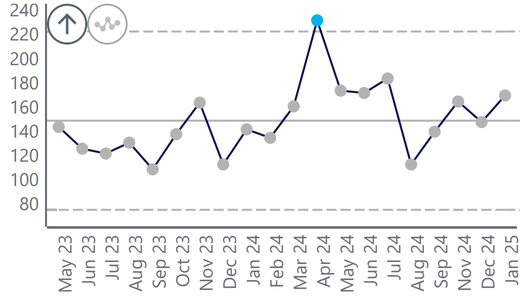
Divisional Performance Summary - Medicine

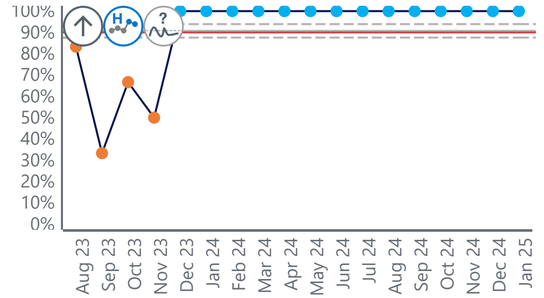
Patient Safety Incidents rated Low Harm & Above



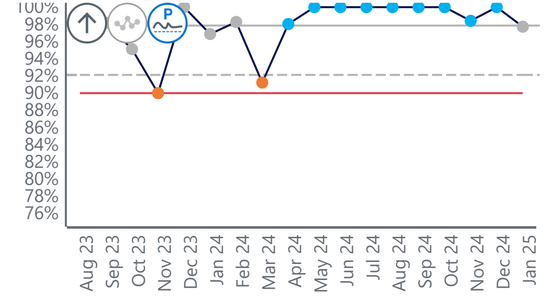
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

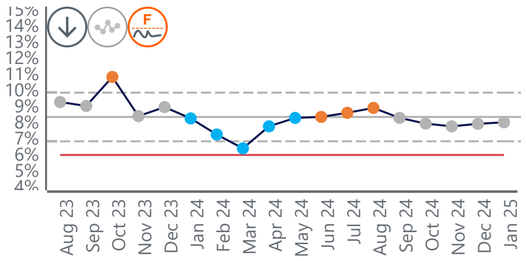


% PALS Resolved within 5 Days

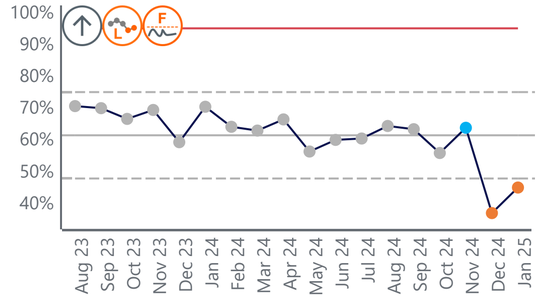


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

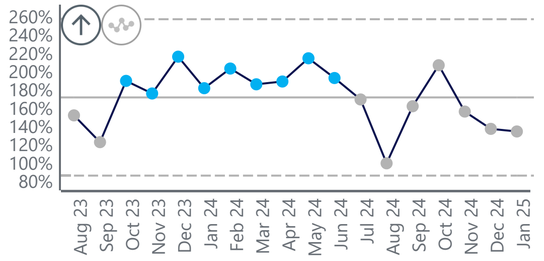


% of Clinical Letters completed within 10 Days

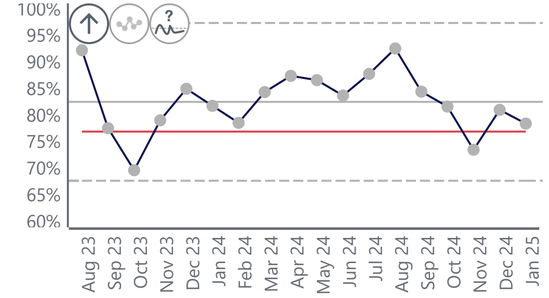


% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

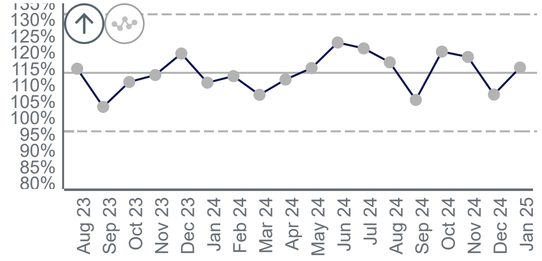


ED: % treated within 4 Hours

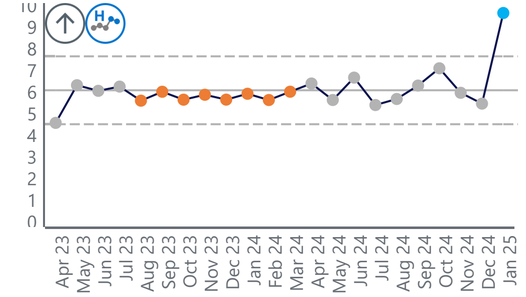


% Recovery for DC & Elec Activity Volume

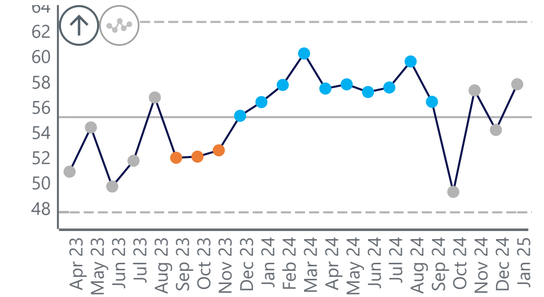
Based on 19/20 baseline



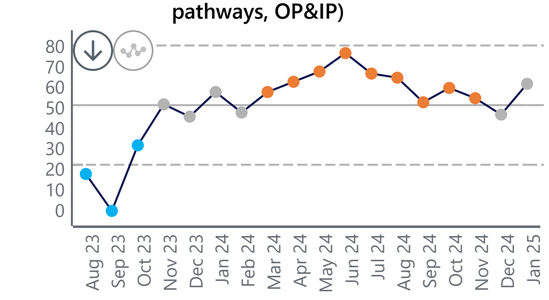
Inpatient Discharges per working day



Day Cases per working day



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



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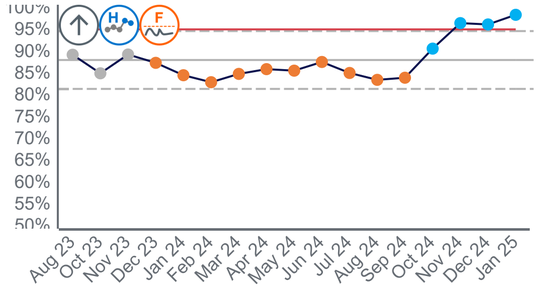
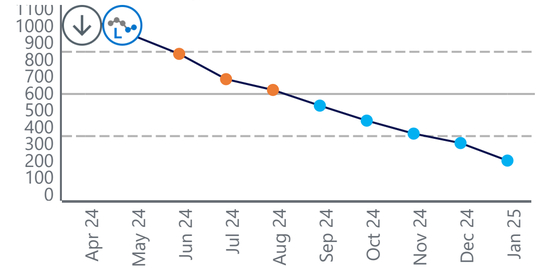
Divisional Performance Summary - Medicine

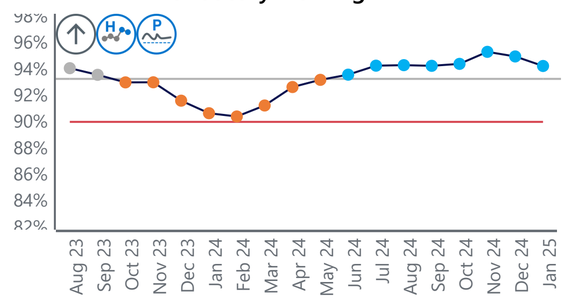
Diagnostics: % Completed Within 6 Weeks of referral



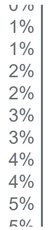
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



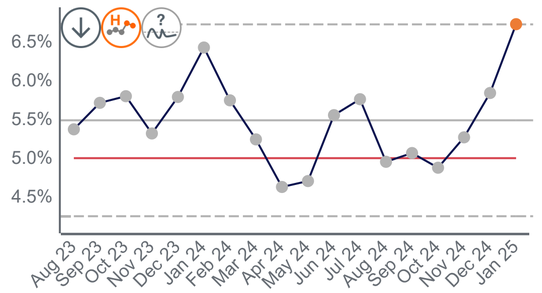
Mandatory Training



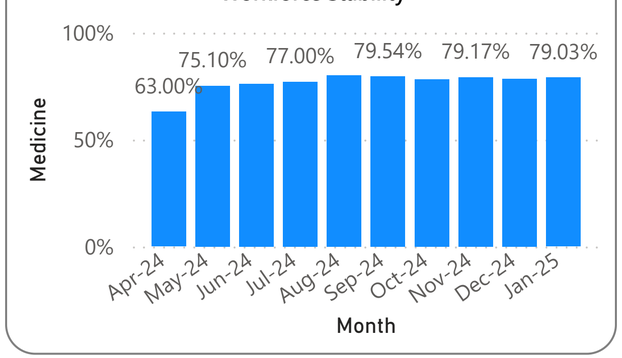
Staff Turnover



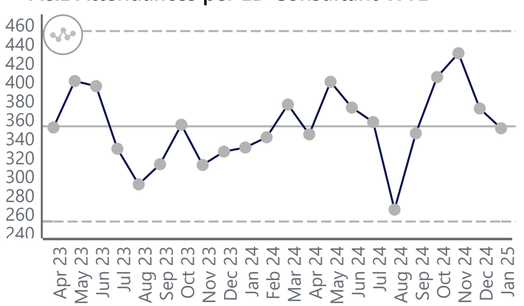
Sickness Absence (Total)



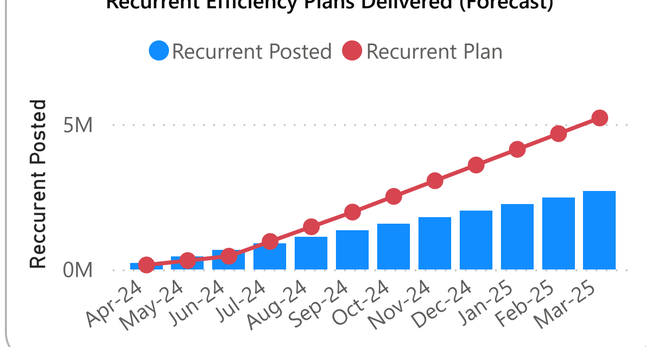
Workforce Stability



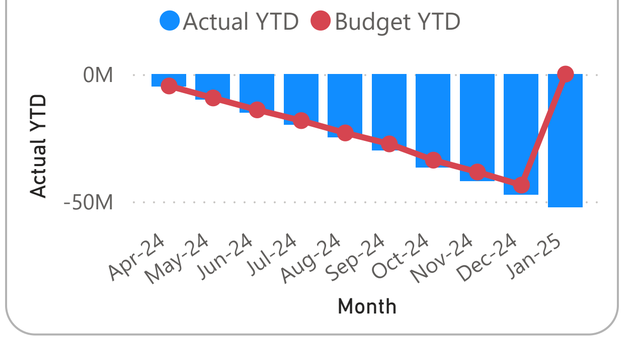
A&E Attendances per ED Consultant WTE



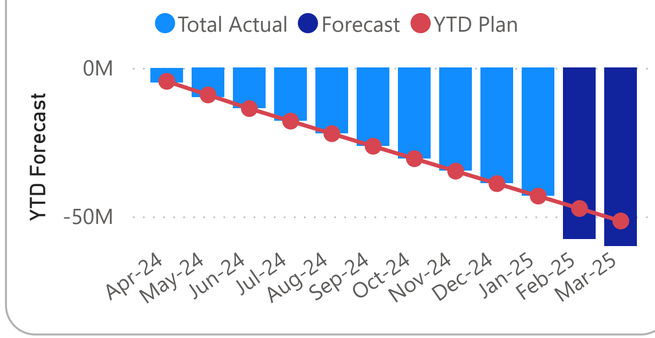
Recurrent Efficiency Plans Delivered (Forecast)



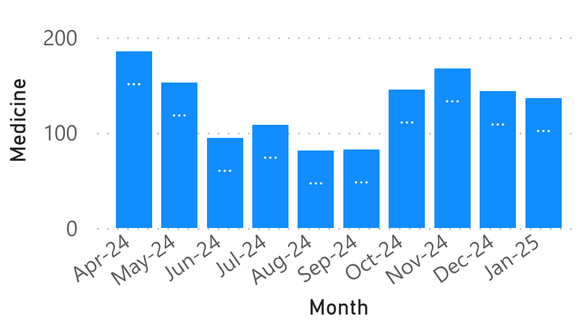
I&E distance from target (cumulative YTD)



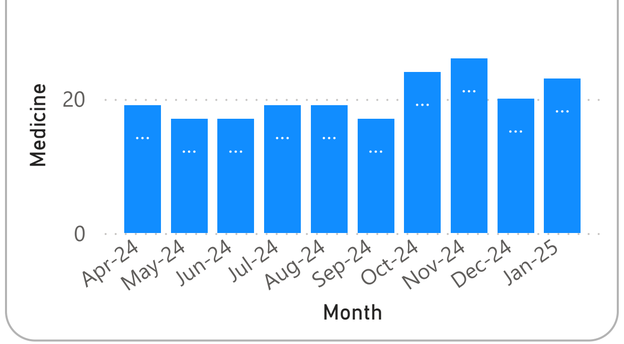
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

- % recovery for both OPNEW and DC/Elect activity was above target in M10
- Increase in inpatient discharges per day (casemix increase)
- Number of RTT patients waiting over 52 weeks although increased slightly, still remains significantly lower than previous months
- Sickness absence decreased in month
- Mandatory training remains above target for the division

Areas of Concern

- WNB rate although decreased is still above target
- DM01 target reduced slightly- impacted by very low volume of patients
- Overdue follow ups remain high, although significant decrease in volume

Forward Look (with actions)

- Focused work on improving WNB will be led via the re-imagining elective care collaborative
- Improvement plan underway to ensure division can maintain diagnostic compliance
- Continued focus on highest volume areas of overdue FU- ENT, Audiology, Cardiology alongside continued use of digital solutions to provide validation reviews

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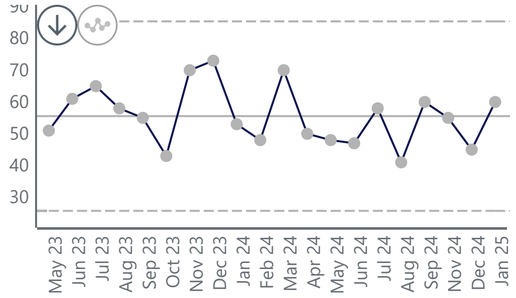
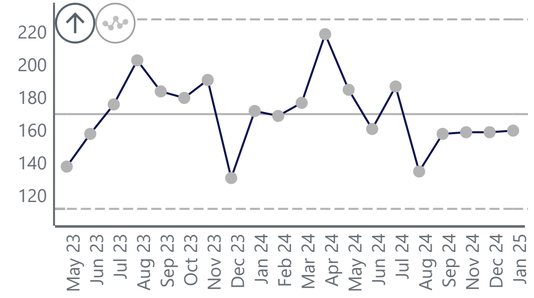
Divisional Performance Summary - Surgery

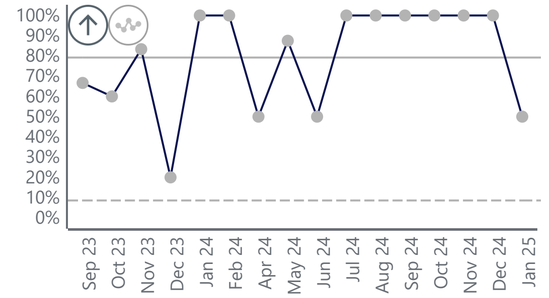
Patient Safety Incidents rated Low Harm & Above



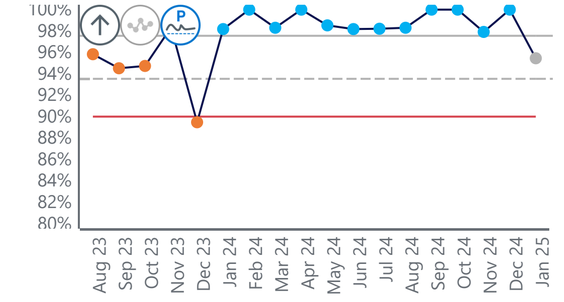
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

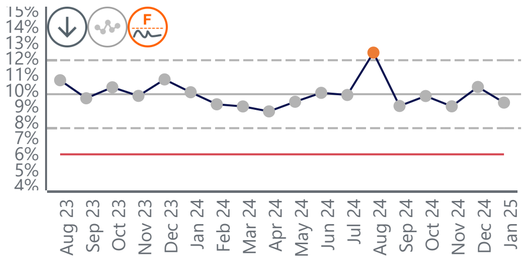


% PALS Resolved within 5 Days

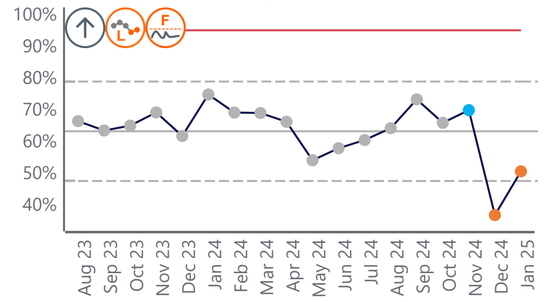


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

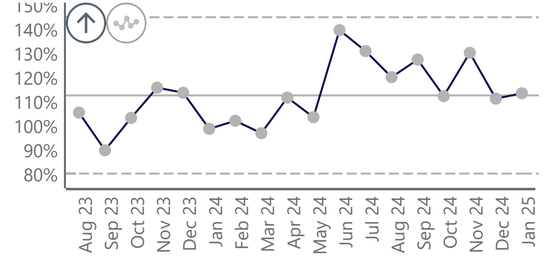


% of Clinical Letters completed within 10 Days



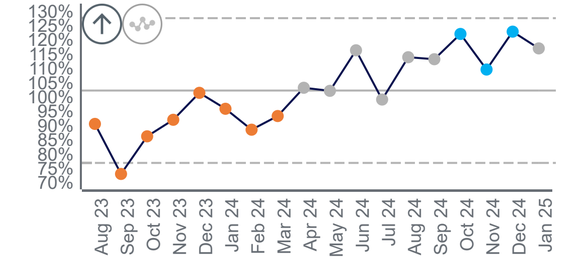
% Recovery for OP New & OPPROC Activity Volume

Based on 19/20 baseline

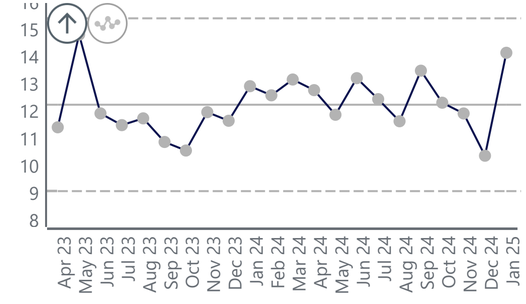


% Recovery for DC & Elec Activity Volume

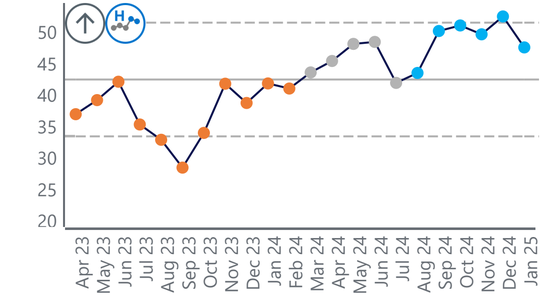
Based on 19/20 baseline



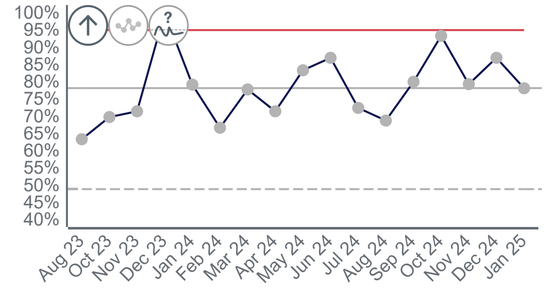
Inpatient Discharges per working day



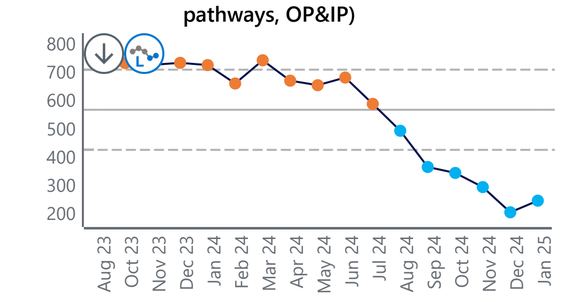
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



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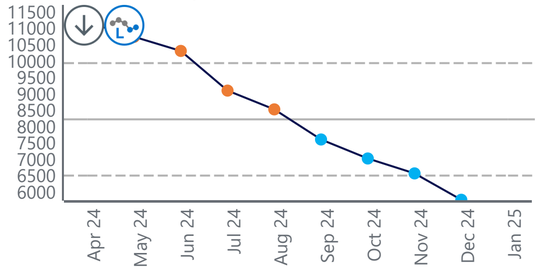
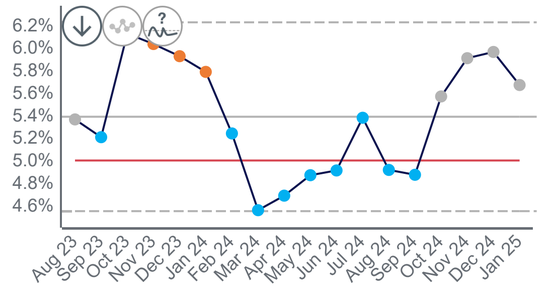
Divisional Performance Summary - Surgery

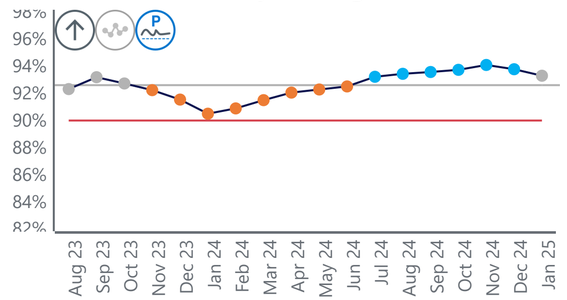
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



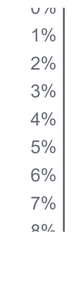
Sickness Absence (Total)



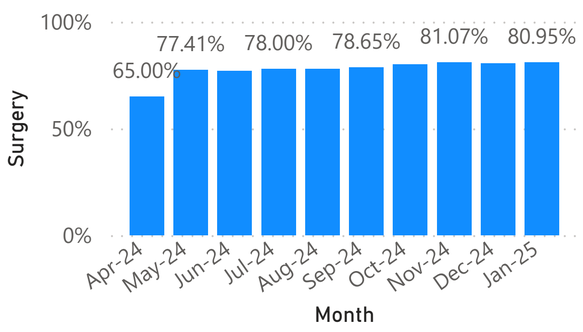
Mandatory Training



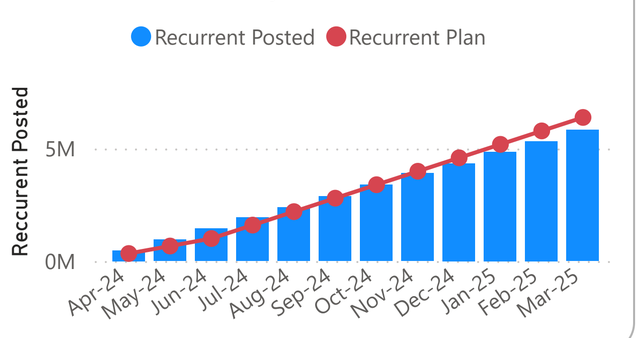
Staff Turnover



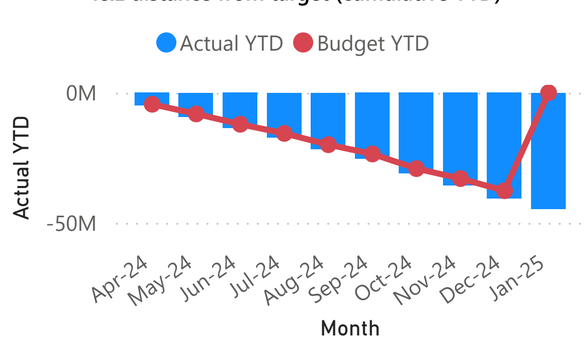
Workforce Stability



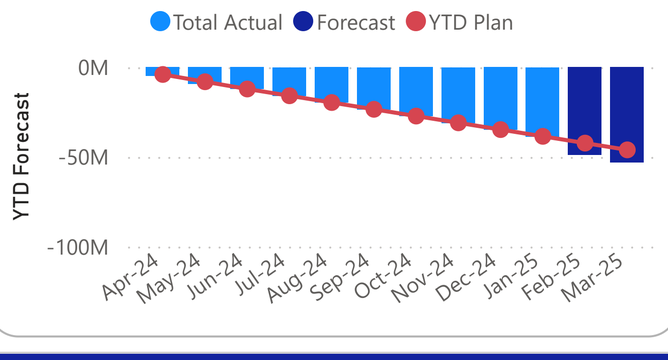
Recurrent Efficiency Plans Delivered (Forecast)



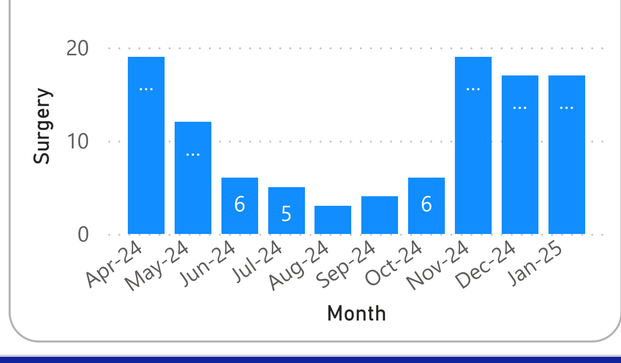
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division



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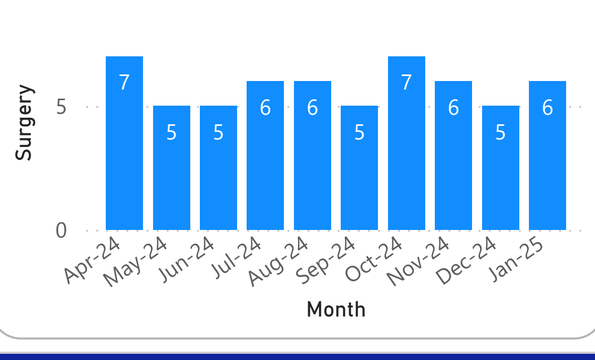

Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

- Mobile Research Unit now in use for community engagement activities
- Commercial research income remains ahead of target offsetting underachievement against MRI business case
- Continued increase in commercial and non-commercial research pipeline
- Internal capacity and capability funding call closed – review planned for Feb

Areas of Concern

- MRI not fully operational for research and pipeline of research activity not yet established – underachievement in 24/25 offset by increased commercial income.
- LWH confirmation of discontinued funding for Starting Well initiative from June 2025

Forward Look (with actions)

- Review of MRI business case underway to ensure clear roles and responsibilities for operational and pipeline activities with dedicated time secured
- Review and realignment of Starting Well staff underway
- Review of internal funding applications taking place in Feb for April 2025 start dates

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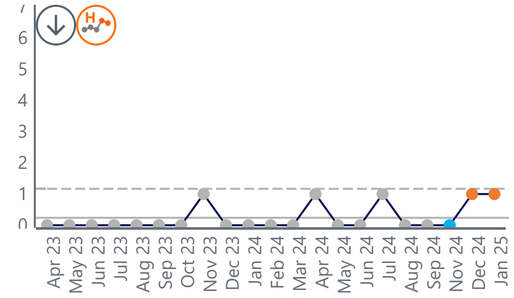
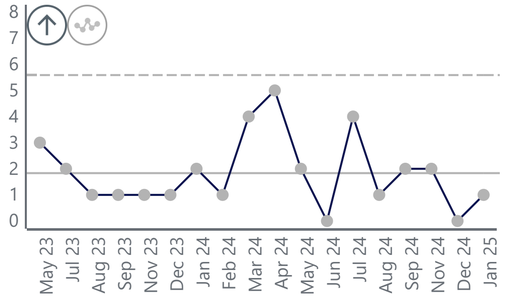
Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

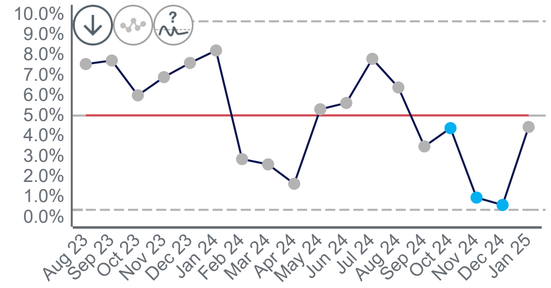


Patient Safety Incidents rated No Harm

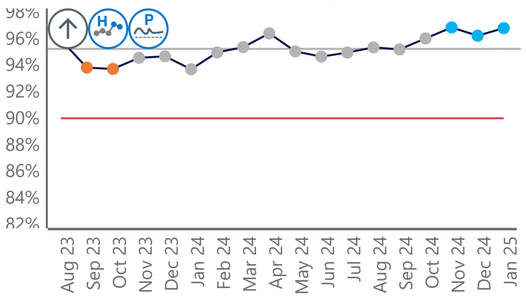


Staff Turnover

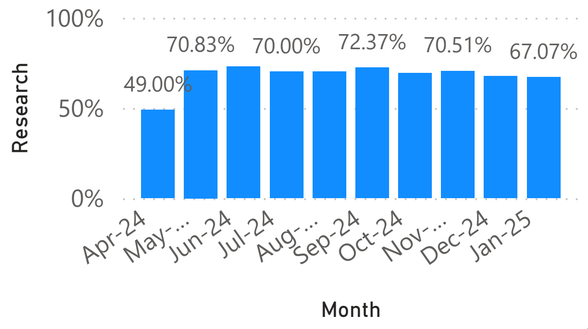
Sickness Absence (Total)



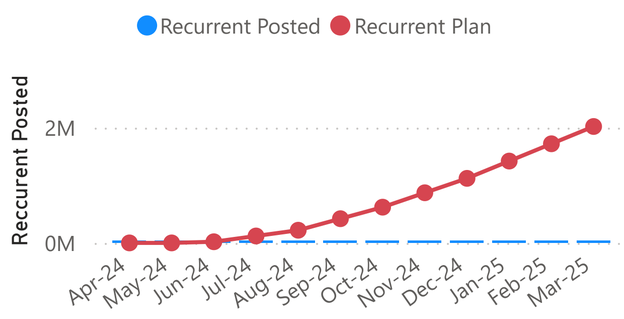
Mandatory Training



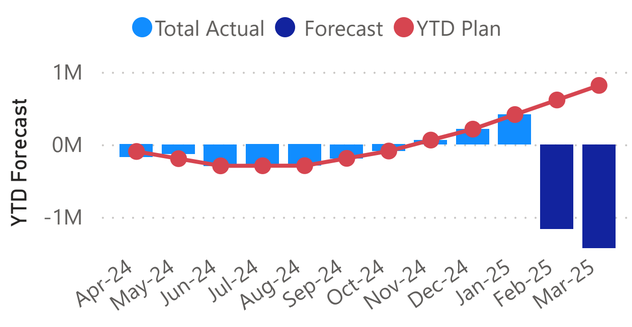
Workforce Stability



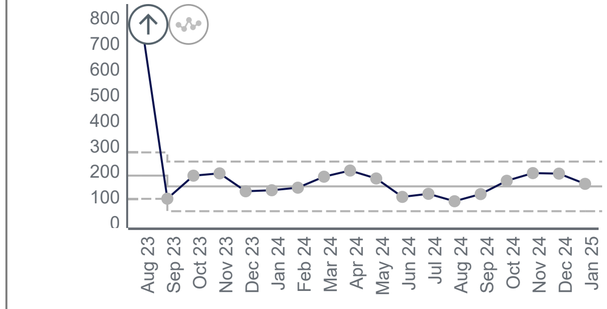
Recurrent Efficiency Plans Delivered (Forecast)



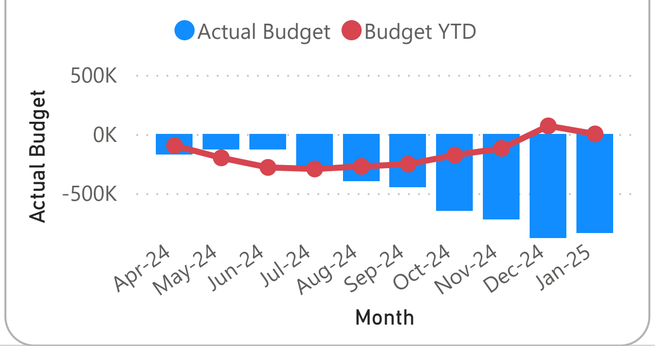
I&E Year End Forecast



Number of Patients Recruited into Research Studies



I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative met on 13th February 2025. Highlights from the January data include:

- Mandatory training remains stable at 94%.
- Short term sickness absence remains within Trust target at 2%.
- Long term sickness has reduced to 3% (5% previously).
- 94% of CIP already identified and/or delivered at M10.
- Income ahead of plan at M10 and YTD.
- Risk management compliance 98% of risks in date

Areas of Concern

- PDRs for all staff is currently sitting at 82%.
- Despite a reduction in-month, overall sickness remains above Trust target at 5.9% (previously 6.8%)
- Policy compliance is an area of concern with 35 policies overdue within Corporate Services.
- Open incidents on InPhase over 28 days (174)

Forward Look (with actions)

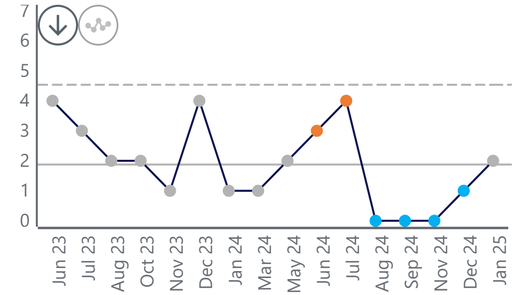
- Continued focus on financial position, system finance and internal controls/opportunities.
- Call to action for Policy owners to update outstanding documentation and submit through the appropriate governance channels.

Integrated Performance Report | February 2025

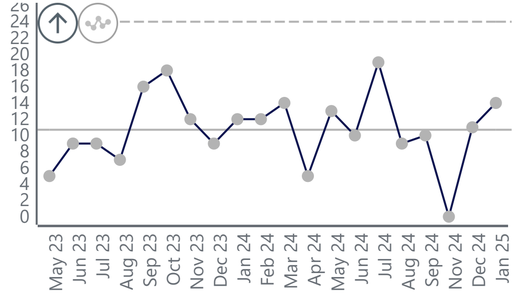
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

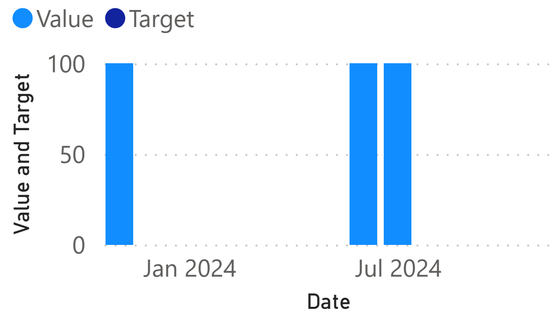
Patient Safety Incidents rated Low Harm & Above



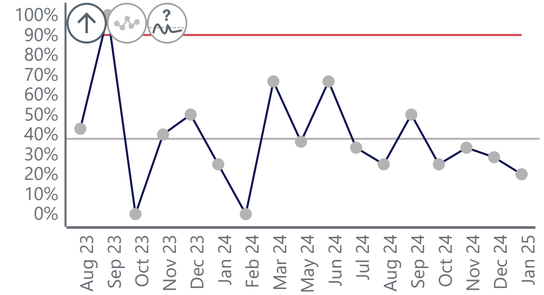
Patient Safety Incidents rated No Harm



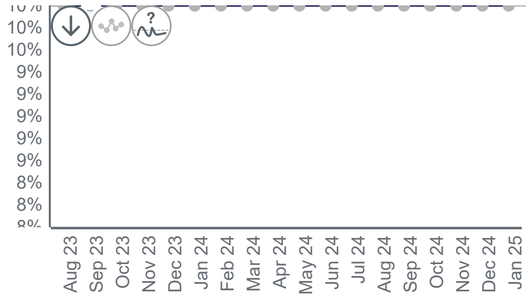
% Complaints Responded to within 25 working days



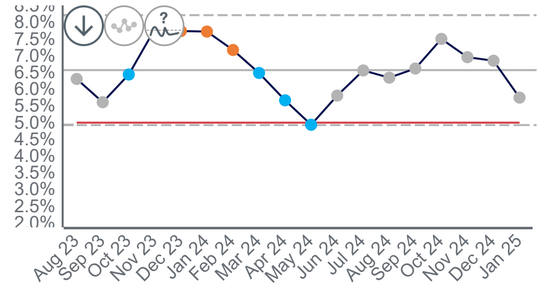
% PALS Resolved within 5 Days



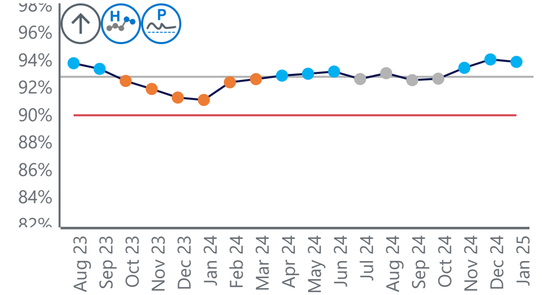
Staff Turnover



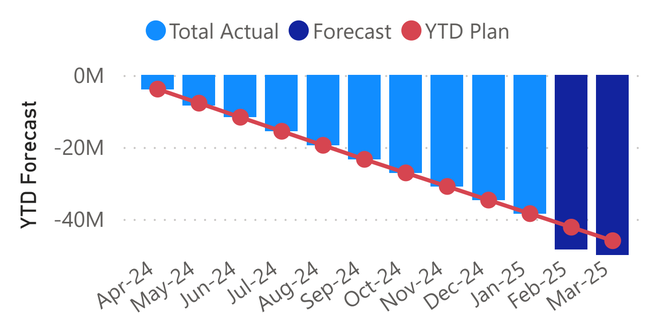
Sickness Absence (Total)



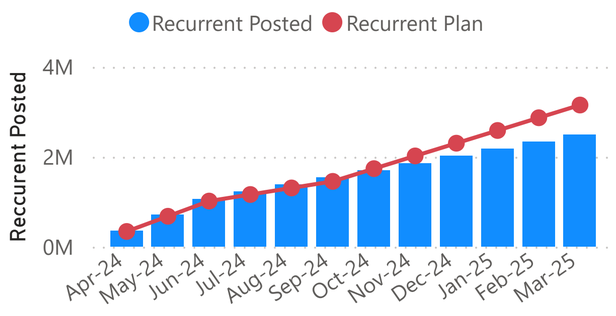
Mandatory Training



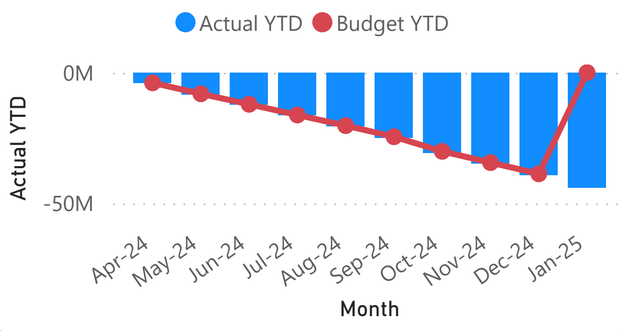
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

Safe Staffing & Patient Quality Indicator Report
January 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	108%		98%		111	19.2	13.56	16.84	0.00%	1.00	0%	0.00	0.00%	0.00	0.00%	17.37	3.17%	5.00	16.13%	0	47	0	1	4	100%	0	0
HDU	79%	35%	79%	74%	327	25.3	27.35	75.67	6.00%	5.33	62%	2.84	3.88%	0.00	0.00%	198.34	8.83%	0.00	0.00%	7	191	0	3	0	0%	0	0
ICU	92%	88%	92%	13%	500	37.9	27.35	161.87	4.00%	4.17	0%	1.00	0.64%	0.00	0.00%	369.09	7.65%	21.00	13.64%	9	262	0	1	3	100%	0	0
Ward 1cC	96%	88%	94%	102%	614	12.5	12.41	58.43	0.00%	5.33	6%	0.92	1.49%	0.00	0.00%	72.21	3.80%	13.23	8.49%	6	146	2	30	14	100.00%	0	0
Ward 1cN	83%	7%	99%		219	19.2	15.09	35.21	14.00%	2.43	67%	1.00	3.24%	0.00	0.00%	86.35	9.13%	0.00	0.00%	1	91	0	9	3	100%	0	0
Ward 3A	97%	78%	98%	115%	773	10.4	10.17	49.23	0.00%	15.98	19%	0.00	0.00%	0.00	0.00%	86.95	5.08%	19.79	4.90%	11	101	0	19	13	100.00%	0	1
Ward 3B	91%	109%	96%		355	16.1	10	43.95	4.00%	5.28	10%	0.00	0.00%	0.00	0.00%	38.80	2.97%	6.00	4.01%	4	149	0	9	1	100%	0	0
Ward 3C	98%	72%	86%	81%	778	11.1	8.65	62.65	0.00%	9.94	10%	0.00	0.00%	0.00	0.00%	96.69	4.90%	29.92	11.02%	11	174	0	7	11	90.91%	1	0
Ward 4A	85%	51%	87%	128%	777	10.7	10.25	67.53	0.00%	5.71	16%	0.00	0.00%	0.00	0.00%	212.49	9.97%	10.73	7.23%	4	116	0	5	23	91%	1	0
Ward 4B	62%	83%	62%	96%	654	12.2	11.92	33.67	0.00%	50.01	26%	0.00	0.00%	0.00	0.00%	139.13	12.43%	70.16	6.13%	8	156	0	9	5	100%	0	0
Ward 4C	67%	61%	69%	63%	582	10.7	11.8	57.68	1.00%	11.69	4%	0.00	0.00%	0.00	0.00%	132.19	7.47%	21.05	6.06%	5	306	0	9	21	85.70%	3	0

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

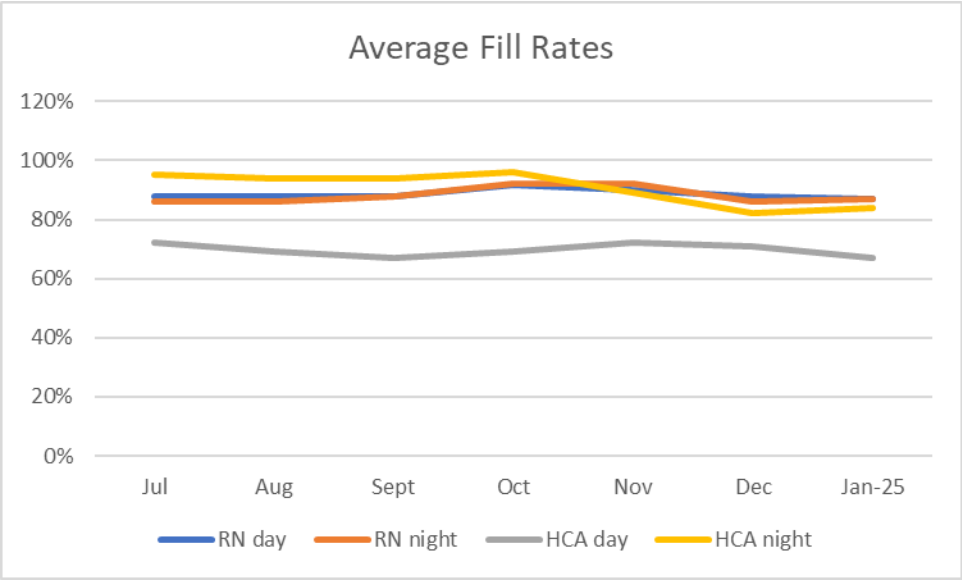
4C: CHPPD just below National Benchmark. January reported an increase in short term sickness for both trained and untrained staff.

HDU: Acuity high particularly with unplanned admissions so reflected in the CHPPD data

Summary

Two areas are reported as falling below the 80% benchmark; however this is due to a change in staffing models in both areas. 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. 4C has a reduced bed base due to PAU relocation and staff have been realigned accordingly leading to a reported lower fill rate.

There are vacancies within HCA's in all wards with the exception of the burns unit and PICU which impacts on the fill rate reported.



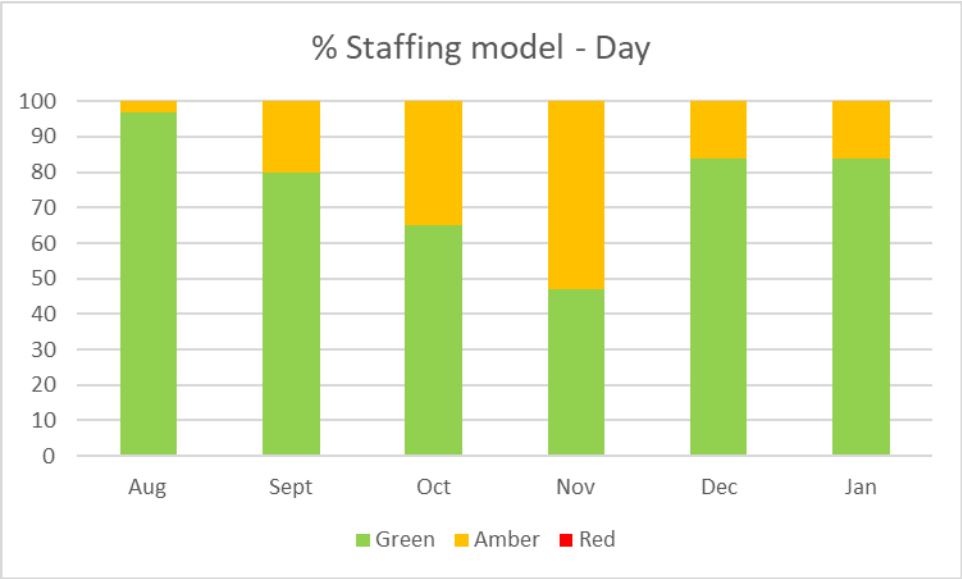
Nursing and care staff average fill rate December 2024	
Day and Night average fill rate	
Registered (%)	**Care Staff**
87% ↔	**76%**↓

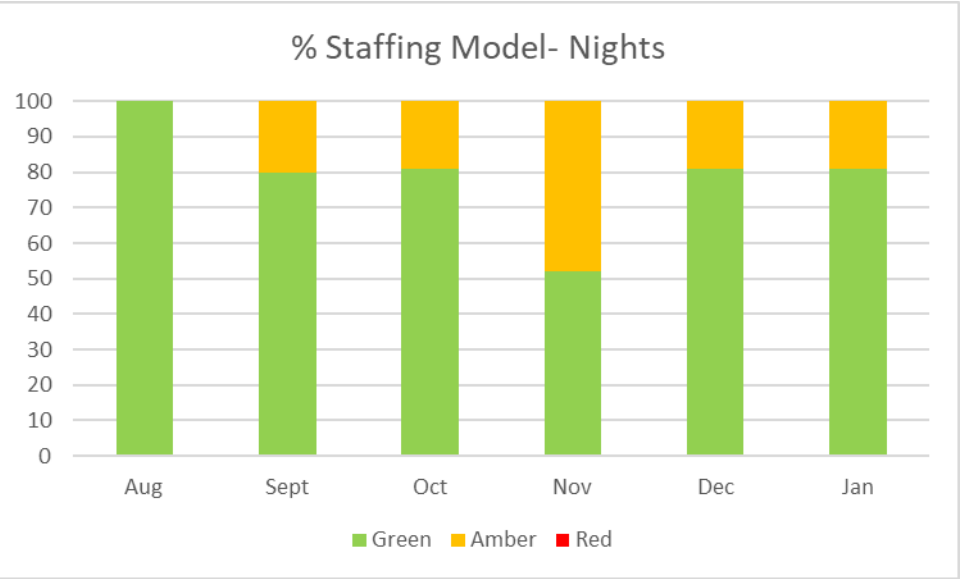
The overall improved position in relation to fill rates across day and nights continues for registered nurses, with a slight reduction for HCA's. There are vacancies within HCAs across the trust which impacts on the fill rate reported in some areas.

Summary of Staffing models August 2024 – January 2025

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

Data recorded for January is comparable to December with an amber staffing model being declared on 16% of days shifts and 19% of night shifts.





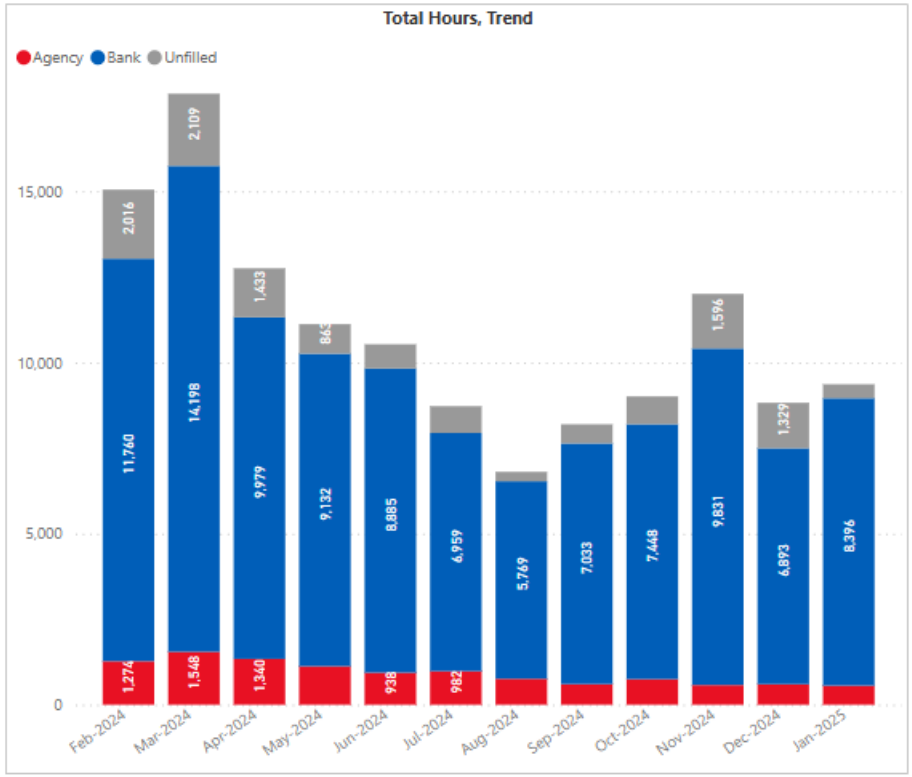
NHSP Bank Spend January 2025

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. We have seen a very slight increase in Registered Nurse Bank spend in January and correlates with higher levels of sickness and increased capacity and acuity across the acute trust. However compared to previous winter, bank spend has significantly decreased. Unregistered Nurse Bank has continued to reduce in the month of January despite the number of substantive vacancies within the trust. Recruitment for HCA is in progress.

Registered Nurse Bank Spend

YOY Comparison for Jan-2025

WTE	57.6 ! 86.3
% Total Fill	95.7% ✓ 88.7%
% Bank Fill	89.7% ✓ 80.2%
% Agency Fill	6.0% ✓ 8.5%
% Unfilled	4.3% ✓ 11.3%



Demand: in Jan-2025 totalled 9,364 hours (964 shifts), a change of 6.1% on Dec-2024

Bank: in Jan-2025 totalled 8,396 hours (868 shifts), a change of 21.8% on Dec-2024

Unfilled: in Jan-2025 totalled 407 hours (38 shifts), a change of -69.3% on Dec-2024

Agency: in Jan-2025 totalled 560 hours (58 shifts), a change of -6.7% on Dec-2024

Unregistered Nurse Bank Spend

YOY Comparison for Jan-20

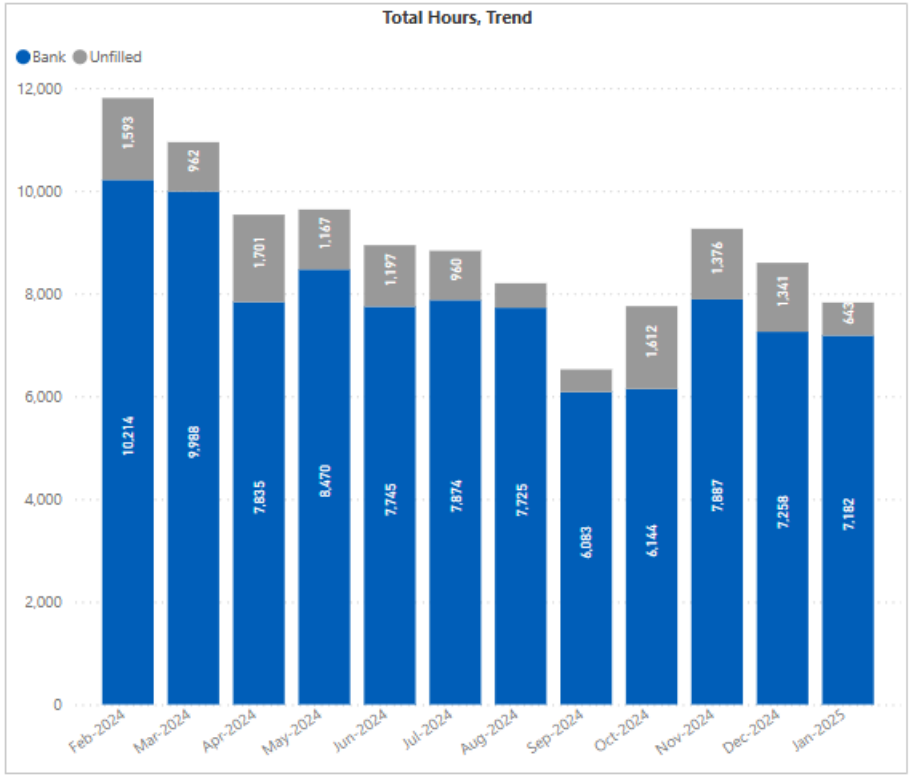
WTE
48.2 !
68.3

% Total Fill
91.8% ✓
89.4%

% Bank Fill
91.8% ✓
89.4%

% Agency Fill
(Blank)

% Unfilled
8.2% ✓
10.6%



Demand: in Jan-2025 totalled 7,826 hours (837 shifts), a change of -9.0% on Dec-2024

Bank: in Jan-2025 totalled 7,182 hours (762 shifts), a change of -1.0% on Dec-2024

Unfilled: in Jan-2025 totalled 643 hours (75 shifts), a change of -52.0% on Dec-2024

Agency: in Jan-2025 totalled hours (shifts), a change of -100.0% on Dec-2024

KPI E-Roster 7th December 2024 -5th January 2025

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 **(9th December to 5th January)**	% 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)	79.00	28.57%	80.00	519.38	0.00%	0.00		30.03%	25.48%	4.01%	1.48%	8.91%	0.00%	39.88%
Accident & Emergency - Nursing (912201)	42.00	32.75%	720.00	592.10	9.34%	867.75	1.00	23.03%	13.05%	0.49%	1.42%	10.80%	9.08%	34.87%
Burns Unit (915208)	44.00	21.43%	140.00	170.75	3.78%	83.00	9.00	10.25%	18.69%	1.17%	0.70%	4.31%	0.00%	28.31%
Critical Care Ward (913208)	44.00	20.74%	1200.00	1720.95	6.85%	1308.00	2.00	12.22%	12.89%	1.16%	1.09%	7.28%	4.62%	27.05%
High Dependancy Unit (HDU) (913210)	44.00	16.87%	640.00	251.06	3.03%	253.00	3.00	23.80%	9.54%	1.25%	0.67%	11.73%	6.08%	29.27%
Medical Daycase Unit (911314)	46.00	29.29%	50.00	-11.22	3.21%	27.25	13.00	31.42%	28.40%	0.57%	0.00%	6.90%	0.00%	35.87%
Outpatients (916503)	40.00	41.59%	420.00	631.61	14.34%	714.50	5.00	54.06%	24.19%	0.24%	2.44%	19.23%	2.90%	48.99%
Sunflower House (912310)	52.00	58.23%	190.00	152.62	25.53%	1049.75	86.00	32.26%	15.86%	0.56%	2.03%	16.84%	3.03%	40.09%
Surgical Daycase Unit (915418)	44.00	48.87%	85.00	1.58	7.93%	197.50	11.00	37.11%	21.69%	0.00%	0.74%	9.45%	3.01%	34.89%
Theatres - Cardiac & Cardiology (915405)	44.00	11.00%	130.00	8.00	3.59%	72.00		11.50%	25.52%	0.41%	0.00%	6.95%	4.16%	37.04%
Theatres - Emergency (915420)	44.00	22.30%	230.00	54.28	1.49%	30.50	4.00	3.63%	20.79%	1.80%	0.40%	6.50%	0.00%	32.35%
Theatres - IP Anaesthetics (915423)	44.00	14.10%	82.00	103.50	1.06%	32.00	3.00	11.78%	19.31%	1.14%	2.13%	5.89%	3.59%	32.07%
Theatres - IP Porters (915435)	44.00	25.76%	101.00	23.00	6.61%	76.25	1.00	23.28%	18.10%	0.00%	0.00%	25.34%	0.00%	43.44%
Theatres - IP Recovery (915422)	44.00	24.35%	103.00	38.13	1.03%	13.00		20.29%	15.88%	0.12%	7.85%	8.88%	0.00%	32.73%
Theatres - IP Scrub (915424)	44.00	21.89%	128.00	208.72	8.10%	108.00	1.00	12.70%	20.29%	0.65%	0.77%	6.34%	6.07%	45.91%
Theatres - Ortho & Neuro Scrub (915436)	44.00	29.17%	37.80	13.50	13.76%	268.50		12.31%	29.69%	0.77%	1.49%	0.00%	3.03%	45.06%
Theatres - SDC Anaesthetics (915429)	44.00	53.61%	58.40	-8.25	42.23%	362.00		36.29%	18.49%	1.01%	6.62%	12.08%	15.89%	54.08%
Theatres - SDC Recovery (915430)	44.00	30.91%	177.30	-0.62	4.60%	62.50	1.00	16.41%	21.02%	0.63%	2.18%	3.88%	7.51%	35.20%
Theatres - SDC Scrub (915421)	44.00	35.71%	532.00	2.21	4.84%	106.75		29.14%	24.76%	0.65%	2.92%	14.34%	0.00%	42.68%
Ward 1C Cardiac (913307)	40.00	28.73%	361.00	682.43	5.73%	385.25	2.00	14.12%	17.43%	0.46%	2.22%	9.25%	5.54%	35.02%
Ward 1C Neonatal (913310)	48.00	32.08%	556.00	1183.66	0.71%	34.50		13.19%	14.55%	2.80%	0.55%	7.27%	5.48%	35.32%
Ward 3A (915309)	44.00	24.42%	371.00	49.54	9.78%	697.25	32.00	15.59%	14.91%	0.11%	6.25%	8.36%	9.75%	39.47%
Ward 3B - Oncology (911208)	46.00	20.46%	555.00	478.56	2.81%	137.25	49.00	24.58%	17.51%	0.31%	0.40%	7.55%	3.77%	34.02%
Ward 3C (911313)	46.00	16.15%	607.00	1081.30	5.21%	422.00	16.00	19.90%	13.96%	1.34%	1.21%	5.89%	4.96%	29.10%
Ward 4A (914210)	44.00	29.06%	634.00	582.03	7.03%	520.00	62.00	27.30%	16.77%	1.79%	1.29%	11.74%	2.64%	35.91%
Ward 4B (914211)	46.00	20.26%	533.00	525.92	5.67%	486.50	29.00	25.47%	12.22%	0.83%	1.09%	8.80%	5.47%	28.42%
Ward 4C (912207)	46.00	23.80%	280.00	304.90	1.72%	103.50	6.00	29.06%	14.03%	0.33%	3.07%	6.84%	5.14%	32.53%

Summary

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

- Lead time has increased from 43.2 days to 45.7 days. All divisions achieved the 42-day KPI (KPI 42 Days)
- Net hours have decreased from 10816 to 9360. (KPI 9001 to allow for up to a day to owe or be owed)
- Bank/Agency has decreased from 14382 to 8419. The total % of shifts filled by temp staffing has reduced from 10.4% to 7.4% (KPI less than 10%)
- Sickness continues to remain high at 9.3%
- Annual leave (11%-17%), Study Leave (<2%) & other Leave (<5%) all within the agreed KPIs

Senior Nurses across all divisions in collaboration with health roster have been working on these KPIs with managers for 12 months with two of the key achievements outlined below

- Staff are now being given on average 45.7 days' notice of roster to be worked (Previous 31 days)
- Net hours have reduced from 29114 to 9360 (This allows managers to see if anyone owes contracted hours before sending a shift to bank)

BOARD OF DIRECTORS
Thursday, 6th March 2025

Paper Title:	Patient and Carer Race Equality Framework Briefing Note – March 2025
Report of:	John Grinnell, Chief Executive Officer
Paper Prepared By:	Lisa Cooper, Director Community & Mental Health Services

Purpose of Paper	Decision Assurance Information Regulation	☐ ☒ ☐ ☐
Summary / Supporting information		
Action required	To Approve To Note	☐ ☒
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

1. Report Purpose

The purpose of this paper is to provide an update to Trust Board of the requirement for Alder Hey, as a provider of mental health services, to implement the national Patient and Carer Race Equality Framework (PCREF) by 31 March 2025.

2. Background

NHS England has launched its first ever anti-racism framework: the Patient and Carer Race Equality Framework (PCREF), for all NHS mental health trusts and mental health service providers to embed across England. It aims to improve experiences of care for racialised communities within mental health services.

This mandatory framework will support trusts and providers on their journeys to becoming actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing actions to reduce racial inequalities within their services.

One development, announced in March 2024, has been the inclusion of a new clause in the NHS Standard Contract to state that implementing the PCREF is a mandatory requirement for providers of mental health services. Trusts and mental health providers are expected to have a nominated lead at board level to drive forward and embed a local PCREF plan.

The CQC have produced initial guidance and learning and are in the process of developing full guidance on PCREF. They will publish guidance later this year setting out how they will assess and rate PCREF-related development and performance using the Single Assessment Framework. For the moment they will look at:

- Providers' and stakeholders' awareness and knowledge about PCREF and its purpose and value.
- Providers' arrangements and plans to develop PCREF, and how this is being overseen and managed.

The mandatory framework focuses on three key areas:

- **Leadership and governance**: trust boards will be leading on establishing and monitoring plans of action to reduce health inequalities.

- **Data**: new data set on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core data sets.

- **Feedback mechanisms**: visible and effective ways for patients and carers to provide feedback, as well as clear processes to act and report on that feedback.

3. Requirements

- All NHS Mental Health Trusts and providers of mental health services should put a Patient and Carer Race Equality Framework in place **by 31 March 2025.**
- Every Trust should have a PCREF lead who makes sure this happens.
- Each Trust must publish the local PCREF on their website every year, so they can be held accountable for progress made.
- Trusts should work closely with local councils and commissioners from NHS England's Integrated Care Systems and Integrated Care Boards to meet the mental health needs of:

- the local population
- racialised groups
- ethnically and culturally diverse communities.

Specifically, Trusts are required to:

- Review their governance structures and board-level accountability. With particular focus on elevating the voices of the community representatives and ensuring better representation of racialised people at trust board-level.
- Review business planning for 2024/25 to agree resources to rollout the framework.
- Plan for how the PCREF will be embedded at a: service / operational level across older adults, adults and children and young people. And at an ICB level - with local population planning for racialised communities, community assets planning and using the information available to coproduce plans to reduce inequity in access, experience and outcomes.
- Put in place strategies, monitoring and reporting and strengthen data collection and flow requirements underpinning the PCREF.
- This includes improving data collection around ethnicity and other demographic.
- Regularly review and monitor the impact of PCREF-related initiatives.
- Trusts must report on different ways they are following the law, for example:
  - Information about the ethnicity of people who live in the local area.
  - The number of people they detain under the Mental Health Act the number of children and young people under 18 years old who access mental health care and treatment.
  - Information about rights, complaints and advocacy services in accessible formats the number of patient safety incidents including incorrect use of force.
  - The number of complaints from racialised and ethnically and culturally diverse patients and carers.
  - Show they have worked out how new policies or practices could affect people from protected groups check that action has been taken from feedback from advocacy services.

There are six organisational competencies which Trusts should do to put the PCREF in place:

1. Cultural Awareness
2. Staff Knowledge and Awareness
3. Partnership Working
4. Workforce
5. Co-production
6. Co-Learning

4. Update March 2025

To support the implementation of PCREF across the Trust by 31 March 2025, the following actions have been taken:

- As an interim the Chief Nursing Officer has been identified at the Board level lead for implementation of PCREF across the Trust.
- The Director of Community & Mental Health Services continues to work with the Trust's BI team to finalise core reporting metrics to be implemented from 01 April 2025, these are:

    - Deaths within mental health settings
    - Use of restrictive interventions
    - Detentions under Mental Health Act
    - Trust wide % compliance with recording of ethnicity for children & young people accessing services
- The Division of Community & Mental Health Services has in place a PCREF implementation plan for all divisional services which will be monitored via the Division's governance structure.

The following Trust wide additional actions remain under review, for discussion with appropriate executive leads:

- Co-develop, implement and review Trust PCREF plans with racialised communities and the workforce.
- Engage with racialised communities to identify and agree core organisational competencies.
- Agree on measurable and practical actions to co-develop in Trust PCREF plans.
- Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans.
- Training plan regarding anti-racism and cultural awareness.
- Ensure patient experience data is used, monitored and flowed to national datasets to enable bench- marking, lesson-sharing and service improvement.
- Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services.
- Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities.

5. Next Steps/Actions

Trust Board are asked to note the actions taken to date to ensure implementation of the national PCREF by 31 March 2025.

BOARD OF DIRECTORS
Thursday, 6th March 2025

Paper Title:	**Patient Safety Response Plan 2025/26**
Report of:	**Associate Director Nursing Risk and Governance**
Paper Prepared by:	**Associate Director Nursing Risk and Governance**

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	In line with PSIRF requirements development of annual Patient Safety Response Plan based on data outlining our patient safety local priorities for 2025/26 • Patient Safety Response Plan approved by the Patient Safety Board January 2025 and ratified at SQAC Feb 25. • In line with PRSIF national directive Trust Board as asked to approve the Patient Safety Response Plan for 2025/26
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

Patient Safety Incident Response Plan 2025/2026

Document Properties	
Version:	2
Name of Originator/Author	Jackie Rooney, Associate Director of Nursing Governance and Risk. Chris Talbot, Trust Patient Safety Specialist
Name of Approval Committee	Patient Safety Board
Date Approved	January 2025
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Date Ratified	February 2025
Executive Sponsor	Alfie Bass, Chief Medical Officer Nathan Askew, Chief Nursing, Allied Health Professional and Experience Officer
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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
2	February 2025	Jackie Rooney Chris Talbot	Active/Approved	Annual Patient Safety Profile developed for 2025
1	October 2023	Jackie Rooney Chris Talbot	Archived	Annual Patient Safety Profile developed for 2025

Record of changes made to Patient Safety Incident Response Plan - Version 1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Section 6	Various	Update to national and local patient safety priorities section 6	Changes made according to patient safety profile for 2024/25

Contents

1. Introduction

This Patient Safety Incident Response Plan (PSIRP) for 2025/2026 sets out how Alder Hey Childrens NHS Foundation Trust (the Trust) intends to respond to patient safety incidents reported by our children and young people, their families and carers and our staff, as part of work to continually improve the quality and safety of the care we provide.

This plan is not a permanent rule that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more child or young person in our care receiving healthcare.

This PSIRP covers responses conducted solely for the purpose of system learning and improvement and that reduce risk and/or prevent or significantly reduce recurrence.

The plan is data driven, will remain flexible and may change to consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

It will be underpinned by the existing Trust Incident Reporting and Management Policy and the Trusts Patient Safety Incident Response Policy.

Responses covered in this Plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Reviews (PSRs)

Other types of responses exist to deal with specific issues or concerns, for example: complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests, or criminal investigations. The principle aims of each of these responses differ from the aims of a PSII or PSR and are therefore outside the scope of this plan.

2. Our Services

Alder Hey Children's NHS Foundation Trust is one of Europe's biggest and busiest children's hospitals, caring for over 330,000 children, young people and their families every year.

Located in Liverpool UK, we treat everything from common illnesses to highly complex and specialist conditions. We also have several community outreach sites enabling us to deliver care closer to children and young people's homes in local clinics locations from Cumbria to Shropshire, in Wales and the Isle of Man.

We know that a children's hospital is different and that our job is more than just treating an illness. To us, every child is an individual. As well as giving them the very best care, we set out to make them feel happy, safe, and confident as they play, learn, and grow. At Alder Hey, we are here to look after a child and their family and that includes mums, dads, brothers, and sisters.

We have several well-established Children and Young Peoples' Forums which help us develop new ideas for how they can be at the centre of the Trust's plans and activities helping us keep children and young people's voices at the forefront, including continuing to play a key role in the recruitment of key Board level posts. In 2025, our recently recruited Patient Safety Partners (PSP's) will be in post, who will be involved in all aspects of patient safety across and throughout the Trust.

The Trust is supported by several charities and through the work that they do to support the hospital, we can ensure that Alder Hey's pioneering work continues to make a difference to the lives of children and young people.

Alder Hey has a strong history of quality improvement and our Brilliant Basics approach supports the team to make small changes that lead to big improvements and healthier futures for our children, young people and families. Brilliant Basics is our approach to improving quality, safety, effectiveness and experience. As we move into 2025 the focus will be on maturing and sustaining our approach to continuous improvement by:

- Supporting leaders at all levels to adopt the style and approach that will support improvement efforts.
- Supporting divisions to go further to align, enable and improve.
- Utilising the voice and ideas of children, young people and families that Alder Hey work with.

3. Defining our Patient Safety Incident Profile

Patient safety incidents for Alder Hey have been profiled using available organisational data between January 2024 to December 2024 from:

- Patient safety incident reports
- Clinical and non-clinical incident data
- Top 10 incident cause groups
- Complaints and PALs themes
- Legal claims
- Staff survey results
- Mortality and in patient death thematic reviews
- Trust wide quality improvement workstreams
- Regulation 28 Prevent Future Deaths reports

Additional resources reviewed include: Freedom to Speak up reports, Annual Quality Accounts, Trust wide Quality Round and Quality Assurance Round insight reports and presentations, Complaints and PALs reports, child deaths and mortality review reports, safeguarding data, patient safety quality improvement dashboards via our quality improvement programme Brilliant Basics, risk data, and direct consultation with children, young people and their families and our staff via open forums and through a range of children and young person's and staff forums that we have in place.

3.1 Data Sources

A data review of the Trusts Risk and Incident Management System (InPhase) was conducted for patient safety risks and incidents reported between 1st January 2024 to 31st December 2024, to establish the number of reported patient safety incidences, reported harm levels and any subsequent patient safety investigations that took place. Data was acquired from the above list of sources to guide this plan.

3.2 Stakeholder Engagement

Key stakeholders have been consulted to determine and agree the identified priorities and Alder Hey's Patient Safety Incident Response Plan for 2025/2026.

3.3 Stakeholder Activity

Feedback and information provided by internal stakeholders, our children, young people, their families and carers and subject matter experts were considered in the development of our patient safety profile. Attendance and discussion at a range of children and young person's forum events (including PSP recruitment events) and staff forums enabled plan development.

Qualitative and anecdotal feedback from our children, young people, their families and carers and our staff were sought via QR code to inform potential future categories for local patient safety responses and system improvement. The review also highlighted areas which required collation of further intelligence to inform subsequent plans.

4. Defining our Patient Safety Improvement Profile

Our patient safety profile and subsequent plan was discussed, shared, and approved by our locally established Patient Safety Board and presented to our Safety and Quality Assurance Committee for ratification.

All patient safety improvement workstreams that currently report into our Patient Safety Board together with other patient safety initiatives ongoing across the Trust were also considered as noted below.

4.1 Current Patient Safety Board Improvement Workstreams:

- Meditech Unacknowledged Notices
- Parity of Esteem (Restrictive Intervention)
- Antimicrobial Resistance (AMR)

4.2 Patient Safety Board Improvement Workstreams completed in 2024 now reporting business as usual:

- Total Parenteral Nutrition (TPN)
- Medication Safety
- Learning Disabilities
- Litigation and negligence

4.3 Assurance reports to Patient Safety Board:

- Sepsis
- Neonate Safety
- Medication Safety
- Pressure Ulcers
- Mortality Review/Learning from deaths
- Trauma Safety and Quality
- National Safety Standards for Invasive Procedures (NatSSIPs)
- Blood Transfusion
- Medical Devices
- Radiation Protection

4.4 Other Trust Patient Safety Improvement Programmes:

- Neonatal team development support
- Laboratory Medicine - blood testing and blood product ordering process improvement
- Clinical summit - leadership development offer
- Divisional productivity - audiology
- 3B day case improvement
- Out-patients; admin process improvement, new model of care
- Neurology Transformation
- General Paediatrics @Its Best
- Vision 2030: personalise my care, thriving leaders, experience (variety of support offers)
- Venous Thromboembolism Improvement Group

All the above patient safety programmes are supported and delivered using our Brilliant Basics Quality Improvement (QI) methodology that is widely embedded across the Trust.

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and quality improvement interventions already in place.

5. Our Patient Safety Incident Response Plan: National Requirements

National patient safety priorities are set by the PSIRF and other national initiatives for the period 2025/2026. These priorities require a Patient Safety Incident Investigation (PSII) to be conducted by the Trust to identify and maximise opportunities for learning.

Patient Safety Incident Investigations (PSIIs) include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

While most PSIIs will be conducted locally by our organisation, some may be conducted independently and funded by our organisation or regionally/nationally.

In addition to a PSII some patient safety incident types will require specific statutory reporting and/or review process to be followed. All types of incidents that have been defined nationally as requiring specific responses are outlined below and will be reviewed according to the national suggested methods.

National Focus Priorities		
Patient safety incident type	**Required response**	**Anticipated improvement route**
All incidents meeting the Never Events criteria (2018) or its replacement	Patient Safety Incident Investigation	Create local organisational actions and feed these into the Patient Safety Board as part of the QI process for Trust wide/Divisional action
Any incident meeting the learning from deaths criteria i.e. death thought more likely than not due to problems in care	Patient Safety Incident Investigation	
All child deaths (including children with learning disabilities)	All child deaths are reviewed as part of the Trusts HRMG process and referred to the Trusts Mortality lead. If relevant, any child death will be referred to the child death overview panel (CDOP) via the Trusts Safeguarding team for investigation. Refer to the Child death review statutory and operational guidance	Safeguarding team to liaise with CDOP as locally led PSII may be required. Respond to recommendations from external parties for learning purposes.

Neonatal incidents	Referred to Maternity and Newborn Safety Investigations (MNSI) for independent patient safety incident investigation https://www.mnsi.org.uk/ All perinatal deaths must be referred to MBRRACE. MBRRACE-UK website	Respond to recommendations as required from external referred agency and feed actions into the Patient Safety Board to be considered as part of QI process. MBRRACE recommendations will be presented and monitored via Clinical Outcomes and Effectiveness Group (CEOG) and if required shared at our local Neonate Partnership (LNP) Board
All Safeguarding/ Rainbow Centre incidents	Incidents must be reported to the Trusts safeguarding team/Named safeguarding leads for review/multi-professional investigation and possible local authority referral.	Respond to recommendations as required from external referred agency and feed actions into the Trust Safeguarding and Statutory Services Assurance Group to be considered as part of QI process.
Incidents in screening programmes	Incidents must be reported by Director of Infection Prevention Control (DIPC) to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)	Respond to recommendations as required from external referred agency and feed actions into the Patient Safety Board to be considered as part of QI process.
Mental health- related homicides by persons in receipt of mental health services or within six months of their discharge	Incidents must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)	Respond to recommendations as required from external referred agency /Divisional oversight and improvement.
Incidents resulting in moderate or above physical /psychological harm to child/young person	Statutory Duty of Candour	All Moderate/severe physical and psychological harm initial reviews presented to the Patient Safety Incident Response Investigation (PSIRI) Panel for discussion/

		decision on requirement for PSII /improvement route (if applicable)
Haemovigilance (MHRA/SHOT reportable incidents)	It is a regulatory and legal requirement to report all serious adverse events (SAE) and serious adverse reactions to the MHRA/SHOT http://www.shotuk.org/reporting. 'Appropriate level of investigation of contributing factors using a systems approach and application of human factors principles'	Appropriate corrective and/or preventative actions identified and taken in response to investigation. Transfusion Committee oversight and improvement Feeding into Patient Safety Board via assurance reports
Ionising radiation CQC notifiable incidents (IR(ME)R)	All significant accidental or unintended exposure incidents (SAUE) are notifiable to regulator within 2 weeks of event. PSII or PSR to be decided locally via PSIRI panel depending on the incident and report available to regulator within 12 weeks	Respond to regulators recommendations following internal investigation. Divisional oversight and improvement in conjunction with radiology radiation protection lead
Health Care Acquired Infections (HCAIs)	Initial Review / SBARD	Via Infection Prevention Control Committee

6. Our Patient Safety Incident Response Plan: Local Focus

Local patient safety priorities are set by the Trust. In addition to analysing our local patient safety profile, we have taken the following considerations into account when defining our local patient safety priorities.

Criteria	Considerations
Potential for harm	• People: physical, psychological, loss of trust (patients, family, caregivers) • Service delivery: impact on quality and delivery of healthcare services; impact on capacity • Public confidence: including political attention and media coverage
Likelihood of occurrence	• Persistence of the risk • Frequency • Potential to escalate

Our local patient safety priorities require a Patient Safety Review (PSR), a PSII will also be undertaken where required.

The PSR's include several techniques to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected child, young person, family, carer, or staff.

Note: There may be patient safety incidents not outlined in the priority list below for which a PSR is undertaken based on the request or views of those affected, including patients and their families.

All PSRs are conducted locally by our organisation with different PSR techniques adopted depending on the intended aim and required outcome.

There are five broad categories of PSRs agreed with stakeholders to be utilised at Alder Hey Childrens NHS Foundation Trust.

- Initial Review
- Situation, Background Assessment, Recommendation, Decision (SBARD) review
- Thematic Review
- Multi-disciplinary team (MDT) review
- After Action Review (AAR)

Local Focus Priorities		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Incidents relating to the recognition and escalation of the deteriorating patient	• Divisional review of incident (Initial review) • PSII (where agreed)	Divisional local improvement / monitoring of actions and via Patient Safety Board as specific workstream
Incidents relating to delay and/or lost to follow up appointments/treatment	• Divisional review of incident (Initial review) • Thematic Review • PSII (where agreed)	Divisional local improvement / monitoring of actions and via Safer Waiting List Programme Board and Patient Safety Board
Incidents relating to medication safety - ***Omission/ delay of critical medications***	• Initial Review • AAR • Thematic review • PSII (where agreed)	Via Medication Safety Group that feeds into Patient Safety Board
Incidents relating to documentation – ***consent & medical record keeping***	• Divisional review of incident (Initial review) • Thematic Review • PSII (where agreed)	Divisional local improvement / monitoring of actions and via PSIRI Panel
Incidents relating to IT system failure leading to patient harm	• Divisional review of incident (Initial review) • Thematic Review • PSII (where agreed)	Via Digital oversight Committee/Divisional governance meetings and PSIRI

In addition to our local patient safety priorities, we have two further improvement priorities to improve patient safety.

- ***To improve safety culture through enhancing levels of psychological safety and civility across the Trust***

- ***To improve how we identify and share learning across the Trust***

These improvement priorities will be developed over the next 12 months and monitored via the Patient Safety Board.

7. Conclusion

This patient safety incident response plan (PSIRP) supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Alder Hey Childrens NHS Foundation Trust (the Trust) intends to respond to patient safety incidents reported by our children and young people, their families and carers and our staff, as part of work to continually improve the quality and safety of the care we provide.

The Trust acknowledges that PSIRF is a new approach to patient safety incidents advocating a coordinated data-driven response to patient safety incidents, prompting a significant cultural shift towards systematic patient safety management.

As we continue to embed this new way of managing our patient safety incidents and learning reviews, we accept that we may not get it right, and we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to.

Most importantly, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our children and young people, their families and carers whilst also protecting the well-being of our staff. We welcome the next phase of our PSIRF journey.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th March 2025

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This report provides assurance on: - progress of the Brilliant Basics Delivery Plan 2024/2025 - progress against NHS IMPACT standards - Alder Hey collaboration in Cheshire and Merseyside Improvement Network In addition this report outlines objectives for 2025/2026.
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	None

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

1. Executive Summary

The aim of this paper is to provide Trust Board assurance on:

- progress of the Brilliant Basics Delivery Plan 2024/2025
- progress against NHS IMPACT standards
- Alder Hey collaboration in Cheshire and Merseyside Improvement Network

and outline objectives for 2025/2026.

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

The key message in this report is one of continued progress towards mainstreaming continuous improvement into the core business of the organisation.

2. Background and current state

Progress on BB Delivery Plan 2024/2025

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

Table 1 below details progress against the driver metric. At the time of writing the Staff Survey Data is embargoed but the table below shows the trend analysis.

Driver	
NHS Staff Survey Involvement Question: The degree to which staff feel that they are involved in making improvements within their organisation.	Brilliant Basics will **contribute** to increasing the numerical value of the survey results.
Question	**Trend**
I am able to make suggestions to improve the work of my team / department.	↑
I am involved in deciding on changes introduced that affect my work area / team / department.	↑
I am able to make improvements happen in my area of work.	⇄

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

Progress has been made against all objectives and a clear plan for further enhancements will be carried out through objectives for 2025/2026.

The SRO has been accountable for all decisions regarding progress and change control during 2024/25.

NHS IMPACT

NHS IMPACT has set out five key components which, when implemented together, build a systematic organisation wide approach to improvement and high performance. The self-assessment against these standards was initially completed in November 2023 and discussed at Strategic Executives. The update for this report can be found in table 3 below.

Table 3: Updated self-assessment against NHS IMPACT standards.

Component	Starting	Developing	Progressing	Spreading	Improving& Sustaining
Building a shared purpose and vision			➢ III	I	
Investing in people and culture			II	➢ II	
Developing leadership behaviours		I		➢ II	I
Building improvement capability and capacity			I	➢ III	➢ I
Embedding improvement into management systems and processes			I	III	

The tally indicates the number of criteria at each level.

- The arrow indicates where there has been a positive shift in position against the standards.

Alder Hey involvement in Cheshire and Merseyside Improvement Network

The Associate Medical Director for Cheshire and Merseyside and NHS England Deputy Director for System Improvement continue to lead the improvement network with collaboration from all C&M NHS providers.

The workplan was approved 20th January 2025 and includes three objectives:

1. Capability building: Strengthen the knowledge and skills of ICB and providers to foster system-wide improvement.
2. Patient participation: Enhance patient and public involvement to co-design better healthcare services.
3. Improvement approach for system priority: Finance.

Alder Hey will be an integral part of each of the working groups; leading where we have direct and demonstrable experience, learning when our approach would benefit from partners expertise and delivering against the workplan to benefit Alder Hey and the ICS.

Alder Hey 2025/2026 Objectives

To continue building a culture and practice of mainstreamed continuous improvement objectives for 2025/2026 will be:

1. Continue to build capability and capacity for improvement across the organisation and build further measurement of impact using The Kirkpatrick Model by March 2026.
2. Mainstream improvement tools, routines and leadership behaviours into Vision 2030 deployment measured by NHS IMPACT programme standards by March 2026.
3. Plan delivery of our improvement approach against NHS IMPACT standards to ensure a shift up from each level by March 2026.

3. Conclusion and Recommendations

Alder Hey's approach to improvement is increasingly more visible, becoming embedded in the way we work and demonstrating tangible benefits across the organisation.

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

The board is asked to:

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

Appendix One: 2024/2025 Plan Assessment.

OBJECTIVE	DELIVERED THROUGH	KEY OUTCOMES	PROGRESS
Bringing what matters most to life at all levels of the organisation so you can see and feel it, collectively and accumulatively delivering the outcomes desired in a systematic and consistent way	Strategy Deployment	• Strategic initiatives that are directly translated into local implementation • Ward to board reporting with clear measures of improvement locally contributing to the driver metric	Examples of strategy deployment through Revolutionise my care programme. This will be carried forward to 25/26 objectives.
Leaders developing problem solving using A3 thinking and coaching conversations during 'go, see' with frontline teams.	Leader Standard Work	• A shift from command and control to humility and coaching style • Teams that are empowered to make improvements • Unblocking barriers to improvement at the frontline	Coaching for team leaders to progress improvement in place and evaluating highly. Managers essentials now BAU with continued promotion to increase attendance.
Effective and productive meeting using standardised meeting hygiene	Meeting Hygiene Standard Work	• Effective us of time in sub-board committees • Succinct and clearly written papers • Assurance and improvement evident throughout	People committee: reporting reduction in papers size, use of data to inform priorities. CEOG: changes to reporting templates to reduce paper size and draw the reader to the pertinent information. A3 problem solving thinking facilitated for DMS and clinical audit.
Supporting priority teams / services to deliver productivity improvements using Brilliant Basics methodology	BB Improvement System; tools, routines, behaviours	• A3 thinking used throughout • Teams that are empowered to make improvements • Productivity improvement in priority teams / services	Supported 3 priority areas to gain greater insight into productivity challenges. Lean sessions evaluating 5/5. Opportunities identified to remove waste and support the trusts cost improvement programme.

ENDS

Compliments, Complaints and PALS Report – Q3 2024/25: Trust Board 6th March 2025

Purpose	To provide update and assurance on the performance against complaints and PALS targets in Q3 2024/25 and a thematic analysis of the top reasons for complaints and PALS
Vision and Goals	The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. Where care and treatment does not meet the standard of care expected, the Trust has a duty to listen to their concerns, wherever possible resolve at the first point of contact, investigate concerns, and provide a full, appropriate, and compassionate response.

Strategic Objective	To reduce the number of PALS concerns and formal complaints by increasing the number of issues that are resolved at the first point of contact
Driver Metric	• PALS concerns responded to within 5 working days • Formal complaints acknowledged within 3 working days • Formal complaints responded to within 25 working days
Graph Key	Medicine Surgery Community & Mental Health Research & Innov Corporate **NB Where no data on graphs is yellow or purple this indicates zero for these services**

Figure 1: Complaints received in Q3 by Division

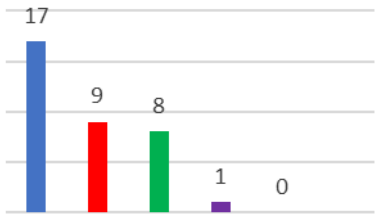


Figure 2: Number of complaints rolling 12 months (not inclusive of withdrawn)

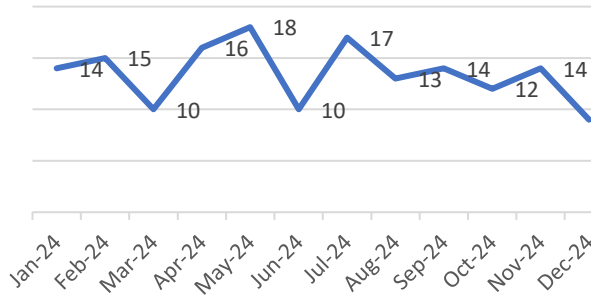


Figure 3: Primary category of complaints

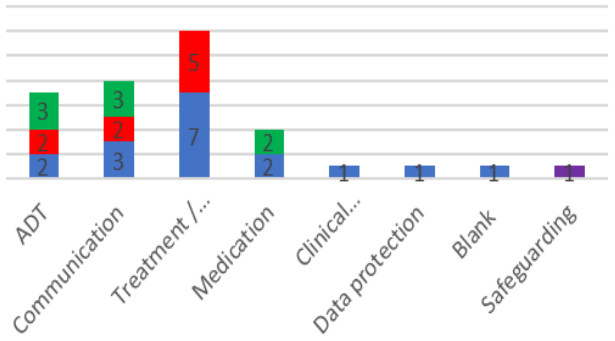


Figure 4: Trust overall compliance with 3 day acknowledgement of complaints rolling 12 months

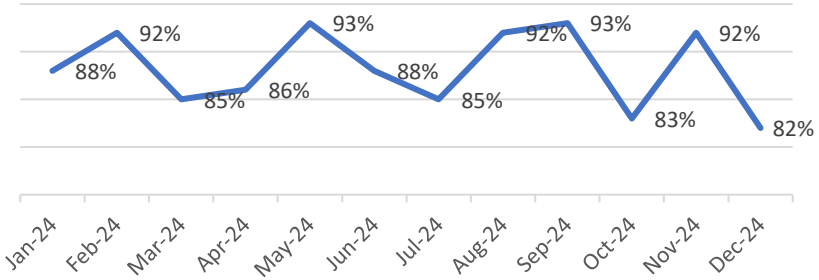


Figure 5: Compliance with 25 day response to complaints rolling 12 months

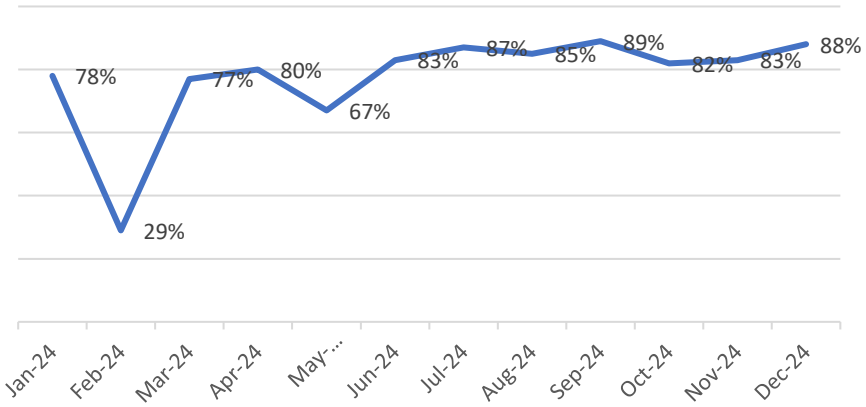
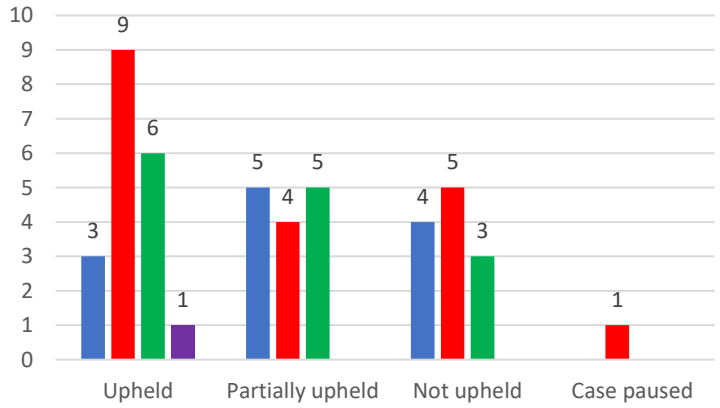


Figure 6: Outcome of complaints responded to in Q3



Complaints: In Q3, 36 complaints received, 1 withdrawn therefore 35 new complaints. Main reason continues to be treatment and procedure accounting for 34% of complaints received. Trust overall not compliant with the 3 day acknowledgement; average 86% compliance. 45 complaints investigated and responded to. Trust overall not complaint with the 25 working day response; average 84% compliance. The Divisions of Medicine and Surgery both achieved excellent compliance of 100%; Community and Mental Health achieved 70% compliance; Corporate services achieved 0% compliance (1 complaint). 19 complaints fully upheld (42%), 14 partially upheld (31%), and 12 not upheld (26%); 1 case paused. 3 complaints were re-opened at second stage; one in Division of Medicine and 2 in Division of Surgery

Compliments, Complaints and PALS Report – Q3 2024/25

Figure 7: PALS received in Q3 by Division

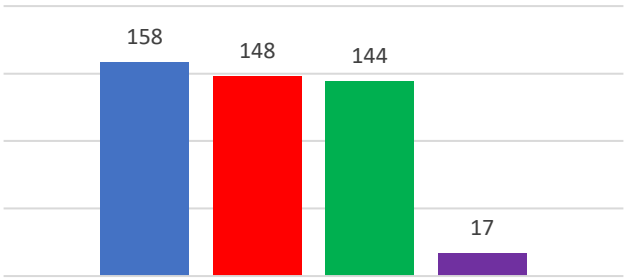
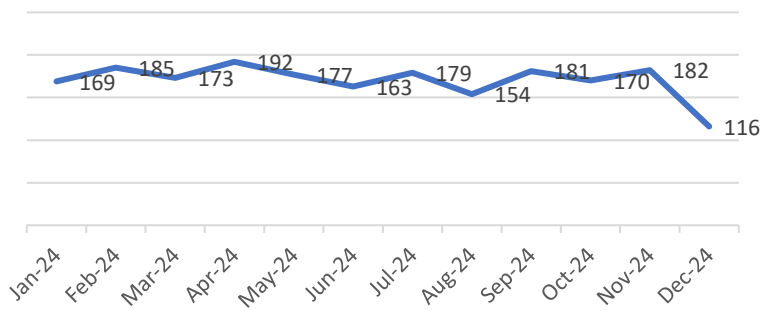


Figure 8: Total number of PALS rolling 12 months



PHSO: One new PHSO investigation was opened in November 2024; no decision from PHSO yet re a previous request for information (April 2024) and one proposal (March 2024) . One new request for information in November 2024 resulted in no further action from PHSO. New PHSO investigation and contacts relate to the Division of Surgery

PALS: In Q3, 467 PALS concerns were received which is a significant decrease from Q2 (514). The main themes continue to be access to appointments and communication. Improvement in compliance with the 5 working day response; average 92% compliance. The Divisions of Medicine and Surgery both achieved excellent compliance of 99% and 98% respectively; Community and Mental Health achieved an improved compliance of 82% compliance. Corporate services only achieved 35% compliance; this is now reviewed on a monthly basis by the Corporate Collaborative.

Figure 9: Category of PALS

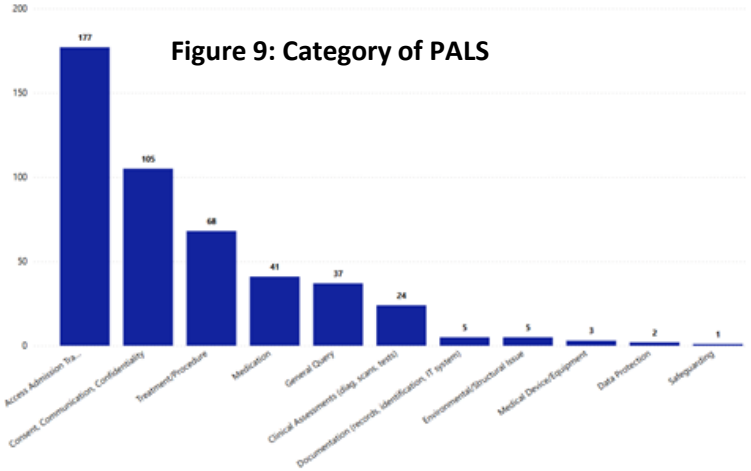


Figure 10: Trust overall compliance with 5 day response to PALS rolling 12 months

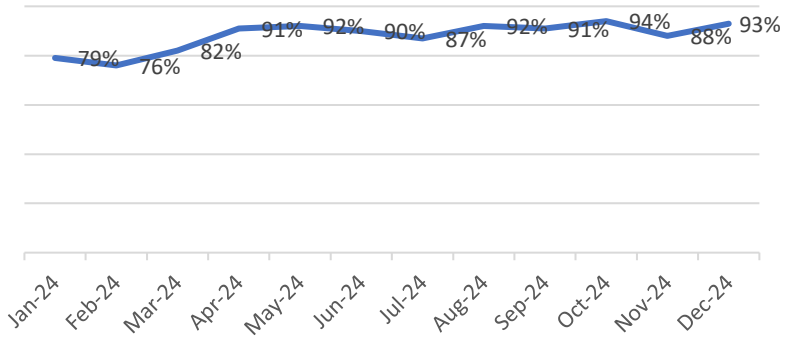
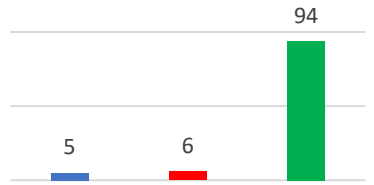


Figure 11: Compliments recorded in Q3 by Division



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

Success Highlights	• 84% of formal complaints responded to within 25 working days however there is significant toom for improvement to ensure families receive a response in a timely manner • Continued excellent compliance in the Divisions of Medicine and Surgery in formal complaints and PALS response compliance and significant improvement in compliance in Community and Mental Health Division • New Head of Experience role advertised and interviews in February
Feedback and lessons learnt	• Divisions capturing actions and sharing learning at the Patient Experience and Engagement Group
Escalations and Risks	• Corporate services consistently failing to achieve 100% compliance in responding to the concerns of families in a timely manner. The Corporate Collaborative have commenced a monthly review of compliance and provide support to Corporate Teams. The Patient Experience team are also providing support to teams and the Divisional PALS & Complaints Officers continue to support Corporate Services on a rota basis

VISION 2030

Compliment demonstrating the difference staff make at every touch point in a family's journey

NHS Alder Hey Children's NHS Foundation Trust

We were at the hospital for the first time this morning – we have a 7-month-old, who has spent 4 months at x hospital in several visits having had 7 neurosurgeries. She had her latest on Friday at x hospital and only got out on Monday. We're obviously no strangers to hospitals.

I really need to say what a positive experience we had, simply attending out-patients at Alder Hey.

The first impressions the Alder Hey gives is brilliant, there are people in the car park helping parents park! The barrier was saying car park full, but there were staff around actually helping. I can't tell you how much anxiety I have about missing appointments due to seemingly trivial stuff like that.

When we were in outpatients, there was a nurse issuing flu vaccinations – we were shocked about the proactive approach to the point we asked what she was doing. My wife and I found this amazing. We have been in hospital during many outbreaks at x hospital during our stays and it is an issue for bed availability etc, causes absolute chaos there with people getting turfed out of beds and rooms. It's common sense that if you take the community approach, you'll likely reduce admissions and outbreaks in the hospital. Very impressed and hope you continue to do that work.

Upon talking to K (nurse), she went the extra mile for us when she'd heard what we'd been through – it turned out she was a neurosurgery nurse. She gave us lots of useful information about the neurosurgery department and team. We had started the process of gaining second opinions at Alder Hey for our daughters care and looking to move more across to the hospital. This is understandability nerve wracking, we know the team at x hospital, warts and all. With proactive and helpful staff around like K – she reduced our anxieties about trusting the team at Alder Hey.

Start to finish it was an amazing first impression of the hospital – things seemed to flow well, staff are friendly – believe it or not we even spoke to the A&E triage nurses due to a rash (daughter) has on her neck. We spent a bit of time familiarising ourselves, knowing with her condition we're likely going to need to know what we're doing in case of any future emergencies.

I hope you can pass on our gratitude to K though, really made our day – and it was my wife's birthday at that, nobody ever wants to be in a hospital on their birthday until now!

respect excellence innovation together openness

BOARD OF DIRECTORS

Thursday, 6th March 2025

Paper Title:	**Chair's Report from the Safety Quality Assurance Committee meeting held on 19th February 2025**
Report of:	**Fiona Beveridge, Committee Chair**
Paper Prepared by:	SQAC Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 19th February 2025, along with the approved minutes from the 22nd January 2025 meeting.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Implications:	None

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

1. Introduction

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

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

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

Minutes of the meeting held on 22.01.25	Minutes Approved
Cardiac Surgery Action Plan	Report noted
Policies/Document Management compliance update	Update noted
ED monthly report: MH attendances and ED@itsBest	Report noted
Divisional updates	Reports x4 noted
PSIRF plan and PSIRF policy	Report noted & policy approved
EPRR Quarterly Update and Annual Assessment Report	Report noted
Patient Safety update	Report noted
Safe Waiting List update	Report noted
Clinical Effectiveness & Outcomes Group Chairs Highlight report	Report noted
Liverpool Neonatal Partnership Monthly update	Report noted
Quarter 3 Safeguarding Report	Report noted
PALS & Complaints Quarterly Report	Report noted
Quarter 3 Patient & Family Feedback Report	Report noted
Children & Young People Engagement Report/Video	Report & Video noted
Never Event – Retained surgical Instrument Action Plan	Report noted
Quarter 3 Gender Service Assurance Report	Report noted
Board Assurance Framework	Report noted
Clinical Ethics Annual Report	Report noted
Breastfeeding Policy – C3	Policy Ratified
Linen Management Policy – M72	Policy Ratified
Disinfection Policy	Policy Ratified
Urethral Catheterisation Policy	Policy Ratfied

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

- Neurology - ongoing fragility, SQAC noted the pro-active executive intervention which is underway
- SQAC noted the Consultant challenges within ED
- SQAC received an update on the current position regarding Essence Study
- SQAC received the EPRR Quarterly update and noted the requirement for improved engagement within divisions to ensure further improvement with compliance
- SQAC received the Quarter 3 Safeguarding Report and noted that there are still some pockets across the organisation where Safeguarding training requires improvement.

4. Positive highlights of note

- SQAC received the Cardiac Action Plan which detailed the Dendrite system adoption and integration, to wider benefit of the Trust; all consent is now e-consent. SQAC noted that overall the review had been very positive for the team and continues to drive improvements and give assurance.

- SQAC welcomed the continued success regarding the ED Waiting Room following the successful move
- SQAC welcomed the Theatre staff large recruitment drive
- SQAC noted the initiation of cleanliness collaboration
- SQAC noted the GMC Training survey - ENT 'excellent' in all domains
- SQAC noted that a review would commence in early March which had been commissioned to review the integrity of surgical instruments
- SQAC noted the relocation of the plaster room and dermatology which had been largely successful
- SQAC noted the ADHD medication/pharmacy collaboration
- SQAC noted the Sim room for neo-natal training
- SQAC noted the CEOG update and noted that Epilepsy 12 cohort 6 submissions had been completed in advance of timescale, Risk had been closed
- SQAC noted that CAS alerts are 100% compliance with the 2-day timeframe.
- SQAC welcomed the Liverpool Neonatal Partnership update
- SQAC welcomed the Quarter 3 Children & Young People Engagement Leads report and the pre recorded video, SQAC noted the ongoing challenges regarding the capacity of the Children & Young People Leads and noted that a risk would shortly be added to the risk register to reflect
- SQAC received the Never Event-Retained Surgical Instrument Action Plan, SQAC agreed that the Action Plan required amending, with an appraisal required with regards to those actions that are due to be completed by the end of February. SQAC welcomed the Action plan to be updated with realistic completion timeframes. Discussion is due to be held at PSIRF panel for review and wider discussion
- SQAC welcomed the Quarter 3 Gender Service (North) report, SQAC agreed it would be helpful for Trust Board to focus on the positive feedback regarding how life changing this service had been for children and young people. ES & LC would undertake an offline discussion.
- SQAC noted the continuing improvements and oversight and learning from clinical incidents.
- SQAC welcomed the Ethics annual report - one year in to the new approach – with excellent breadth and scale of engagement across the Trust, and including CYP and families
- SQAC RATIFIED the Patient Safety Incident Response (PSIRF) Policy
- SQAC RATIFIED the Breastfeeding Policy -C3
- SQAC RATIFIED the Linen Management Policy M72
- SQAC RATIFIED the Disinfection Policy
- SQAC RATIFIED the Urethral Catheterisation Policy

5. Issues for other committees

None to report

6. Recommendations

The Board is asked to note the contents of the report

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 22nd January 2025
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing, AHP and Experience Officer	NA
	Adam Bateman	Chief Operating Officer	AB
	Urmi Das	Director of Medicine	UD
	Rachael Pennington	Associate Chief Nurse - Surgical Division	RP
	Kerry Byrne	Non-Executive Director	KB
	Lisa Cooper	Divisional Director – Community & Mental Health	LC
	Gerald Meehan	Non-Executive Director	GM
	Laura Rad	Head of Nursing – Clinical Research	LR
	Erica Saunders	Director of Corporate Affairs	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Leila Brown	Associate Director – Digital Transformation	LB
	Jill Preece	Governance Manager	JP
	Hilary Peel	Governor	HP
	Amy Tantum	Senior Clinical Site Practitioner	AT
	Peter White	Chief Nursing Information Officer	PW
	Julie Creevy	Executive Assistant (Minutes)	JC
Item 24/25/212	Jennie Williams	Head of Improvement	JW
24/25/216	David Porter	Sepsis Lead	DP
24/25/216	Kim Hewittson	Sepsis Nurse	KH
24/25/217	Paul Sanderson	Chief Pharmacist	PS
24/25/220/226	Linda Wain	Corporate & Governance Risk Manager	LW
24/25/221	Sue O'Neill	Acting Head of Neonatal Nursing, LNP	SON
24/25/222	Shirley Peel	Head of Nursing for Complex Care & Community Nursing	SP
24/25/226	Sarah Craig	Project Lead	SC
Apologies:	Alfie Bass	Chief Medical Officer	ABa
	Pauline Brown	Director of Nursing	PB
	Ian Gilbertson	Deputy Chief Digital & Information Officers	IG
	Natalie Palin	Director of Transformation & Changes	NP
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health Division	JP
	Jackie Rooney	Associate Director for Nursing & Governance	JR
	Melissa Swindell	Chief People Officer	MS

24/25/208 Welcome and Apologies
The Chair welcomed everyone to the meeting and apologies were noted.

24/25/209 Declarations of Interest
None declared.

24/25/210 Minutes of the Previous Meeting
The Committee members were content to APPROVE the minutes of the meeting held on 18th December 2024, subject to the amendment of 24/25/197 as the Mortality Report should read Quarter 2, rather than Quarter 1.

24/25/211 Matters Arising/Review of Action log
The action log was reviewed and updated.

24/25/212 Policies Deep Dive (Document Management System)

LW introduced the Policies Deep Dive, and provided a summary of the Trust wide position. LW advised that the process for the authoring, review and approval of documentation, before it is added to the DMS is not robust, with variable processes across the organisation, an additional problem which compounds this is the challenge regarding the system and its functionality to support timely reviews.
Aims and goals - A clear process to support documentation compliance to reach 90% by March 2025, and to reach 95% gold standard compliance by September 2025.
LG referred to the Metrics and Analysis which detailed the Processes for Policies, Guidelines and other documentation being maintained in date on the DMS are not within the control limits. For those document types, the previous 3 month figures are showing an upward trajectory with the exception of patient information leaflets which had reduced in December. LR referred to the forward view for the next six months which indicated a significant number of documentation which require updating in addition to the current position.

LG referred to the challenge regarding Transition of staffing within the Corporate Governance and Risk Team and advised that the new post holder is due to commence on 17th February 2025.

Actions planned

- Options paper for alternative DMS solution to be presented to Executive Team
- Whole review of the DMS, a data cleanse and validation of document which is a first priority for the new postholder
- Consultation with procurement and decision on a new system to be made
- Process to improve committee oversight to be designed

KB referred to the Document Management Storage policy which is included in the SQAC meeting pack and sought clarity whether this means that the policy is not being followed. LW stated that she did not want to make any assumption that the policy is not being followed, as there are inconsistencies across the divisions.
KB queried what lessons had been learned from the recent DMO procurement process.
FB stated that it is important to procure a platform/software that is going to work.
JW advised that from a trust wide perspective, all of the documents at the inception of the DMS were added with the same or similar date for expiry and therefore this had impacted at the same time. JW referred to challenges regarding the functionality of the current system and the interoperability of the process of the interaction with the system which had been challenging. JW stated that the functionality required review in line with a new system and that any key learning which had been gained needed to be incorporated into procurement of a new system.

NA referred to the extensive focus which had previously been provided and stated that there had been a decline from April 2024 month on month in the data of non compliance. NA welcomed updates from the divisions regarding how this had been addressed through the divisional governance meetings. NA advised on the need for a trust wide review of governance processes to move to an integrated governance model rather than devolved governance model as there is far too much variation. NA stated that this needed to be a priority to enable a robust and unified way of working which does not rely on individuation variation. NA stated that this is not additional duties, and that this is core functionality of the work performed.

KB stated that each policy has a requirement to be audited and for compliance against it reported, and that at present KB stated that this is not taking place.

Division of Medicine

CW advised that the Division of Medicine had shown common cause variation in compliance for all documentation which is on average 90%. There had been a decline from April 2024 which had been raised at that time with JR. CW advised that there had been ongoing challenges with the DMS, and that this is not always due to the clinicians not updating or reviewing policies but relate to challenges with the system. CW stated that there are a number of policies awaiting approval, or had been lost in the DMS and advised that there is an ongoing challenge regarding admin.

CW stated that from a Pharmacy perspective there are a significant amount of guidelines that align with Pharmacy, with a high number of policies which had expired at the same time, which require approval through the Drugs & Therapeutics Committee.
CW advised that the Clinical leads and Senior staff within the division need to continue to remain focussed on this ongoing challenge. CW confirmed that this issue is discussed at the monthly governance meeting and is regularly monitored within the Division.
PS advised that numerous policies or guidance need to be presented to Medical Management Optimisation Committee (MMOC) and that during September & October 2024 pharmacy colleagues had understood that they had around 25 policies and guidelines to be reviewed, which arose to 83. PS advised that there are also a number of patient information leaflets which are also out of date and that MMOC is relying on the good will of consultants and ANPs to review guidance, with multiple requests made to support into MMOC, a small response had been received from ANP's.
PS stated that he is aware that there are certain guidelines and policies which departments have in paper form which are kept on an individual's drive, PS advised on the need to make all staff aware that these policies/guidelines needs to go through MMOC and onto DMS.
PS reiterated the challenges given that policies all expire at the same time
FB stated it is important to understand whether they all expire at same time and that leaders need to take the initiative to decide how to stagger expiry dates. FB indicated that the Trust could accept temporary extensions on some policies or guidelines that are lower risk in order to produce an equal spread across the year. LW advised that the task and finish group had discussed a staggered approach in 2024, and colleagues did try and include staggered dates in place. LW stated it would be helpful to consider streamlining of policies and guidelines which is a significant factor.

Division of Surgery
RP echoed CW comments and stated that the Document Management system is not helping people to undertake the process as quickly and as efficiently as possible. RP stated that engagement in reviewing the guidelines and taking ownership required improving. RP advised that the Division of Surgery had agreed to group into specialty guidelines or service guidelines, with a plan to bring guidelines requiring review 3 months in advance to review and ratify collectively, with a clear process to be followed. RP stated that the process is clear and is being followed, however the system in part isn't facilitating the process to work smoothly, and that the engagement required improving. RP described the disjointed process and the challenge regarding lack of admin support and stated that this is not helping divisionally as a whole to ensure focus on a daily basis, as this takes significant oversight and chasing to manage.
RP stated that within the Division they had agreed to have a meeting to review all outstanding and outcome guidelines and policies.

Community & Mental Health Division
LC advised that the Division now have dedicated admin support in place. There are a high proportion of statutory policies within the division, particularly safeguarding, some policies are extensive and algin to legislation that is required, in addition to the capacity required for authors to undertake review/update. LC advised that as a division they had approved all of the Policies relating to the Gender service and also to the SARC Accreditation. There is a Policy & Procedures Group who meet monthly, and any ad hoc meetings are arranged if required. There is an escalation process in place, the division had seen significant improvements, and this is a standard agenda item on the Community & Mental Health Divisional Board.
FB stated that all have a clear understanding regarding the issues, with positive practice shared and honest reflections regarding the issues relating to the system and on occasions people not taking ownership, with more oversight required. FB requested that a set of recommendations be developed to enable an improved position and the need to ensure lessons learned are used when procuring a new system.

Research Division
LR advised that Research have 1 policy on DMS which is in date and acknowledged that all the Research guidelines are on Ipassport to provide compliance as the division are audited by MHRA. The division are reviewing how the Research division could potentially move away from this and that LR would be keen to be involved in any further discussions to ensure that Research documentation is easily accessible. The division had been reviewing all Standard Operating Procedures to ensure that they are current and up to date.
Resolved: FB welcomed a brief report to be presented to the February SQAC detailing actions to be implemented immediately together with a forward view.

Resolved: NA would follow up separately governance review.
FB agreed it would be helpful to receive monthly compliance updates within the Divisional updates as an appendix with the SPC charts.
Resolved: SQAC received and **NOTED** the Policies Deep Dive update and welcomed monthly compliance updates within the Divisional update report.

24/25/213 ED monthly report: MH attendances and ED@its best

CW presented the Emergency Department (ED) Monthly Report

- During the Month of December 2024 the ED department had seen a slight reduction of attendees, which is comparable with December 2023.

Highlights

- During December 2024 the Trust achieved 80.8% against the four hour target, which is higher than the national standard, which is a 7.2% improvement from November 2024.
- There had been an increase in the usage of the UTC with most metrics improving, particularly the number of children and young people being referred back to ED which had reduced to 2.9%.
- Improvements with triage times, first clinical reviews and improvements in handover performance
- First time within a four month period that ED had seen the number of patients receiving antibiotics within 60 minutes achieve over 90% and is 94%
- Success noted regarding the management of the ED waiting room, the move occurred seamlessly and was well managed.

FB commended the progress regarding the ambulance handovers
KB sought clarity regarding time to clinical assessment and referred to Table 2 and stated that the target is 60 minutes, however the information in the table is green with the exception of 180 minutes. KB stated that she would expect this to go orange or yellow at 61 minutes which would help operationally. CW confirmed that this would be reviewed within the division
Resolved: SQAC received and **NOTED** the ED Monthly Report.

24/25/214 Nuclear Medicine CQC Improvement Notice – closedown report

ES presented the close down report from the Nuclear Medicine CQC Improvement Notice.
ES congratulated the team for the ongoing work to achieve this result.
ES advised that there had been many lessons learned and that a reflective update would be presented in due course with general advice for other areas of the Trust.
Resolved: SQAC received and **NOTED** the Nuclear Medicine CQC closedown report.

24/25/215 Divisional Updates

Clinical Research Division

SQAC received the Clinical Research Division report.

Community and Mental Health Division

SQAC received the Community & Mental Health Division report.

Division of Medicine

SQAC received the Division of Medicine Report
FB referred to SPC chart on virtual outpatients versus the national standard, and queried whether given the introduction of national standard whether this is starting to change thinking regarding how the Trust move forward with virtual outpatients, and whether there is a live discussion regarding this.
UD stated that overall virtual appointments were high during the pandemic and that previously the division had contacted every service to see if this is something they would favour to enable a mixture of virtual appointments. UD stated that within the division there is a mix and that UD preferred to have at least 25% of each clinicians time virtually. UD stated that at present this is clinician dependent, and as a division they are reviewing this as there are no clear policies stating that she service requires a set amount of virtual clinics. UD stated that the virtual ward is separate, and that UD would be happy to provide an update at a later date if required. FB queried whether this standard would work for a paediatric hospital.

NA commended the Division of Medicine for the clarity and format of the Medicine report, and the compliance and improvements across a range of metrics and expressed his thanks to CW and the Division of Medicine for the ongoing improvements.

FB referred to the peak in hospital initiated clinic cancellations in November 2024 and sought clarity whether this related to staff illness or some other factor. CW confirmed that this would be reviewed by the Division.

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

---- *Safe* ----

24/25/216 Sepsis Quarterly Report

DP presented the Sepsis Quarterly Report, and provided an overview of the current position regarding the sepsis dashboard, ED inpatient working, training, retirement of vitals, inpatient data, inpatient data drop in compliance, ED Antibiotic compliance and details regarding focus for the next 6 months.

- Sepsis training remained an ongoing focus, with the Sepsis software package under development, with focus on finalising with the BI team.
- Inpatient data - quarterly data indicates that there had been a decrease in compliance during the last quarter, the Trust had maintained >90% since data reporting resumed June 2022 with the exception of 89% September 2023, and 87% in July 2024. DP advised that the Trust are within the slightly more relaxed target of 90 minutes rather than the 60 minutes.

DP stated that these are relative small numbers and small change in the sepsis figures month to month makes a significant difference, this would continue to be reviewed by Sepsis Team.
DP advised on the ongoing work to increase education to ensure colleagues consider intra muscular route to administer antibiotics, with guidance issued as appropriate, KH is working with teams to ensure that this is considered more promptly.
DP detailed the suggested 45 minute target to deliver antibiotics, and the multi factors contributing to a delay in administering antibiotics.

- There is planned focus on PAU for the next 3 month period, KH is working with nursing leads to ensure continued focus.
- ED AB<60 minutes had slightly improved over the last quarter.
- ED AB<90 minutes target maintained >90% consistently since June 2022, with the exception of 83.7% in June 2023, and 83.3% in August 2024.
- There is ongoing focus on improving Sepsis Training compliance with improved compliance across all staff categories, however Medical and dental compliance are still relatively low at 78.5%.
- DP advised that Sepsis colleagues are hoping that the clinical simulation training held in 2024 is supplementing in the knowledge across the wards.

DP advised on the ongoing focus for next 6 months regarding the dashboard, ED/Inpatient working, training and retirement of Vitals.

RP stated that she struggles with the % compliance as the volumes are different each month, and that it would be helpful to review any learning from those cases that received antibiotics in a timely manner.

GM referred to the treatment window for sepsis and sought clarity regarding 60 minutes and 1-3 hours. DP described the 60 minute target which was a previous CQUIN target, and still remains in NICE guidance as a clinical standard. DP provided an update on the adult data regarding 60 minute target and the Trust 2nd target of delivering antibiotics within 90 minutes, and advised that in some case there is good reason why antibiotics had not been given as colleagues are trying to prioritise ensuring that the patient receives the right investigations.
CW advised that significant work had been undertaken with the response team to enable the response team to consider methods of alternative access.
DP stated that administration at 45 minutes is still correct and that this would be discussed at the Sepsis Steering Group on 22.1.25.
KH referred to the 45 minute target and stated that it is included within the Sepsis Policy and the Antimicrobial policy and working with the IVAC team they had implemented new training guidelines and competencies which require sign off at DIG, practice educators had been requested to join a meeting to raise the profile of the 45 minute target.

FB thanked all for good discussion held with assurance received regarding active management.
Resolved SQAC received and **NOTED** the Sepsis update

24/25/217 Quarter 3 Drugs & Therapeutics Committee quarterly report

PS presented the Quarter 3 Drugs & Therapeutics Committee Quarterly Report.

- There are no governance and safety concerns to raise to SQAC.
- The Quarterly report continues to develop and evolve
- Committee structure for Drugs & Therapeutics Committee is due to change, the first DTC committee is envisaged to take place by the end of February 2025
- Organisational change consultation had concluded on 17th January 2025, feedback would be provided to the team to enable appropriate appointment
- A positive Quality Assurance Round was held in December 2024
- 1 risk had been closed regarding Smoking cessation and NICE guidance
- There are 3 long terms risks and no risks with a score of greater than 12
- PS advised on a Sodium valproate CAS alert, and the requirement to complete work in relation to people becoming pregnant and the risk to unborn children, with a completion date by 31st January 2024. PS advised that significant work is involved and that the Trust is working closely with the ICB and are working internally and externally to ensure that dashboards are in place. PS advised that whilst the Trust is overdue with this alert the Trust is not an outlier and provided assurance that the ICB are happy with the progress being made.

PS advised that there are more shortages that are included on the slide within the meeting pack and that PS had undertaken a deep dive regarding the new shortages that had arisen since December 2024 and confirmed that there is a pharmacy multi-disciplinary approach, with a weekly shortage meeting held. PS provided assurance that the shortages are extremely well managed within the Trust.

PS stated that the MMOC slide required updating to reflect the current position regarding out of date guidelines year to date, with 98 new and updated guidelines with MMOC at end of Quarter 3.

NA welcomed the report which is continually evolving and sought clarify whether there were any themes or trends regarding the CD compliance. SQAC welcomed inclusion in the report about policies not updated.

PS stated that he would include any trends or themes in future reports. PS confirmed that there are no issues to raise regarding patient safety.

Resolved: SQAC received and **NOTED** the Drugs & Therapeutics Committee quarterly report

24/25/218 Patient Safety Update

SC introduced the report detailing the work undertaken during December 2024 by the Patient Safety Programme Board (PSPB) and drew attention to the following key highlights:-

Highlights:

- Workstream 1 – positive reporting culture for incidents continues
- There had been a reduction in PALS responses within 5 days and a reduction in the Friends and Family Test - trust recommendation which is 70% from November 2024 data.

Challenges

- There is increasing trajectory in the number of patients from HDU to PICU, from feedback from the clinical team for November is that from the 82 patients to PICU 3 admissions were likely to have stayed on HDU who had a 24/7 consultant and medical cover associated with the Risk on the Risk Register (Risk 46/47) this risk would continue to be monitored at Patient Safety Strategy Board.
- Challenges in reporting Parity of Esteem and a programme of work is being agreed to report on restrictive interventions and provide a summary update on the four work streams, assurance is also to be provided regarding training and education programme of work for this workstream and the new reporting outline which is due to be provided in January 2025.
- Consultant and medical cover risk 46 and 47-this metric would continue to be monitored at Patient Safety Strategy Board.
- There are no NatSSIPs /Sepsis/Parity of Esteem update to offer assurance this month. Sepsis update to follow in January 2025.

SQAC NOTED the Patient Safety Strategy Programme for information

NA referred to the AMR work which had previously been shared at December 2024 and advised that this is a continuation of what had previously been discussed.

FB stated that there is a much smaller number of workstreams open and sought clarity regarding the next steps and how this is agreed. NA advised that colleagues are undertaking the annual review Patient Safety, PSIRF plan and the outcome of that review of data, metrics and triangulation would inform new workstreams and would focus attention for 2026. This is due to be presented to Trust Board in April 2025, NA is hopeful that this would be shared at SQAC in March 2025.

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

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

24/25/219 Fuller Inquiry Action Plan

NA presented the Fuller Inquiry Action Plan on behalf of NO. NA acknowledged NO leadership in working with a range of teams across the organisation.

NA stated that there is a significant amount of recommendations in phased 1 that had been fully implemented, and that the Trust is still awaiting the final recommendations from Phase 2 which would apply to all organisations. NA stated that he envisaged that many of the actions would be closed following the next meeting.

NA described a challenge regarding CCTV and the appropriateness, and the management specifically related to the postmortem room, with a detailed and thoughtful options appraisal required.

NA stated that the plan is to continue with the actions, and await phase 2 recommendations of the Inquiry, and at that point make a decision regarding the CCTV in the postmortem room, with the aim of completing all other actions ahead of the final recommendations.

Resolved: SQAC received and **NOTED** the Fuller Inquiry Action Plan

24/25/220 Clinical Effectiveness & Outcomes Group Chairs Highlight report

LW presented the CEOG report from the Clinical Effectiveness & Outcome Group meeting held on 10th January 2025

- There are no escalation to SQAC

Highlights

- Improved position for Division of Surgery regarding closing of overdue divisional audits
- LNP policy guidelines - task and finish group are progressing the review and streamlining of Alder Hey and Liverpool Women's' NHS Foundation Trust documents across the LNP
- Document Management System Policy had been approved at CEOG
- Continued improvements are noted with oversight and learning from clinical audit

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

24/25/221 Liverpool Neonatal Partnership Monthly Update

NA presented the Liverpool Neonatal Partnership update report and highlighted the following key points on SON behalf.

LNP Board had met on 21st January 2025, phenomenal progress had been reflected within LNP Board with improvements with BI issues regarding data collection from both organisations. There was an acknowledgement at the LNP Board that the report continues to evolve, with the aim of moving towards an IPR for the LNP which would be welcomed.

NA advised on the stabilisation regarding nurse recruitment and staffing numbers and that colleagues would start to see through the LNP Board and within the LNP monthly update to SQAC the trajectories of the education programme that is in place to prepare nursing staff for vent training and other key tasks.

FB stated that there is a need to move to a position whereby the report that is presented to SQAC is slightly different than the report that is presented to Trust Board e.g. there are items on the report that are suggested for escalation and that SQAC is not the correct forum to approve, disapprove or escalate, and that the lines of responsibilities required review.

KB advised that there is ongoing work taking place to review what reports are required at Trust Board, LNP Board and what report should be shared at lower levels, KB stated that she did not envisage this would change for next month, however the work is currently ongoing.

FB requested whether the colour coding within the report could be reviewed. NA confirmed this would be reviewed and stated that all of the information would move to SPC type of reporting.

Committee agreed that all of the items for decisions within the report are not for decisions to be made by SQAC.

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

24/25/222 Healthcare Transition report

SP Presented the Healthcare Transition Report

Highlights

- There had been a positive reduction in the number of over 18's in both inpatients and outpatients

- The Transition team had been working with the BI team to review data and the forms that are available to clinicians on the system, once this work with BI has been completed and the forms had been updated run charts would also be available.

Challenges

- Challenges are noted with the collection of data, colleagues are exploring making fields mandatory within forms to ensure that data collection is easier and more accurate.
- Wider discussions are taking place regarding resources required for Healthcare Transition to continue making improvements

FB queried the Healthcare Transition reporting cycle to SQAC and sought clarity whether this would be quarterly reporting, both SP and NA agreed that quarterly oversight at SQAC is appropriate.

GM sought clarity regarding feedback from Children & Young People.
NA advised the committee of the plans to engage with a young person's voluntary group who work with young people post transition, particularly 18-25 years old regarding their experience of onward healthcare. NA and JP have agreed to meet with the voluntary group to review whether a co-ordinated piece of work could take place to understand this further.
SP confirmed that this is something that the Transition teams are mindful of and are exploring.
NA stated that the Trust can obtain feedback on the transition process and learn and evolve, however post transition their satisfaction with care and treatment feedback no longer resides with Alder Hey, with further work required to include patient experience into this activity and eventually into the Healthcare Transition report.
Resolved: SQAC received and **NOTED** the Healthcare Transition Report

---- Well Led ----

24/25/223 Board Assurance Framework

ES presented the Board Assurance Framework for the month of December 2024 and advised on the good practice for SQAC to continue with the deep dive cycle in the forthcoming financial year.
ES advised of the need to undertake a formal review of the way the strategic risks are framed for each committee to ensure that they are properly described.

NA referred to the opportunity to realign to strategic vision, and to review all of the risks over the coming months.
Resolved: SQAC received and **NOTED** the Board Assurance Framework.

24/25/224 Board Assurance Framework deep dive of BAF Risk 1.4 (CAMHS waiting times)

LC presented the Board Assurance Framework deep dive of BAF (CAMHS waiting times), and provided a comprehensive overview of CAMHS waiting times, current position of Locality Mental Health Services waiting times, Access to Crisis Care, controls and actions.
LC advised that there is no national standard for waiting times for access to CAMHS services and as a Trust, the Trust introduced an internal waiting list standard around 92% of children waiting for treatment within 18 weeks which the Trust were on course to meet, until COVID 19. Some of the consequences was the number of children and young people being referred, increased waiting times, for both referral and treatment within 18 weeks and the impact on partner agencies, particularly the third sector organisations that provide initial mental health support to Children & Young People, and their impact and ability to provide support to children & Young People.
Service had seen continued increases in referrals since 2019/20 and ongoing challenges with staff recruitment and retention. Improvement plans are in place for both localities regarding waiting times.
LC stated that the Trust as part of a national pilot agreed a referral to assessment which is first appointment, and a referral for treatment, the standards remained the same (6 weeks for referral to assessment and 18 weeks to referral to treatment). CAMHS services is delivered to Liverpool and Sefton, with significant improvement noted in Sefton waiting times, with some Improvement in Liverpool but also some deterioration due to losing some of the workforce from Liverpool CAMHS to the Gender Service.

- There had been significant improvement for those children and young people waiting over waiting 52, and there are no children waiting over 52 weeks to commence treatment.
- Calls to crisis care are static, approximately 600 per month, with a decrease in August 2024, and a significant increase in September&October 2024 as children and young people returned back to school.
- A home based treatment team is now provided, and this has supported children and young people to prevent attendances to ED.

- Compliance with urgent 7-day appointments for EDYS is high with young person's choice impacting on compliance not capacity. For routine appointments, increased demand is having a moderate impact on waiting time. Actions to increase capacity within the team are ongoing and the service is due to open the day case unit at Alder Park during Quarter 1 2025/26.
- LC provided an overview of the Graduated approach and the Mental Health support teams in schools, and advised that there are currently 8 teams across Liverpool and Sefton who work in collaboration with education partners and schools as part of the 'Whole school and College approach', with positive evaluation noted.LC advised that there had been challenges regarding retention and recruitment of staff.
- LC described the enhanced support to teams provided particularly for children, young people with complex needs across multiple domains, between the ages of 0-18, to prevent these children from going into care, entering the criminal justice system or going into secure accommodation with local authority colleagues, which is based on trauma informed care, with an enhanced pathway in place regarding assessment and diagnosis for neurodiversity, this cohort of children are likely to be neuro diverse either ADHD an/or Autism with regards to risk taking behaviour.
- Control are in place regarding performance and waiting times
- The Trust is part of the C&M Workforce collaborative to collectively train and develop staff

LC advised that despite all of the support in place nationally the demand for children's services continues to rise.

- There had been 18 actions completed and closed, with no change in current risk score during 2024.
- A full review of this risk was undertaken in June 2024 and actions updated.
- An action relating to lack of/incomplete data for Mental Health Services via NHS England reporting systems to the national Mental Health Services Data Set (MHSDS) and actions being taken were added to the BAF risk (linked to service risk 214).
- A full rewrite of the MHSDS data flows is currently ongoing and due to be completed by 31 March 2025. Once assurance regarding MHSDS data flows has been received a full review of the BAF risk will be undertaken with a view to decreasing score/potential closure

GM sought clarity whether the Trust could gauge the impact of the additional mental health services, given the ongoing increasing demand on mental health services.LC advised that mental health in school teams are regularly evaluated with regular reports undertaken and that from review of the latest quarterly report for mental health in schools' teams, that the impact is the number of children seen and the enhanced support team is the same.
LC stated that once the data is available that the patient reported outcome measures, then the Trust should start to be able to report on what children and young people are saying and the report outcomes. LC had requested whether the Trust could gauge average length of stay and to review C&YP coming into the Trust and ending the episode of care and what timeframe this is in, LC stated she would like to like to see how and what more data the Trust could obtain, and what systems are required to support that data, caveat regarding the increase in numbers, increased complexities, the age of children presenting significantly lower, and the complexity and risk taking behaviour. Have some evaluation for some services and no other services, LC would welcome further discussions at board.

NA stated that given the discussion the risk needed to be rearticulated and gaps in assurance and welcomed a refreshed review of BAF Risk 1.4 for the new financial year.
FB thanked LC for comprehensive update on BAF Risk 1.4 and expressed thanks to LC and her team.
Resolved: SQAC received and **NOTED** the Board Assurance Framework deep dive or Risk 1.4.

24/25/225 High Profile Patients and Families Policy

NA presented the High Profile Patients and Families Policy, this policy had previously been approved approximately 3 years ago, the policy has had minimal changes in terms of job roles, process for managing this policy remains the same.
FB sought clarity whether this policy had been through Patient Experience. NA stated that there had been an anomaly and that this had been presented to Executive Team and then to SQAC for approval
FB sought clarity whether the committee were happy to ratify, Committee confirmed approval to ratify.
Resolved: SQAC received and **RATIFIED** the High Profile Patients and Families Policy

24/25/226 Document Management Policy – M38

LW presented the Document Management Policy – M38 which had previously been presented and approved in CEOG in January 2025. The Document Management Policy – M38 outlines additional

responsibility, with minor amendments to the style and formatting, terminology of procedures had been changed to Standard Operating Procedure.
KB referred to minor amendments regarding the ratification committee on page 17 and advised that Business Continuity Plans be ratified at SQAC rather than Audit & Risk Committee and that the RABD and People & Wellbeing section requires referencing/updating as appropriate.

RP referred to the flow chart on page 5 and the author of the policy engaging with relevant stakeholders and directly contacting a central team to ensure changes are made, and ensuring divisional oversight in the current position is challenging and whether this required a review prior to approval.
FB stated that SQAC could ratify the policy today, recognising that it is the current policy and that the group that are going to agree actions could review and bring an amendment forward once any amendment had been agreed. FB highlighted the importance of work required in terms of process mapping and acknowledging that this may require digital support. FB envisaged a further update within 6 months establishing what needed to be included within the full policy.
FB requested feedback whether SQAC were happy to ratify the Document Management Storage Policy -M38 – subject to the amendments suggested. SQAC were happy to Ratify.
Resolved: SQAC **RATIFIED** Document Management Policy – M38, subject to minor amendments on Page 17.

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

24/25/227 SON provided an update on the Speech and Language recruitment and confirmed that LNP had recruited a Band 8A SALT part time at .6 with some additional hours which would be put out as a band 7 for support and some training regarding succession planning.

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

24/25/228 The key assurances and highlights to present to the Board

- Good discussion held regarding Deep Dive on Policies Document Management Storage, noting ongoing work required
- Good discussion held regarding Deep dive of BAF risk 1.4 (CAMHS)
- Positive update received regarding Fuller inquiry action plan
- Positive update received regarding CQC nuclear medicine issue closure report
- SQAC noted challenges and concern regarding the number of Policies and guidelines not in date, and noting the need to take urgent action to address, SQAC agreed to received monthly compliance updates
- SQAC welcomed good assurance within the Divisional updates
- SQAC received the LNP update and noted the assurance, with ongoing work required to ensure the correct reports are shared at the correct forum.
- SQAC received Sepsis Quarter update, with good assurance provided
- SQAC received Drugs & Therapeutics Report.
- SQAC RATIFIED the High Profile Patients and Families Policy
- SQAC RATIFIED the Document Management Storage Policy – M38 – subject to minor amendments with the expectation that the policy would be re reviewed and any amendments to be provided within 6 months.

Date and Time of Next Meeting: 19th February 2025 at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 6th March 2025

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

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

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

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

3. Priority actions:

One Alder Hey & Thriving

Inclusion & belonging:

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

Values:

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

Integrated safety culture:

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

Thriving Leaders framework:

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

Thriving Teams:

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

Thriving Staff Index:

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

Professional Development / The Development Hub

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

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

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

- An **extended programme of learning and development** opportunities is now in place (including a wide range of clinical and non-clinical opportunities). Full details are in the Prospectus, available on the Intranet and also accessible from staffs' ESR landing page. The L&D work with subject matter experts and key leads to continually review and refresh the programme and the Training Needs Analysis in underway to inform additional priority topics for 25/26.

Future Workforce

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

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

- **Comprehensive workforce planning templates** will be used to shape ongoing discussions following completion of the annual planning round, in respect of sustainable workforce models aligned to vision 2030 as well as operational need. HR and finance colleagues working closely on Trust workforce numbers currently.

4. Conclusions & next steps

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

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

Appendix 3.

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

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

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

BOARD OF DIRECTORS

Thursday, 6th March 2025

Paper Title:	**Chair's Report from the Finance, Transformation & Performance Committee meeting held on 24th February 2025**
Report of:	**John Kelly Committee Chair**
Paper Prepared by:	Amanda Graham, Executive Assistant

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☑ ☑ ☐
Action/Decision Required:	To note To approve	☑ ☑
Summary / supporting information:		
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care **Support** our people **Pioneering** breakthroughs **Strong Foundations**	☑ ☐ ☐ ☐ ☐ ☐
Resource Implications:	None	

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

1. Introduction

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

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

- Top Five Risks update
- Meditech contract renewal update
- M10 Financial update including forecast for year end
- Deep dive of 2025/26 annual plan submission
- M10 Integrated Performance Report
- Campus update

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

- Ongoing work of the implications for the 25/26 planning assumptions including the cap on elective activity.
- 24/25 outturn remains a risk to delivery of plan due to pay award funding gap, however 50% mitigation delivered in month.
- Emerging risk on completion of key campus projects due to building safety act and delays with connections.

4. Positive highlights of note

- Deep dive & detailed discussion on planning for 2025/26

5. Issues for other committees

- Recommendation for Trust Board to approve Meditech contract renewal
- Agreement for futures bid to be presented for approval at Futures Committee in March.

6. Recommendations

The Board is asked to note the Chair's Highlight report for the Finance, Transformation & Performance Committee meeting that took place on 24th February 2025.

Finance, Transformation and Performance Committee
Confirmed Minutes of the meeting held on Monday 27th January, 1pm, Innovation Park

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 CFO	(RL)
	Melissa Swindell	Chief People Officer	(MS)
In attendance:	Nathan Askew	Chief Nursing Officer	(NA)
	Kerry Byrne	Non-Executive Director	(KB)
	Sian Calderwood	ACOO, Medicine	(SC)
	Audrey Chindiya	Associate Finance Director	(AC)
	Esme Evans	Business Accountant, Community & MH	(EE)
	Rachel Greer	ACOO, Community & MH	(RG)
	Ian Gilbertson	Deputy Chief Digital & Information Officer	(IG)
	Jayne Halloran	Deputy Development Director	(JH)
	Dani Jones	Chief Strategy & Partnerships Officer	(DJ)
	Emily Kirkpatrick	Deputy Director of Finance	(EK)
	Chloe Lee	ACOO, Surgery	(CL)
	Andy McColl	Deputy Director of Finance	(AMC)
	Graeme Montgomery	Business Accountant, Surgery	(GM)
	Natalie Palin	Associate Director Transformation	(NP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Laura Simons	Business Accountant, Medicine	(LS)
	Gary Wadeson	Associate Finance Director	(GW)

24/25/150 Apologies

Apologies were noted from:

Kate Warriner	Chief Digital & Information Officer	(KW)

24/25/151 Minutes from the meeting held 16th December 2024

Subject to a review of commercial content by RL, the minutes were approved as a true and accurate record.

24/25/152 Matters Arising and Action log

Actions not on the agenda for further discussion were updated.

24/25/153 Declarations of Interest

There were no declarations of interest.

24/25/154 Top 5 Risks

1. **Immediate financial performance including system position**

RL presented an update on the current position for both the Trust and C&M system and the risks associated with delivery of the plan for 24/25.

Planning guidance for 25/26 is still awaited, however discussions are continuing both internally and in the system on the potential areas of changes and risks that this will present, and how they can be mitigated throughout the planning process.

2. **Capital Programme**
Update was presented on the capital forecast for the year and the management of the spend to ensure the CDEL target is met by 31st March including the recent PDC grants allocated from NHSE bids.

3. **Efficiency Programme**
An update on the efficiency programme is included in the Monthly pack and will be covered by the divisional updates.

4. **Benefits realisation, governance and prioritisation of change programme to 2030**
NP presented an update to the committee which includes an improving position with 83% rated as green and on track. There are a number of outstanding benefits in Collaborative Communities and only 50% of Futures milestones have been achieved. A discussions was held on the assumptions included in the original case and benefits and how this informs 25/26 projected benefits.
JK noted that there needs to be robust sight of benefits before claiming / tracking.
JK asked for an overview of bids won to show achievement & review benefit for Futures.

24/25/154.2 **Action: RL / EK**

5. **The Campus & Park developments**
An update on the campus was included under the agenda item.

24/25/155 **Finance Report**
Month 9 Financial Position
EK gave an overview of the financial position as at M9, noting the following:

- Another challenging month, reporting away from plan due to pay award funding gap.
- ERF performance in month positive and higher than planned.
- Further review of non recurrent mitigations but have flagged to ICB the unmitigated risk relating to the pay award funding gap.
- WTE remains similar over strength against plan but bank & run rate coming down. Bank driver is sickness absence. MS & SO working on this however significant risk of not achieving the WTE plan at year end.

Update provided on status of coding included the actions taken to improve the depth of coding and level of uncoded activity at the month end whilst also reviewing acuity and validations with clinical teams. Remains a key areas of focus to ensure accurate reflection of work being undertaken.

24/25/155.1 Review of acuity scoring / value to be brought to February meeting
Action: GW / IG

Resolved:
FTPC received and noted the M9 Finance report.

24/25/156 **Annual Plan**
RL gave an update on Annual Planning for 2025/26, noting that the full guidance is yet to be published. Emerging messages have not changed from those shared at Board and it is expected to have something to share at March Trust Board.

DJ noted work on addressing children's inequalities & avoiding further impact due to potential changes to ERF and activity payments within ICB and nationally.

AB shared the emerging goals for 25/26 that will be developed for the final annual plan to be presented in March.

NP noted the creation of three clinical collaboratives as part of the transformation programme for 25/26 – neighbourhood preventative care models (community); acute diagnostics & urgent care (medicine); centres of excellence & reimagined elective care (surgery) set within divisions with Exec sponsors CMO, CNO and COO.

RL presented an update on the 25/26 Financial approach for sustainability – improvement / transformation / governance / skills development. Short/medium term strategy of financial improvement programme to drive savings through cost reduction with an equivalent figure to be achieved through the Transformation programme. Emphasis is on financial governance & finance skills. RL noted that this needs to feel different with tough choices & decisions to be made to make plan feel achievable.

JK reflected on the scale of ambition and if the financial targets needed to be higher. RL noted the current ambition in the plan including workforce changes and transformation changes that will be multiyear but acknowledges the ambition needs to be high.
Discussion took place on understanding the optimal workforce required to deliver operational targets and plans and the management of the expectations within this and the potential to work with industry partners on new support function models. Discussion on transformation and the use of technology/AI. AB noted KW is looking at emboldening transformation using AI for next Futures committee. JK suggested a transformational resource group reporting t Board; NP replied that is the approach being taken, would be helpful to have FTPC oversight and will bring to Feb meeting.

24/25/156.1 NP to bring transformational resource group approach to next meeting
Action: NP

Resolved:
FTPC received and noted the Annual Planning update.

24/25/157 **Month 9 Integrated Performance Report**
The report was included within the pack and was taken as read.

Resolved:
FTPC received and noted the M9 Integrated Performance report.

24/25/158 **Medicine Division**
SC gave an overview of the slides contained within the pack, noting the following:

- December was the closest month to achieving plan;
- Already at 97% activity for Radiology;
- Unavoidable pay pressures within the division including WLI and locums, due to high maternity, consultant absences. JK commented maternity number should be in general forecast; SC replied it is but the current number is higher than

trend. AB queried the nurse bank WTE given the new recruitment, however NA noted there is a time delay to the benefit of this.
- Key challenges in drugs moving from unlicensed to licensed with associated increase in costs.
- Non-pay challenges. JK queried forecast accuracy & what variables are creating such differences; SC noted reviewing with teams weekly.
- CIP also an area of challenge with only 63% posted YTD.
- RL noted that variance includes in-year pressures as well as CIP and need a clear plan on how to address as we move forward.

Resolved:
FTPC received and noted the quarterly update from the Division of Medicine.

24/25/159 **Community Division**

RG gave an overview of the slides contained within the meeting pack, noting the following:
- Overall favourable position YTD which is expected to continue through to year end, improvement in income position a driver of this.
- Recruitment remains a challenge but improving
- JK received update on the procurement process for additional neurodevelopmental assessment's

Resolved:
FTPC received and noted the quarterly update from the Division of Community & Mental Health.

- **Capacity required for ASD assessments**

Paper presented to committee by RG to request support to proceed with additional capacity for ASD assessments to be supported by funding received from NHSE. Discussion took place on the case including complexity cases, reporting requirements with agreement to proceed.

Resolved:
FTPC noted and approved the proposal to increase ASD assessment capacity.

24/25/160 **Surgery Division**

CL gave an overview of the slides contained within the meeting pack, noting the following:
- Adverse position in M9 predominantly due to locum spend for sickness, maternity and other absence but also due to high occupancy.
- Agency spend in Theatres is decreasing with expectation to be nil from March.
- M10 expected to be positive in relation to activity with some challenges in day-case but improvement in acuity and high value cases.
- Currently achieving 89% of CIP target
- Large amount of activity awaiting coding before year-end, with specialities still on paper system being coded towards month-end

24/25/160.1 Clarity to be given on follow-up / pre-op numbers
Action: GW

Resolved:
FTPC received and noted the quarterly update from the Division of Surgery.

24/25/161 Campus & Development Update

JH presented the paper on campus programme with key areas being on Elective Hub and NICU/SDEC development.
Risk flagged relating to building control on Elective Hub with work ongoing with contractor to mitigate as far as possible but likely ton be an overall delay of 4 weeks with final programme yet to be confirmed.
In relation to the NICU/SDEC risks emerging on programme due to delays in service connections however not yet formalised. Design workshops are highlighting some potential changes that are required that may be regulatory or choices but could have a financial ask. CL highlighted risks around costs have now been amalgamated; workshops have been held along with conversations with the Charity. AB noted that was discussed at Liverpool Neonatal Partnership Board (LNP) and agreement on next steps to be completed, but looking at pragmatic approach. NA & RL agreed a post-occupation review of decisions is needed noting changes in guidance mid-build

24/25/161.1 Action RL / CL / JH

SA queried what the cost of the works required may be. JH noted that this was being assessed and is not yet known as some may be nil cost. JW asked whether the changes are future proofing the build. AB noted that the water safety changes will be future-proofing and mean no future retro-fit changes but some may be above what is required and will cause a significant delay and cost. JG asked that the vision for delivery of services for Neo and SDEC is brought back to compare with what has been delivered.

JG asked that the vision for delivery of services for Neo and SDEC is brought back to compare with what has been delivered.

24/25/161.2 Action: AB / JH / CL / SC

Discussion took place on the commercial and legal support provided on this project and agreement for update to be provided at a future meeting.,

24/25/161.3 Update on commercial and legal position to be brought to a future meeting
Action: RL / JH

Resolved
FTPC received and noted the Campus & Development update.

24/25/162 Update on Catkin / Sunflower car park

A proposal was presented in relation to car park provision on site and within the Catkin/Sunflower building. It was noted that the Travel plan & off-site parking is also being reviewed. RL noted that the proposal offered an income opportunity and a cost saving. SA asked why it had taken so long to resolve the problem; JH noted that cost was a factor, with one failed tender followed by another tender process..

Resolved:
FTPC noted and approved the proposal.

24/25/163 Board Assurance Framework

The BAF report was included in the meeting pack. ES noted that strategic risks will be reviewed going into year-end; while potentially adequate at the moment there are

increasing gaps going forward. Needs to be wide look across this, the annual plan & risk appetite work.

A deep dive report into Risk 3.4 is to be brought to a future meeting, with a review of Risk 1.3 on building defects also ongoing. JK noted that the overall top 5 risks position has gone more red & are already highly scored. JG added that the digital risk has increased after cyber piece, suggesting that Committee needs to look at the overall piece given shift in score; JK asked whether Digital Futures sits within Futures; SA unsure where this is held as sitting between FTPC and Futures.

24/25/163.1 A conversation is to be had offline around the Digital Transformation risk
Action: JK / JG / SA

Resolved:
FTPC received and noted the risks recorded within the Board Assurance Framework.

24/25/164 **Any Other Business**
No other business was recorded.

24/25/165 **Review of Meeting**
The Chair noted that this meeting had been face-to-face and there are still challenges due to planning constraints.

Date and Time of Next Meeting: Monday 24th February, 1pm on Teams

24/25 FTPC Key Risks – Month 10 Position

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M9
Financial Performance including system position	Challenging 24/25 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High	Month 10 position reported £1.7m surplus to plan in month and a £0.6m surplus to plan ytd. In month Corporate, Medicine and Surgery were off plan, however this was offset by Community underspends, and technical benefits (circa £2.3m) supporting the position. Forecast for year remains in line with plan £3.3m, however following another challenging month, the trust has maintained the risk adjusted forecast submitted to the ICB of £2.2m in M9. A number of mitigations are being explored, including finance improvement workstreams (workforce, drugs, coding) as well as increased technical improvements, income opportunities and programme/vacancy slippage giving the trust assurance to continue to report a forecast a risk adjusted forecast of £2.2m. System gap remains with ongoing national discussions . Weekly gold command now in place FICC return from all providers.	High
Capital Programme	Limited CDEL allocation in 24/25 Significant capital investment required, and prioritisation required.	Medium	Capital broadly on plan YTD however internal forecast is currently £1.5m above plan (excluding allowable overspend on IFRS16 remeasurement), with best and worst case ranging from £0.5m below plan to £2.7m above plan on the same basis. This position is following decisions to progress with AlderPark second floor, second CT and bring forward £1.3m of urgent medical equipment spend from 25/26 (in order to manage risk of underspend at year end). New funding (£1.5m) has been added to plan in month (PDC funding for LED (£0.5M), Federated Data Platform (£0.5m), Perinatal Pathology (£0.2m), and new NIHR capital (£0.3m). Several national funding bits submitted still outstanding (e.g 2nd CT scanner, and Digital bid). Conversations ongoing with ICB around potential for further additional capital. Final capital position will be driven by progress on major capital schemes, and review of all remaining planned spend, and accruals. Position to be closely managed between now and year end.	Medium
Efficiency Programme	Plan assumes delivery of £19.3m recurrent savings. Highest level set in any one year. Managing of message to organisation alongside delivery of 2030 vision.	High	M10 reporting slightly behind plan but forecast to achieve in full in year. Recurrent CIP forecast now stands at £14.7m (green and amber schemes) significantly higher than previous year achievements. Planning underway for 25/26 CIP development	Medium
Benefits Realisation	New benefits realisation framework launched to ensure delivery of benefits across all programmes.	Medium	We have completed a stock-take on our approach to 2030 delivery and the results from the which have been reviewed alongside the benefit review and assessment on our delivery milestone.	Medium
Campus	Complex campus programme across multi sites.	Medium	All schemes progressing as detailed in the Campus Update within the full Committee pack. Two risks are highlighted for the attention of Committee members in relation to construction completion dates for	Medium

BOARD OF DIRECTORS

Thursday, 6th March 2025

Paper Title:	**Board Assurance Framework (BAF) Report January 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 January 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	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.5	Lack of visibility at Board level across the Gender Service	Trust Board
1.6	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People Committee
3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	Finance, Transformation and Performance Committee
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	Finance, Transformation and Performance Committee
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	Finance, Transformation and Performance Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People	Futures Committee
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	Finance, Transformation and Performance Committee

3. Summary of the BAF at 10th February 2025

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x2
1.2 AB	Children and young people waiting beyond the national standard to access planned care and urgent care	FT&P / SQAC	**4x5**	3x3
1.3 AB	Building and infrastructure defects that could affect quality and provision of services	FT&P	4x3	2x3
1.4 LC	Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	FT&P / SQAC	**3x5**	3x3
1.5 LC	Lack of visibility at Board level across the Gender Service	Trust Board	4x2	4x1
1.6 LC	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board	**4x4**	4x2
STRATIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	People Cttee	3x4	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Cttee	3x3	2x2
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	People Cttee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	FT&P	4x2	3x2
3.2 KW	Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan	FT&P	4x3	4x2
3.4 RL	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments	FT&P	**4x4**	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	**4x4**	3x3
STRATEGIC OBJECTIVE: Pioneering breakthroughs				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Futures	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	FT&P	**4x4**	2x4

4. Summary of January 2025 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk 1.1 has been reviewed and the gaps in assurance and controls remain. As the priorities for next year as part of 2030 emerge this risk will be reviewed and updated.

- ***Lack of visibility at Board level across the Gender Service (LC).***
  Review of risk and actions undertaken by Clinical Lead.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  Review of risk and BAF actions undertaken and updated by ACN.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance maintains above the national standard of 78%, achieving 83%. Capacity to reduce long waits (RTT) continues to remain the focus for services. The access target for 24/25 is to have a maximum of 278 patients waiting over a year for treatment by March 2025. The trust is closely monitoring the patients who would breach 52 weeks and treatment plans are being put in place to achieve the target.

- ***Building and infrastructure defects that could affect quality and provision of services (AB).***
  Out-of-range water temperatures continue to be monitored and local mitigations are in place such as filters on water outlets. Booster pumps installed on the hot water system have proved effective and this will now be discussed as to introduce to cold water. Review being undertaken by new Mitie director and changes to the AE/AP for water are imminent.

  Meetings with Project Co partners and execs over corroded pipework have taken place to discuss the future repair/replacement of the affected areas. Further meetings are planned and to date good progress has been made. Exec representatives are aware of the issue and involved in discussions with Project Co Directors.

  Internal AH staff pipework meetings have also taken place

  Dosing system is now on hold due to improved controls.

- ***Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (LC).***
  Risk reviewed and actions updated. SQAC deep dive uploaded to evidence file.

- ***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. Thorough discussions taking place across divisions in

respect of Annual planning and WTE and workforce plans. No current change to risk score.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).***
  Risk reviewed. All actions reviewed and updated with progress made since last review. No change to risk rating.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risks reviewed. Actions on track and progress being made.

- ***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 and support delivery of the NHS Long Term Plan (KW).***
  As part of the ongoing programme scoping process, we are finalising the closure of the 2024/25 programme and transitioning key elements into BAU while integrating new priorities into the emerging strategic programme.

  Following the December 2024 Strategy Board session, the leadership team has committed significant capacity to shaping the new strategic direction. Key mitigating actions include:

  - Development of a milestone plan to drive focused action through to March 2025.
  - Executive Team oversight to ensure alignment with strategic priorities and timely delivery.
  - Finalisation of both the 24/25 single-year programme and the multi-year strategic framework by March 2025, ensuring a seamless transition into the new financial year.

  This structured approach, with clear leadership, defined milestones, and robust governance, is expected to mitigate the risk of ineffective strategy deployment***.***

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***
  Risk reviewed and update to issues to reflect recent guidance and context. No changes to risk score. 25/26 planning ongoing both internal and external with ICB for submission in March.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk reviewed; no change to score in month. Actions and controls reviewed.

- ***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. No change to risk score in month. Overall review of risk underway in line with updated targets for new financial year.

- ***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. Expedited device refresh plans in development however deployment continues each week. Workforce status and risk areas paper will be presented to Execs in Feb as a result of iDigital disaggregation. EPR roadmap plan being refined before being submitted to Executive Committee. Digital collaborative being scoped out as part of 2030 strategy and a refresh of Digital and Data Strategy at inception stage.

5. Corporate risks (15+) linked to BAF Risks (as at 29th January 2025)

There are currently 23 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
2450	There will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres, Major Trauma, specialist surgery, burns and ECMO. Inability to provide 24/7 haematology laboratory service.	5x5	Medicine	2.1	Jul 2021	Mar 2024
2635	Risk to business continuity of radiography services trust wide due to staffing availability and skill mix resulting in interruption to elective services and delay to non-elective services	4x4	Medicine	2.1	May 2022	Oct 2024
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4	Dec 2019	*Apr 2023
2100	Risk of inability to provide safe staffing levels due to absence.	4x4	Business Support	2.1	Jan 2020	*Apr 2023
2487	Disruption in patient's supply of medication and / or treatment	4x4	Community		Apr 2023	July 2024
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program	4x4	Surgery	3.4	Aug 2022	Feb 2024
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
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	4x4	Medicine	2.1	Feb 2023	Oct 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	could have a significant impact on the health and wellbeing of the IR Consultant currently in post.					
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
253	Loss of GRID posts	4x4	Business Support		Sept 2024	Sept 2024
2704	Potential reduction in ultrasound service provision	3x5	Medicine	2.1	Oct 2022	Sept 2024
027	Fragility of Inherited Metabolic Disease Service (IMD) ***(NEW)***	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
189	EPRR Assurance Non-Compliance	3x5	Business Support		Jul 2024	Jul 2024
271	Safeguarding Nursing Team Capacity	5x3	Community	2.1	Nov 2024	Nov 2024
299	Nurse Led Ultrasound for Nephrology	3x5	Medicine		Dec 2024	Dec 2024
288	CAMHS Planned Safeguarding Supervision	3x5	Community	2.1	Nov 2024	Nov 2024
2491	Risk of burnout of current workforce	4x4	Community	2.1	Sep 2021	Nov 2024
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (4x5=20)						
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.4	Jul 2021	*Apr 2023
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)						
	None					
1.4 Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies (3x5=15)						
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1	Dec 2019	*Apr 2023
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2	Jul 2021	*Apr 2023

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
1.5 Lack of visibility at Board level across the Gender Service (4x2=8)						
	None					
1.6 Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (4x4=8)						
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	4x4	Community	1.2	Jun 2024	Jun 2024
STRATEGIC OBJECTIVE: Support our people						
2.1 Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (3x4=12)						
2450	There will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres, Major Trauma, specialist surgery, burns and ECMO. Inability to provide 24/7 haematology laboratory service.	5x5	Medicine	1.1	Jul 2021	Mar 2024
2704	Potential reduction in ultrasound service provision	3x5	Medicine	1.1	Oct 2022	Sept 2024
140	Anaesthetic cover out of hours - ward based issues	5x3	Business Support		Feb 2024	Feb 2024
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.2	Aug 2022	Jan 2024
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
288	CAMHS Planned Safeguarding Supervision	3x5	Community	1.1	Nov 2024	Nov 2024
027	Fragility of Inherited Metabolic Disease Service (IMD) ***(NEW)***	3x5	Medicine	1.2	Jun 2023	Dec 2024
2491	Risk of burnout of current workforce	4x4	Community	1.1	Sep 2021	Nov 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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 (3x4=12)						
	None					
3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people and support delivery of the NHS Long Term Plan (3x4=12)						
	None					
3.4 Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments. (4x4=16)						
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Programme	4x4	Surgery		Aug 2022	Feb 2024
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (3x4=12)						
229	PIMP end-of-life server which is no longer supported by the supplier	4x4	Business Support		Jul 2024	Sep 2024

* risk movement data not available pre-move to InPhase

6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

Erica Saunders
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

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	Safety & Quality Assurance Committee

Description

Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards..

Feb 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	February 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

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

Description

Capacity and Demand modeling undertaken during March 2023 shows that a small number of specialties have a long term challenge relating to waiting times for planned care.

Feb 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	February 2025	
Follow up working group	Aim: zero patients waiting >2 years for a follow up appointment by March 2025 Tasks: Submit paper to request funding to undertake clinical validation - complete, funding granted Follow up dashboard to track progress - in development Specialty-specific action plans to achieve zero patients waiting over 2 years for a follow-up. - specialities with a high volume are due to present at safe follow up programme board	31/03/2025	
Reduce the long-wait backlog for planned care	The trust access target for 24/25 is to reduce the number of patients waiting over a year to a maximum of 278 patients at the end of March 2025. Each specialty has a local recovery plan, with themes including 1) investment in additional capacity with insourcing, LLP, Business Cases. 2) improved productivity with focus on reducing WND rate (through use og AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time. 3) robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting.	30/09/2024	Deadline extension to achieve zero 65 weeks extended by NHSE to 30th September 2024. Vast majority of services have already reached this target but concern remains in Paediatric Dentistry and Paediatric Neurology. Whilst there is capacity in dentistry within the month of September to meet target there is a risk due to to patient cancellations or was not brought that the target may not be met. Within the Paediatric Neurology service there are concerns regarding capacity which are being reviewed by the service, currently a risk of 7 patients not meeting the 65 week target. All services working towards zero 65 week waiters by 31st March 2024. Particular concern in ENT, Dental and Spine where additional investment continues in insourcing and theatre time protection for services.
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	31/01/2024	

Building and infrastructure defects that could affect quality and provision of services

Risk Number	Strategic Objectives
1.3	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Adam Bateman

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

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

Feb 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	February 2025 Due Date	Action Update
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	31/03/2025	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.

Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies

Risk Number	Strategic Objectives
1.4	Outstanding care and experience

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

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

Description

There has been a significant increase in demand for Specialist Mental Health Services at Alder Hey following the COVID-19 pandemic which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours. This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.

Feb 2025

Control Description	Control Assurance Internal
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)
Business case for investment submitted to Liverpool and Sefton Place and approved. This is is now being fully implemented.	Business case (attached)
Weekly performance monitoring in place for operational teams which includes: • Weekly Tuesday/Wednesday meeting with PCOs • Divisional Waiting Times Meeting each Thursday • Trust Access to Care Delivery Group each Friday This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required.	Monthly assurance processes include: • Monthly contract statements • Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Weekly allocation meetings
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software
Ongoing attendance at Cheshire and Merseyside Mental Health Workforce Planning groups	- Reviewed attendance across the range of meetings and Alder Hey lead/s identified - Feedback loop agenda item as part of Mental Health Business Meeting - Cheshire and Merseyside Lead attends Alder Hey business meetings.

Gaps in Controls / Assurance

1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to legacy waiting times and recruitment issues as a result of national workforce shortages.

Action	Description	February 2025 Due Date	Action Update
Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	30/04/2025	
Improve routine outcome measures collection	Continue to roll out e-proms app across CAMHS Improve roms collection and reporting Extended date due to MHSDS work ongoing.	31/01/2025	
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/03/2025	
Review of RTT performance trajectories and improvement plans for Liverpool and Sefton CAMHS	Performance trajectories and improvement plans to be produced and shared at Access to Care on a regular basis to track progress. Latest date for performance (Sefton) to be met end of September 2025. Liverpool's trajectory in progress - capacity and demand underway to be reviewed monthly as part of BAF Risk Review	30/09/2025	

Lack of visibility at Board level across the Gender Service

Risk Number	Strategic Objectives
1.5	Delivery of Outstanding Care

CQC Domains	Linked Risks	Owner	RM03 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.

Feb 2025

Control Description	Control Assurance Internal
Dedicated communications lead and communications plan in place to manage internal and external communications and media.	Internal and external communications plan
Monthly Operational and governance meeting to be in place to review service delivery and escalate key issues to Division and Trust Board.	Divisional governance meeting minutes
All identified risks within the Gender Service are reflected on the risk register. Appropriate controls and actions are in place and are reviewed on a fortnightly basis with Gender Service Senior Leadership Team.	risks on InPhase being managed closely
Regular operational performance report (to be further developed as the service embeds) to SQAC	Operation Performance Reporting
Regular reports to Parts 1 and 2 of Board from Director Community & Mental Health Services on development of the GDS within Alder Hey and nationally, and on the relationships with other providers	Board reports received

Gaps in Controls / Assurance

o Extensive media attention
o Risk of involvement with a range of legal proceedings
o Unknown changes or asks to the service

Action	Description	Due Date	February 2025 Action Update
Annual Review of Gender Service to Board	Provide an annual review of Gender service to Board / SQAC to consider learning from current and prior years to identify potential changes in treatment pathway and follow up of prior CYP to understand if they subsequently dropped out of the service or transitioned / de-transitioned and potential learning from this	15/10/2025	
Comprehensive suite of KPIs to be developed	Comprehensive suite of KPIs for GDS to be developed and reported to Board / SQAC including: demographics of referrals (1), compliance with service specification relating to number of appointments / interventions and time taken (2), compliance with the % "drop out" rates at the various assessment stages in the service specification (3), any contact from external activist / pressure groups (4), trends in active caseload and waiting list size (5), referrals to research trials, income / expenditure v budget (6), complexity of cases (e.g. what % have eating disorders, ASD/ADHD/OCD (7), details of % of staff time spent inside / outside of the service by individual (8), gap between appointment versus service specification requirements (9), compliance with data recording requirements (10)	30/09/2025	Request in with BI for data dashboard to include all KPI requirements. On track.
Escalation of Key Issues to Divisional Integrated Governance Meeting	Key Issues to be reported to Divisional Integrated Governance Meeting on a monthly basis.	25/06/2025	Reporting into Divisional Integrated Governance to be embedded.

Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.

Risk Number	Strategic Objectives
1.6	Outstanding care and experience

CQC Domains	Linked Risks	Owner
		Lisa Cooper

RM03 Risk Rating		
Actual	Target	Assurance Committee
16	4	Trust Board

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

Feb 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	February 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 2	Increase capacity to the prescription rota to cover the additional work.	28/02/2025	New prescribers now in the process of being signed off in order to independently staff the rota. Action on target. This work continues as the medication shortage continues- More nurses have now completed their V300 training and will be ready to support the rota by February. Pharmacy technician is being recruited to support the advice and guidance and support element of the prescription rota. The rota has been reviewed in an attempt to increase capacity to the prescription rota- further work needs to be done to review all professions who are contributing to the rota as some are also contributing to other rotas that equally need resourcing. Ongoing to ensure this rota is as efficient as it can be.
Risk 236 - Action 8 (carried over from Risk #70)	Daily reviews to take place to monitor progress against actions and monitor supply of relevant medications.	31/10/2024	medication shortage continues still reviewing this weekly(not on a daily basis) this is because all other stocks of ADHD medications are now at sufficient supplies within our area . 12 hour medications prep still unable to obtain supplies, Alder Hey ADHD CYP being moved over to different medications . Currently no end date
Risk 236 - Action 9 (carried over from Risk #70)	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative if necessary	30/09/2024	ongoing

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	
Risk Number	Strategic Objectives
2.1	Support our People

CQC Domains	Linked Risks	Owner
Safe Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	6	People Committee

Description

1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation. 3. Not developing inclusive recruitment and talent management practices to improve workforce diversity

Feb 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	February 2025	
1. Not meeting compliance target in relation to some mandatory training topics	Head of L&D has a full action plan in place to increase compliance across the organisation and this is supported by the Academy Director.	31/03/2025	Mandatory training activity is monitored by Education Governance Committee as a standard agenda item. As at May 24 overall trust compliance was 93.00%. Areas of concern are highlighted, discussed and supported with subject experts. The current area under review is SEPSIS.
2. Sickness absence levels higher than Trust Target	Ongoing interventions remain in place to support the management of sickness, however until the absence has had a sustained reduction it will continue to monitored as a risk impacting on this overall BAF risk.	31/03/2025	
3. Future Workforce	3. Review of skill mix, talent and succession planning across the organisation against full demographic analysis. Annual operational plans are in place, Establishment control in place.	31/03/2025	Establishment control project close to completion before commencing the wider workforce planning project
4. Lack of Robust talent	The next stages of the People Plan and key deliverables for 24/25 were presented to Trust board on 6th June 2024 and the plan approved. The plan requires key strategic areas of focus, one of those three areas is the development plans for Future workforce. Succession and Talent management is a workstream that sits beneath this strategic initiative. HR, OD and Academy will work together to review skill mix, talent and succession planning, prioritising those areas were there is the most need over the next 12 months.	11/06/2024	
5. Lack of a robust Trust wide Recruitment Strategy	The next stage of the people Plan 24/25 there is a key work stream related to the Future Workforce, which addresses accessible and diversified recruitment and the Trust recruitment strategy. This action is addressed through the 24/25 People Plan.	31/03/2025	action linked to Trust's People Plan and delivery will be dependent on resource within HR team being increased, business case has been shared with Exec Team - outcome awaited.
6. Lack of inclusive practises to increase diversity across the organisation	A comprehensive EDI plan is in place, which is aligned to the NHS England gh impact changes.	31/03/2025	

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families

Risk Number	Strategic Objectives
2.2	Support our People

CQC Domains	Linked Risks	Owner
▪ Caring ▪ Safe Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	4	People Committee

Description

Failure to set up the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision.

Feb 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	February 2025	
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards. Thriving Staff Index and Thriving Teams Index to be developed.	30/04/2025	Thriving Teams Index proposal paper to be presented at the People Committee in March. Interim plan to be proposed for agreement by the committee to use the staff survey data to ensure that struggling teams are identified at divisional level with action plans in place and monitored to improve team functioning and culture. Proposal to include systematic assessment of small teams who are not currently captured in staff survey results. Draft People Plan presented to October Board with agreement for priority actions for 25/26 to include development and roll out of Thriving Staff Index and Thriving Teams Index. Capability and resource to be scoped for both in discussion with Innovation team (Futures). Staff Thriving Index pilot complete and implementation plan being developed. Thriving Teams MDT up and running with work planned to develop metrics for identifying vulnerable teams as part of this process. Discussed with CPO. Methodology to be agreed and to incorporate work already done by Director of Medical Services in discussion with MD Staff survey data packs complete with methodology developed by BI. Work now in progress to develop a BI dashboard beginning with the staff survey results. Safety Culture data available at an organisation level and shared with Patient Safety lead. Work underway to ensure safety culture metric developed and part of overall team effectiveness dashboard. Staff Thriving Index pilot complete and index agreed with CPO. Implementation plan now in development. Staff survey data deep-dive planned with OD team to establish areas of excellence and challenge Staff Thriving Index in pilot stage Thriving Teams MDT operational and feeding into OD, QI, Transformation, HR, FTSU and Divisional Leadership meetings.
Culture strategy development to include governance framework supporting culture work	Culture strategy to be developed and to include review of governance framework and reporting processes for culture work including via Patient Safety Strategy Board and People and Wellbeing Committee.	31/03/2025	Culture presentation given at June Trust Board and broadly supported with agreement to move into next steps/agreeing and defining actions. Further meeting to be held with MD and CPO to agree actions with comms and engagement plan. Will inform reporting Developing culture strategy to be presented and discussed at Trust Board in June.
OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/03/2025	Meeting with Director of Transformation on 4th April to discuss @its Best MDT model and underpinning resource. Output to be reviewed with Head of OD. Consider next stepts in terms of building capability across HR and other supportive People functions.
Restorative just and learning culture	Restorative just and learning principles to be embedded through patient safety work and all people practices. Consultation on approach to be provided to patient safety leads and investigators to support the implementation of PSIRF and to help to facilitate learning reviews where indicated. Work to be progressed about Avoidable Employee Harm with HR, staffside and other key stakeholders through workshops, consultation, policy review and training	31/03/2025	Avoidable employee harm session delivered to senior HR colleagues on 9th October to discuss this concept and reflect together on how we need to develop as an organisation to understand and minimise the risk of harm to employees that can come through people and change practices. Agreed to run a second workshop with case examples on 13th November and then agree next steps in terms of implementation of this approach in policy and practice
Safety culture training	Safety culture training to be developed and implemented with teams to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors.	29/09/2025	No further progress with this action. Proposal still with execs and resource to be agreed for the delivery of the training. Meeting held to look at integration of safety culture training and STAT programme running in theatres. Further meeting to be arranged by Patient Safety lead to be confirmed

Action	Description	February 2025	
Thriving Leaders framework	Thriving Leaders programme to include: Strong Foundations review and update to reflect wider culture work (including safety culture) and Vision 2030 & Clinical Leadership focussed review and development and Operational Leaders programme.NHSE Board level leadership competencies published with full appraisal process to follow in autumn 2024. All leader competencies to be developed based on same principles with reference to NHSE line manager competencies and other published leadership competencies.	31/03/2025	Clinical leads listening sessions complete and feedback to be presented at Clinical leads Summit on 15th Nov with a view to agreeing next steps in consultation with clinical leads. Management essentials sessions reviewed with plans for further development of the programme agreed. Strong Foundations review complete. Clinical Leaders programme scoping underway with listening sessions with all clinical leads to take place between July and Sept 2024. Scoping also underway to develop Operational Leaders programme. Thriving Leaders Framework to include these components and to be supported as part of Vision 2030 programme support with relevant people invited to attend and become part of development team. Strong Foundations review planned with a view to enhancing culture component. Clinical Leadership review in planning stage following Clinical Leaders away day. Plan to engage in individual listening sessions with all clinical leads in July. Insights to inform second Clinical Leads away day and to inform potential redesign of Clinical Lead roles to include consistent and robust set of leadership competencies coupled with an enhanced development and support offer.
Values and behavioural framework review, update and implementation	Current values and associated behavioural framework to be reviewed in dialogue with segmented groups of staff to develop updated values and underpinning framework. Both to be embedded across the organisation with support from Brilliant Basics.	30/04/2025	Culture document/blueprint in development with CPO and CEO to include revised values. Document to be shared with organisation when ready for consultation, feedback and engagement. Draft People Plan presented to October Board with proposal to undertake values work as priority action 25/26 to support Vision 2030. Work to be scoped as part of new culture workstream (One Alder Hey).

Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation

Risk Number	Strategic Objectives
2.3	Support our People

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Well-Led		Melissa Swindell

RM03 Risk Rating		
Actual	Target	Assurance Committee
12	4	People Committee

Description
- Failure to have a diverse and inclusive workforce which represents the local population - Failure to take steps to become an inclusive work place where all staff feel their contribution as an individual is recognised and valued.- Failure to provide equal opportunities for career development and growth - Non-compliance with the public sector equality duties

Feb 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

		February 2025	
Action	Description	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.

Feb 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	February 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 and support delivery of the NHS Long Term Plan

Risk Number	Strategic Objectives
3.2	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Kate Warriner

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

Description

Risk of failure to: - translate the 2030 Vision into operational plans and systematically execute
- deliver on the strategic ambitions to make a difference to CYP impacting on the delivery of the NHS Long Term Plan and Trust's reputation.

Feb 2025

Control Description	Control Assurance Internal
Collaborating in Communities is a key theme in the 2030 Change Programme: assurance received through Strategy Leadership Group and Strategy Board	
2030 Vision: Alder Hey strategy refresh - Q4 23/24 - delivery of brochure and final comms collateral	Council of Governors strategy session (full overview) (Jan 2023) Strategy 2030 - Approved at Trust Board (March 2023) Strategy 2030 wider Staff Launch (May 2023)
CYP System update report to Strategy Board, incorporating partnership assurance periodically throughout the year.	Building upon Growing Great Partnerships report
Operational Plan incorporates Vision 2030 deliverables (2024/25)	Operational Plan
Executive Portfolios all incorporate elements of Vision 2030 delivery	
SRO Group established	
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	

Gaps in Controls / Assurance

1. 2030 delivery programme and plan in development
2. Failure to develop capacity for delivery
3. Failure to build capacity and skills within our workforce to deliver the 'new' aspects' of the 2030 Strategy
4. Failure to deprioritise to enable requisite focus on areas of need and transformational change
5. Risk of 'mission creep' associated to the Strategy

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

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

Risk Number	Strategic Objectives
3.4	Collaborate for children & young people

CQC Domains	Linked Risks	Owner	RM03 Risk Rating		
			Actual	Target	Assurance Committee
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Rachel Lea	16	12	Finance, Transformation & Performance Committee

Description

Failure to meet NHSI/E targets.
Inability to invest in the capital programme.

Feb 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	February 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

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

Description
System working to deliver 2030 Strategy

Feb 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	February 2025 Due Date	Action Update
1. Uncertainty over future commissioning intentions	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2025	Continual influencing of commissioning priorities to align with AH Vision 2030 ambitions e.g. Place priorities, C&M CYP Committee priorities, influencing NHS 10YP at National level
2. Future delegation of Specialist Commissioned services into ICSs	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2025	Delegation in shadow form of specialised services completed into ICB's. NW Joint Specialist Committee established - leadership via 3 x ICB CEO's. Low emphasis on specialist services in current NHS policy / 10year plan development - however Alder Hey and Children's Hospital Alliance incorporating clear asks pertaining to acute CYP illnesses into 10YR plan engagement process.
4. National mandates forcing us to prioritise unexpected programmes of work	4. Horizon scanning	31/03/2025	Formal contribution to NHS 10 Year Plan development on behalf of both Trust and CYP being undertaken by Chief Strategy Officer and Policy Lead/Advisor to CEO - in order to optimise reference to CYP and AH priorites within 10YP
Stakeholder & Partnerships Plan - Phase 2 of Vision 2030	A stand back on stakeholders and approach to partnership governance will be undertaken alongside re-framing of next phase of Vision 2030 - in line with transformation plan shape for 25/26+	31/03/2025	

Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People

Risk Number	Strategic Objectives
4.1	Pioneering Breakthroughs

CQC Domains	Linked Risks	Owner
Well-Led		John Chester

RM03 Risk Rating		
Actual	Target	Assurance Committee
9	6	Futures Committee

Description

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.

Feb 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	Due Date	February 2025 Action Update
2a. Sustainable activity levels	Engagement with and influence via Futures leadership group	31/03/2025	Replanning underway for Futures leadership for 2025/26 L&D Facilitator appointed – stat date 6th Feb. External consultants continuing to support external partnerships activity until 31 March 2025. Review of options for longer term arrangements underway.
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	no update in month – still expecting final IZ decision in March 25
4. Capacity and capability	Greater engagement with and education of R&I communities Futures people pillar established, Futures programme Board to commenced in May 2024. New infrastructure being established followjbg approval of business case in August	31/03/2025	L&D Facilitator appointed and start date confirmed for Feb 25. Admin support identified for develop pillar. Work underway to align work across academy, CRDP programme and Starting Well programme.
4. Sustainable Activity Levels	Review of IC product pipeline	31/03/2024	2 x Iyvalabs workshops completed with planning for open innovation approach aligned with IZ funding underway.
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	Comms and Marketing post out to advert and closing on 14th Feb.

Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families

Risk Number	Strategic Objectives
4.2	Revolutionise Care

CQC Domains	Linked Risks	Owner
		Kate Warriner

RM03 Risk Rating		
Actual	Target	Assurance Committee
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.

Feb 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	Due Date	February 2025 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	

BOARD OF DIRECTORS

Thursday, 6th March 2025

Paper Title:	Corporate Risk Register Report (CRR)
Report of:	Chief Corporate Affairs Officer
Paper Prepared by:	Associate Director of Nursing and Governance Trust Risk Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ■
Summary / supporting information:	This paper provides the Trust Board with the opportunity to scrutinise and discuss the current Corporate Risk Register (CRR) for the reporting period 1st December 2024 – 31st January 2025 The paper was presented at RMF (26.2.25) for individual risk in-depth discussion and assurance of mitigation and progress. At the time of reporting there are 9 'long standing high risks' (greater than 12 months since identification as a high risk) on the CRR with continuous progress made in reducing risk score or closing these risks. Themes for the remains 9 risk are as follows: Workforce/staffing- 5 Capacity & demand-1 Reputaional-1 Financial -1 National drug shortage-Patient safety-1 Since reporting to RMF the following risk has been reduced in score: • Risk # 253 reduced from 15 down to 12. Full details outlined in the paper.

	Supporting documents include: Risk Strategy & Risk Management Policy & Procedure and supporting policy documents.
Action/Decision Required:	To note ■ To approve ☐
Strategic Context: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations**
Resource Implications:	Supports resource identification.

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

This paper provides the Risk Management Forum with the opportunity to scrutinise and discuss the current Corporate Risk Register (CRR) for the reporting period 1st December 2024 – 31st January 2025.

2. Summary CRR:

Total number of open high risks = **21** (excluding BAF, Cheshire & Merseyside Children's & Young People's Partnership and network risks).

Table 1

High risks	1st December 2024 - 31st January 2025	1st September - 30th November 2024	1st July - 31st August 2024	1st - 30th June 2024	1st - 31st May 2024
Number of new high risks reported	0	2	0	1	3
Number of high risks closed or removed	0	0	0	0	1
Number of high risks with increased risk score	2	9	2	2	2
Number of high risks with decreased risk score	4	4	2	3	2
Number of high risks overdue review	1	2	2	0	6
Number of high risks with no agreed action plan	3 (271, 288, 253)	3 (271, 288, 253)	0	3 (2643, 151& 2077)	2 (140 & 178)
Number of high risks with actions past expected date of completio	6	4	6	9	7
Number of high risks with static risk scores	17	10	13	26	25

Table 2

Alder Hey - Corporate Risk Register

Community & Mental Heath	Rare	Unlikely	Possible	Likely	Almost Certain	Almost Certain	Likely	Possible	Unlikely	Rare	Medicine
Negligible											Negligible
Minor											Minor
Moderate					0	2					Moderate
Major				5	0	1	3				Major
Catastrophic			2	0	0	0	1	0			Catastrophic
Catastrophic			2	0	0	0	0	0			Catastrophic
Major				3	0	0	1				Major
Moderate					1	0					Moderate
Minor											Minor
Negligible											Negligible
Corporate & Research	Rare	Unlikely	Possible	Likely	Almost Certain	Almost Certain	Likely	Possible	Unlikely	Rare	**Surgery**

Table 3: THEMES

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Compliance and Regulatory							**Oct-24**	**Nov-24**	**Jan-25**
173	Corporate	Emergency Preparedness	22/03/2024	15 (5x3)	Business Continuity Incidents disrupting the Trusts ability to maintain statutory duties The risk is the potential for the Trust unable to meet its obligations in alignment with legislation, NHS England national policy, local guidance, and good practice, impacting on staff, patients, finance, reputation, and the wider health economy.	Workshops delivered to support business continuity plan (BCP) authors in the creation of their BCPs aligned to NHS England Framework. Trust's IM&T Team have a Data Security Protection Toolkit (DPST) Plan in place for the Trust. All Trust local and divisional BCP's to follow NHSE Themed developed and adopted toolkit. EPRR centralised lessons learned action plan following large disruptive events. Trust has an Incident Coordination Centre SOP in place and drafted a generic Incident Response Plan. The Trust has a generic Incident Response Plan.	15	15	15
Risk remains the same as above due to low compliance with divisional and corporate BCPs. Additional Business continuity workshops offered and attended by BCP owners. Ongoing monitoring via EPG and SQAC.									
271	Community & Mental Health	Rainbow - Safeguarding	07/10/2024	15 (5x3)	There is a risk that the Safeguarding Nursing Team will be unable to provide a service for children/young people and/or staff in the hospital due to staffing rota gaps.	Use of NHS Professionals to support the team until vacancies can be filled. Vacancies out to recruitment. 2 WTE Band 7s have been appointed and at last stages of recruitment. Outstanding 2 WTE Band 7s are currently being shortlisted. 2 WTE Band 6s have been added to Trac, awaiting approval. Oversight via Associate Director for Safeguarding and Statutory Services and		15	15

						Named Nurses. Weekly emails outlining recruitment position.			
The four WTE Band 7 roles have now all been recruited to. Three people have now commenced in post as of mid-January. One person has been issued with an unconditional offer and one is still undergoing pre-employment checks The two WTE Band 6 roles have been recruited to and have been issued with unconditional offers. Anticipated start dates will be March 2025. Once all staff have been inducted this risk can be reduced.									
253	Corporate	Academy	05/08/2024	16 (4x4)	Lack of access to sufficient training and education to complete the requirements of the GRID programme resulting in removal of GRID trainee posts.	Co-ordination of meetings and targeted actions focused on key areas of concern. Affects specialty residents in medicine.		16	16
A meeting has been arranged, 15.1.25, with GRID residents to review actions. The meeting will be attended by Executives, GM for Medicine and Medical Education Team. Discussed at RMF 26/2/25 and risk score has been reduced to 12 in February 2025									
189	Corporate	Emergency Preparedness	24/04/2024	15 (3x5)	The risk is the non-compliance in statutory requirement to formally assure NHS England with the Trusts readiness to respond to emergencies, provided through the EPRR annual assurance process.	Annual work programme to include incident response plan annual reviews for 2024 forward. Trust has overarching Business Continuity System Strategy, endorsed and signed off by the Board. As part of the Trust incident specific Incident Response Plan, the Trust's BCP requires informing by Divisional Business Continuity Plans and criticality. This is a wider piece of work relating to the BCMS and EPRR risk on the risk register. Emergency Planning Group Meetings moved to once per month for 2024/25. All incident response plans to be in date, refer to current legislation and guidance, consultations evidenced, signed off via EPR, SQAC and Board (as applicable).	15	15	15
No significant update in overall compliance. Continued progression across all sub-stands.									

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Financial - Investment							**Oct-24**	**Nov-24**	**Jan-25**
2643	Surgery	Medical Devices Safety	15/08/2022	16 (4x4)	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program.	Access Charity funding. £50k emergency equipment fund. A process has been developed to risk access the priority of device replacements. Escalation of risks and area lead engagement - Ongoing concerns requiring escalation will be reported via the Capital Committee. Area leads will be given more responsibility for identifying and managing their capital replacement priorities.	16	16	16
2nd CT approved by Execs 18/12/24. Order placed for both scanners December 2024. Capital spend for 24/25 re-profiled and orders to be placed ASAP to ensure delivery prior to April 2025.									

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Quality - Safety							**Oct-24**	**Nov-24**	**Jan-25**
140	Corporate	Resuscitation Department	02/02/2024	15 (5x3)	Out of hours there may not be Anaesthetic attendance at cardiac arrests if the anaesthetist is busy (i.e. emergency surgery). Consequently, there may not be anyone with advanced airway skills to assist during a resuscitation attempt/ 2222 call.	Regular contact with surgery division to raise any issues occurring. Resus team has basic airway skills.	15	15	15
Awaiting outcome of meeting between senior staff to reach resolution.									
288	Community & Mental Health	Rainbow - Safeguarding	21/11/2024	15 (5x3)	CAMHS practitioners who hold specific and ongoing responsibility for safeguarding children may not receive timely and reactive safeguarding supervision and will not receive planned supervision they require to support safe and effective safeguarding practice.	Communications have been sent to all CAMHS Practitioners to advise that planned supervision has been temporarily suspended, however reactive supervision is still available daily via the Safeguarding Duty Team. CAMHS Practitioners have been directed to seek immediate and reactive safeguarding supervision as required via the Safeguarding Duty Team which is available Monday - Friday between 8am-6pm.		15	15
Reactive CAMHS Supervision still being managed via Safeguarding Duty Team. The 4 WTE Band 7 Safeguarding Specialist Nursing vacancies have now all been recruited to with 3 WTE now being in post. New staff are being inducted to the team. CAMHS Safeguarding Practitioner is now back in work as of mid-January 2025 and is subject to a phased return. Business Continuity continues to be considered twice daily via the Safeguarding Team Safety Huddles. A safeguarding supervision list is being operated to ensure all staff requiring safeguarding supervision are allocated time slots. Capacity continues to be reviewed and as soon as capacity allows planned CAMHS safeguarding supervision will be reinstated.									

It is hoped this risk can be reduced at the next review.									
229	Corporate	IM&T	20/06/2024	16 (4x4)	Alder Hey Pathology reports are sent electronically to primary care organisations. This process utilises an end-of-life server which is no longer supported by the supplier.	Pathology IT team monitor the reporting systems daily to ensure they review any failed reports.	15	16	16
Agreement made not to peruse the regional option. Business Case for AH LabComm upgrade has been drafted for approval.									
2740	Medicine	Radiology	06/02/2023	16 (4x4)	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. 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.	Previous interventional radiologists have agreed to provide cover when the sole IR consultant has planned leave.	16	16	16
From 31/01/2025-11/02/2025 we have no IR cover in the Trust. The Paediatric IR Consultant is on leave 6th/7th February and no list on 5th February as per week 4 theatre schedule. We have reached out to supporting trusts (RMCH and Belfast), but they cannot provide cover until 12/02/2025. Emergencies will have to be transferred to RMCH.									
2431	Community & Mental Health	ASD/ADHD	23/07/2021	16 (4x4)	Children and young people will not receive the outcome of their ASD assessment within the agreed timescale (90% of cases within the 65 weeks Trust standard).	Clinical review of waiting list completed monthly and appointments allocated to longest waiters first. Regular performance reports provided to ICB to monitor compliance with standard. Service is fully staffed to capacity (recurrent funding). ASD Administrative Staff Review	16	16	16

						completed, and additional Assistant Operational Manager post is in place to oversee the Admin Team. Bank staff being used to cover admin and clinical gaps. SOPs in place to standardise assessment and administrative processes.			
Risk reviewed and remained the same. Clinical model is currently in progress and due to be presented at Trust board. Regional work still ongoing to align all Cheshire and Merseyside Neurodevelopmental services. Helios contract agreed and 360 routine referrals to be sent to Helios for action and outcome.									
2650	Medicine	Haematology	26/08/2022	16 (4x4)	If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4.	Lead for haemoglobinopathies and laboratory being covered by other haematology consultants. Additional waiting list initiative clinics put on to ensure elective work is completed in a safe and timely fashion. 1x substantive haematology consultant post advertised. Additional Specialty Doctor and 2 WTE Fellow recruited.	16	16	16
Clinical Lead for Haematology currently off sick, so not able to organise a meeting to discuss next steps for our vacancy									
2685	Medicine	Neurology	04/11/2022	20 (4x5)	There is a risk to being unable to provide a safe, effective and timely service for Tertiary Neurology patients. This includes the ability to diagnose, treat and manage patient demand. Reduction in consultants WTE to be able to maintain a safe neurology service with an inability to recruit.	Permanent post in place. Locum consultant in post (0.6 WTE). Locum sessions to existing consultants for on-call controlled out of hours provision. Trust Improvement Programme to review current provision and support development of alternative Neurology model.	16	20	20

						Additional consultant appointment will offset leaver. Locum consultant in post and Specialist Doctor due to start February 2025. Introduction of Patient Pass to support local DGH timely review for urgent requests.			
Risk reviewed and score remains the same. Team have received a further resignation.									
27	Medicine	Metabolic Disease	20/06/2023	15 (3x5)	The Metabolic Disease service is fragile and could fail to deliver the appropriate standard of care needed by our patient cohort.	Hub and Spoke model with Manchester Consultant attendance at Alder Hey 2/7 days. The metabolic service have identified patient cohorts in order to safely manage the patients moving forwards. A patient database of all metabolic prescriptions has been established. Sourced 2PA worth of General Paediatrics consultant time for the Metabolic Service.	12	12	15
Since the last review there has been another moderate harm incident and further incidents in relation to this risk. Risk score remains the same. Ongoing incidents have been escalated to the divisional triumvirate. There have been no PALS or complaints since the last review. This risk will be aligned to the BAF									
2419	Medicine	Pathology	06/07/2021	20 (5x4)	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO.	2 x Band 7 staff filling 1 rota place to help ensure service continuity. 1 x Band 5 BMS is being trained in blood transfusions and will undertake out of hours shifts in the presence of the Acting Haematology Manager later in October. 1 x Band 6 BMS has just started and is being fast tracked	25	25	20

						through competency assessments in haematology.			
All upcoming gaps in rota due to sickness have now been filled. Transfusion training for staff ongoing, gap analysis to be completed for estimated sign off. SBMS cross training to commence to add resilience. 3 new starters should be in post by beginning of April. Service review feedback session with staff 4th February. UKAS reinstatement inspection planned for March (pending allocation of technical assessor). Amended business case to be resubmitted.									

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Reputation							**Oct-24**	**Nov-24**	**Jan-25**
2745	Community & Mental Health	Community Division - Division Wide	10/02/2023	16 (4x4)	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.	Strategy agreed at GDS North Programme Delivery Board and Trust Board. A GIDS North Programme has been established. There is a supporting governance structure that engages with the South Hub to ensure a consistent national service, as well as regular engagement with NHS England. A gateway review process is also in place. There is a national communications group, with North hub representation and a regular meeting in place with the PMO and communications lead. Process in place for directing queries regarding the service to NHSE. External organisation and SME commissioned to support the Trust.	16	16	16

						Service will continue to work to the NHS England Clinical Policy, media queries to be diverted to NHSE where appropriate.			
Risk reviewed, no change to risk score due to potential future media attention about the research trial. NHS England has proposed a communications strategy (see attachments); action added in relation to role of providers.									

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Description	Controls	Risk Score		
Workforce							**Oct-24**	**Nov-24**	**Jan-25**
2051	Community & Mental Health	Clinical Health Psychology	18/04/2023	16 (4x4)	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service.	Weekly waiting list management to review the waiting list and prioritise young people based on risk. Offering brief intervention, group interventions and providing self-help resources whilst on the waiting list. Daily Duty Team in place Monday-Friday to triage referrals and offer urgent intervention if required.	16	16	16
Risk reviewed - Actions updated. Waiting times continue to improve with RTT at 57% with 6 YP waiting over 6 weeks. 5 have booked appointments 4 of which will take place in January. Waiting list has reduced to 241 across CHP.									
2077	Corporate	HR	31/01/2020	16 (4x4)	Staff ill health and absence higher that the Trust absence target of 5% (2024/25). Risk of inability to provide safe staffing levels due to absence.	Sickness Absence Policy in place which is reviewed regularly, HR Business Partners and Advisors provide support to managers across the divisions within the Trust, managing absence in accordance with the policy. Additional staffing is made available through the bank, which is provided by	16	16	16

						NHSP. This provides cover largely for registered and unregistered nurses. Corporate report monitors Trust absence level. The Trust target is 5.5%. Occupational Health Service is available to all staff. Monthly Health and Wellbeing team meetings, which focus on improving employee wellbeing. Reviewing analysis of current data and feedback through Staff, Managers, Occupational Health, HR, Psychological Services and Health and Safety. A staff availability group has been set up and chaired by the HR Director, specific actions are in place and monitored by this group - which reviews the impact of sickness amongst other factors contributing to staff availability.			
Sickness is 6.00%. Sickness absence has remained high and are similar to absence levels during this period last year. Additional case and trend reviews have been held with the Deputy CPO.									
2602	Medicine	Radiology	11/05/2022	16 (4x4)	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.	Two radiographers working over their hours on a regular basis to sustain specialist business activity. Weekly rota meeting to review what theatre lists are running in the weeks ahead to highlight any lists that cannot be supported with a radiographer. Radiographers are working over their hours to support elective work. Strengthening Me session with SALS booked.	16	16	16

						Agency staff currently in post. Radiology has a fully established training programme to support new staff on recruitment to train in the above specialties.			
New starters in situ and undergoing basic induction but will need further training of approximately 5 months before competent in Hybrid/Cath Lab. 2 locums still in situ. posts from skill mix to the approved and advertised - approximately 2 WTE band 6 radiographers.									
2670	Medicine	Radiology	05/10/2022	15 (3x5)	Potential reduction in ultrasound service provision. Difficulty in recruitment of sonographers and age demographic of 1/3 of U/S team will result in retirement/retire and return within the next 5 years. The U/S department is a small team of 4.5 WTE, 1 sonographer (0.8WTE) currently on long term sick leave. All except 1 sonographer are part time and there is also 0.4 WTE of a vacancy unfilled.	Patients are booked according to sonographer availability on any given day and in accordance with annual leave. To explore if patients referred from external hospitals e.g. Wrexham for Urology can be scanned locally rather than in Alder Hey from Dec 24 when Mat Leave commences.	15	15	15
Outsourcing company ATLAS employed to deliver 4000 scans including urology planned scans. Sonographer post has been withdrawn.									
2459	Community & Mental Health	CAMHS SPA / Crisis Care Team	21/09/2021	16 (4x4)	Risk of burnout of current workforce.	Completion of Beat the Burnout national training for Crisis Care Teams. Access to SALS provision in place in the Trust to provide support to staff. Availability of the Alder Centre to provide support and counselling for staff. Weekly Team Meetings in the service which includes time on staff support. Individual supervision sessions in place for all staff.	12	12	16

						Trust Sickness Policy in place.			
This risk continues to be monitored as there is significant pressure on the crisis team at present due to vacancies/unsuccessful recruitment and long-term sickness. Request on tracker to go out for agency band 6 to bridge gap between next recruitment drive. X 3 band 7 and x 3 band 6's to go out asap. The last successful candidate for the AP post declined offer but the next person on the offer reserve list has accepted and so the start date has been delayed for x 1. Another AP due to start 3rd February.									
2455	Community & Mental Health	Developmental Paediatrics	16/09/2021	16 (4x4)	Disruption in patient's supply of medication and / or treatment.	Prescription rota in place.. Online form in place to allow timely requesting of prescriptions by parents / carers. Overtime provision available for clinicians if needed to ensure cover for the prescription rota. Additional capacity can be provided by Registrars to do prescriptions if required. Prescription turnaround time audit to assess timeliness. Prescription productivity audit. BI periodic reporting strategy and dashboard.	16	16	16
Digital developments ongoing and new prescribers recruited.									

Table 4: NEW HIGH RISKS No new high risks reported in this reporting period. **Table 5: CLOSED HIGH RISKS** No closed high risks in this reporting period.

Table 6: RISKS WITH DECREASED SCORES

Risk	Risk	Score	Reason for Decrease
Medicine			
2419	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO.	**25 Decreased 20**	Risk reduced in January 2025 but remains high. All upcoming gaps in rota due to sickness have now been filled. Transfusion training for staff ongoing, gap analysis to be completed for estimated sign off. SBMS cross training to commence to add resilience. 3 new starters should in be in post by beginning of April. Service review feedback session with staff 4th February. UKAS reinstatement inspection planned for March (pending allocation of technical assessor). Amended business case to be resubmitted.
Community & Mental Health			
2800	A child may be harmed in the process of holding them to complete an intervention anywhere in the Trust due to an absence of a Trust-wide overarching strategy and training programme to managing the spectrum of holding children for clinical intervention through to restrictive intervention in response to Violence and Aggression/absconding behaviour.	**16 Decreased 10**	Risk reviewed in the Divisional Risk Review Meeting - risk description and cause updated to reflect the changes in the Trust. Risk scores updated and reduced from 16 to 10 due to re-evaluation of the risk.
2573	Delays in the long-term management of respiratory physiotherapy needs for children and young people due to capacity within the Community Respiratory Physiotherapy Teams in Liverpool and Sefton to meet the demand.	**15 Decreased 12**	Risk review - risk score reduced from 15 to 12 due to new starters now in post All substantive posts now filled. New starters currently undergoing induction and will be able to support with the management of the caseload, including responding to 'acute calls' for children in the community and providing training for parents/carers. Will monitor impact of substantive posts being filled. Business case for increased staffing in Liverpool and Sefton Place still with ICB with no update.
Corporate			
117	Patients on follow up waiting lists are not being seen as originally requested (i.e. overdue). Potential harm to patients who have not been seen in line with their treatment plan.	**16 Decreased 12**	Risk reviewed. Source Group commenced Audiology service, operational delays due to IT breach, scheduled to complete by 17/01/25. Bi-weekly Safe Follow Up Care workstream commenced 01/12/24. This will report into Safe Waiting List Programme Board - interim target remains to have no-one waiting over 2 years by March 2025. Final target to have no-one waiting over 6 months - target date to be determined.

Table 7: RISKS WITH INCREASED SCORES

Risk	Risk	Score	Reason for Increase
Medicine			
27	The Metabolic Disease service is fragile and could fail to deliver the appropriate standard of care needed by our patient cohort.	**12 Increased 15**	Due to an ongoing lack of regular consultant cover and a decrease in dietetic cover due to sickness, the decision to increase the risk score was made at the last Metabolic Management meeting.
Community & Mental Health			
2459	Risk of burnout of current workforce.	**12 Increased 16**	Risk score increased to 12 to 16 due to current long- and short-term sickness impacting on staffing levels and need. Updated actions to reflect increasing the number of CAMHS staff that can provide NHSP staffing.

Table 8: LONG-STANDING HIGH RISKS (greater than 12 months since identification as a high risk)

Risk	Risk Owner	Risk Score	Risk	Date Identified	Review Update
Community & Mental Health					
2051	Lisa Cooper	15	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service.	Apr-23	Risk reviewed - Actions updated. Waiting times continue to improve with RTT at 57% with 6 YP waiting over 6 weeks. 5 have booked appointments 4 of which will take place in January. Waiting list has reduced to 241 across CHP. **Theme: Workforce/Funding**
2431	Lisa Cooper	16	Children and young people will not receive the outcome of their ASD assessment within the agreed timescale (90% of cases within the 65 weeks Trust standard).	Jul-21	Risk reviewed and remained the same. Clinical model is currently in progress and due to be presented at Trust board. Regional work still ongoing to align all Cheshire and Merseyside Neurodevelopmental services. Helios contract agreed and 360 routine referrals to be sent to Helios for action and outcome. **Theme: Capacity and demand**
2455	Lisa Cooper	16	Disruption in patient's supply of medication and / or treatment.	Sep-21	Digital developments ongoing and new prescribers recruited. **Theme: National drug shortage outside of organisational control**
2745	Lisa Cooper	20	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.	Feb-23	Risk reviewed, no change to risk score due to potential future media attention about the research trial. NHS England has proposed a communications strategy (see attachments); action added in relation to role of providers. **Theme: Reputational**
Medicine					
2650	Urmi Das	16	If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4.	Aug-22	Clinical Lead for Haematology currently off sick due to bereavement, so not able to organise a meeting to discuss next steps for our vacancy. As soon as she returns will get a meeting in as a matter of urgency. **Theme: National workforce shortage**

2685	Alf Bass	16	There is a risk to being unable to provide a safe, effective and timely service for Tertiary Neurology patients. This includes the ability to diagnose, treat and manage patient demand. Reduction in consultants WTE to be able to maintain a safe neurology service with an inability to recruit.	Nov-22	Risk reviewed and score remains the same. Team have received a further resignation. **Theme: National workforce shortage**
2419	Adam Bateman	16	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO.	Jul-21	All upcoming gaps in rota due to sickness have now been filled. Transfusion training for staff ongoing, gap analysis to be completed for estimated sign off. SBMS cross training to commence to add resilience. 3 new starters should be in post by beginning of April. Service review feedback session with staff 4th February. UKAS reinstatement inspection planned for March (pending allocation of technical assessor). Amended business case to be resubmitted. **Theme: Workforce shortage**
Surgery					
2643	Raymond Lewis	16	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program.	Aug-22	2nd CT approved by Execs 18/12/24. Order placed for both scanners December 2024. Capital spend for 24/25 re-profiled and orders to be placed ASAP to ensure delivery prior to April 2025. **Theme: Financial**
Corporate					
2077	Melisa Swindell	15	Staff ill health and absence higher that the Trust absence target of 5% (2024/25). Risk of inability to provide safe staffing levels due to absence.	Jan-20	Sickness is 6.00%. Sickness absence has remained high and are similar to absence levels during this period last year. Additional case and trend reviews have been held with the Deputy CPO. **Theme: Staffing**

BOARD OF DIRECTORS

Thursday, 6th March 2025

Paper Title:	Infection Prevention & Control Quarterly Report Q3 October – December 2024
Report of:	Infection Prevention & Control Team
Paper Prepared by:	Dr Beatriz Larru Director of Infection Prevention & Control

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	To provide the Committee with the IPC activity for Q3 October – December 2024
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☐
Resource Implications:	N/A

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
2747	• Inability to maintain IPC required standards	9
2749	• Lack of advanced data skills within the IPC team resulting in inability to monitor and recognise IPC standards across the Trust	9
2744	• Non delivery of IPC standards due to insufficient IPC staffing levels	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

The purpose of this report is to provide the Trust Board with oversight of Infection Prevention Control (IPC) activity and reporting for the Q3 period (1st October – 31st December 2024) ensuring the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice.

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

2. Background and current state

During Q3, the IPC committee received reports from the following subgroups.

Clinical Advisory Group: No meetings held in Q3 as this group is undergoing transformation into HAIs prevention working groups.

IPC Champions Group: The group continue to meet on a monthly basis and discuss infectious diseases where there is high transmission within the community. There are now 2 groups, hospital based and community with dedicated meetings for each. We have continued to provide sessions in line with the NHSE IPC Educational Framework. Rolled out the Glove Smart Campaign and collaborated with the Antimicrobial Stewardship (AMS) team to comply with the IPC educational framework. A new Hand Disinfection Audit tool has also been created and shared with the group.

Antimicrobial Resistance Steering Group: The ongoing workstreams focus on 1) De-labelling penicillin allergies, 2) Promote IV to PO administration of antimicrobials, 3) Promote nursing role in AMS, 4) Understand health inequities and antimicrobial resistance, 5) Promote diagnostic stewardship by limiting unnecessary blood cultures in ICU, 6) Understand behavioural change science in antibiotic prescribing and 7) Surgical prophylaxis. The group have also began planning for World Antibiotic Awareness Week: 18th – 24th November 2025.

Hand Hygiene Improvement Group: no meetings held in Q3, but work is ongoing; meetings with Innovation team to move forward with automatic methods of monitoring hand hygiene compliance to effectively promote behavioural change through auditing results.

Environmental Cleanliness Group: No meetings held during Q3, but work continues on the below actions:

- *how to best implement the Hospital Cleaning policy RM49 across the Trust*
- *new electronic auditing system being procured.*
- *SharePoint page developed with instructions for cleaning and decontamination of items, in accordance with the National Standards of Healthcare Cleanliness 2021.*

High Consequences Infection Diseases (HCID Steering Group): Alder Hey are now an accredited airborne HCID Centre. On-going HCID training programme for staff and local SIM and induction sessions continue.

3. Main body of report – Infection Prevention & Control Metrics

3.1 Bacteraemia Surveillance

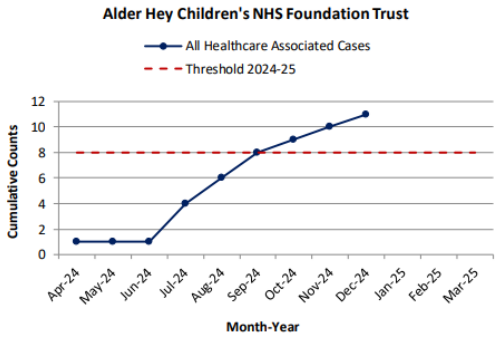
3.1.1 Healthcare-associated Gram-negative Bloodstream Infections

A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA (UK Health Security Agency) is shown below. During Q3, 11 patients had healthcare-associated Gram-negative blood stream infections. Cases were identified in Neonatal (3), Cardiac (1) Oncology (3) Medical wards (2) and Critical Care (2)

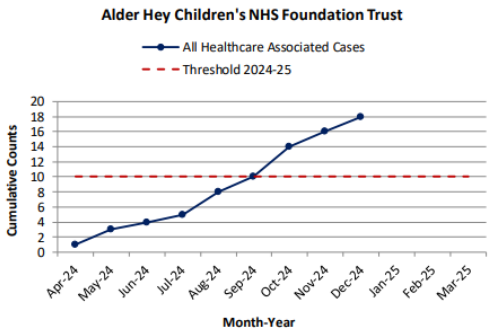
The post-infection reviews (PIR) of these cases identified previous antibiotic exposure, critical illness, and significant patient comorbidities as predisposing factors, which are well known high-risk factors for Gram-negative blood stream infections.

The workplan to reduce Central Line Related Line Infections (CLABSI (Confirmed central line associated bloodstream infection)) across the Trust has continued during Q3, with a closer collaboration between IPC and the Microbiology laboratory to include in our PIRs all significant blood stream infections (not just those subject to mandatory UKHSA reporting such as *E. coli, Pseudomonas aureginosa* or *Klebsiella spp.*) to engage with all stakeholders in the development of the CLABSI steering group.

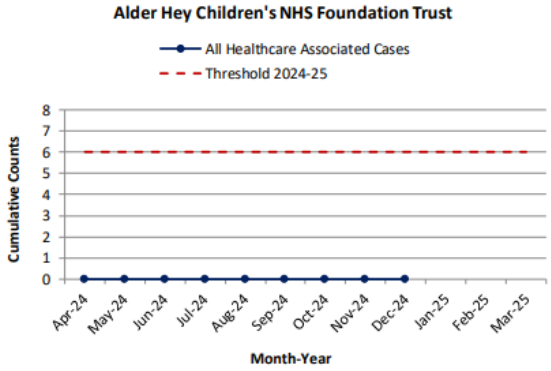
E. coli bloodstream infections



Klebsiella spp. bloodstream infections



P. aeruginosa bloodstream infections



UKHSA HAIs monthly tables for Gram-negative bloodstream infections.

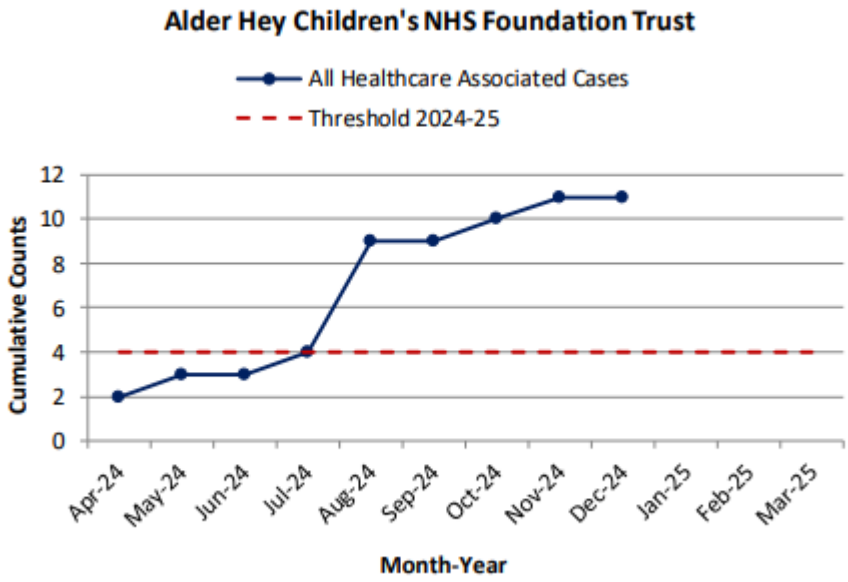
Note: Healthcare-associated infections include: 1) Hospital Onset-Healthcare acquired (**HOHA**) *(i.e.*, occurs in patients admitted >48Hr) and 2) Community Onset-Healthcare acquired (**COHA**) (*i.e.,* occurred in patients who have received healthcare in either the community or hospital in the previous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

3.1.2 Healthcare-associated *Staphylococcus aureus* bloodstream infections

During Q3, 1 patient had a healthcare associated MSSA blood stream infection. The case was identified in Neonatal (1). The post-infection review (PIR) prompted a review of ANTT processes for dressing changes.

6 cases of MRSA bloodstream infection were reported during Q3, Neonatal (1) Cardiology (1), Neuro Medical Ward (3).

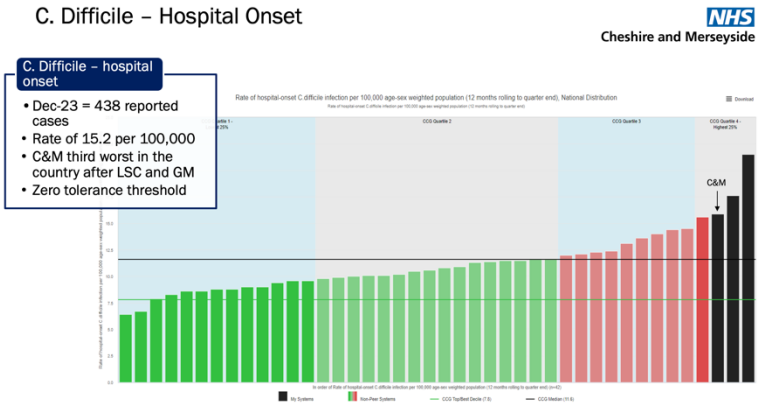
3.1.3 *C. difficile* Infection



During Q3 there was 1 healthcare associated *Clostridioides difficile* infection identified within General Paediatrics. A PIR for the case identified that there were no identified lapses in care, the case was a long-term inpatient and had exposure to multiple antibiotic treatments prior to their C. diff infection. No previous testing on patient and unable to gain accurate history due to social restrictions.
Multiple risk factors included antibiotic use, complex needs, multiple external carers, regular attendance at a specialist school and regular trips out into community with external carers.
No themes noted as no other cases on the ward and no transmission to other patients or staff.

Learning from PIRs - education to staff to isolate based on symptoms and send off samples at the earliest possibility and to ensure adequate/appropriate documentation (utilising the Bristol stool chart) of patient stool/output in patients' records.

Since January 2024, UKHSA has alerted a sharp increase in *C. difficile* cases across the UK, for which there is not a clear explanation. The Northwest is the third area worst affected.



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

3.2 Healthcare acquired viral infections.

3.2.1 Respiratory viral infections

During Q3, we continued to see that a large proportion out of the positive respiratory viral tests analysed in the microbiology laboratory, were obtained on patients admitted for longer than 3 days (*i.e*., viral healthcare acquired infection). We also continue to report rates of inappropriate sue of viral respiratory testing to the ED team to ensure appropriate use of diagnostic resources across the Trust.

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

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

The IPC team continues to perform daily "isolation walks" among all areas of the Trust to communicate to staff the appropriate IPC precautions and has developed visual graphics to identify contagious patients. The IPC team sends out monthly newsletters with key messages and updates and provides bespoke education sessions for areas.

3.2.2 Gastrointestinal viral infections

During Q3, there was 1 healthcare associated Norovirus case, outbreak declared. 5 Patients exposed and 2 staff members.

3.3 Other Notable Infections

3.3.1 Group A *Streptococcus*

0 cases of healthcare associated Group A *Streptococcus* identified during Q3.

3.3.2 Measles

There was 1 positive measles case reported during Q3. No significant contacts were identified following the exposure. The IPC department and DIPC closely collaborate with Liverpool City Council, NHSE and UKHSA to develop a collaborative approach to enhance MMR vaccination

rates in the community and increase awareness of healthcare workers to promptly recognise measles cases.

4. Conclusion

During Q3, the IPC department has continued to maintain their increased visibility across the Trust through daily isolation ward rounds and monthly steering group meetings. Despite low staff capacity within the team have actively worked alongside the DIPC and deputy director of AHP for the majority of Q3. Despite challenge, the IPC team was able to perform its daily activities and actively participate in the response to outbreak incidents within the Trust.

Recruitment update:

- Band 7 Data Scientist Apprenticeship – Successfully recruited with a start date of 17.03.2025
- Band 6 IPC Specialist Practitioner – post approved and advertised 13.02.2025

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

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

5. Recommendations & proposed next steps

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