BOARD OF DIRECTORS PUBLIC MEETING
Thursday 5th June 2025, commencing at 13:20
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
1.	**25/26/64**	**13:20 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**25/26/65**	**13:21 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**25/26/66**	**13:22 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **1st May 2025.**	**D**	Read enclosure
4.	**25/26/67**	**13:24 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**25/26/68**	**13:25 (10 mins)**	**Chair's/Chief Executive's Update.**	Chair/ J. Grinnell	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**25/26/69**	**13:35 (5 mins)**	**Trust Strategy Board Update from June's Meeting.**	J. Grinnell	To receive an update.	**A**	Verbal
7.	**25/26/70**	**13:40 (30 mins)**	**C&M System Wide Issues Update; including:**	D. Jones	To receive an update on the current position.	**N**	Presentation
			• **Liverpool Plan, 2040.**	D. Jones	To receive an update on the current position.	**N**	Presentation
			• **Beyond Annual Report, 2024/25.**	L. Crabtree	To receive the Beyond Annual Report for 2024/25.	**N**	Read report
			• **ICB and Annual Plan update.**	J. Grinnell	To receive an update on the current position.	**A**	Verbal
Improvement Programme							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
8.	**25/26/71**	**14:10 (15 mins)**	• **Financial Improvement Programme Update.** • **Transformation Programme Update.**	A. Bateman/ R. Lea N. Palin	To receive an update on the current position. To receive an update on the current position.	**A** **A**	Presentation Read report
Performance Against Annual Plan							
9.	**25/26/72**	**14:25 (40 mins)**	**Evidence of Our Performance:** • **Flash Report, M2.** • **Integrated Performance Report for M1, 2024/25:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.**	A. Bateman N. Askew A. Bateman J. Chester M. Swindell D. Jones R. Lea Divisional Directors	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A**	Read reports
Unrivalled Experience							
10.	**25/26/73**	**15:05 (5 mins)**	**Compliments, Complaints and PALS Report, Q4.**	N. Askew	To receive an update on the Q4 position.	**A**	Read report
11.	**25/26/74**	**15:10 (5 mins)**	**Nursing Workforce Annual Report, 2024/25.**	N. Askew	To receive the Nursing Workforce Annual Report for 2024/25.	**A**	Read report
12.	**25/26/75**	**15:15 (5 mins)**	**CQC Children and Young People's Survey, 2024.**	N. Askew	To receive an update on the outcome of CQC's Children and Young People's survey for 2024.	**N**	Read report
13.	**25/26/76**	**15:20 (5 mins)**	**Digital, Data and Information Technology Update.**	K. Warriner	To receive an update on the current position.	**A**	Read report
14.	**25/26/77**	**15:25 (5 mins)**	**Infection, Prevention and Control Report, Q4.**	A Bass	To receive an update on the Q4 position.	**A**	Read report
15.	**25/26/78**	**15:30**	**Use of the Mental Health Act**	L. Cooper	To receive the Use of the Mental Health Act	**A**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
		(5 mins)	**Annual Report, 2024/25.**		Annual Report for 2024/25.		
16.	**25/26/79**	**15:35 (5 mins)**	**Use of Restrictive Physical Interventions Annual Report, 2024/25.**	L. Cooper	To receive the Use of Restrictive Physical Interventions Annual Report for 2024/25.	**A**	Read report
17.	**25/26/80**	**15:40 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 21.5.25.** - **Approved minutes from the meeting held on the 30.4.25.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 30.4.25.	**A**	Read enclosure
Supporting our People							
18.	**25/26/81**	**15:45 (10 mins)**	**People Plan Strategic Update; including:** • **EDI update.**	M. Swindell	To receive an update on the current position.	**A**	Read report
19.	**25/26/82**	**15:55 (5 mins)**	**People Committee:** - **Chair's Highlight Report from the meeting held on the 22.5.25.** - **Approved minutes from the meeting held on the 12.3.25.**	J. Revill	To escalate any key risks, receive update and note the approved minutes from the 12.3.25.	**A**	Read enclosure
Strong Foundations (Board Assurance)							
20.	**25/26/83**	**16:00 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's verbal update from the meeting held on the 21.5.25.** - **Approved minutes from the meeting held**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 28.4.25, and to receive an update on the top key risks for 2024/25.	**A**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			on the 28.4.25.				
21.	**25/26/84**	**16:05 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
22.	**25/26/85**	**16:10 (5 mins)**	**Board of Directors Annual Fit and Proper Persons Checks.**	E. Saunders	To receive the Fit and Proper Persons Test Assurance Report.	**N**	Read report
Items for Information							
23.	**25/26/86**	**16:15 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
24.	**25/26/87**	**16:19 (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 July, 9:00am, LT4, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in May: • 425: Building contract between Alder Hey and KROL Corlett Construction (*amendment to the JCT design and contract*).

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M1, 2025/26	R. Lea

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 1st May 2025 at 9:00am**

Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	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)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/39	Mrs. N. Palin	Director of Transformation	(NP)
Item 24/25/46	Mrs. K. Turner	Freedom to Speak Up Guardian	(KT)
Observing:	Dr Jia Yi Leow	Member of the public	(JYL)
	Dr. Hannah Mechie	Member of the public	(HM)
Apologies:	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)

Staff Story

The Chair welcomed Vicky Gray (*Consultant Clinical Psychologist*) who was invited to May's Board to share an overview of the Trust's 'Travelling Companions' project. Scarlett, one of the young people who participated in the development of the animation *('our travelling companion – life with a chronic health condition')* was unable to attend and sent her apologies.

It was reported that the Trust collaborated with the multimedia charity Twinvision to develop the 'Our Travelling Companion' video. The video's language is designed to help children and young people (CYP) understand their medical journey. Additionally, the video encourages CYP to engage with their support networks and explore alternative methods to manage challenging treatments. The animation is non-condition specific, conveying the idea that having a lifelong travelling companion makes the journey easier. This represents a step care model aimed at providing CYP with the appropriate level of care as promptly as possible while optimally utilising the organisation's resources. Numerous CYP participated in creating the animation, although not all clips were included in the final film. The Trust supported the

therapeutic narrative, hosted a number of outpatient workshops, organised an awards evening, and invited families to the film's premiere at Alder Hey's Medicinema.

The Board was informed that while there is a lot of information available on managing anxiety, there is comparatively little guidance on coping with uncertainty or envisioning the future. It was confirmed that the service will incorporate the video into the Psychology Hub to provide others with access to this resource.

The Chair felt that this is truly a moving and inspiring initiative and congratulated everyone involved in creating such a remarkable piece of work. It would be greatly beneficial to extend this across the country, providing comfort to many CYP. A suggestion was made about launching the film nationally.

25/26/33 Welcome and Apologies

The Chair welcomed everyone to the meeting and noted the apologies received. The Chair also mentioned visiting the new MRI scanner and encouraged Board members to see it before leaving.

25/26/34 Declarations of Interest

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

25/26/35 Minutes of the previous meeting held on 3rd April 2025.
Resolved:
The minutes from the meeting held on the 3.4.25 were agreed as an accurate record of the meeting.

25/26/36 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

25/26/37 Chair's and CEO's Update

The Chair began by expressing gratitude to everyone for their hard work, which had resulted in the Trust ending the 2024/25 financial year in a good position. This success was attributed to the collective efforts of all those involved. However, the Chair emphasised that the current year presents significant challenges, and it is crucial for the Board to maintain focus on Vision 2030. The primary goal is to improve the lives of CYP in the community and provide the best quality care to service users. While addressing business-as-usual issues and ensuring safety, the Board must not lose sight of its long-term aspirations. The Chair highlighted the importance of leveraging artificial intelligence (AI) and other available tools to navigate these challenges.

John Grinnell provided a comprehensive update on the organisation's current position and the strategic direction moving forward. The key points included:

Financial Targets and New Operating Frameworks – John Grinnell acknowledged the challenging financial environment and the need to connect all decisions with the Trust's Vision 2030 Strategy. It was reported that the organisation is reflecting on a twelve-week delivery plan for the year to ensure alignment with long-term goals.

From a system perspective significant strides have been made in meeting financial targets, with a notable reduction in the financial gap over a six-week period to £2.5b. Nationally the Treasury are supporting a new target of £2.3b. Meeting this new target will mean no future debt in the system therefore it is important to maintain the progress that has been achieved to date.

The new operating framework, set to go live in the coming weeks, will introduce five segments of risk levels, with level 1 being the lowest risk. The framework aims to simplify the payment and commissioning structure, with new tariffs incentivising productivity. Work is ongoing on the new NHS 10 Year Plan which is to be launched before the summer recess.

Liverpool 2040 Plan – It was reported that a session took place recently on the Liverpool 2040 Plan. The Chief Strategy and Partnerships Officer, Dani Jones, attended the session and was a member of one of the panels that discussed neighbourhood care. It was pointed out that the work being undertaken by the Liverpool provider triumvirate is critical to ensuring clarity.

CQC Inspection of the Trust's Specialist Mental Health Services for (CYP) – Since the recent inspection the Trust has fundamentally changed the digital system for clinical teams both in CAMHS and the wider organisation. A lot of progress has been made which will be demonstrated to CQC during a meeting scheduled for the 8.5.25.

A question was raised about CYP inclusion in the long-term plan. It was reported that the consultation process has been challenging, particularly as it could not include under-16s. Feedback has been provided via the Children's Hospital Alliance and other forums, and it is felt that there will be certain aspects of CYP inclusion.

Resolved:
The Board noted the updates provided by the Chair and the CEO, recognising the importance of maintaining focus on Vision 2030 and leveraging AI and other tools to navigate the current challenges.

25/26/38 Deployment of Vision 2030

Report from Portfolio Board

The Board was informed that the Portfolio Board will bring together a single portfolio discussion around the Trust's Financial Improvement Programme, Transformational Programme and the work relating to growth opportunities.

An overview of the Portfolio Board's key actions was provided in terms of the macro plan view and programme view over the next three years across the pillars. It was pointed out that the Strategic Outcomes Framework is in its development stage and will be monitored by the Portfolio Board. It was confirmed that further detail will be provided during June's Strategy Board.

Resolved:
The Board noted the Portfolio Board update.

24/25/39 Improvement Programme

Financial Improvement Programme (FIP)

A number of slides were shared with the Board that provided the following information:

- *Allocation of £25m* - External "CIP" target (reported to the ICB) is £22.7m. In addition to this the Trust is also planning to deliver a further £2.2m of savings through run rate reduction to deliver the full £25m target. The Board received a snapshot of the savings that the collaboratives are working towards.
- *Latest Position* – The Trust still has £10m that it needs to address and is aiming to submit the full £25m of schemes for approval via FIP by the end of June 2025. The latest position has been reported to the ICB and the Trust is addressing this work promptly.
- *ICB letter relating to Expenditure Controls* – The Board was asked if it was in agreement with the controls identified in the presentation, which it confirmed it was.
- *FIP* – An overview was provided of the model for delivery and assurance.
- *NHSP Dashboard* - It was reported that there has been a reduction in shift hours and costs for bank staff in April 2025. This impact is as a result of the decisions that have been made following the implementation of the FIP.
- *Communication and Participation* – Information sessions have been arranged for colleagues and a letter from the Chair and CEO has been circulated to staff to advise of the challenges. Mixed feedback has been received, and this has been discussed openly at the bi-weekly Executive briefing sessions. Productivity packs have been issued to highlight opportunities for improving efficiencies and to underline that collaborative transformation is essential in contributing to the £10 million goal. Each department is to submit a plan, and Divisions are encouraged to continue to provide feedback.

A question was raised about whether the Trust is asking teams to improve patient care or save money, as they are separate issues. It was reported that money and efficiency was initially at the forefront of the Trust's plans, but the organisation is now thinking about waste reduction steps that will improve a patient's journey and save money. The Board was advised of the focus that is taking place to try and capture efficiencies/benefits and bring the data together in one place.

The Chair felt that it would be beneficial to provide staff with some examples to make them aware that the FIP is not just about cost reduction, it is also an opportunity to improve patient care.

Decision Making Framework

The Board received a paper that set out the proposed processes by which the Trust will support its intention to exercise 'safe and compassionate decision-making' in the context of the current FIP.

In developing an annual plan for the year risks have been identified and articulated. The Trust's ability to navigate the challenges of delivering this plan will

be dependent upon the development of detailed actions to underpin the mitigations described in the report. An overview of the principles/structure for the framework was provided and attention was drawn to the revised Quality Impact Assessment (QIA) process and the draft Terms of Reference for the Clinical Cabinet.

The Board was asked to approve the decision-making framework and confirm their agreement in terms of receiving reports from the Clinical Cabinet in support of the safe delivery of the annual plan.

A discussion took place, and feedback was provided by Board members about the importance of having colleagues involved in meetings who are able to think strategically and identify unintended consequences, reducing the bureaucracy of documentation by developing QIA codes to enable staff to answer questions, and having a process in place to manage evidence of deterioration from an unintended consequence perspective.

A question was raised about transitioning cost reduction sprints into business as usual. It was pointed out that the Trust still needs to address savings of £10m via the FIP therefore there is a need to remain focussed before defining the transition position into BAU. It was reported that the Clinical Cabinet will work on framing new models of care, indicating FIP's gradual phase-out and growth in collaboration. John Kelly felt that the continuation of cost reduction could impact the strategic efforts of the Divisions.

The Board confirmed their approval of the principles and structures taking into account the comments that were made during the meeting.

Transformation Programme Update

The Board was provided with a Year-to-Date (YTD) update on the Trust's Vision 2030 Transformation Programme, with a focus on progress since the establishment of the Portfolio Board in April 2025.

The paper outlined the organisation's progress to date in terms of working towards a £10m transformation target, the governance programme and 90-day plans. While a complete overview cannot be provided at the present time it was confirmed that the Trust is working hard to identify new opportunities/address gaps and updates will follow in due course. The 'Fit for the Future' approach involves working differently whilst staying connected to seize opportunities. It was reported that the aim is to turn opportunities into financial gains. The Board was advised that the Trust is aware of the risks, as detailed in the report, and is actively working to mitigate them.

Attention was drawn to the importance of improving the organisation's ability to translate opportunities into financial benefits as it is these benefits that will help Alder Hey treat more patients and improve patient care.

Resolved:
The Board noted the update on the Improvement Programme and confirmed their approval of the Decision-Making Framework principles and structures, taking into account the comments made during the meeting.

25/26/30 2025/26 Integrated Performance Report (IPR) Proposal

The Board received a report proposing four key developments and enhancements to the IPR for 2025/26; a new summary page, alignment with national objectives for the 2025/26 IPR, new metrics to monitor important service developments, and focus on productivity and associated metrics. As part of the Annual Planning process and the development of Vision 2030 the IPR requires an update to align with the objectives and priorities contained in the 2025/26 Integrated Operational Plan and to reflect the challenges and goals for the 2025/26 financial year.

It was pointed out that this piece of work is in progress and feedback was requested in respect to the front page summary which is being modified. A question was raised about whether the IPR will capture patient experience. It was confirmed that it will in terms of traditional measures but by March 2026 a strategic approach will be implemented that will capture more in-depth data. Attention was also drawn to the importance of looking at productivity measures for the whole of the Trust.

Following discussion, it was agreed to submit a final version of the IPR in June, noting the request by governors for a reader friendly version of the document. It was agreed to take this request into account whilst the document is being developed.

25/26/30.1 Action: KW

Resolved:
The Board noted the proposal for the 2025/26 Integrated Performance Report.

25/26/31 Evidence of Our Performance

Flash Report, M1

The Board received the Flash Report for April 2025. The following points were highlighted:

- There were zero Never Events or new patient safety incident investigations in April 2025.
- There were five healthcare associated infections in Oncology; 4 Cdiff and 1 MSSA.
- 86% of patients were treated in ED within four hours.
- Diagnostic performance for April was 94%.
- There has been an increase in CYP waiting over 52 weeks due to capacity challenges in ENT. Improvement work will take place to address this matter. It was reported that there has been a resignation in the department therefore a review of resources will be undertaken.
- Was Not Brought (WNB) figures are reducing on a quarterly basis (Q4; 8.9%). Work is ongoing to support the reduction of this target to under 8%,

Outstanding Care and Experience – Safe and Caring

- The decline in Friends and Family Test (FFT) figures was resolved in April.
- 91% of PALS concerns were responded to within 5 working days.
- There has been an increase in patients deteriorating from an inpatient bed and admitted to Critical Care. All cases of unexpected admission have been reviewed by the Response Team. Going forward, the Response Team will review patients who have been admitted to Critical Care unexpectedly and identify and share any themes and learning with the Deteriorating Patient Working Group.

- *Cdiff Cases* – The Trust has reverted to using original cleaning products due to a change in the products causing an issue.

Support our People

- There has been a reduction of 55 WTEs in month 1.
- Staff turnover increased in March 2025, primarily due to an increase in fixed term contracts ending in comparison to previous months.
- Sickness absence levels are high, though declining since December. As part at the People Committee actions to support attendance, the return-to-work process is being reviewed and updated.
- The Trust will receive notification of the outcome of the tender for an Occupational Health provider on the 2.5.25.

Financial Sustainability: Well Led

- The Trust is reporting a £3.3m surplus position for 2024/25, in line with plan.
- The full £19.9m CIP has now been achieved in year, with £13.6m identified as recurrent savings. The remaining £5.7m gap will be carried forward into 2025/26.

Community and Mental Health Division

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

Division of Medicine

The Board was advised of a clinical trial that has taken place in respect to a drug that will delay the progression of muscular weakness in patients with Duchenne Muscular Dystrophy. It was reported that there is a gap between evidence coming out of clinical trials and the drug being licenced thus causing a delay in terms of NICE approval and funding. It was reported that the drug company is offering the medication on a free basis, but there is a cost for monitoring the safety of the drug on patients. The approval process is ongoing, and resource costs remain a significant issue, making it a lengthy process. Families have been invited to a meeting at Alder Hey next week to discuss this matter.

Questions were raised and responded to about whether the Trust is in a position to provide clarity in terms of when the drug can be accessed by patients, and whether during the interim period the Trust is covered from a liability perspective ahead of NICE approval.

Attention was drawn to the importance of being transparent about the NICE guidance process, and it was suggested that an information leaflet be compiled for clarity purposes and shared with the respective families ahead of next week's meeting. It was confirmed that the Comms team has drafted a leaflet with a reader friendly/open approach.

The Chair offered thanks for the update and queried as to whether there is anything that the Trust can do to expedite this matter for the families concerned. The Board was advised of the challenges in receiving a rapid decision and the necessity for an improved process for bridging periods (licencing to commissioning). It was confirmed that the Trust will look at what needs to be done to address these issues.

Division of Surgery

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

Resolved:
The Board:

- Noted the Flash Report for M1.
- Noted the content of the IPR for Month 12.

25/26/42 Learning from Patient Safety Incidents, Q4

The Board was provided with a summary of activity during Q4 following the transition to the Patient Safety Incident Investigation Framework (PSIRF) on the 1.1.24. The paper identified areas of system-wide learning, improvement and next steps.

It was reported that MIAA was commissioned to undertake an internal audit into the Trust's PSIRF arrangements to evaluate the operating effectiveness of controls and level of consistency in place for the management, recording, monitoring, and reporting of incidents following the adoption of PSIRF. The review concluded in March 2025 with a 'Substantial' level of assurance and 2 recommendations. The findings were submitted to the Audit and Risk Committee (ARC) who will continue to monitor this area of work.

Resolved:
The Board noted the activity that has been undertaken during Q4 2024/25 following the Trust's transition/embedding of PSIRF, and the next steps.

25/26/43 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 26.3.25 were submitted to the Board for information and assurance purposes.

During April's meeting the Committee agreed the Terms of Reference for the Patient Experience and Engagement Group, received Divisional updates and the outcome of MIAA's audit on patient safety. There was also a focus on the CQC inspections that had taken place in the Community and Mental Health Division.

Resolved:
The Board noted the approved minutes from the meeting held on the 26.3.25.

25/26/44 Artificial Intelligence (AI) Strategy

The Board received the final version of the Trust's AI Strategy which outlines a comprehensive plan to integrate AI into everyday lives at Alder Hey. It was reported that the strategy aims to enhance patient care, empower staff, and transform paediatric outcomes through innovative AI solutions. The following points were highlighted:

- A soft launch of the strategy took place w/c 28.4.25, followed by a lunch and learn session with positive feedback and significant interest received from colleagues.
- It was reported that NHS Providers is publishing an article on the Trust's AI Strategy in May and the national guidance that Alder Hey contributed to will also be published externally.

- The AI Strategy is designed to deliver significant benefits across several key areas. By quantifying these improvements, the organisation can measure success and refine its approach as required.
- The Trust aims to maximise clinical productivity and administrative support through AI automation, fully roll out Lyrebird licences in July, ensuring efficiency. The Trust is also trialling 100 Copilot licences with positive early feedback. The priority is to automate processes, with the patient portal set to go live later in 2025.
- A comprehensive investment plan for the delivery of the strategy will be developed. The investment will cover the necessary resources to deliver on the strategy, including infrastructure, staff training, and project implementation.

A discussion took place about the investment that will be required to drive the strategy forward. It was reported that a sub-group of the Futures Committee will come together to look at opportunities, partner involvement, and non-recurrent investment.

Questions were raised and responded to in relation to data protection/GDPR issues and the deploying of AI to reduce errors, the arrangements in place if the organisation's Emergency Preparedness, Resilience and Response (EPRR) digital system failed, and the plans for initiating conversations about the opportunities for linking systems with GP practices and primary care.

Resolved:
The Board approved the AI Strategy and noted the next steps in terms of resource planning and benefits realisation.

25/26/45 People Plan Strategic Update

The Board received an update on the progress that has been made against core workstreams of the People Programme. The following points were highlighted:

- As of the 1st of April, the Trust has launched a new Performance and Development Review (PDR) process supported by associated training and guidance documents. The feedback from staff to date on the new approach is positive
- It was reported that the EDI Lead, Angie Ditchfield, now works full time for the Trust as of the 1.5.25. This will provide scope for a lot more work to take place in this space.
- Reference was made to April's landmark Supreme Court judgment that established that the terms 'man' and 'woman' in the Equality Act 2010 refer to biological sex rather than gender identity. The Trust has received advice from Capsticks regarding the implications of this case along with interim guidance, but it was pointed out that the Trust's facilities and the way it delivers care is already inclusive. The organisation wants to ensure that the outcome of the legal case doesn't change the way in which it supports service users/staff therefore the Trust will review its policies and assess as to whether anything needs to be altered. It was agreed to provide an update once further guidance has been published.

25/26/45.1 Action: MS

Non-Executive Director, Garth Dallas, referred to the Reciprocal Reverse Mentoring Programme and informed the Board that the staff networks have

advised that the title of the programme should be changed to the Mutual Mentoring Programme. It was also reported that the EDI Lead has been actively involved in the work that is taking place in the Liverpool City Region on the Anti-Racism Strategy.

Resolved:
The Board noted the People Plan strategic update.

25/26/46 Freedom to Speak Update

The Board was provided with a summary of the activities of the FTSU team for 2024/25 including Q4 data and an outline of the actions planned for the coming period. The following points were highlighted:

- The data in the report demonstrates a slight increase in staff using FTSU to raise concerns, however during Q1 and Q3 there was a decline in reporting numbers which in part can be attributed to the FTSUG being on annual leave and therefore not visible. With the appointment of the Deputy FTSUG, reporting numbers are expected to remain similar each quarter.
- Based on data reviewed from the NGO portal and the Northwest, Alder Hey is reporting some of the highest number of cases, which may indicate the confidence staff have in raising concerns via this route
- In Q4 there are 29 open cases and 7 that have been closed. Of the 29 cases open, 14 are pending closure following a final meeting or email correspondence to confirm agreement with the decision to close. The remaining 15 cases are all complex active cases that require increased support and sensitivity. It was reported that 3 members of staff who used the post closure process advised that they didn't feel safe from a psychological perspective.
- *Staff Survey Results* - Q25e (I feel safe to speak up about anything that concerns me in this organisation) saw a slight decrease, however the national picture (72.15%) also saw a decrease from 2023, which was 73.98%.
- Collaborative efforts with the Network Chairs are ongoing, and the FTSU app went live last week.
- Speak Up training is now mandatory and is currently compliant at 98.19%.

A suggestion was made about combining the FTSU app with the CYP As One app, and it was queried as to whether there is any data that maps themes in terms of concerns by staff group that can be included in the quarterly FTSU report. It was agreed to include this information in the next report, but it was pointed out that the data will relate to all staff groups and not just nursing.

25/26/46.1 Action: KT

Reference was made to the data in the report relating to claims of sexual harassment made by staff. It was felt that it is this is a positive response following the launch of the Trust's Sexual Safety Strategy. A suggestion was made about closing the loop with HR/Safeguarding and consolidating efforts.

Resolved:
The Board received the FTSU report for Q4.

25/26/47 Freedom to Speak Up Review Tool for Boards

The Board received the completed annual FTSU improvement tool for boards. The document provided a comprehensive overview, highlighting key developments from the previous year. It reflected positive outcomes in terms of integration. Moving forward, the primary focus should be on measuring the effectiveness of training, communications, and other related areas. Although the Trust doesn't have a standalone strategy specifically for this purpose, FTSU is incorporated within the People Strategy.

A debate took place about having a standalone FTSU Strategy and it was agreed to continue with the approach that has previously been approved especially as FTSU is to be included at the heart of the Trust's cultural plan which is to be launched in the near future.

Resolved:
The Board received the completed annual FTSU improvement tool.

25/26/48 Statement of Going Concern for the 2024/25 Annual Accounts

A review of the Trust's going concern status has been undertaken in the preparation of the 2024/25 accounts. Given the strong liquidity status of the Trust, its overall cash position, and its status in terms of the draft plan submitted for 2025/26, it is proposed that the Trust does meet the criteria for the 2024/25 accounts and associated financial statements to be prepared on a Going Concern basis.

It was reported that ARC reviewed this proposal in April 2025 and supported this view. The Chair of ARC advised that there were no issues raised by Ernst and Young with regard to the 2023/24 annual accounts and associated financial statements being prepared on a Going Concern basis.

Following discussion, the Trust Board confirmed its support and recommended that the 2024/25 annual accounts and associated financial statements should be prepared on a going concern basis.

Resolved:
The Board consider it appropriate for the Trust to prepare its 2024/25 financial statements on this basis.

25/26/49 Audit and Risk Committee

The approved minutes from the meeting held on the 16.1.25 were submitted to the Board for information and assurance purposes.

During June's meeting the Committee received an update on the outcome of the first internal audit of the Patient Safety Incident Response Framework (PSIRF) which resulted in 'Substantial Assurance' with 1 Medium and 1 Low risk rated recommendation. The Internal Audit Annual Plan for 2025/26 was approved, and 3 audits were left unallocated at this stage to enable the Committee to respond to changes in, and requirements of, the external environment. It was also agreed that a deep dive of Cybersecurity and the Lessons Learned from the iDigital Partnership will be presented to ARC in July.

Reference was made to the investigation that took place with NHSE and their partners following a recent cyber-attack. It was confirmed that the attacker did not gain access to any of Alder Hey's data and there was nothing published unlawfully. There was no clinical or operational impact to the Trust's services as a result of the incident and a press statement has been published for completeness. It was agreed to share a copy of the press release with the Trust's governors.

25/26/49.1 Action: KW

Resolved:
The Board noted the approved minutes from the meeting held on the 16.1.25.

25/26/50 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 25.3.25 were submitted to the Board for information and assurance purposes.

During May's meeting the Committee focused on an additional request that was received from Chesire and Merseyside Integrated Care Board (C&M ICB) for extra resources beyond the Trust's agreed annual plan due to a shortfall in the ICB's year-end figures and a 'fair share' adjustment. The Committee discussed its response to this request, noting that this additional sum is beyond the Trust Board's original maximum realistic commitment.

It was reported that significant improvement work will need to be undertaken to address the figures, and a review will take place at the end of May to look at opportunities and to see where the additional resources could come from. It was agreed to submit an update to the Board in June to provide clarity on the implications of the ICB's request and what it means for the Trust.

25/26/50.1 Action: RL

2024/25 Top Key Risks (M1)

The Board was advised of the latest position of the 2024/25 Finance, Transformation and Performance Committee's key risks.

Resolved:
The Board noted the approved minutes from the meeting held on the and the update on the Committee's top key risks in M1.

25/26/51 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:

- A number of risks have been updated to reflect the current year's financial challenges, including impact on patient safety which has been explicitly stated for the first time.
- A further review of the risk relating to the Gender Service will be undertaken especially in light of a forthcoming national trial that will explore the effects of puberty blockers on young people with gender incongruence and/or gender dysphoria.

- A review of the risk relating to the shortage of ADHD medication is to take place with a view to possibly reducing the risk rating.

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

25/26/52 Any Other Business

There was none to discuss.

25/26/53 Review of the Meeting

The Chair offered thanks to everyone for their contributions during the meeting. It was pointed out that the key message is to maintain a focus on growth and efficiency whilst ensuring that staff are aware that it is also about improving the service that the Trust provides to its patients.

Date and Time of Next Meeting: Thursday 5.6.25 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 June 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	Jun-25	**3.4.25** - An update will be provided during June's Board. **ACTION TO REMAIN OPEN**
6.6.24	24/25/83.1	2023/24 Annual Submission to NHS England North West Framework for Quality Assurance and Improvement	Covering report sheet to be more specific to identify actions that are important versus business as usual.	A. Bass	Jun-25	On track Jun-25	
3.4.25		Staff Story	Liaise with the Conflict in Compassion Team to see what support can be given to prepare for future complex patient cases.	A. Bass	Jun-25	On track Jun-25	
3.4.25	25/26/10.1	Gender Service National Provider Network - Memorandum of Understanding	Compile a short paper advising of the actions that the Trust needs to undertake in respect to Alder Hey's responsibilities as a member, as detailed in page 2 and 3 of the report, and submit it to SQAC for assurance purposes.	L. Cooper	Jun-25	On track Jun-25	
1.5.25	25/26/49.1	Audit and Risk Committee	Circulate the press release to the Trust's governors relating to the recent cyber attack.	K. Warriner		On track Jun-25	
Actions for July 2025							
1.5.25	25/26/30.1	2025/26 Integrated Performance Report (IPR) Proposal	Submit a final version of the IPR in June, noting the request by governors for a reader friendly version of the document.	K. Warriner	Jul-25	On track July-25	
1.5.25	25/26/45.1	People Plan Strategic Update	Landmark Supreme Court Judgment - Provide an update on the implications of this case for the Trust once further guidance has been published.	M. Swindell	Jul-25	On track July-25	
Actions for September 2025							
5.9.24	24/25/149.1	Wellbeing Guardian Dashboard	Integrate Freedom To Speak Up in the next iteration of the Wellbeing Guardian Report.	J. Revill	Sep-25	On track Sep-25	
7.11.24	24/25/214.2	Integrated Performance Report	Invite the family of a patient who were supported by the Wellbeing Hub, to a future Board meeting to share their story.	D. Jones/ K. McKeown	6.2.24	Sep-25	**31.1.25** - The family advised that February is too soon for them to attend Board to share their story. Contact will be made with the family again in six month's time. **ACTION TO REMAIN OPEN**
1.5.25	25/26/46.1	FTSU	Include data that maps themes in terms of concerns by staff group, in the next quarterly report	K. Turner	Sep-25	On-track Sep-25	
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							

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
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
1.5.25	25/26/50.1	Finance, Transformation and Performance Committee	Submit an update to the Board in June to provide clarity on the implications of the ICB's request for additional resources beyond the agreed annual plan and what it means for the Trust.	R. Lea	Jun-25	Completed	**30.5.25** - An item has been included on June's agenda relating to this action. **ACTION CLOSED**

BOARD OF DIRECTORS

Thursday, 5th June 2025

Paper Title:	**Beyond Programme Annual Report, 2024/25**
Report of:	**CYP Transformation Programme Director**
Paper Prepared by:	CYP Transformation Programme Director

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

beyond

Children and Young People's Transformation Programme

Cheshire and Merseyside Health and Care Partnership

Beyond Programme

Annual Report 2024/25

Contents

Message from a Young Person

"Working with the Beyond team has given me incredible opportunities I never imagined. Initially, I joined to gain campaign experience and make a difference, but it became so much more. Collaborating with diverse peers, we shared stories and developed solutions for young people facing similar struggles.

Presenting our ideas at the Cheshire and Merseyside CYP Committee meeting was both nerve-wracking and inspiring, leading to work experience with Alder Hey's Communications team. Further workshops opened doors to a placement with Kaleidoscope, deepening my understanding of graphic design and the professional world.

Speaking at the NHS England CYP Showcase further built my confidence thanks to the support of Mel and the welcoming environment of Beyond. I'm incredibly grateful for these experiences and excited to see where they take me next."

Izzy Gavin
Young Person, 19

Executive Summary

Beyond has continued to focus on transformational delivery across Cheshire and Merseyside (C&M), prioritising early intervention and prevention to address the impact of health inequalities for our children and young people (CYP). Key programmes of work align to both national and local policy drivers. Alongside existing workstream delivery, Beyond has continued to support system transformation work.

- **System governance has embedded during 2024/25.** The Children's Committee is well established and its key priorities align with Beyond delivery. Beyond supports system oversight through the Single Line of Sight report with colleagues across the ICS. It is central to development and co-ordination of strategic plans for CYP, working with the ICB on HCP strategy, joint forward planning, and commissioning intentions.

- **Beyond has made strong links with the ICS Data into Action programme** to promote the needs of CYP. Improved reporting of metrics and key performance indicators has enabled further development of the evidence base to show impact and improved outcomes.

- **Children's voice and influence continue to expand**, with young people actively participating in the Children's Committee, the Beyond Board, the Health Equity Collaborative, and the Annual Conference.

- **The CYP Voice & Influence campaign has made significant progress**. Beyond is working in partnership with Edge Hill University to roll out iSupport standards across all sectors, ensuring broader implementation and impact.

- **The All Together Smiling Supervised Toothbrushing programme has been mobilised across all nine Places in Cheshire and Merseyside.** 232,535 toothbrush and toothpaste packs have been delivered to Place teams to support children aged 2-7 years, living in our most disadvantaged communities.

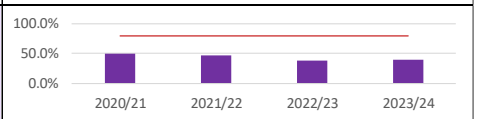
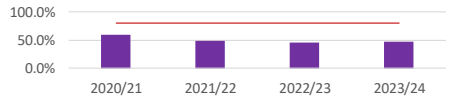
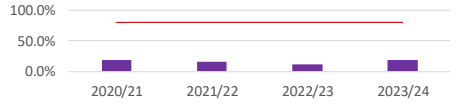
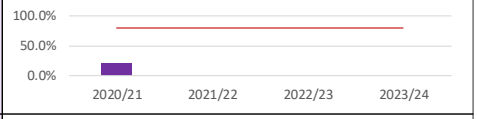
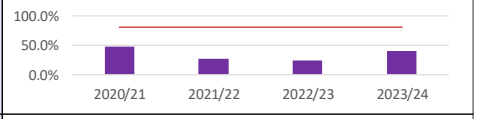
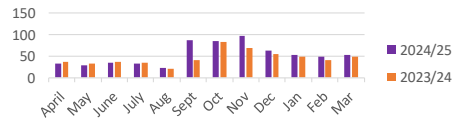
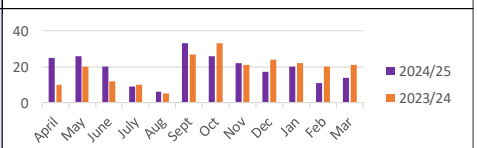
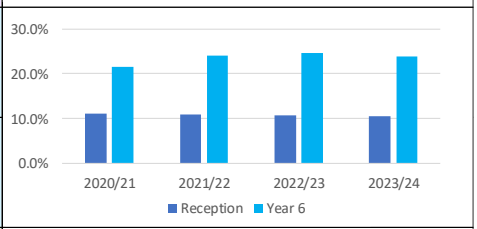
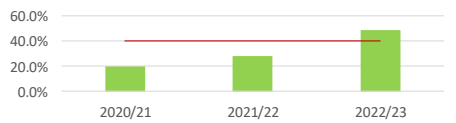
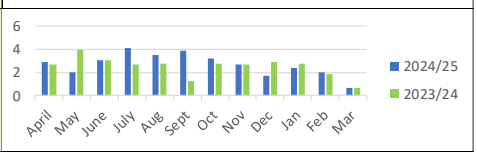
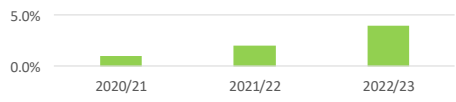
- Beyond has **continued to support the Neurodiversity (ND) Pathway** programme through the provision of programme management and support of programme evaluation.

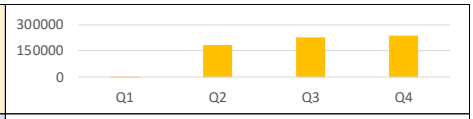
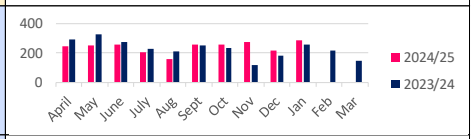
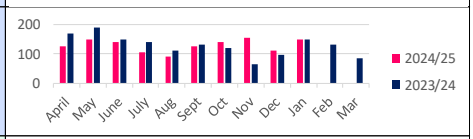
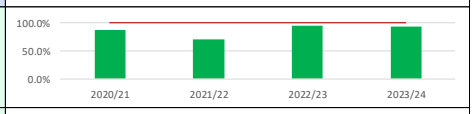
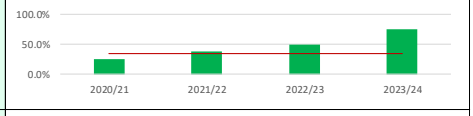
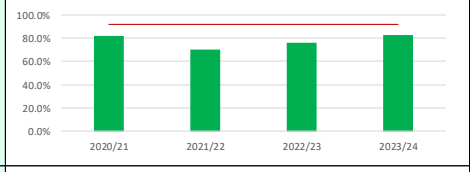
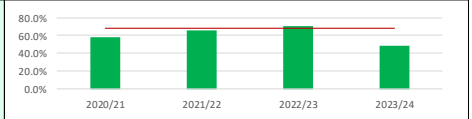
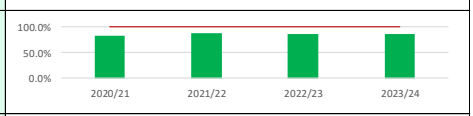
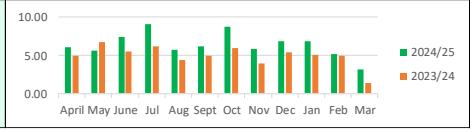
- **Appropriate Places of Care (APoC) is continuing to support CYP with complex multi-agency needs.** A regional proposition and business case were presented to the ICB Children's Committee in November which was accepted in principle. The work continues in providing leadership, oversight, and assurance on APoC developments across Cheshire and Merseyside.

- **15 programmes of work concluded** this year with sustainability plans in place. All ongoing project delivery is on track within agreed tolerances. Comprehensive delivery plans have been developed for 2025/26.

High-Level Metrics

Evaluation is ongoing and outcomes are being tracked, with further details in the body of the report.

Workstream	Metric	Trend
Respiratory	Increase % of CYP (6-18) with steroids administered within 1 hour of arrival (KPI1)	
	Increase % Children seen acutely in secondary care settings who have inhaler technique checked (KPI4)	
	Increase % Children seen acutely in secondary care settings who have tobacco dependancy addressed (KPI2)	
	Increase % Children seen acutely in secondary care settings whose parents smoke have parents who have tobacco dependancy addressed (KPI3)	
	Increase% Children seen acutely in secondary care settings who have a written asthma management plan at discharge (PAAP) (KPI5)	
	Reduction in number of CYP attending A&E with asthma exacerbations (number of asthma attendances) - per 100k	
	Reduction in the number of emergency attendances leading to admissions due to asthma exacerbations	
Healthy Weight & Obesity	Reduction in percentage of children aged 4-5 (Reception) classified as obsese (including severe obese)	
	Reduction in percentage of children aged 10-11(year 6) classified as obsese (including severe obese)	
Diabetes	Increased % of patients using diabetes related technologies - CGM and Pumps	
	Reduction in emergency diabetes admissions (due to DKA) per 100k	
	Reduction in CYP with Type 2 Diabetes	

Oral Health	Number of oral health packs delivered *Tiny Teeth + All Together Smiling*	
Mental Health & EWB	Reduction in CYP emergency attendances due to mental health	
	Reduction in CYP emergency attendances due to self harm	
Epilepsy	Increased percentage of CYP with epilepsy with input by epilepsy specialist nurse within the first year of care	
	Increased percentage of CYP with epilepsy and a mental health problem who have evidence of mental health support.	
	Increased percentage of CYP with epilepsy after 12 months where there is evidence of a comprehensive care plan that is agreed between the person, their family and/or carers and primary and secondary care providers.	
	% of CYP meeting defined criteria for paediatric neurology referral, with input of tertiary care and/or CESS referral within the first year of care	
	Overall proportion of trusts contributing to Epilepsy12	
	Reduction in unplanned hospital admissions for CYP with epilepsy, per 100k	

Sustainability

Key programmes of work have been delivered during 2024/25 with a number of funded projects ending in March 2025. The approaches piloted in these programmes have been evaluated to measure impact and outcomes and, together with the priorities in the NHS 10-year plan, they will shape programme delivery moving forward. The outcomes of completed projects have been shared to support learning. Where positive impact has been seen, this has been shared with a view to formal roll-out of delivery across the region and embedded within commissioning and delivery.

Sustainability of programmes of work is detailed below.

Workstream	Programme of Work & Outputs	Sustainability/Roll-Out
Respiratory and Asthma	Parent Champions: • Little Lungs • Breathe Buddies (St. Helens)	Breathe Buddies has been commissioned for 25/26 though HCP funds. Learning has been collated from all models and shared through the Beyond Board and wider networks.
Emotional Wellbeing and Mental Health	Team of Life	Trained professionals now use the Team of Life approach to benefit CYP on an ongoing basis. The provider is developing a package for schools to support adoption including training for senior leaders and staff not directly involved in delivery.
Learning Disability, Difficulty and Autism/ Neurodiversity	CYP Complex Needs Escalation and Support Tool (CNEST): Training Children's Social Care	CNEST embedded within multi-agency delivery and as part of Gateway meetings.
	Sensory Friendly Environments in Urgent Care	Resources and social stories available in support of patients. Training available for staff across the Trust.
	Sensory Friendly Settings in Colleges	College environment adapted. Learning from this project shared via: • Cheshire West and Chester Post-16 Forum • Cheshire East Post-16 Forum ALS Network (with over 40 FE providers)
	Sleep Service - Support of Neurodiverse CYP	Learning informed the development of the sleep project to meet the expectations of the CYP MH Plan.
Healthy Weight and Obesity	The People's Health Project	Each school received tailored recommendations to sustain outcomes. Learning has informed plans to support CYP with learning disabilities and autism.

	Halton Healthy Lifestyles App	Project continuing in Halton. Costs for RSPH funded through Halton Public Health, and the Health Improvement Team will continue to deliver courses.
	Why Weight to Talk	Food Active delivering WWTT in Cheshire and Merseyside supporting NHS and affiliated staff.
Epilepsy	Levelling Up	Both pilot sites have embedded the 1.0 WTE epilepsy nurse into business as usual.
	Psychology Adding Value – Epilepsy Screening (PAVES)	Project evaluation did not support continued delivery of the model, but learning has been taken to inform the 2025/26 plan to address the mental health and wellbeing of CYP with epilepsy.
Diabetes	NHSE Technology Pilot	Patients now offered CGM and Hybrid Closed Loop (HCL) as part of ongoing care.
Oral Health	Tiny Teeth (Early Intervention Pilot)	All Together Smiling mobilised for 3-year supervised toothbrushing approach across all 9 Places.
Paediatric Network	Family Support Workers in A&E Pilot (Ormskirk General District Hospital)	Barnardo's is assessing the individual position of each site involved in the pilot programme to identify any opportunities for extending delivery.
	MH Champions in Acute Settings	All eight champions in post. Additional funds identified for 2025/26.

Background

Beyond continues to deliver system transformation and programmes of work with a population health focus across key priority areas. We work across the HCP in partnership with Local Authorities, health providers, and the voluntary, community and social enterprise (VCSE) sector to promote a focus on children's early intervention and prevention. Multi-agency leadership and representation is woven throughout the programme governance, with Public Health, Directors of Children's Services (DCS), and ICB Place Directors working as key partners on the Beyond Board and a Local Authority Chief Executive acting as chair.

Children, Young People, Parent and Carer Involvement

Beyond is committed to amplifying the voices of children, young people, parents and carers across the ICS and is embedding co-production into planning and delivery.

Beyond has worked directly with young people to ensure their voices are heard and valued in decision-making and has adopted the Lundy Model of Child Participation across all workstreams. This work has been undertaken in partnership with Youth Focus North West and has strengthened our commitment to co-production.

Key successes include:

- Lundy training has been provided to 75 colleagues (including senior leadership) to ensure that children's voices are considered within strategic design and delivery. Over 200 Lundy conversations and activities have been undertaken.
- Four young people remain as Child Health Equity Champions (CHEC).
- Young people are actively supporting the design and delivery of the #Beyond25 Annual Conference, providing keynote speeches, co-leading breakout rooms, and providing animations and stories that will be spotlighted at the conference.
- Beyond is working collaboratively with the Mental Health Programme, Transforming Care, and SEND to standardise participation, ensure links with existing groups, and support meaningful engagement. The previous stocktake of participation groups undertaken by the Point of Care Foundation will be refreshed to support co-production. Local authorities and the VCFSE sector are being included to ensure full representation.

NHS 10-Year Plan

Beyond gathered the perspectives of young people and the professionals working with them as part of the ICB consultation response to the 10-year plan. This consultation used resources from the Royal College of Paediatrics and Child Health for the young person consultation and the "workshop in a box" materials published nationally for the workforce consultation. Three hundred and eighty-six responses were received, 73 of which came from children and young people. Young people were clear about the benefits and challenges of access to NHS care and presented key ideas for change (further info is available in Appendix 3).

CYP Voice and Influence (V&I) Campaign

During 2024/25, Beyond consulted with 65 children and young people to understand their experience of meeting with professionals to access support. Many young people told us that they felt invisible or that doctors primarily addressed their accompanying adults.

The findings were presented to the Children's Committee who supported the development of a co-produced campaign to develop clear standards and training to address these concerns and to enable young people to feel heard, included, and respected during appointments across all sectors. Review of existing delivery programmes identified iSupport[1] as a programme with an established, co-

[1] iSUPPORT: International collaborative rights-based standards to SUpport Paediatric Patients during clinical procedures by Reducing harm and establishing Trust. ISUPPORT

produced approach to children's involvement within health settings. Beyond will be working in partnership with iSupport to develop this as a regional, cross-sector approach during 2025/26.

Health Inequalities

Beyond continues to focus on "shift-left" via integrated early intervention and prevention that addresses the wider determinates of health and social outcomes, including CORE20+5 CYP. The programme is linked to the "All Together Fairer" Marmot programme in relation to the wider determinants of health inequalities and is involved in the Child Health Equity Collaborative (CHEC).

Beyond is supporting the regional Child Poverty Agenda led by CHAMPS and DPHs, with the ambition that no child in Cheshire and Merseyside lives in poverty. This work is developing a regional strategy alongside the national cross-government child poverty strategy expected in Spring 2025.

Children's Health Equity Collaborative (CHEC)

During 2022-23, Beyond successfully supported a system-wide bid for a CHEC in partnership with Barnardo's, the Institute for Health Equity, NHS South Yorkshire, and NHS Birmingham and Solihull.

CHEC Framework

During 23/24, partners developed the CHEC Framework for the Drivers of Health Inequalities in consultation with children and young people, gathering insights on what mattered most to them[2]. Four young people from Cheshire and Merseyside were recruited as CHEC Champions and continue to work alongside the programme.

Data and Insights

Data-driven work has focused on the prioritisation of indicators within the CHEC Framework to measure child health equity within each domain. A data stock-take identified sources of publicly available and routine data from across health and social care. Work continues regarding data sharing to support collation into meaningful dashboards.

Cheshire and Merseyside Intervention

A 12-month pilot intervention was identified to address key drivers of health inequalities based on data indicators and focused on population need. Delivered in partnership with the Dolly Parton Imagination Library, this public health initiative targets teenage parents and infants in Liverpool who are known to the Family Nurse Partnership, and supports them to improve literacy confidence, skills and school readiness through storytelling and book gifting. The intervention has formally launched, and participant recruitment and baseline assessments are underway.

[2] The Child Health Equity Framework for the Drivers of Health Inequalities - IHE (instituteofhealthequity.org); Children and Young People Health Equity Collaborative - IHE (instituteofhealthequity.org)

Programme Delivery 2024/25

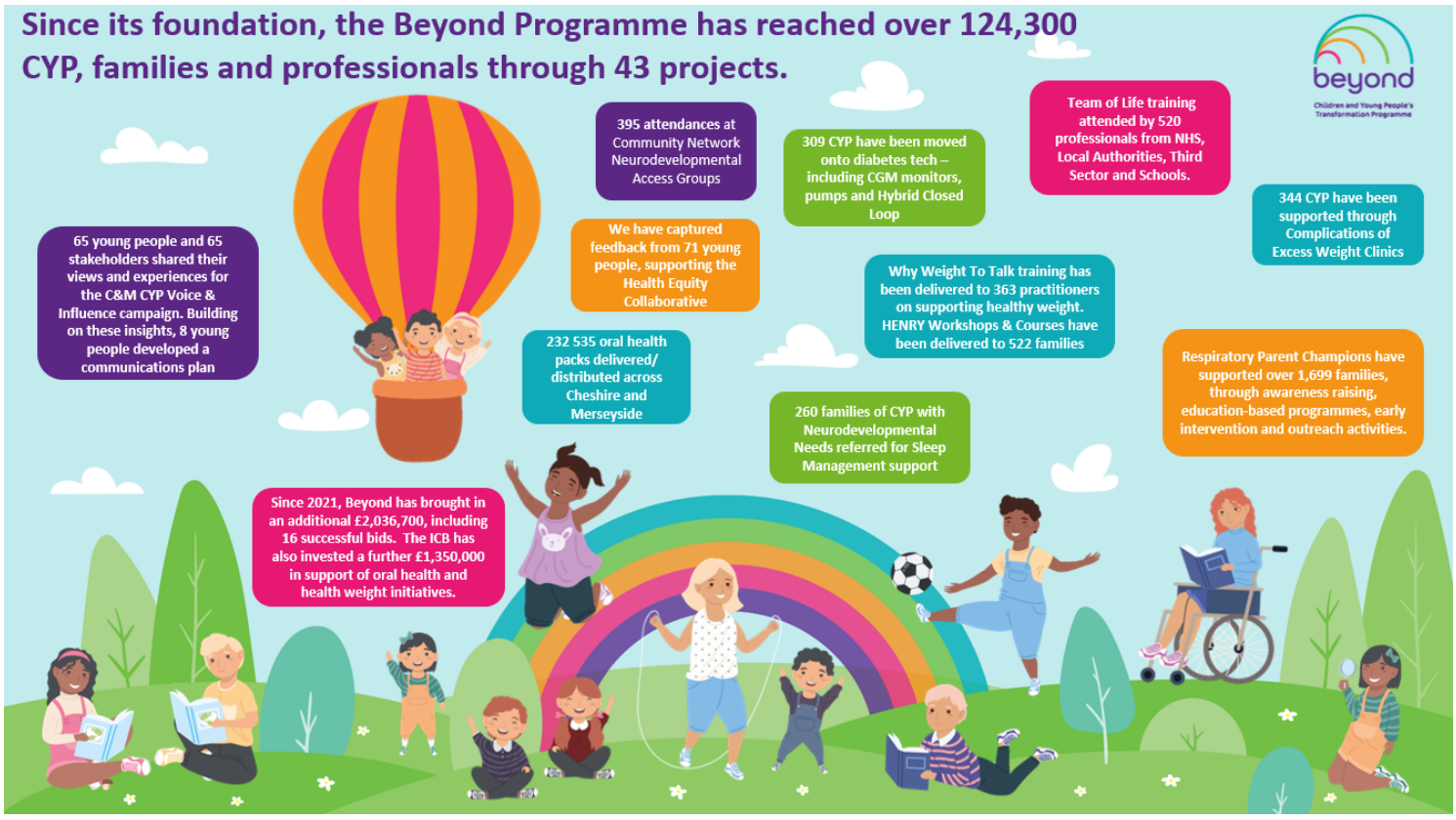
Programme Reach

Key programmes have continued, working with dedicated clinical and organisational leadership to ensure focus on delivering transformational quality improvement.

Programmes delivered since the inception of Beyond have been consolidated, with lessons learned integrated into the mobilisation of new projects. Prioritisation continues to be evidence-led, based on data insights, risk stratification, and CORE20+5 CYP. Programmes are delivered across all Place areas.

Since its inception, Beyond has reached over 124,000 children, young people and those who support them, representing a reach of 64,400 in 2024/25. In addition, we have delivered 232,535 "All Together Smiling" oral health packs to children and families across Cheshire and Merseyside.

Existing planned delivery means that the programme will have reached at least 240,800 CYP by the end of 2025/26 and we will have delivered a total of 586,295 oral health packs.



Respiratory

The national bundle of care for CYP with asthma was published in September 2021 and provided a series of standards to help integrated care systems to improve health outcomes for all CYP with asthma.

Programmes of Work

- **INTENT:** Ensuring that teachers have access to appropriate resources to support CYP to "stop the start" of smoking and vaping.
- **Respiratory Parent Champions:** Providing peer support to families with CYP with, or at risk of, respiratory disease in partnership with the voluntary, community and faith sector (VCFS).
- **Asthma Friendly Schools:** Improving outcomes for children living with chronic asthma and enabling schools to meet agreed standards of care.
- **Respiratory Hubs:** Community-based teams providing assessment, diagnosis and management plans for children with chronic respiratory symptoms, providing early and accurate diagnosis and a bridge between A&E, primary, and secondary teams.
- **Digital Health Passports:** A personal health record app to help patients improve their management of asthma, allowing CYP, parents and carers to take ownership of their care.
- **Asthma Training:** Roll-out of NHSE eLearning for Health Tier 1-3 training.
- **Enhancing Asthma Care in Primary Care:** Training primary care colleagues to deliver enhanced annual reviews incorporating Personalised Asthma Action Plans (PAAPs), inhaler technique checks, and exploration of extrinsic factors (mould, smoking, vaping, etc.), and supporting them to risk-stratify patients for review based on number of SABAs.
- **Discharge from Secondary Care:** Discharge document to standardise discharge to include PAAPs, inhaler technique checks, and smoking cessation signposting for CYP and/or parents and carers.

Outcomes and Impact

- **INTENT:** 52 schools and one youth worker setting signed up to participate. 77 staff completed training over the lifetime of the programme. Smoking sessions were delivered to 5,222 CYP and vaping sessions delivered to 236 CYP[3].
- **Parent Champions:**
  - Little Lungs (Wirral) supported 129 parents/carers and professionals (1,008 since launch), reducing A&E attendances. The project has now closed.
  - Breathe Buddies (St. Helens) supported 375 parents/carers (735 since launch). Further funding has been identified locally to extend the project throughout 2025/26. Nine parent champion volunteers were recruited. Workshops were delivered to 26 CYP in two schools. Now affiliated with Asthma & Lung UK (ALUK).
- **Asthma Friendly Schools:** 171 schools are working towards accreditation and seven schools are accredited to improve asthma safety in schools and reduce missed school days. 62% of schools working towards accreditation have completed training.
- **Respiratory Hubs:**
  - St Helens: 178 CYP seen, six follow-ups following commencement of new medication, and 119 onward referrals for housing support.
  - Warrington: 29 CYP seen.
  - Halton: 5 CYP seen.

Warm Homes for Young Lungs

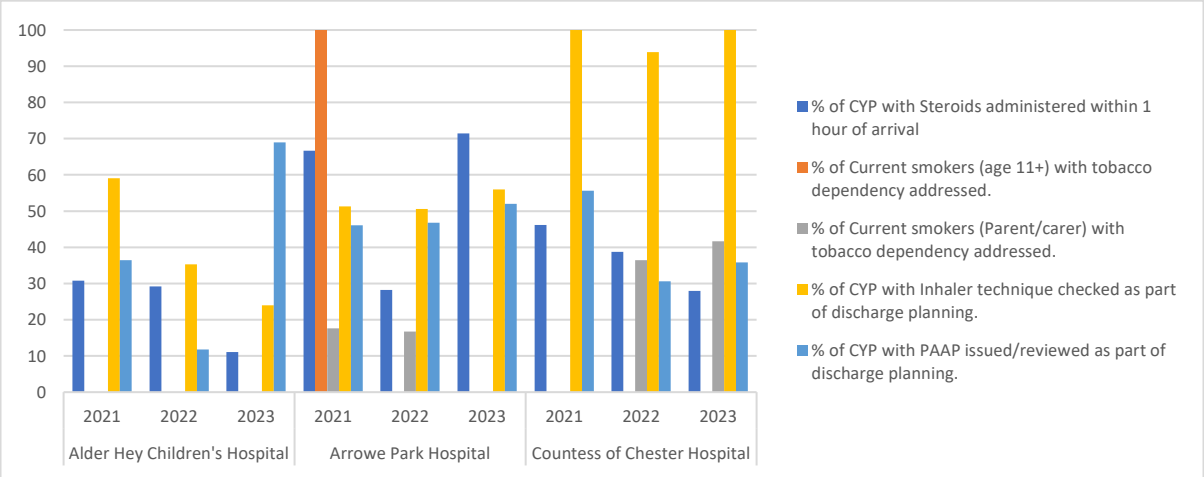
A 4-year-old boy was highlighted via CIPHA as having 22 SABAs in 12 months, with an admission in 2022 requiring cannulation and oxygen. Mum has health anxiety around his respiratory health since then, having inhalers in every location. On review in February 2024, PAAP and roles of medication were discussed with mum and inhaler technique was checked. They were referred to Breathe Buddies (Parent Champions) for peer support and mum now feels confident symptoms are well-managed. Damp in the home was assessed and the family were deemed eligible for the household support fund to support with heating costs. He was referred to the GP for advice and medication for eczema and allergies. No further admissions were recorded and SABA used was reduced.

- **Digital Health Passport:** Now mobilised and has 303 downloads with 1,862 interactions. It is the most downloaded app on the ORCHA App Library for Cheshire and Merseyside for Nov-Feb (2024/25). 51.53% of downloads are from IMD 1 and 2.
- **Asthma Training:** 1,247 individuals completed Tier 1 asthma training, three respiratory nurses completing Tier 4 training, and 16 practitioners attended spirometry training.
- **Enhancing Asthma Care in Primary Care:** A comprehensive workplan has been developed to address priority areas identified through data analysis. 461 individuals were trained during

[3] These figures are based on the number of surveys completed; the actual number may be higher if surveys have not been submitted.

the 2024/25 via Protected Learning Time (PLT) sessions. A pilot initiative has been launched within a Liverpool PCN, offering diagnostic testing and ongoing monitoring for CYP identified through risk stratification searches. These CYP have now received an enhanced annual review and been issued with a PAAP.

- **Pharmacy Project:** Worked with 35 pharmacies in areas with high levels of prescribing of short-acting beta-2 agonists (SABA) inhalers to increase monitoring of inhaler techniques and improve asthma management. 152 CYP were reviewed and 77 were invited for follow-up. This project has closed.
- **Discharge from Secondary Care:** A discharge bundle was developed in response to scoping work with secondary care to address challenges in completing the NRAP audit. The bundle aims to improve the delivery and recording of inhaler technique checks and PAAPs whilst addressing key audit areas such as extrinsic factors (cold, mould, damp, smoking, vaping, allergens), medication adherence, and signposting.
    - The bundle was piloted in three trusts:
        - Countess of Chester Hospital NHS Foundation Trust (April 2024)
        - Wirral University Teaching Hospital NHS Foundation (April 2024)
        - Alder Hey Children's Hospital NHS Foundation Trust (August 2024)
    - Improved delivery and recording of inhaler technique checks and PAAPs has been noted in pilot sites. The number of cases reported to NRAP has increased, improving data accuracy.
    - Improvements have been noted in identification and management of extrinsic factors as evidenced in the NRAP KPI regarding smoking status of CYP and parents/carers.



Completed Projects

Inhaler Technique Reviews in Pharmacies

Building on a successful pilot in Greater Manchester, the inhaler technique review service, delivered by pharmacists or registered pharmacy technicians, was piloted in four Place areas (Cheshire East, Liverpool, St Helens, and Knowsley). The service focused on children aged 16 and under who used inhaled medication and included inhaler technique review, disease control assessment, and health promotion. Patients without a PAAP were directed to their GP.

Payment schedules were identified and CHL Healthcare was commissioned to manage contracts on behalf of Beyond.

- 80 pharmacies engaged.
- 35 pharmacies delivered.
- 152 CYP reviewed.
- 77 CYP offered follow-up.

Outcomes

The project did not provide the level of reach needed due to conflicting priorities within pharmacies e.g. vaccine programmes and the launch of Pharmacy First. It was noted that pharmacies co-located within GP surgeries demonstrated better engagement.

Little Lungs Parent Champions

Delivered by Koala North West, the initiative provided peer-led support, awareness raising, and direct engagement with families in managing respiratory conditions such as viral wheeze, asthma, and croup, particularly those in high-need areas.

- 610 one-to-ones were held with parents/carers.
- 294 families received onward referrals.
- 52 families received telephone support.
- 5,255 outreach contacts were made in the community.
- 55,614 social media interactions took place across multiple platforms.

Outcomes

- Improved access to respiratory health information for families in deprived areas.
- Strengthened community engagement through parent champions with lived experience.
- Enhanced links between families and local health, social care, and voluntary services.
- Greater awareness of good inhaler technique and the impact of external factors (e.g. cold, mould, damp) on respiratory health.

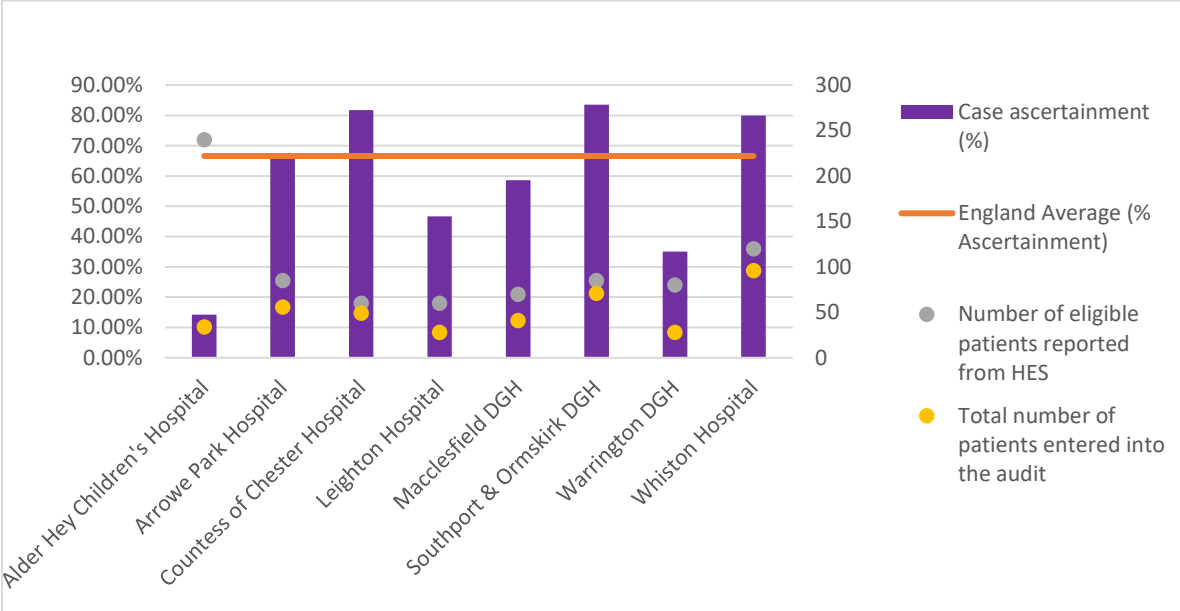
Sustainability

Despite the project's positive impact, financial sustainability proved challenging. Both Wirral and Cheshire West were unable to commit to further funding.

KPIs and Workstream Metrics

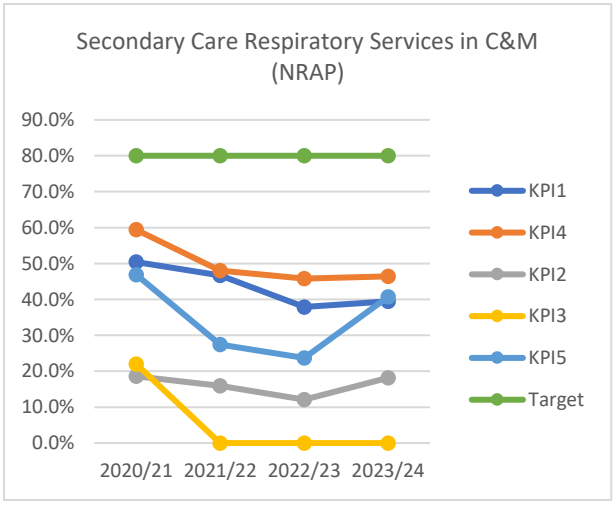
The workstream monitors data to ensure progress is being made to improve outcomes for children and young people. Progress is monitored via several sources: National Respiratory Audit Programme (NRAP) in secondary care, emergency hospital attendances and admissions due to asthma, and respiratory exacerbations from Secondary Uses Services (SUS) data, as well as primary care activity.

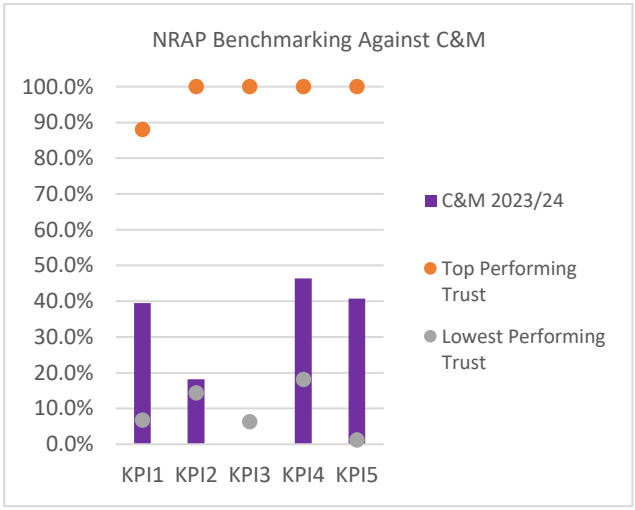
Integral to data reporting is the case ascertainment of the annual NRAP by individual trusts. Trusts have been noting issues with capacity for completion of the audit and the trend for completion varies across Cheshire and Merseyside. However, quarterly reporting has shown a 48% increase in case ascertainment in 2024/25.



NRAP monitors respiratory services within secondary care through five KPIs:

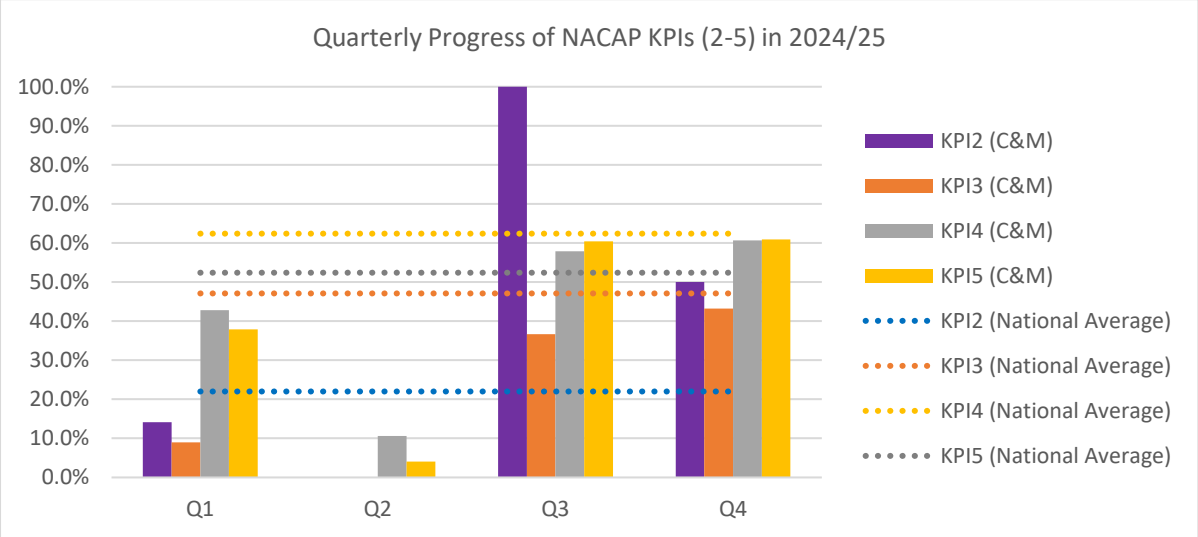
- KPI 1: Steroids administered within 1 hour of arrival
- KPI 2: Current smokers (patients 11+) with tobacco dependency addressed
- KPI 3: Current smokers (Parent/carer) with tobacco dependency addressed
- KPI 4: Inhaler technique checked as part of discharge planning
- KPI 5: Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning





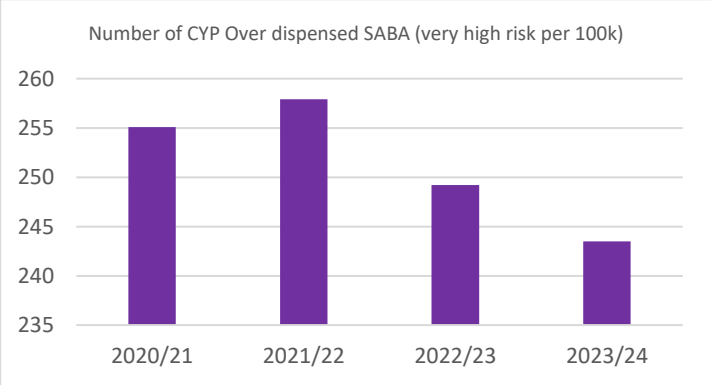
Data quality for key areas of the respiratory bundle continues to be challenging due to inconsistency in data reporting causing issues when reviewing data trends. 2023/24 results from Cheshire and Merseyside Trusts have been benchmarked against the highest and lowest performing trusts in England and Wales and show that significant improvements are still required across key areas of delivery. Significant drops in reported performance were noted post-COVID and, whilst rates have stabilised, work is still required to improve delivery.

Targeted work in secondary care is being undertaken to address issues. The TAPES bundle has been implemented, providing a framework for improving practice, whilst also improving NRAP reporting. Implementation in DGH settings has resulted in steady improvements over 2024/25.



Data reviews for asthma and respiratory have been undertaken since the workstream commenced. Challenge is noted with data from 2020–22 due to the impact of COVID and issues regarding access to care, and as such trend lines need to be treated with caution.

In primary care, the focus has been on improving proactive support for CYP with asthma through increasing the number of CYP who have had their annual reviews and reducing over-dispensing of SABAs to reduce emergency exacerbations. It is recognised that over-use of SABA medication can be an indicator of poor asthma control. Since 2020/21, there has been a 4.5% decrease in the number of CYP on 6+ SABA inhalers.



During 2024/25, there has been a 21% increase in CYP attending A&E with asthma exacerbations (549.2 per 100k in 2023/24, 663.3 per 100k in 2024/25). However, attendances remain lower in Cheshire and Merseyside compared to the rest of the Northwest (691.3 per 100k in 2024/25).

Emotional Wellbeing and Mental Health

Programmes of Work

Key areas of work have been delivered and ongoing priorities have been reviewed following the publication of Cheshire and Merseyside's Children and Young People's Mental Health Plan 2024-2026.

- **Self-Harm:** Working in partnership with CHAMPS to develop support booklets and guidance, reviewing data insights from the emergency care data set, and offering an overview on the work currently in action in collecting self-harm data from schools across Cheshire and Merseyside. Analysing demographic and socioeconomic factors of CYP attending A&E due to self-harm will inform both local and regional work of the programme moving forward.
- **Safety Planning:** Working across health, social care and education to promote the use of safety planning tools.
- **Team of Life (completed July 2024):** Supporting early intervention and prevention of mental health difficulties through the promotion of support networks, relationships and friendships, and helping to move children out of isolation.
- **As One Platform:** Working with Alder Hey Innovation to scope the expansion of the Child and Adolescent Mental Health Services (CAMHS) integrated referral platform for CYP mental health. The aim is to bring together a single point of access for referrals, support, therapeutic delivery, patient reported outcome measures (PROMS) and educational resources.
- **Family Hub Best Start for Life:** Bringing together key partners to transform family and Best Start for Life services, ensuring there is a strategic approach to service development and alignment of work with other interdependent programmes across the region.

Outcomes and Impact

- **Self-Harm:** Support booklets and guidance[4] have been developed.
- **Safety Planning:** A safety planning film has been developed. Safety planning tools have been collated and uploaded for access. There have been 1,252 views on safety planning resources from 516 users.
- **Team of Life:** Mental health support teams, educational psychology teams, VCSE sector organisations and schools are adopting narrative principles and delivering Team of Life. 520 practitioners across Cheshire and Merseyside have been trained across the lifetime of the project.

[4] Suicide Prevention

Teams of Life

"It complemented the atmosphere of reflection and celebration that we try to foster throughout Year 6 and especially during the second half of the summer term. We have been very fortunate to have been involved in the programme and are looking forward to having our own in-house practitioner so that we can experience its impact in other aspects of our work."

David Hird, Deputy Headteacher, Netherton Moss Primary School, Sefton

- **As One Platform: Scoping has been undertaken and landing pages agreed for Mid-Mersey and Cheshire.** Technical architecture and software are being shared with the ICB's Digital Information Assurance Group (DIAG), who will take the platform documentation to the DDA (Digital Design Authority) for approval. Challenges remain regarding identification of funding routes and consensus across Places for delivery.

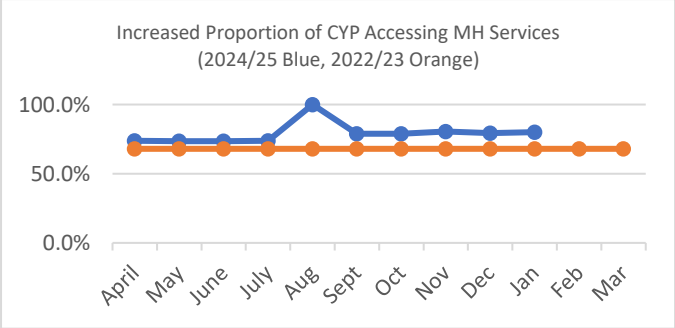
- **Family Hub Best Start for Life:**

  - Sharing of best-practice models (e.g. Restore (Warrington) and Baby Showers (Halton)).
  - Networking outside of Forum.
  - DfE attendance of key messages and headlines.
  - Quarterly self-assessments by all nine Local Authorities, identifying common themes, patterns and challenges.
  - Sharing of supporting documents including strategies and publication updates.

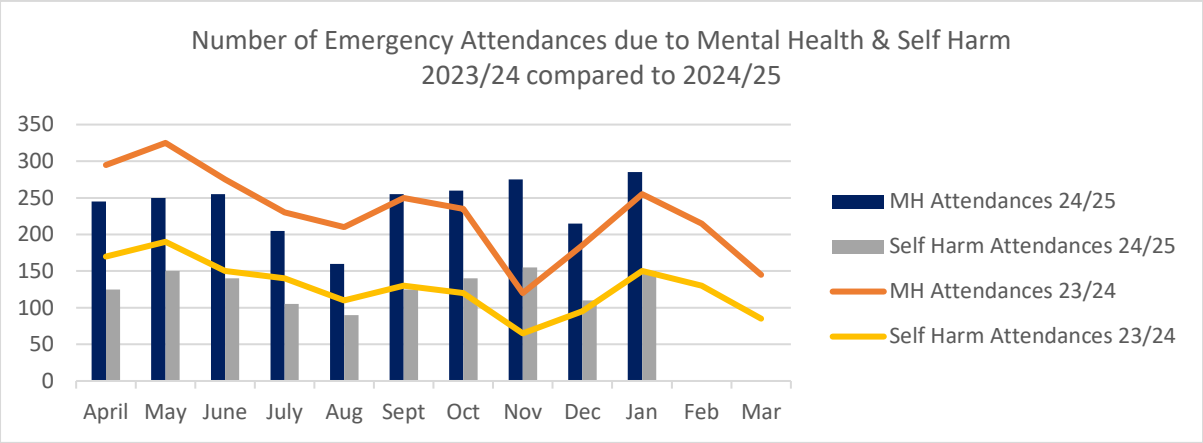
KPIs and Workstream Metrics

KPI outcomes for the Emotional Wellbeing and Mental Health workstream are influenced by the work of the Beyond workstream and the all-age Mental Health programme. The workstream monitors data to ensure progress is being made to improve outcomes for children and young people. The collective work aims to ensure CYP have planned access to mental health services through community mental health access reporting via the Cheshire and Merseyside Business Intelligence Platform (BIP).

In 2024/25, there has been an average of 79.2% of CYP referred to mental health services having received first contact. This represents a 16.4% increase compared to baseline data from 2022/23 (68%).



Given progress in planned access to mental health services, this should result in a reduction of the number of children and young people attending A&E for unplanned hospital attendances due to mental health and self-harm. There has been a 1% increase and 2.3% decrease in year-to-date total of number of mental health and self-harm attendances respectively.



Learning Difficulties, Disabilities and Autism

In Q1 2024/25, the Learning Difficulties, Disabilities and Autism workstream was realigned to support the delivery of the ICB's Neurodiversity (ND) Pathway programme as part of the ICB recovery programme. Several existing projects were completed and learning shared.

Programmes of Work

- **Integration (project complete):** Delivery of Cheshire and Merseyside Children and Young People's Complex Needs Escalation and Support Tool (CNEST) training to the children's social care workforce across Cheshire and Merseyside.
- **Sensory-Friendly Environments in Urgent Care (project completed July 24):** Developing sensory-friendly environments in A&E Departments across Cheshire East, Cheshire West and Wirral.
- **Sensory-Friendly Settings in Colleges (project completed Sept 24):** Working across Cheshire to establish sensory-friendly settings in college environments.
- **Sleep Service (project completed):** Delivered by Koala North West - Sleep Support Service for children who are autistic and have a sleep disorder.
- **Neurodiversity (ND) Pathways:** Implementing a standardised model for CYP neurodiversity (primarily ADHD and autism) that focuses on meeting need and earlier access to support.
- **Appropriate Places of Care for CYP with Complex Needs:** Developing service models for children with multi-agency complexity.

Outcomes and Impact

- **Integration: 222 colleagues across all nine local authorities** have undertaken Complex Needs Escalation and Support Tool (CNEST) training. CNEST champions have been identified in four areas.
- **Sensory-Friendly Environments in Urgent Care (Cheshire and Wirral Partnership NHS Trust):**
    - "Supporting Neurodivergent Young People in A&E" training shared across all four acute Trusts (disseminated to HCAs, nursing staff, ANPs, medics, etc). 30 professionals trained.
    - Bespoke sensory voyagers and specialist sensory equipment delivered to three hospitals. Specialist sensory equipment provided to East Cheshire NHS Trust (Macclesfield District General Hospital) to support redesigned A&E.
    - 13 Social Stories developed to support autistic children and young people to promote interaction during visits to A&E.
- **Sensory-Friendly Environments in College Settings (Cheshire College South and West):** Calm places developed in co-production with learners**,** 133 learners provided with inclusion needs adaptations, and 46 staff members trained on inclusion and adaptations.
- **Sleep Service**: 183 sleep referrals received, 81 families supported, and 17 sleep courses provided to over 50 parents/carers across Wirral.

Sleep Service (Koala North West)

John has a diagnosis of autism and attends mainstream school. He has had disrupted sleep since 18 months old. A sleep practitioner supported his mum Sandra over six weeks, providing psychoeducation on fluid intake, sleep hygiene and supporting John's sensory needs. Initially, she felt that support had not worked and that she would be requesting melatonin. Advice and support were reviewed and changes agreed. John's sleep pattern improved, he rarely woke in the night, and he was easier to settle when he did. Sandra was offered melatonin by the paediatrician but no longer felt it necessary.

Neurodiversity (ND) Pathways

During 2024/25, LDD&A leadership monies were realigned to support the ND recovery programme in the ICB. Programme Management support was recruited, with additional monies allocated to support research and evaluation of delivery.

Key ambitions of the Pathway redesign include development of:

- A capacity and demand model that identifies level of demand over next 10 years.
- An ND training plan to meet need and enable wider professionals to support signposting, assessment and diagnosis.
- A consistent core support offer that provides early support and tailored ongoing support.
- A shared care prescribing model for ADHD medication.
- Cultural change, co-produced with people with lived experience.
- Consistent and streamlined needs-based approaches to referral, assessment and diagnosis.

The following work has taken place in 2024/25:

- ND Pathway Oversight Group, Empowerment Early Help & Ongoing Support, Clinical Professional Reference Group, and ADHD Shared Care workstreams have been mobilised.
- CYP co-production work has facilitated 458 in-depth conversations, 267 engagements with CYP, and 191 responses from families and carers.
- A Cheshire and Merseyside CYP support offer online survey has received over 1000 responses.
- A workshop has been held to develop consistent standards and improve CYP ND support.
- Two "early adopter" trailblazer sites have been mobilised.

Appropriate Places of Care

Meeting the Needs of CYP with Complex Multi-Agency Needs

The Cheshire and Merseyside ICS CAMHS Review Oversight Group concluded in 2022, identifying a cohort of CYP who needed support that crossed organisational delivery boundaries. These CYP:

- Cannot be supported in their family home.
- Are not assessed as being suitable for Tier 4 inpatient admission.

- Have been deemed to have needs for which Local Authorities are unable to source regulated provision.

Across Cheshire and Merseyside, there is an increasing number of looked-after children (a 16% increase between 2019-2023). A review of high-risk, high-cost placements found significant variation in spend, with a lack of consistency in cost and the efficacy of therapeutic programmes within care settings. A snapshot of four Local Authorities found that the average monthly cost per child varied from £6600 to £9700, and the average spend per Local Authority over 24 months was greater than £12M. There has been a 42% increase in the average Children's Social Services spend from 2019-2024.

Key stakeholders have convened to find solutions to issues identified and have been involved in the development of proposed models and the aligned business case. The work has been co-chaired across Health and Social Care and stakeholders have included DCSs, Provider Trusts, Level Up, Clinical Leads, and representation from all nine Place areas.

In November 2024, a regional proposition and business case was presented to the Children's Committee. Support was provided and the business case presented via ICB governance to seek formal approval.

Healthy Weight and Obesity

Programmes of Work

- **HENRY:** Promoting a holistic approach to 'a healthy start' focusing on:
  - Supporting breastfeeding
  - Improving nutrition
  - Emotional wellbeing
  - Parenting skills
  - Healthy nutrition
  - Oral health
  - A more active lifestyle
- **Complications of Excess Weight (CEW):** Developing a clinical model for treating complications associated with severe obesity.
- **The People's Health Project (concluded 2024/25):** Delivery of a co-produced health literacy programme by Everton in the Community with five primary schools (including SEND) to provide holistic support on physical activity, nutrition and wellbeing.
- **Why Weight to Talk (concluded 2024/25):** Supporting staff to optimise conversations and improve practitioner knowledge and confidence to discuss healthy weight with children and families.
- **Halton Digital App (concluded 2024/25):** A system approach to tackling childhood obesity via a co-produced digital app for teenagers.
- **Royal Society of Public Health (RSPH):** Delivering courses for professionals and young people.

Outcomes and Impact

- **HENRY:**
  - Phase 1: Training commissioned across all nine Places, with 84 workshops completed and 375 families supported.
  - Phase 2: Seven out of nine Places received training, with eight workshops delivered and 34 families directly supported.
- **CEW Clinic:** 179 CYP were supported and discharged, and there are 264 active patients.
- **The People's Health Project:** 162 CYP engaged in co-production, and 200 CYP and 43 parents were directly supported.
- **Why Weight to Talk:** 8 Local Authorities and 622 practitioners were trained to have conversations regarding healthy lifestyles.
- **The Halton Digital App:** 224 CYP accessed the app, 124 accessed leisure facilities, and 40 collected vouchers to purchase home equipment.
- **RSPH:**
  - Understanding Health Improvement course delivered to 69 practitioners.
  - Healthy Eating course delivered to 16 practitioners with a second course arranged.
  - Three RSPH Young Health Champions courses delivered to 21 CYP.

Halton Teen App

IB is a 15-year-old girl open to youth drug and alcohol support. She struggles with peer pressure and self-esteem, has episodes of self-harm and is supported by CAMHS. She is also a young carer. IB accessed the Halton Teen app and signed up for local leisure centre. She enjoyed attending Brookvale Gym where she can focus on herself. IB has presented a lot better during appointments and reported her substance use had dropped.

Completed Projects

The People's Health Project (Everton in the Community)

The People's Health Project was an eight-week health literacy initiative led by Everton in the Community, delivered to five primary schools (four mainstream and one SEND school) to help reduce health disparities in the Liverpool City Region.

The project provided engaging and educational sessions to improve health literacy among children aged four to 11. It was delivered to a total of 200 children: 150 in Year 3 (aged seven to eight years old), 30 in Year 5 (aged nine to 10 years old), and 20 of mixed ages.

Outcomes

- 97% of children expressed that they learnt more about leading a healthy lifestyle.
- 71% showed increased interest in healthier food options.
- School staff praised the project, particularly highlighting its multi-design approach.
- The key learnings reported by the children aligned with the project's three focus areas: sleep, physical activity and nutrition. They gained knowledge in areas such as:
  - Practical cooking skills
  - Understanding ultra-processed foods
  - Healthy eating habits
- The 'hook' of Everton in the Community was seen as beneficial for delivering and enhancing engagement.
- 93% of parents or guardians strongly agreed or agreed that their child had learned more about leading a healthy lifestyle.
- 55% noted that their child had a heightened awareness of healthier living.
- Parents/guardians reported that their children showed increased interest in preparing and cooking meals, actively involving them in meal planning, and seeking healthier alternatives.

Feedback

"Healthy eating can help you get more energy throughout the day. It makes you less tired so you can do more stuff. It makes you get strong, and it can make you healthy so you don't get any illnesses or diseases, and it can help you lose some weight."

"If you do something that makes you happy -- say playing football makes you happy -- you're doing physical things that not only help you with your physical health, but also your mental health."

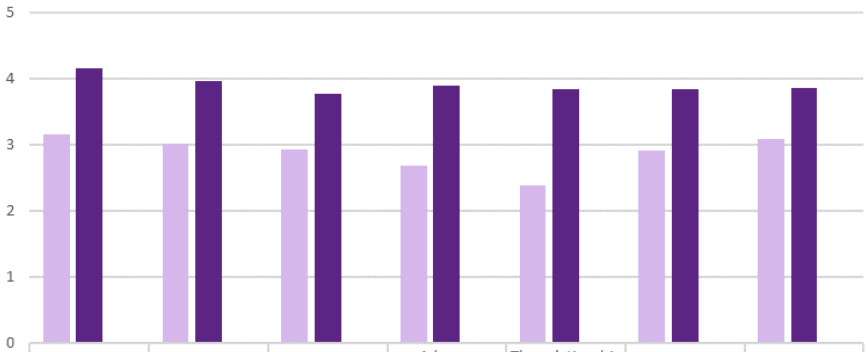
Why Weight to Talk

"Why Weight to Talk" is online/face-to-face training designed to equip frontline practitioners with the skills to provide effective brief advice to children and families about maintaining a healthier weight and to direct them to additional support when needed.

The project has been delivered across a total of eight Place areas.

Outcomes

- Increase in practitioners' knowledge and confidence to offer brief advice and onward referral.



	Causes of overweight and obesity	Wider determinants of health	Weight stigma	Adverse Childhood Experiences (ACEs)	The relationship between weight stigma, ACEs and weight gain	Confidence to engage children and families	Confidence to refer children and families
Pre	3.16	3.01	2.93	2.69	2.39	2.91	3.09
Post	4.16	3.96	3.78	3.89	3.85	3.85	3.86
Difference	1	0.95	0.85	1.2	1.46	0.94	0.77

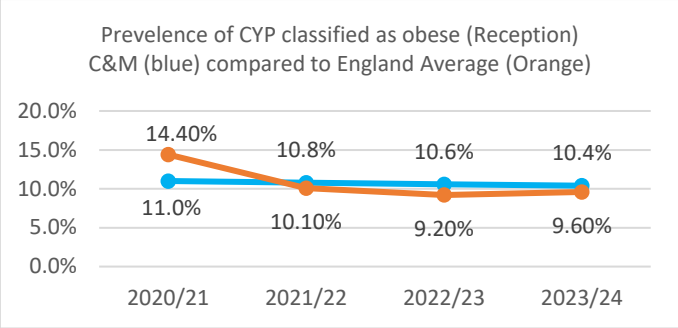
Sustainability

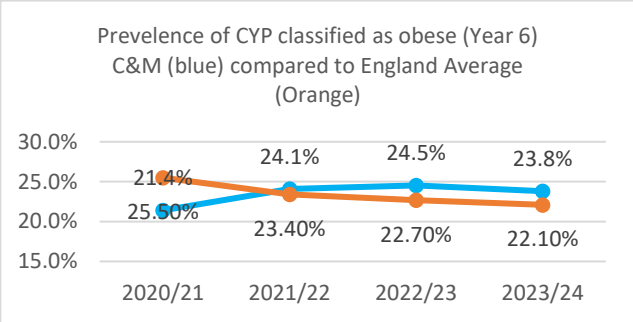
During 2024/25, Why Weight to Talk was extended to further Place areas. The Cheshire and Merseyside Cancer Alliance-sponsored Strategic Obesity Project will further support delivery to colleagues in the VCFSE sector with an aim to build capacity through the delivery of 30 sessions in 2025/26, reaching approximately 300 practitioners and volunteers.

KPIs and Workstream Metrics

Children living in the most deprived areas in England are more than twice as likely to be living with obesity compared to those living in the least deprived areas. The NCMP data and trends at a Place/Local Authority level are being used to inform workstream-specific targeted projects and interventions.

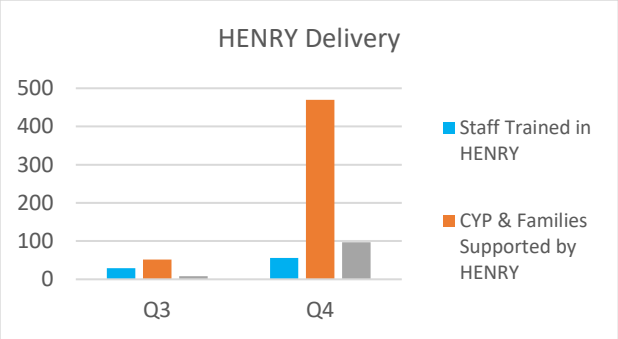
From the baseline data in 2018, there has been a 5.4% decrease in Cheshire and Merseyside in the proportion of Reception-aged children classed as obese, with a consistent decrease year on year nationally. Obesity prevalence in Reception-aged children in Cheshire and Merseyside is higher than national prevalence.

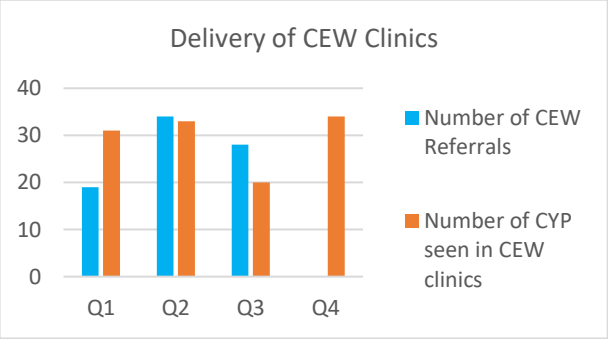




For Year 6-aged children in Cheshire and Merseyside, there has been a 2.4% increase, but a decrease of 0.7% was seen from 2022/23 to 2023/24. This is potentially driven by increased awareness and prevention intervention work.

Delivery of local projects and initiatives, such as HENRY and CEW, allow for targeted work to reduce the prevalence of obesity and increase healthy lifestyles and attitudes in CYP and families.





Epilepsy

Programmes of Work

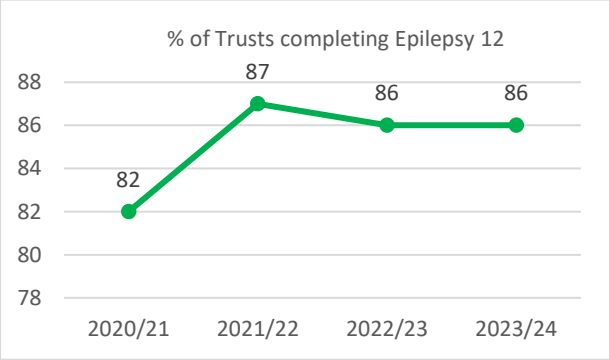
- **Psychology Adding Value – Epilepsy Screening (PAVES):** PAVES is a pilot programme providing access to a tailored early intervention pathway, including mental health screening, for CYP with epilepsy.
- **Improving Transition Care from Paediatric to Adult Epilepsy Services:** Increasing epilepsy specialist nursing delivery to support CYP with complex needs who require co-ordination of care across multiple settings.
- **Addressing Variation in Care via Youth Workers:** Youth workers will be employed in two areas of highest need to provide holistic support to children with epilepsy.
- **Integrated Epilepsy Specialist Nurse (ESN):** ESNs will support development of acute and community epilepsy services, with a focus on reducing the gaps and variations across the ICS.
- **Accessing Tertiary Care:** This remains a significant risk. A briefing paper has been submitted to the ICB and mitigations such as interim MDTs are being implemented. A formal process is being finalised for launch of MDTs in 2025/26.

Outcomes and Impact

- **Psychology Adding Value – Epilepsy Screening (PAVES):** Eight virtual sessions and three 'drop-in' sessions have been delivered to 31 CYP with epilepsy. Eight virtual sessions and three 'drop-in' sessions were offered to parent/carers and 17 attended. Three CYP completed 1:1 sessions.
- **Transition:** Clinical leads have collaborated with colleagues in adult care to create a draft pathway and resources, which have now been signed off. 2025/26 will focus on the creation of joint MDTs.
- **Youth Worker Pilot:** Two youth workers recruited in two pilot sites.
    - Mersey and West Lancashire Teaching Hospitals NHS Trust: The youth worker started in role October 2024 and has created SOPs and referral pathways. CYP will be offered support over six weeks and will then be reviewed. Three CYP have been referred and two CYP have completed the intervention.
    - Mid Cheshire Hospital NHS Foundation Trust: The youth worker started in role January 2025.
- **ESNs:** Levelling Up funding resulted in full-time ESNs being added to two pilot sites as business as usual to support in achieving the ratio of 1:250.
- **Integrated ESNs** supported access to tertiary insight, created genomics, tertiary and transition pathways, and benchmarked care across Cheshire and Merseyside to highlight any variation that could be supported with QI projects.
    - **Variation in care:** Benchmarked DGH provision, highlighted variation in care, and developed action plan to address gaps. Worked with neuro-pharmacist on medication access issues and explored alternative medications. Scoped rescue medication in schools, highlighting variation in practice.

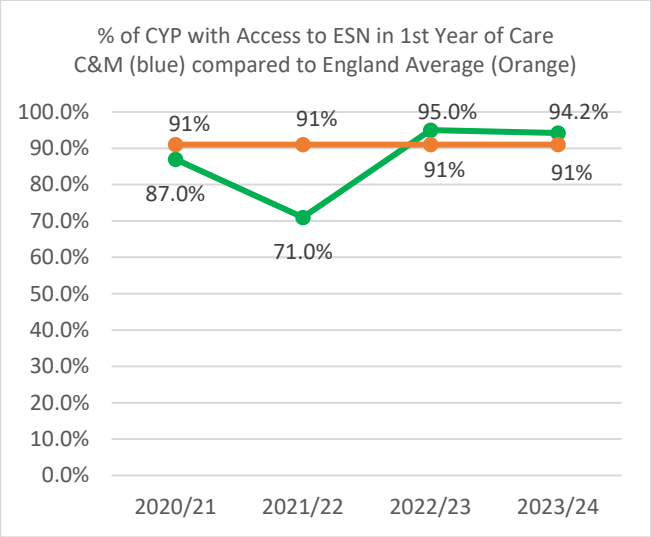
- **Tertiary service:** Created draft pathway. Worked closely with tertiary provider on risks, waiting lists, referral pathways, etc. Established Clinical Oversight Meetings, bringing together a neurologist and the integrated ESN to review CYP identified by DGHs as requiring neurology input. Through these meetings, neurology advice has been provided to DGHs for over 100 CYP.
- **Mental health:** Supported Psychology Adding Value – Epilepsy Screening (PAVES) pilot with the dissemination of information, SDQ's, etc.
- **Transition:** Met with transition nurses and DGHs to collaborate on draft pathway and resources.
- **Genomics:** Attended neurogenetics meetings and collaborated on the neurogenetics pathway.
- **Valproate:** Maintained active membership of ICB Prescribing & Comms T&F group and dashboard meetings contributing to role and responsibilities from CYP perspective.

KPIs and Workstream Metrics



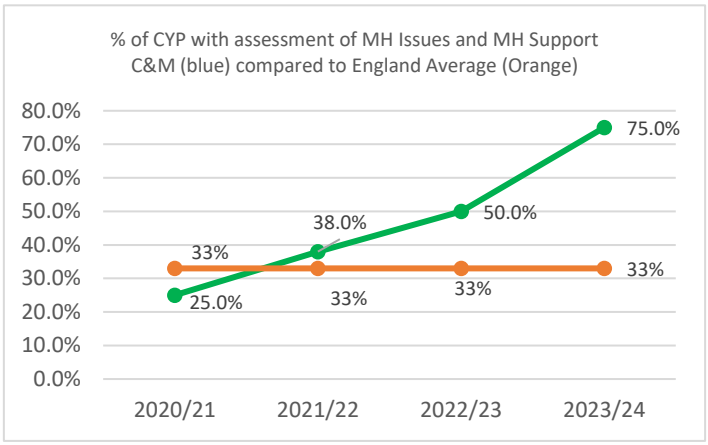
The workstream monitors data to ensure progress is being made to improve outcomes for children and young people. Progress is monitored via the Epilepsy 12 annual audit and emergency unplanned hospital admissions due to epilepsy from Secondary Uses Services (SUS) data.

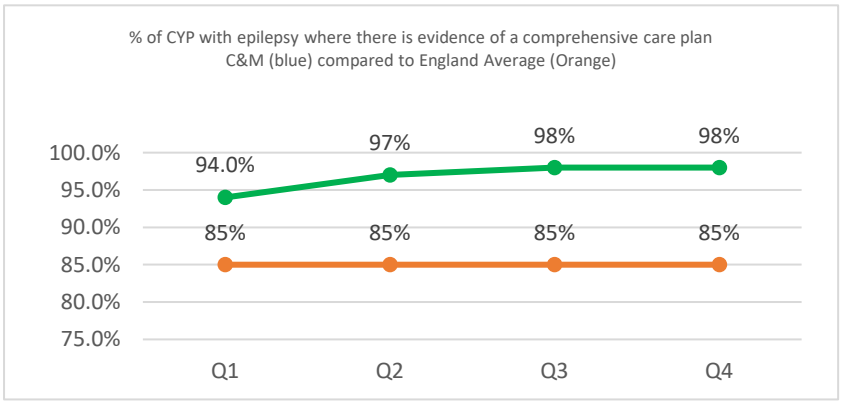
Integral to data reporting is the completion of annual Epilepsy 12 audit by trusts. Trusts have been noting issues with capacity for completion and the completion rate has plateaued at 86%, which has an impact on data quality. Macclesfield District General Hospital is the only Trust in Cheshire and Merseyside that has not completed the Epilepsy 12 audit. Workstream leads are connecting with them to explore any challenges to completion.



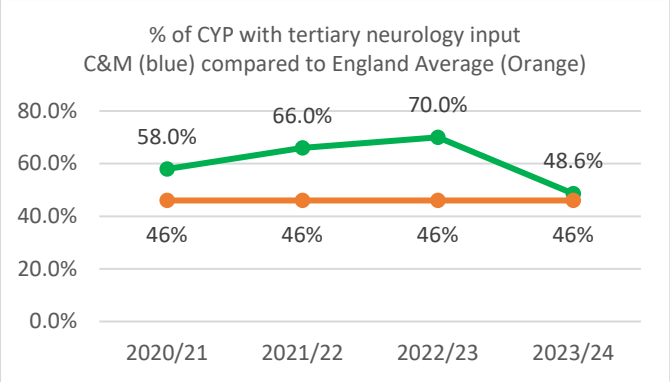
The Levelling Up project focused on increasing access to epilepsy specialist nursing in the first year of care through pump priming of roles in hospitals where access was below recommended levels. This work has now been mainstreamed. Data shows a steady improvement in access rates via audit and now surpasses the England average. Epilepsy 12 insights are monitored on a quarterly basis to track ongoing delivery.

Access to mental health support for CYP with epilepsy is a key requirement of the epilepsy bundle. Audit data indicates that there has been a steady improvement in CYP having access to this support since baseline in 2020/21, with rates of over 75% reported in 2023/24 and 2024/25. Whilst this data is positive, stakeholders have expressed concern that this is not a true reflection of access rates. This will be further explored during 2025/26.



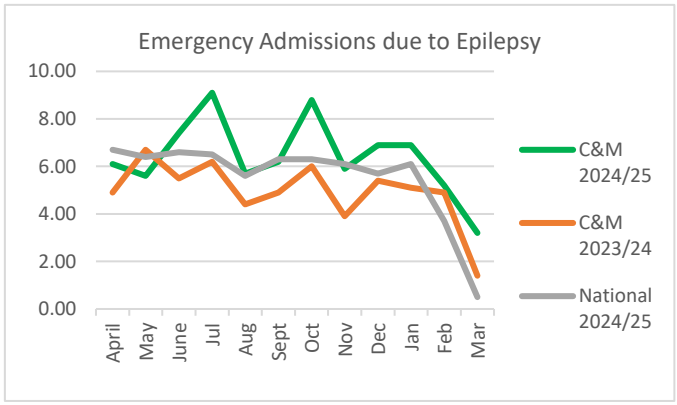


Strong progress has been seen in CYP having access to a comprehensive care plan, with an improving trend since baseline and rates of over 95% for 2024/25.



Challenge continues with CYP having access to tertiary neurology care due to issues with recruitment and retention of staff within the specialist tertiary provider. A recovery plan is in place with interim mitigations identified where possible. Support is being identified from both the ICB and NHSE.

The progress in areas identified above should result in a reduced number of children and young people attending for unplanned hospital admissions related to their epilepsy. Despite this progress, emergency unplanned admissions remain higher in Cheshire and Merseyside compared to both the 2023/24 trends and national admissions (per 100k) in 2024/25. These trends are being explored at a local level to understand drivers of this trend.



Diabetes

Programmes of Work

- **Improving Diabetes Transition Care:** Joint working across Trusts to improve transition from paediatric services to adult services.

- **Type 2 Risk Stratification Project:** Identifying CYP at risk of developing Type 2 Diabetes based on family history, weight, ethnicity, and deprivation.

- **Getting it Right First Time (GIRFT):** Addressing variation in care and outcomes across ICSs. The GIRFT recommendations align with the national Diabetes Right Care Toolkit, focusing on four key areas:

    - Addressing diabetes health inequalities in children and young adults.
    - Reducing variation in treatment, care and outcomes across health systems.
    - Improving treatment and care for people transitioning from paediatric to adult services.
    - Improving treatment and care for children and young adults with Type 2 diabetes.

Outcomes and Impact

- 309 CYP started on new diabetes technology through the Diabetes Technology access pilot. The workstream baseline was 19.9% in 2019/20 with an increase of 61.2% in 2023/24.
- The transition team and pathway are in place across all Transition of Young Adults pilot sites.
    - Alder Hey Children's Hospital Trust: 35-40 CYP transferred to Aintree University Hospital and Royal Liverpool University Hospital Trust as part of their transition.
    - Aintree University Hospital: 57% increase in patients from paediatric services making it to their first adult appointment. There was and eight-fold increase in patients referred in from primary care.
    - Royal Liverpool University Hospital Trust: 260 CYP screened and 103 CYP triaged.
    - Southport and Ormskirk Hospital NHS Trust: A significant increase in the proportion of 16–25-year-olds initiating or upgrading to hybrid closed-loop pumps, rising from 27.7% to 50%.
- The GIRFT report and recommendations have been reviewed and the action plan is in development.
- Type 2 Risk Stratification Project: 25 families with a history Type 2 or gestational diabetes were identified with 29 highlighted as 'at risk', and six CYP with a high BMI were identified.

Completed Projects

Continuous Glucose Monitoring (CGM) Technology Pilot

In 2022, Beyond submitted a bid to NHSE to improve access to technology for CYP with Type 1 Diabetes. Two NHS Trusts were identified to pilot the approach: Wirral University Hospital NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust. Allocation

was based on data analysis of ethnicities, deprivation levels, and levels of technology use. Phase 2 of delivery was conducted in 2023/24 with Whiston Hospital.

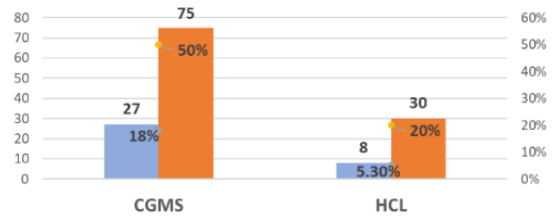
During Phases 1 and 2 of delivery, 309 CYP started on diabetes technology with a particular focus on those young people from areas of highest deprivation:

- Arrowe Park: 123 CYP started on technology, with 65% from the lowest two quintiles.
- Warrington & Halton: 101 CYP started on technology. 42.4% were from deprivation index <5 and 22% were from IMD 1&2.
- Whiston: 85 patients started on technology, with 49.3% from the lowest two quintiles.

Case Study: "Pump therapy is 10/10 vs pen therapy 5/10."

"When I got diagnosed with type 1 diabetes, I hated it. I would always have to give injections which I really hated because I felt singled out. I was always high at night and finger pricking was hard. I have been on pump for six months now and it's changed my life completely. I can now have a normal life like my friends and give insulin easily. I feel like I can be a child again now. My pump has made it so easy, and the pump always has me 90% in range. I'm so grateful - it's changed my life completely."

The increase in CYP accessing digital technologies, particularly those from areas of highest deprivation, has resulted in an improvement in diabetes management. The below data from Warrington and Halton showed an increase in CGM usage from 18% to 75% and in increase in Hybrid Closed Loop usage from 5.3% to 20%. This is associated with an increased time in range from 58% to 65.5% and an associated reduction in HbA1C levels



Technology usage pre- and post-project

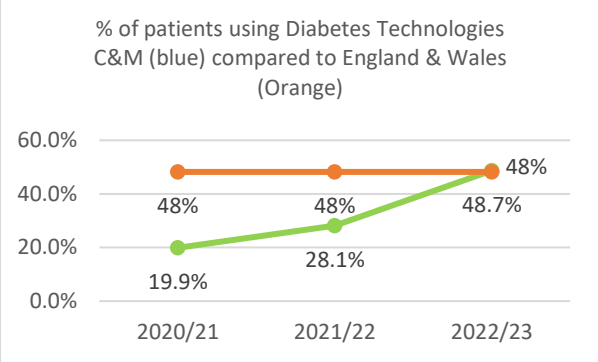
Time in range and HbA1C pre- and post-project

KPIs and Workstream Metrics

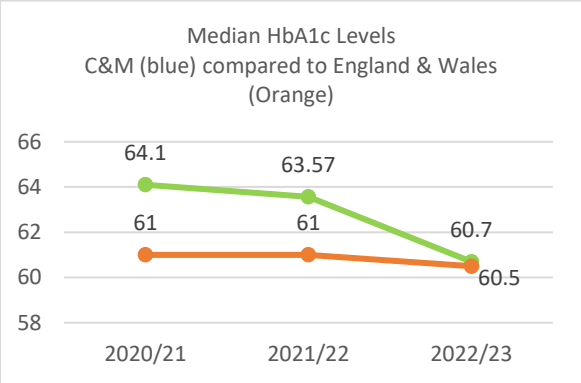
Type 1 Diabetes

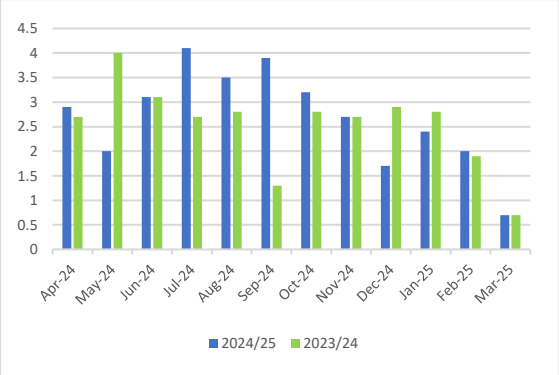
The workstream continues to monitor data to ensure progress is being made to improve outcomes for children and young people. Progress is monitored via the National Paediatric Diabetes Audit (NPDA) and by emergency admissions due to diabetes ketoacidosis (DKA) from Secondary Uses Services (SUS) data.

Key to diabetes management is ensuring that more children and young people are accessing digital technology to support them to manage their condition. The NDPA review shows a steady increase in access to technology from initial baseline in 2019/20 to the most recently available audit data in 2022/23[5]. The percentage of patients using diabetes technologies has now exceeded the England & Wales average as of 2022/23.



Access to technology supports an improvement in diabetes management which is measured both by median HbA1C levels and emergency diabetes admissions due to DKA. These have both seen improvements, with HbA1C levels showing a steady decline since 2019/20 baseline and emergency admissions showing a reduction over time.





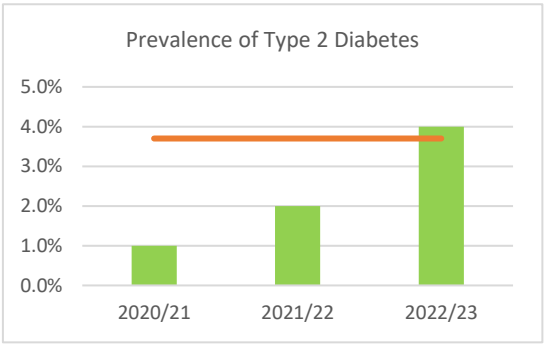
Based on baseline data from 2020/21, there were 37.5 DKA admissions per 100k annually. For 2024/25, there is a predicted decrease of 12.8% (32.7 per 100K). Despite this, annual DKA admissions in Cheshire and Merseyside remain higher than the national average (26.6 per 100K).

It is expected that this trend will show continued improvement due to the focus on access through the CGM technology pilot and the roll-out of HCL technology in the ICB.

Type 2 Diabetes

Delivery of targeted support for children with Type 2 diabetes is part of CORE20+5 CYP. Data shows that rates of CYP with Type 2 diabetes have increased from 1% in 2020/21 to 2% in 2021/22 to 4% in 2022/23.

All CYP with Type 2 diabetes should have an annual health check that assesses:



[5] 23/24 data is due for release in April 2025

- HbA1c, BMI, cholesterol, blood pressure and albumin in under-12s.
- HbA1c, BMI, cholesterol, blood pressure, albumin, eye exam/retinopathy and foot health in 12- to 18-year-olds.

Based on a new NPDA measure as of 2022/23, 40% of CYP with Type 2 diabetes in Cheshire and Merseyside received their annual reviews.

Oral Health

All Together Smiling - Supervised Toothbrushing Programme

In April 2024, NHS Cheshire and Merseyside committed to the delivery of an evidence-based, supervised toothbrushing programme (STP), hosted by Beyond. This is focused on CORE20 populations across Cheshire and Merseyside, working in partnership with Local Authority oral health and children's education leads.

The three-year programme includes:

- Increased access to free toothbrushes and toothpaste targeting children most at risk of dental decay.
- Supervised toothbrushing targeting 2– to 7-year-olds in CORE20 populations at Place.
- Additional epidemiological survey investment.
- A targeted communications campaign.

The programme will:

- Contribute to the CORE20+5 indicator for tackling tooth extractions in under-10s.
- Reduce demand for dental and urgent services in coming years.
- Contribute to giving every child the best start in life.

Tiny Teeth

Tiny Teeth is two-year oral health parent champions project running in Liverpool from October 2023 to October 2025. In partnership with Koala North West and City Healthcare Partnerships CIC, the project provides peer support to CYP and families with, or at risk of, poor oral health outcomes. It includes delivery of STPs and distribution of toothpaste and toothbrush packs.

Outcomes and Impact

- Procurement has been completed for a programme consumables supplier and a training and quality assurance provider.
- Trailblazer delivery with Halton Borough Council and Knowsley Council has supported understanding of local learning, challenges, and opportunities that will inform wider roll-out.
- A communications campaign has been developed to raise awareness of the programme offer and communicate oral health key messages.
- Programme roll-out has commenced in all nine Places.
- 232,535 oral health packs (including packs for children with SEND) have been distributed across Cheshire and Merseyside via health visitors, food banks, Holiday Activity and Food (HAF) programmes, and early years and primary school settings.
- 5,099 families have been directly supported through Tiny Teeth delivery.
- 36 settings have received supervised toothbrushing training supporting 2,227 children.

- 12 oral health awareness training sessions have been delivered.
- 93 onward referrals to other services have been made for families accessing support.

Case Study

A family living in a deprived ward in Liverpool were referred to the Tiny Teeth project via their social worker. Both children (aged 1 and 4) were on a "child in need" plan with the family requiring a range of oral health-related (toothbrushing and visiting a dentist) and wider support. The parent champion offered 1:1 support, provided oral health education, improved engagement with school, assisted in developing new routines, and provided guidance on addressing housing issues.

KPIs and Workstream Metrics

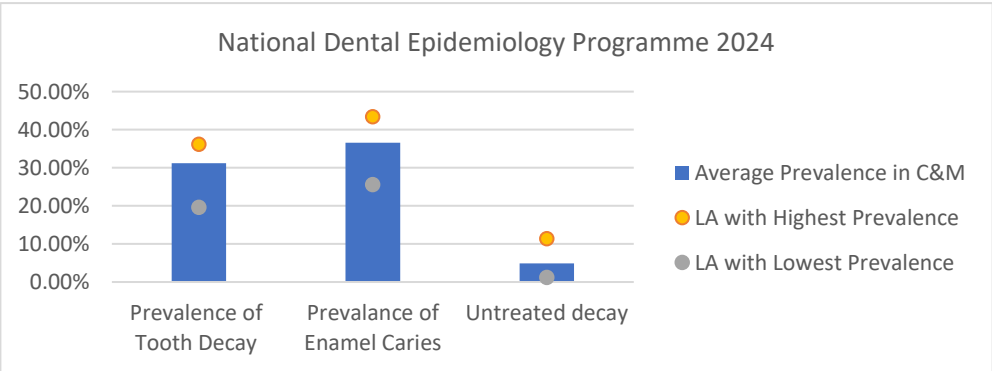
National Dental Epidemiology Programme (2024)

The workstream monitors data to ensure progress is being made to improve outcomes for children and young people. Progress is monitored via the National Dental Epidemiology Programme (NDEP) for England oral health survey of five-year-old children, through elective hospital admissions for tooth extractions, and through the delivery of the ATS programme and oral health packs.

In the Cheshire and Merseyside ICB, it was found that 31.2% (Northwest 28.7%, England 22.4%) of five-year-old school children who participated in the survey had experience of tooth decay in the deciduous dentition. This was the second highest proportion reported at any ICB in England.

Children with tooth decay had three or four affected deciduous teeth. The prevalence of enamel caries and/or dentinal decay experienced in the Cheshire and Merseyside ICB (36.6%) was comparably the third highest of any ICB (Northwest 36.8%, England 26.9%). Most five-year-old children's decayed teeth across the region were untreated.

The Care Index is the proportion (%) of decayed deciduous teeth treated by filling (CM ICB 4.9%, Northwest 7.4%, England 10.5%). Caution should be taken in making any assumptions about the extent or the quality of clinical care available when using the Care Index.

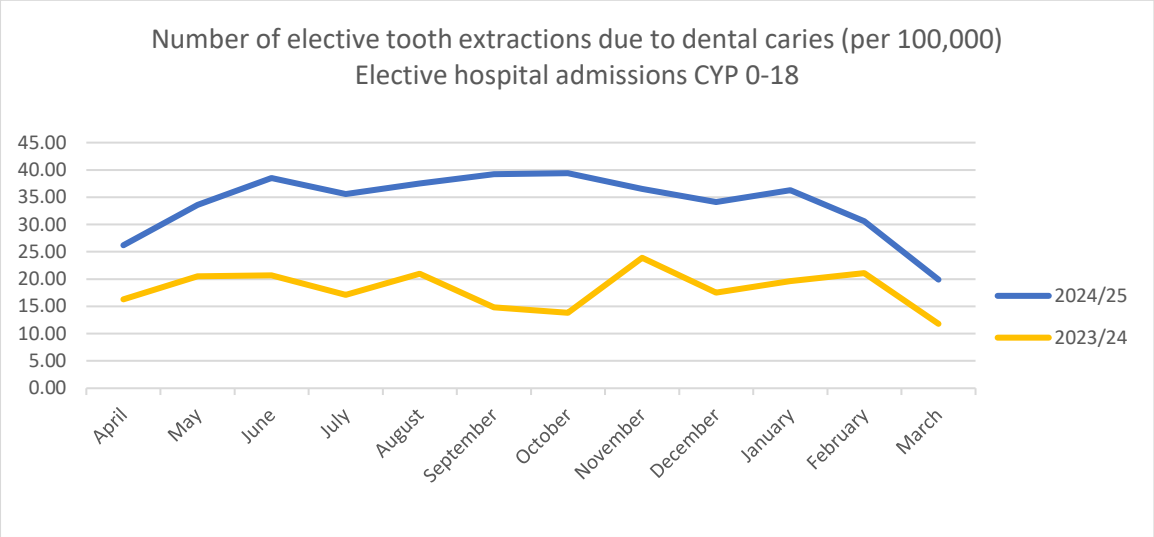


Hospital Tooth Extractions in 0-19-Year-Olds (2024)

In 2024, there were 2,335 episodes of tooth extractions in NHS Cheshire and Merseyside hospitals for children and young people aged 0-19. This represents a rate of 413.1 episodes per 100,000 children (England 368 per 100,000 children). The total number of hospital episodes for tooth extraction has increased since last year but is still lower than the pre-pandemic figure of 2,430 episodes in 2019.

Of the total in 2024, there were 1,600 episodes of decay-related tooth extractions for 0-19-year-olds (England 30,587). This represents 68.5% of all tooth extractions for children up to 19 years old (England 62.3%).

There were 1,025 decay-related extractions in NHS Cheshire and Merseyside hospitals for children up to the age of 10. This was a rate of 167.9 and 562.1 episodes per 100,000 children aged 0-4 and 5-9 respectively (England 124.9 and 527.5 per 100,000 children).



Paediatric Network

The Cheshire and Merseyside Paediatric Network is primarily a clinical operational network. The network reports on capacity and demand across the region and responds to regional pressures, developing responsive action plans to address critical issues, e.g. bronchiolitis surge, Strep A.

Programmes of Work

- **Mental Health in Acute Settings:** Skill development for staff in acute physical health settings in relation to mental health presentations.

- **Mental Health Champions:** Each trust with a paediatric acute ward will identify a paediatric Mental Health Champion to facilitate joint working, increase staff confidence, improve patient experience, provide leadership, and advocate for the mental health of children and young people within paediatric departments.

- **Paediatric Early Warning Systems (PEWS):** A tool that will support paediatricians and wider child health teams to identify deterioration of children in hospital and act as a national tool that is transferable across organisations.

- **Family Support Workers in A&E (Pilot):** Barnardo's has been commissioned by NHSE to run a 12-month pilot embedding Family Support Workers (FSWs) in emergency departments to provide non-clinical, tailored support for families.

Other Activities

- Same-day emergency care and winter planning.
- Cheshire and Merseyside Paediatric Silver command meeting: Ongoing monitoring of capacity and demand (NSR and paediatric bed state), triggering/feeding into Gold command as required.
- Cheshire and Merseyside Senior Nurse meeting.
- Representation at Northwest Paediatric Intensive and Critical Care (PICC) and surgery Operational Delivery Network (ODN).

Outcomes and Impact

- Mental Health Champions: All eight Trusts now have fully embedded Mental Health Champions. A bi-monthly MH Champions network has been established to share learning, provide support and overcome challenges.

- PEWS: Seven Trusts have committed to implementation of National Paediatric Early Warning Systems (PEWS). A bi-monthly Cheshire and Merseyside PEWS implementers network has been set up. Challenges remain regarding integrating PEWS into existing digital systems.

- Family Support Workers in A&E: 60 support requests have been made and at least 78 young people have been supported between June 2024 and March 2025

- 80 key stakeholders attended the Winter Planning event focused on urgent care and CYP mental health. Colleagues from acute and community providers attended, including clinicians, service managers, CYP commissioners, VCSFE, mental health workers, NHSE and NW long-term conditions clinical leads.

During 2024/25, the Provider Collaboratives across Cheshire and Merseyside convened a CYP Alliance. Co-chaired by the Paediatric Network Lead, the CYP Alliance aims to bring together senior clinical and operational colleagues from across the region, increase system connectivity, and provide system-wide solutions and learning to issues impacting CYP. During 2025/26, the Paediatric Network and the CYP Alliance will combine, providing a clear system response to supporting the needs of CYP in acute settings.

Completed Projects

Mental Health Champions in Acute Settings

The Paediatric Mental Health Champion's role is to be an ambassador for CYP with emotional needs on a Paediatric ward. They will champion new ways of working so that staff and acute trusts can provide a better experience for young people.

Delivery

All eight DGHs have identified a Mental Health Champion. They come from range of professional backgrounds:

- Practice Development Nurse
- Team Leader
- Vulnerable CYP Wellbeing Specialist Nurse
- Paediatric Clinical Educator
- Staff Nurse
- Consultant Paediatrician
- Paediatric Nurse Consultant
- Practice Development Nurse

MH Champions meet bi-monthly to share updates, provide practical solutions, and discuss best practices in a closed forum focused on case reviews.

Case Study

The ward has worked with the eating disorders team to facilitate assessment, investigation and monitoring of young people with eating disorders on the children's ward and in the community (by the community nursing team). These young people can now be seen rapidly by the medical team when indicated and managed in the community rather than as an inpatient when appropriate. This has helped to avoid stressful admissions for these patients and their families whilst ensuring they are receiving appropriate medical care.

Sustainability

Funding from NHSE concluded at the end of 2024/25. All Champions remain in post and will maintain focus and peer support on an ongoing basis.

Paediatric Early Warning System

NHS England is implementing a standardised approach to monitor and identify the deterioration of hospitalised children through the National Paediatric Early Warning System (PEWS). This aims to improve the quality of care for children and young people and ensure consistency in recognising clinical deterioration across hospitals by standardising monitoring, enhancing patient safety, facilitating staff mobility, and integrating digital solutions.

Delivery

Eight District General Hospitals are involved in PEWS implementation:

- Four hospitals are on track for delivery (Countess of Chester Hospital Trust, East Cheshire Hospital Trust, Mid Cheshire Hospital Trust, Warrington and Halton Hospital Trust). None of these sites were using digitised escalation prior to implementation and have now transferred to paper-based PEWS.

- Three sites are already digitised and so cannot proceed until a digital solution has been agreed with IT providers (Mersey and West Lancashire Teaching Hospitals (Whiston), Mersey and West Lancashire Teaching Hospitals (Ormskirk), Wirral University Teaching Hospital). These sites are using their existing PEWS to ensure appropriate care for CYP until the digital solution is available.

- Alder Hey Children's Hospital Trust has submitted a letter of derogation as they are part of a Detect Study.

Sustainability

Funding from NHSE concluded at year end 2024/25. However, all Trusts continue to work towards implementation.

Family Support Workers in A&E (Pilot at Ormskirk General District Hospital)

Barnardo's was commissioned by NHSE to run a 12-month pilot embedding Family Support Workers (FSWs) in emergency departments (EDs) to provide non-clinical, tailored support for families. The programme aims to reduce pressure on EDs by guiding families to appropriate services and resources. This was piloted at Mersey and West Lancashire Teaching Hospitals (Ormskirk).

Delivery

- 113 children and their families were supported.
- 63 referrals were received, resulting in support to 81 children and young people.
- A further 32 CYP have been supported via brief conversations or signposting in the ED.
- Ormskirk had very low referral rates from the clinical team.
- Referrals were mainly from Skelmersdale residents.
- The most common reason for requesting support was neurodiversity/SEND support and housing followed by parental support.
- The majority of cases were outreach and more intensive support needs.
- Various staff changes, challenges and delays with Barnardo's impacted honorary contracts.
- Feedback from the clinical team indicated a gap in provision for the 12+ age range.

Programme Governance and Oversight

System Leadership

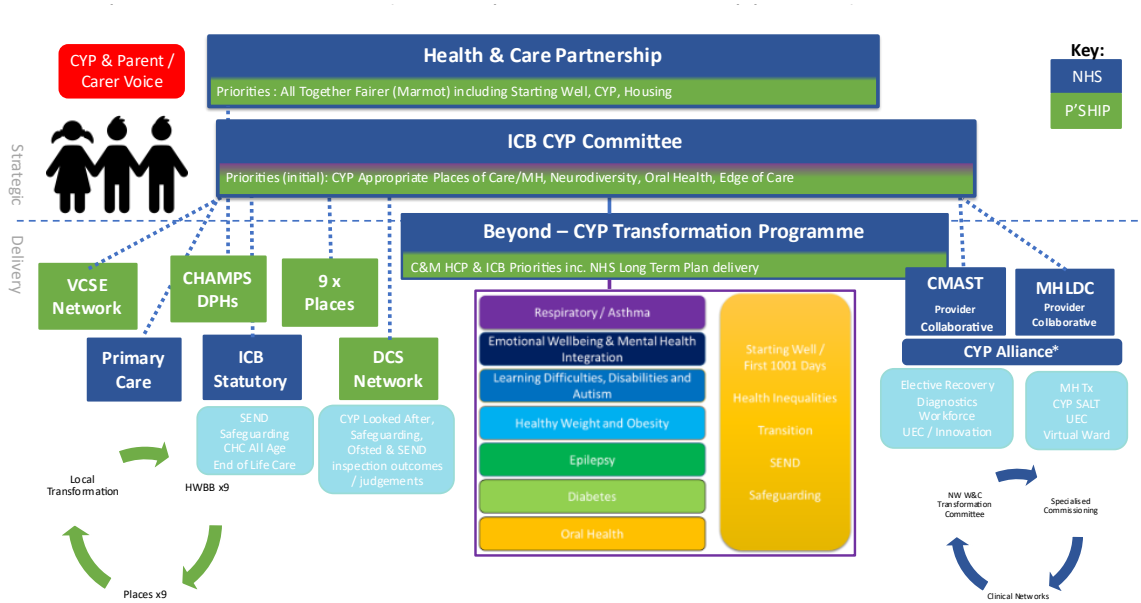
The programme has strong system leadership and sponsorship to support delivery. Key roles within the Integrated Care System include:

Children's Champion:	Raj Jain, Chair, NHS Cheshire and Merseyside
ICB Executive Lead for CYP:	Christine Douglas, Executive Director for Nursing and Care, NHS Cheshire and Merseyside
Chair Beyond Board:	Kath O'Dwyer, Chief Executive, St Helens Council
SRO, Beyond:	Louise Shepherd, Chief Executive, Alder Hey Children's NHS Foundation Trust, with John Grinnell taking over this role in November 2024
Executive Lead (host organisation):	Dani Jones, Chief Strategy and Partnerships Officer, Alder Hey Children's NHS Foundation Trust
Programme Director:	Dr Elizabeth Crabtree, Beyond

System engagement remains in place, with Place, provider and clinical involvement reflected in the Beyond Board and workstream leadership. This approach to partnership working recognises the complexity and multiple stakeholders involved within the children and young people's arena to ensure that we add value and avoid duplication.

Governance

The system architecture for CYP in Cheshire and Merseyside has continued to embed, with system partners convening to ensure a strong focus on CYP. Beyond remains an integral delivery vehicle within this, supporting system connectivity to deliver transformational change.



Finance

Beyond is jointly funded by the ICB and NHSE. The programme reports financial position via both NHSE and ICB governance structures on a minimum of a quarterly basis.

Funding from NHSE is allocated on an annual basis to deliver specific workstreams and projects aligned to the Long-Term Plan and NHSE Children's Transformation Programme. ICB funding supports core programme delivery and the broader HCP priorities and has been granted on a recurring basis since 2023/24. In addition to core funding, Beyond also received funding in support of delivery of All Together Smiling and the sustainability of the HENRY programme in local areas.

ICB Programme Funding	2024/25 Budget	2024/25 Outturn	Variance
Core Funding	£661,031	£696,633	-£18,597
All Together Smiling - Supervised Tooth Brushing	£503,530	£503,530	0
HENRY Sustainability funding	£54,199	£54,199	0

The underspend is a result of in-year staff vacancies

The programme team successfully bid for a number of NHSE projects during 2022/23, with the second year of funding received in 2024/25. The funding profile for NHSE is split across two bundles, as detailed below.

NHSE Programme Funding (Bundle 1)	Provider	24/25 Budget	2024/25 Outturn	Variance
Regional and System CYP Clinical and Management & Leadership	Beyond	£328,267	£326,004	£2,262
Asthma	Beyond	£99,487	£99,487	0
Diabetes	Beyond	£25,555	£25,555	0
Epilepsy	Beyond	£24,597	£24,597	0
Integration (to support integrated working across the CMAST Provider Alliance)	Beyond	£31,977	£9,836.79	£22,140
CEW Clinics	Alder Hey	£408,422	£408,422	0
		£918,305	**£893,902**	**-£24,403**

The underspend is a result of in-year staff vacancies.

NHSE Programme Funding (Bundle 2)	Provider	2024/25 Budget	2024/25 Outturn	Variance
Early Years: Oral Health	Beyond/Koala NW/CHCP	£140,987	£140,987	0
Epilepsy: Integrated Mental Health	Alder Hey	£59,669	£59,669	0
Epilepsy: Integrated Epilepsy Specialist Nurse	Alder Hey	£63,784	£63,784	0
Levelling up - ESN (Leighton and Crewe)	Mid Cheshire FT Trust (TBC)	£14,403	£14,403	0
Epilepsy Youth Work Admin	Beyond	£8,038	£8,038	0
Epilepsy: Youth Workers	Merseyside & West Lancs/ Mid Cheshire/Beyond	£68,483	£68,483	0
CEW Expansion	Alder Hey	£111,107	£111,107	0
Mental Health Champions in Acute Provides	£19,547K to eight hospitals with a paediatric ward	£156,376	£156,376	0
PEWS (£6,300 per trust)	£6,481 to eight hospitals with a paediatric ward	£51,848	£51,848	0
		£674,695	£674,695	**0**

Programme Evaluation

Beyond commissioned The Child Outcomes Research Consortium (CORC) at Anna Freud to undertake an evaluation of the programme delivery guided by the participation of young people.

Recommendations

- Continue to respond to opportunities and promote investment in children and young people.
- Continue to maintain and develop Beyond as a multi-agency initiative.
- Develop a stronger online presence to raise the profile of the programme among cross-sector partners.
- Further develop approaches to co-production, building on a growing culture of engaging children, young people, parents and carers to:
    - Address young people's feedback that they are not taken seriously in healthcare and school, and that communication and inclusion could be improved in their care.
    - Ensure activity to involve young people, parents and carers is meaningful and has impact.
    - Support the programme to hear a diversity of views, reflecting the diversity of the population.
- Clarify and communicate to those involved in the workstreams regarding regional governance and governance processes for the programme.
- Develop approaches to capture return on investment and financial impact.
- Continue to develop the outcome and measurement framework for the programme.

The full report can be found in Appendix 2.

Data and Dashboards

Data science remains fully embedded within the programme and enables identification of key areas of health inequality to support risk stratification. The data science programme of work closely aligns with the ICB data programmes through the Data into Action Group, as well as the Population Health Intelligence Group. This collaboration ensures interconnectivity and the effective use of data and information to inform Beyond programmes and projects, and to improve services and transform care for children and young people.

In 2024/25, Beyond has expanded partnership working across Local Authorities and the University of Liverpool to improve our understanding of the lives of children and young people, and the pathways across health and social care. This work has enabled a granular understanding of impact for our most vulnerable and at-risk population.

The Paediatric Storyboard continues to act as a consistent approach to share information about programme priorities in as close to real time as possible. Through regular feedback, content is frequently updated and amended to ensure it meets the needs of colleagues across the region and supports programme delivery. In 2024/25, there were 168 users actively accessing the Paediatric Storyboard.

We continue to expand on the development and delivery of functional and interactive tools to ensure accessibility and transparency in the data and insights that inform the programme. The latest development is the Respiratory Dashboard, which is currently under review for release to wider colleagues. This will enable improved oversight of primary care data alongside secondary care to better understand a child's pathway throughout the healthcare system.

In 2024/2025, the Beyond Programme created placement opportunities for two data science trainees as part of the National School of Healthcare Science (NSHCS) Scientist Training Programme (STP). This enabled trainees to develop an understanding of their speciality and the role of clinical scientists while working as part of a multidisciplinary team. These placements have allowed students to explore the benefits of real-world health care data and its use to support children and young people.

Cheshire and Merseyside
Health and Care Partnership

beyond
Children and Young People's Transformation Programme

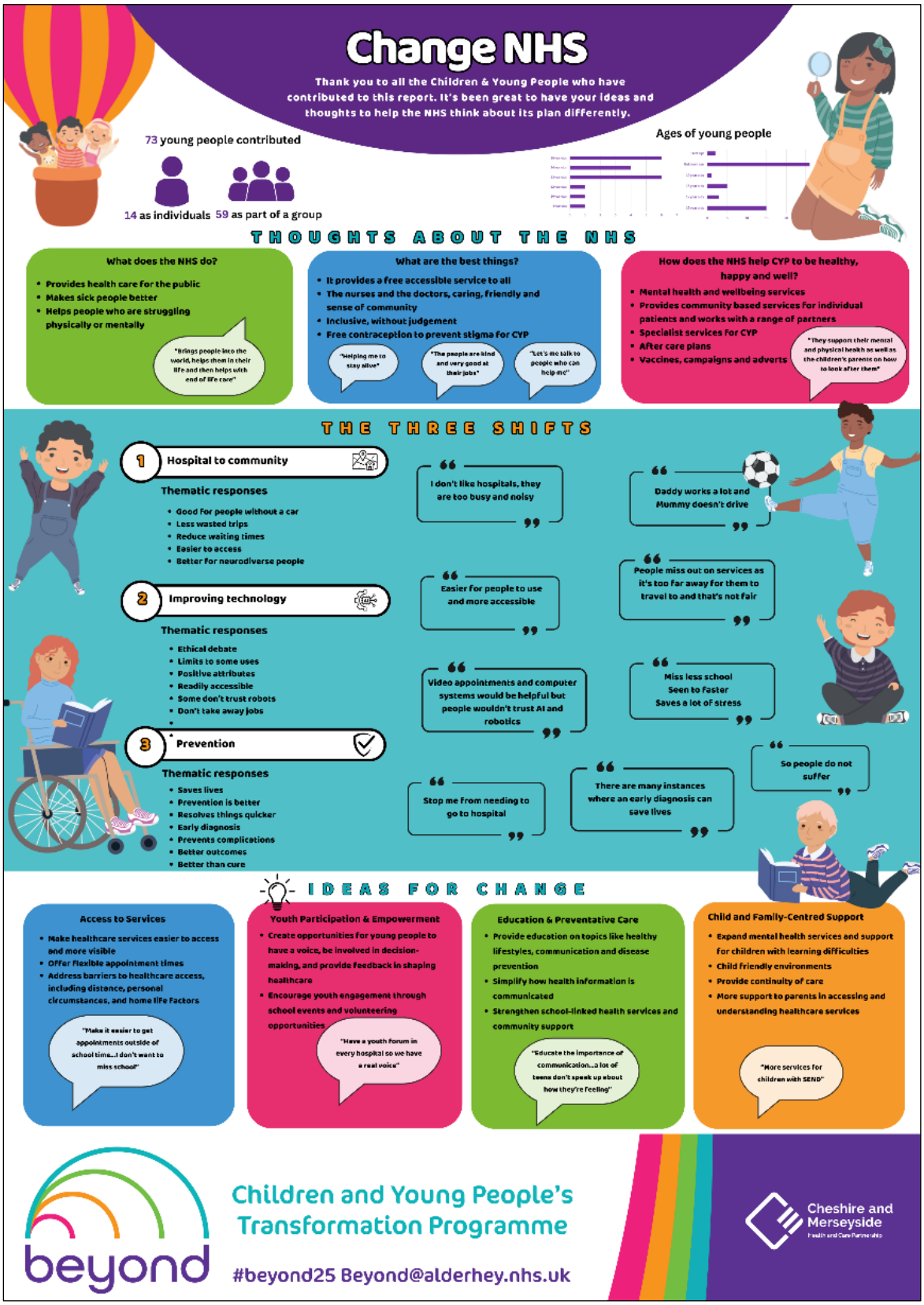
Appendices

Appendix 1: Key Partners in Delivery

Appendix 2: Evaluation Report

6. Beyond
Programme evaluatio

Appendix 3: Change NHS Infographics



BOARD OF DIRECTORS

Thursday, 5th June 2025

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

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score
3.2	BAF Risk 3.2 Confidence in delivering the financial plan and benefits remains limited. Mitigations include Executive-led plan refinement, analytical support, and outcome-focused delivery assurance	16

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

1. Executive Summary

Since April 2025, we have transitioned from design to delivery, establishing the infrastructure to lead one of the most ambitious transformation portfolios in the Trust's history. We now have five active collaboratives functioning under a consistent rhythm, each contributing uniquely to our shared strategic priorities outlined in 2030:

- Reimagined Elective Care & Centres of Excellence
- Acute, Diagnostics & Urgent Care
- Neighbourhood & Prevention
- Digital, Data & AI
- Organisational Design

The Transformation Board, meeting monthly, is now acting as the engine room for aligning delivery pace with strategic ambition. This structure is enabling clearer oversight, faster escalation, and more focused delivery support.

We are now at a pivotal moment. Initial traction has been achieved, but the shift from planning to sustained impact demands greater focus and delivery discipline across all levels of the programme. This includes making tough choices, sharpening execution, and ensuring we are collectively focused on the priorities that will unlock the most value. Our delivery ambition remains high — and so too must our confidence in the ability to convert plans into tangible benefits for children, young people, and the system.

2. Financial Delivery Gap and Strategic Risk Exposure

The Trust has set a transformation-led benefit target of £25m for 2025/26. Current plans account for approximately £19.75m of transformation-led savings, leaving a gap of £5.25m. This underlines the reality that while our people are working exceptionally hard and momentum is building, we must ensure that effort is focused in, the right places. It is not just about effort — it's about directing that effort toward the areas that will deliver the greatest impact. The pace and scale of change must increase, but with disciplined prioritisation and sharper focus on the areas that will unlock the most value. We are supporting collaboratives to:

- Strengthen alignment between strategic ambition and delivery plans, ensuring collaboratives are targeting areas with greatest impact and feasibility
- Refine benefits with stronger evidence and clearer assumptions
- Re-sequence milestones to unlock earlier delivery where feasible
- Explore opportunities for deeper redesign, particularly in digital integration and elective reform
- Consider wider system contributions, including neighbourhood models that could yield medium-term impact
- Conduct an urgent review of Trust programmes and projects to identify opportunities to pause, reprofile, or reduce non-core activities, thereby freeing delivery capacity and enhancing organisational focus.

A key priority across June 2025 will be growing confidence in the deliverability of these financial plans. While the overall value of identified benefits is material, much of the forecasted benefit remains unproven or contingent on future conditions. We must continue to challenge assumptions, validate the benefit logic, and ensure that delivery

plans are appropriately phased to yield tangible, measurable results.

The gap between ambition and readiness is reflected in the persistent high rating of BAF Risk 3.2. While this risk is actively managed, it reflects the degree of uncertainty in our ability to convert delivery into sustainable financial value at the required pace.

3. Progress Against 90-Day Milestones

To support faster execution and learning, all collaboratives are operating on a 90-day planning and delivery cycle. This structure was introduced not only to gain early traction but to help us embed new ways of working, improve cross-functional teaming, and shift our culture towards delivery discipline and outcome ownership.

The aim is to test, learn and iterate in focused delivery sprints. These 90-day cycles serve as a key mechanism for building momentum, enabling us to track progress, address delivery risk early, and mobilise support where needed. They also give teams a structured cadence to align short-term actions with our longer-term strategic goals.

To date, milestone delivery has been variable. While there is evidence of genuine progress and increased ownership within collaboratives, only a proportion of planned milestones have been delivered in full. A number are on track but not yet complete, and some have required re-scoping or deferral due to resource constraints or wider operational pressures.

Table 1: 90- Milestone Delivery Overview

Collaborative	On Track	Completed	Off Track	At Risk	Critical	Not Started	Comments
Acute, Urgent Care & Diagnostics	50%	–	–	10%	30%	10%	Key milestones scheduled related to the Business Care approval on SDEC – have led to critical milestones being missed. Focus is on-going to support decision making; risk of in-year slippage due to critical path dependencies.
Neighbourhood & Prevention	17%	–	–	–	–	83%	Still early-stage; bulk of work planned to commence in future 90-day cycles.
Workforce & Org Transformation	43%	–	–	14%	–	43%	Capability-building and governance actions initiated; further sequencing required.
Reimagining Elective Care	75%	17%	8%	–	–	–	Strong momentum in key clinical areas such as Cardiology and Productivity.
Digital, Data & AI	60%	20%	20%	–	–	–	AI pilot launched; and significant improvement work on track across June / July.

Across the collaboratives, there is increasing evidence of self-reflection, prioritisation, and responsiveness to challenge. The 90-day framework has helped surface delivery barriers early and enabled more agile responses. While milestone completion is not yet

universal, it is directional we are starting to see embedded routines and increasing confidence in collaborative structures.

The next cycle will require us to double down on focus, ensure milestones are better aligned to benefit delivery, and continue to build capacity to deliver at pace. As part of this, collaboratives will be finalising their Programme Initiation Documents (PIDs) by the end of May, which will also set out the next phase of their longer-term transformation plans. This will enable the Trust to assess readiness, prioritise delivery support, and ensure that medium-term ambitions are aligned with organisational strategy and resource assumptions.

4. Conclusion and Forward Priorities

This is a critical period for our organisation. The foundations are in place, and the transformation infrastructure is fully mobilised — but delivery confidence remains mixed. To bridge the gap between ambition and achievement, we must now bring greater structure, sharper prioritisation, and increased pace to how we work.

We recognise the significant effort already underway across our teams. However, effort alone will not be enough — we must ensure that this energy is aligned to the right priorities, backed by robust plans, and focused on the areas with the greatest potential for impact.

The next phase must prioritise:
• Converting planning into benefits with tighter accountability
• Re-sequencing deliverables to generate earlier impact
• Aligning leadership time and resource to unblock delivery barriers
• Creating the headspace for disciplined focus and decision-making that enables real delivery traction

We must now shift from delivering plans to delivering value — with clarity, with urgency, and with purpose.

Next Steps: June – July 2025

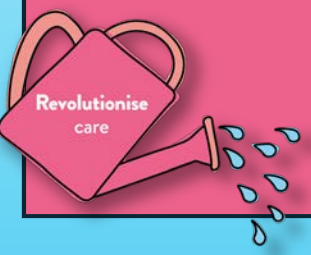
1. Financial Plan Finalisation
    - Collaboratives to re-submit plans with enhanced benefit models (PIDs)
2. Portfolio Scorecard Rollout
    - Power BI dashboard piloted and embedded across reporting cycles
3. Delivery Acceleration
    - Executive focus on highest-impact, highest-confidence initiatives
4. Programme Portfolio Review
    - Undertake a Trust-wide review of current programmes and projects to identify opportunities to pause, reprofile or step down activity that does not align with current strategic priorities. The goal is to release delivery capacity and sharpen organisational focus
5. Full 5 year programmes
    - A complete 5-year plan, aligned with Vision 2030 and PIDs, will be shared and discussed at the September Strategy Board.

Flash Report May 2025

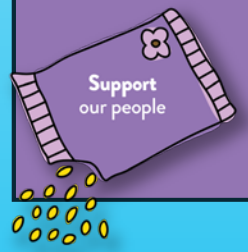
Performance is subject to change

Alder Hey Children's NHS Foundation Trust

1	0	91.2%	5	10*
Severe/Fatal Incidents/Never Events	Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections	Patients deteriorating from an inpatient bed



84.8%	349	56.2%	1.73	95.3%
ED: %Treated within 4 Hours	Number of RTT Patients waiting >52weeks	% Patients treated within 18 weeks (RTT)	Elective activiy per clinical WTE	Diagnostic Performance



-163	11.9%	79.2%	TBC
Estimated Workforce Plan	Staff Turnover	%PDRs Completed	% Sickness

Financial Sustainability

-£1m	-£3.8m	-£6m	TBC
I&E position	I&E year end forecast to plan (Variance)	CIP (Forecast vs full year target)	Cost per patient treated

HIGHLIGHT

- Sustained performance for time to be seen and treated in ED - 3rd consecutive month 80%+.
- High proportion of diagnostic tests completed in six weeks.
- Good patient experience scores.
- No never events or new patients safety incident investigations.
- Reduction in number of patients deteriorating from an inpatient bed and admitted to PICU*

CHALLENGES

- Slight reduction in the number of CYP waiting >52 weeks however this continues to be a challenge.
- 5 healthcare associated infections with 2 Cdiff and 3 MSSA.
- 1 Severe incident although investigation not yet complete at time of reporting.

* *Patients deteriorating from an inpatient bed as to 27th May*

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: May 2025

Contents

IPR – Executive Summary

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience

	Value	Target	Trend
Patients deteriorating from an inpatient bed admitted to PICU	19	n/a	↓
Number of Incidents per 1,000 bed days – No Harm	87	77.4	↑
Number of Incidents per 1,000 bed days – Low Harm and above	22	19.6	↑

Executive Summary

All staff have achieved 100% compliance with Patient Safety Level 1 training, reflecting a strong organisational commitment to safety education. Medication errors resulting in harm remain low, highlighting the effective practices of the Pharmacy and wider multi-disciplinary teams in ensuring the safe administration of medications. Both Inpatients and the Emergency Department (ED) reported 91% compliance with timely antibiotic administration for sepsis, indicating consistent adherence to clinical protocols. All complaints have been responded to within the required 25 working days, demonstrating the Trust's responsiveness to concerns. While there has been an increase in the number of restrictive interventions, these were all associated with specific episodes of care. It is considered both positive and necessary that staff report these interventions, supporting transparency and safety in care delivery. Friends and Family Test (FFT) results in ED have been below the expected threshold.

Support Our People

	Value	Target	Trend
Workforce Plan	4,360	4,482	↓
Staff Turnover	11.4%	10%	↔
Sickness Absence (Total)	5.7%	4.5%	↑

Executive Summary

Mandatory training completion across the Trust remains strong at over 90%, and PDR (Personal Development Review) completion reached 90% by the end of March 2025, based on a rolling figure. In April 2024, the Trust reported a positive staffing position, with actual workforce numbers slightly below plan (plan: 4481.85; actual: 4360.36), though significant cost improvement efforts are still required throughout the year. These are being addressed through the Organisation Design and Workforce Efficiencies programmes. Sickness absence levels continue to present challenges, and a detailed paper on managing sickness, including updated return-to-work processes and the potential benefits of a new occupational health contract, is scheduled for the July People Committee. Additionally, PDRs for staff at Band 7 and above were reset from April 1, 2025, and are expected to be completed by the end of July, with completion rates anticipated to rise over the summer.

Revolutionise Care

	Value	Target	Trend
ED % Treated Within 4 Hours	86%	78%	↑
%RTT Patients Waiting >52 Weeks*	1.8%	1.6%	↑
RTT Waiting List Within 18 Weeks*	54.5%	60.6 %	↔

Executive Summary

ED performance continues to exceed national target.

Statistical improvement in the number of elective admissions treated per WTE.

Diagnostic performance has remained consistently strong over the past six months, with more than 94% of patients completing their tests within six weeks.

The increase in patients waiting >52 weeks is primarily driven by ENT and Dentistry. The main factors, include staff vacancies, reduced activity due to half term and long-term sickness throughout April.
The elective waiting list has decreased by 9% from December 24 to April 25. This aligns with the downward trend in RTT (%) and indicates that the majority of patients treated or discharged had been waiting under 18 weeks

Financial Sustainability

	Value	Target	Trend
I&E Year End Forecast	-£1.165m	-£,1.165m	↔
Recurrent CIP Delivered	£7.2m	£22.7m	↓
%ERF Value (Income)	141%	n/a	↑

Executive Summary

In April (Month 1), the Trust reported a £1.165 million deficit, which is in line with the financial plan. Currently, the CIP is £0.7 million behind plan for the month, with £3 million transacted to date, £7.2 million in progress, and a further £13.3 million identified as opportunities. Delivery remains on track, contingent on the successful execution of amber and red-rated schemes. Cash levels have remained strong and in line with expectations, while capital expenditure is currently behind plan due to budget phasing. Efforts are ongoing to achieve the full £22.7 million savings target through the Financial Improvement Programme (FIP). However, it is recognised that the available capital allocation may not cover all requirements, and a Capital Prioritisation Workshop will be held to address this. Continued cost control, particularly in non-clinical areas targeting a 10% reduction, and a sustained focus on efficiency delivery and capital programme prioritisation will be critical to meeting the year-end position.

*RTT targets based on trajectory (plan)

NHS
Alder Hey Children's
NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

• 100% of staff compliant with Patient Safety Level 1 training • Medication errors resulting in harm continues to be low demonstrating the hard work of Pharmacy and the wider multi-disciplinary teams in safe medication practice • Both Inpatients and ED achieved 91% compliance with the administration of antibiotics for sepsis • 100% of complaints reported to be responded to within 25 working days

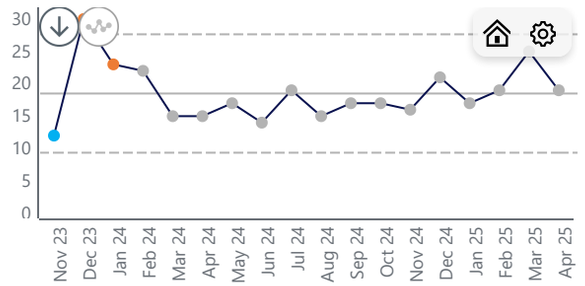
Areas of Concern:

• Increase in number of restrictive interventions however associated with an episode of care and both positive and important that staff report when there is a requirement for restrictive intervention • FFT results in ED below threshold however increased to 87% • Compliance with PALS resolution reported to drop to 86%; Divisions and Corporate Services to review

Forward Look (with actions)

Patient Experience strategy under review which includes how feedback from families is collected and analysed

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



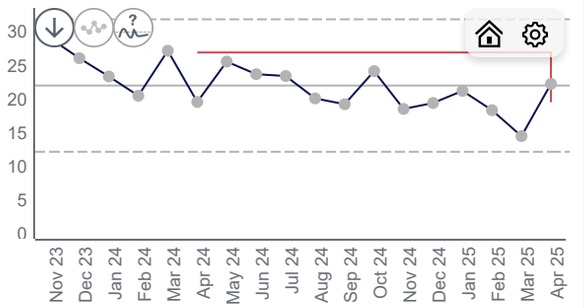
Technical Analysis:

Common cause variation with 19 patients deteriorating from an inpatient bed to PICU with an average of 19 a month during the last 18 months.

Actions:

New drive metric, continuing to demonstrate the Trust's commitment to improvement in regard to the deteriorating patient. A new deteriorating patient workstream has been established. In April, 19 patients were admitted to Critical Care unplanned. Each case will be reviewed to determine whether they are 1. Predictable and preventable; 2. Predictable but not preventable; 3. Predictable but potentially preventable; 4. Not predictable and not preventable

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



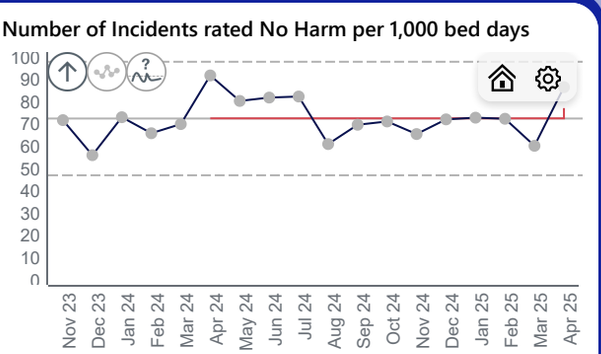
Technical Analysis:

The target is set on a 5% reduction of 24/25, with a monthly target of 19.6.

Actions:

Incidents of harm continue to be on an overall downward trajectory. PSIRI panels now well embedded within the Trust

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



Technical Analysis:

The target is set against a 5% improvement on 24/25 with monthly target 77.4

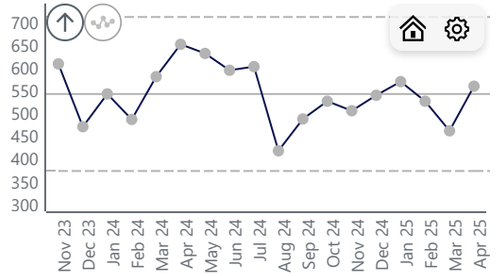
Actions:

Increased number of incidents resulting in no harm in month however demonstrates culture of positive reporting. Incidents reviewed by Divisions and nominated incidents reviewed at weekly Patient Safety Meeting

Alder Hey Children's NHS Foundation Trust

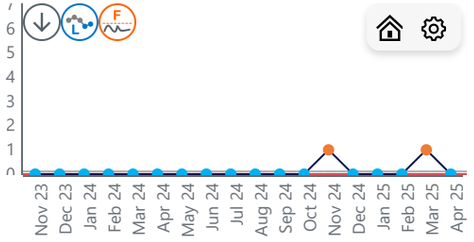
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



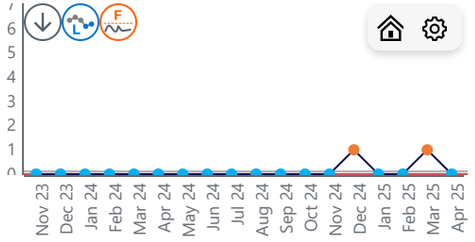
Severe or Fatal Incidents – Physical only

Target: Internal

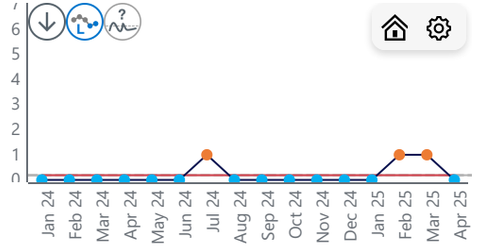


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

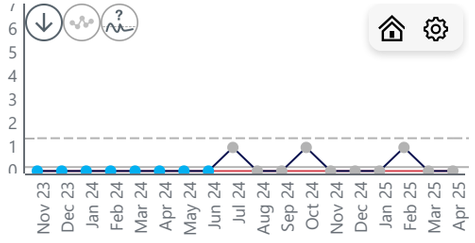


Number of PSIIs (Patient safety incident investigation) undertaken



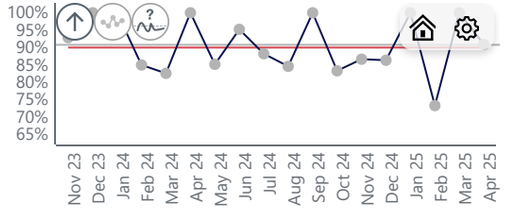
Number of Never Events

Target: Internal



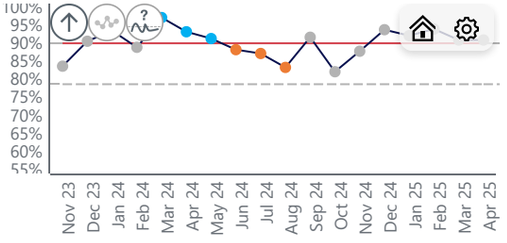
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

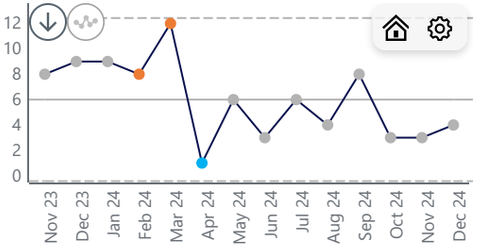


Sepsis % Patients receiving antibiotic within 60 mins for ED

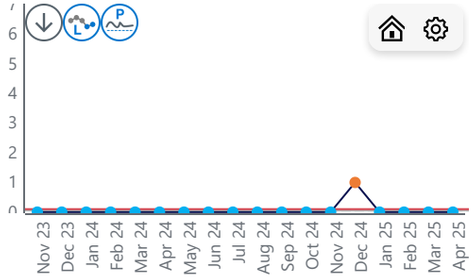
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

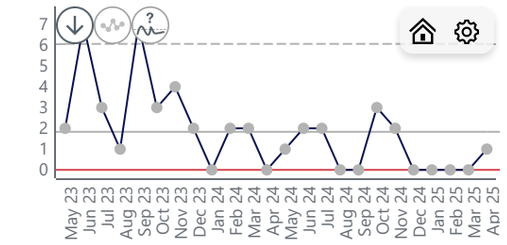


Pressure Ulcers Category 3 and 4

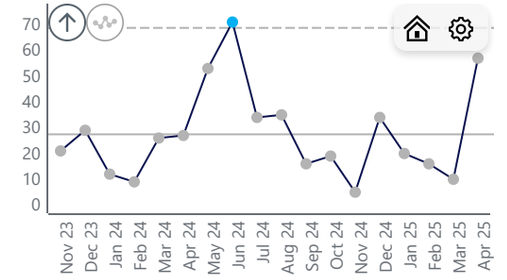


Pressure Ulcers Category 2

Target: Internal

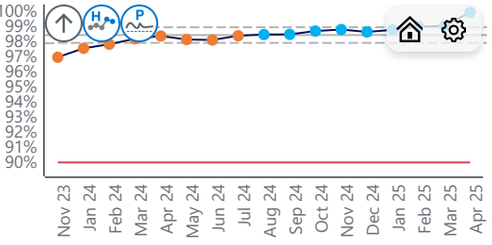


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal

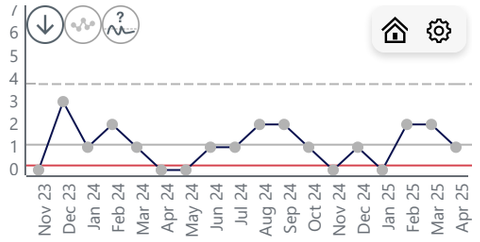


Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

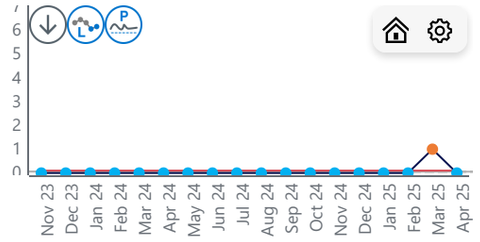
Hospital Acquired Organisms - MSSA

Target: Internal



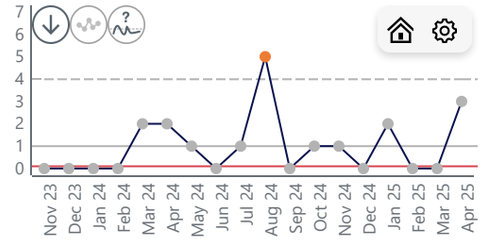
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



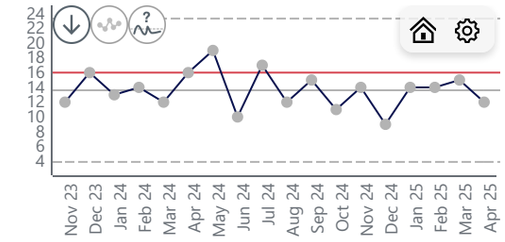
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



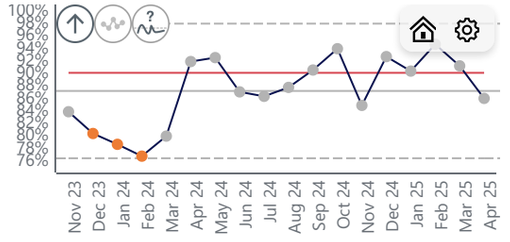
Number of formal complaints received

Target: Internal



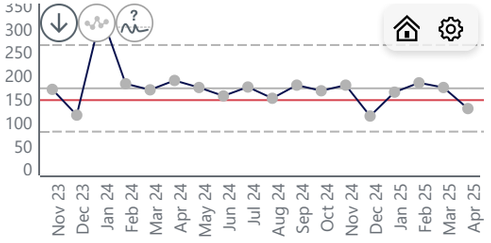
% PALS Resolved within 5 Days

Target: Internal



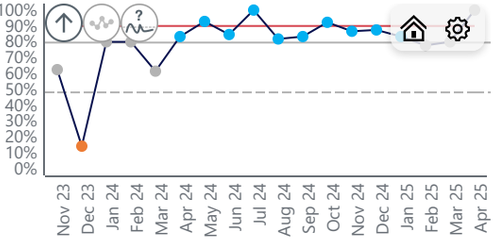
Number of PALs contacts

Target: Internal



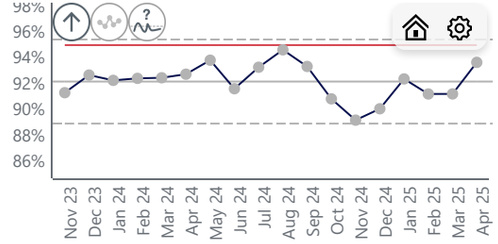
% Complaints Responded to within 25 working days

Target: Internal



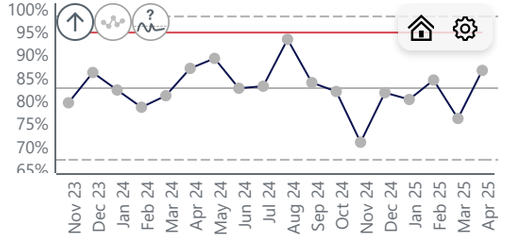
F&F Test - % Recommend the Trust

Target: Statutory

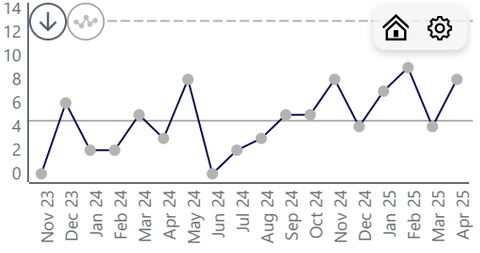


F&F ED - % Recommend the Trust

Target: Internal

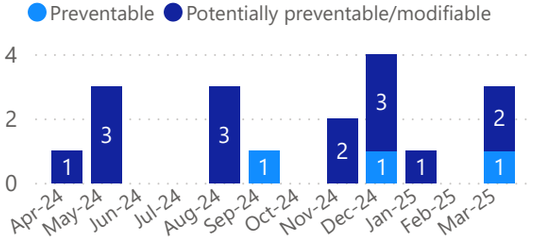


Number of patients deteriorating from HDU admitted to PICU

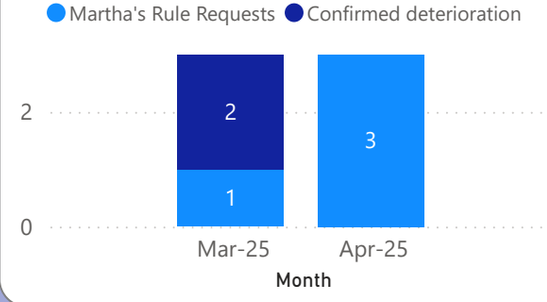


Predictable and preventable deteriorating patients

Not inclusive of all categories



Martha's Rule



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:

• Inpatient and day case touch-time utilisation increased to 85.4% and 72.7%, respectively. This marks the highest utilisation each department has achieved individually and collectively (81%). • Income and spells in M1 exceeded the plan for Elective & Daycase (113.9%) and Outpatient New and Procedures (112.7%) • The "Reforming elective care for patients" plan sets a long-term ambition to significantly increase the uptake of PIFU to at least 5% of all outpatient appointments by March 2029. Alder Hey is currently meeting this target, but further efforts are ongoing to establish PIFU as a standard follow-up method for all conditions where it is safe and appropriate • Diagnostic performance has remained strong over the last six months, with over 94% of patients completing their tests in under six weeks • The time required to clear the outpatient waiting list has been decreasing monthly for over a year, assuming no new patients are added.

Areas of Concern:

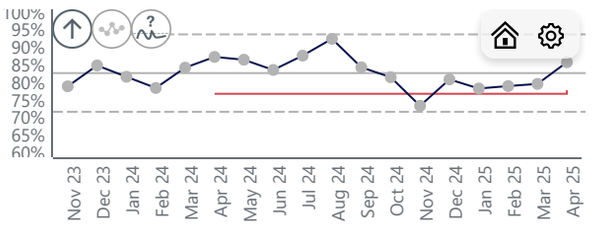
• WNB remains above trust target • The number of follow-ups that will be two years overdue by March 2026 is similar to the target we aimed to clear in 2024/25. Several surgical specialties did not meet this target, and action plans with specific milestones are being developed • Transcription delay and increase of turnaround times has led to clinic letters completed performance decreasing.

Forward Look (with actions)

WNB improvement workstream – ongoing actions:
• Community Ophthalmology has begun overbooking Mere Lane clinics to counteract their high WNB rate and improve overall clinic utilisation
• Orthotics now contacts families who are WNB via phone and, where possible, conducts the appointment virtually. This has led to a 30% reduction over the past five months, with the WNB performance in May at 7.73%.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

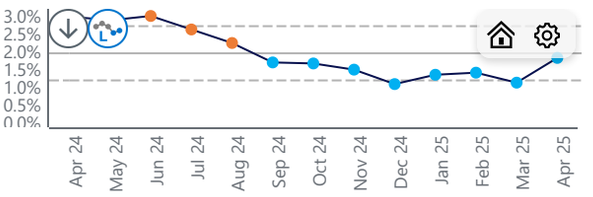
Achieved the national target in Apr-25. Common cause variation observed with performance of 86%, a rise from Mar-25 (79.8%). Apr-25 performance is -1.5% compared to Apr-24 (87.5%). Apr-25 seen 38 greater attendances compared to Apr-24 however Apr-25 had +1.2% greater ratio of Resus and Very Urgent patients compared to Apr-24.

Actions:

Positive achievements in month, aiming to focus on maintained streaming % , triage times and clinician wait to be seen time in order to provide greatest opportunity for achievement in May. Will also be focusing on NWAS turnaround times as part of our contribution to system UEC metrics.

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

Target : Statutory



Technical Analysis:

1.84% of our open IP & OP RTT waiting list is waiting >52 weeks against a national target of less than 1% waiting lists waiting >52 weeks. Dentistry, ENT & Neurology currently top 3 services patients > 52 weeks.

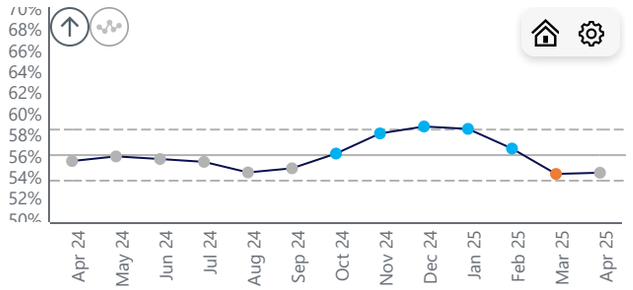
Actions:

The increase is primarily driven by ENT and Dentistry. The main factors, include staff vacancies, reduced activity due to half term and long-term sickness throughout April.

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

RTT waiting list within 18 weeks



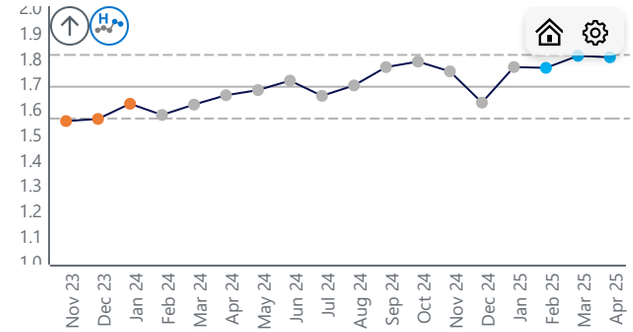
Technical Analysis:

Common cause variation with performance of 54.4% against a year end target of 63.1% by March 2026. Neurology, Dentistry & Plastics lowest performing of services with >100 waiters.

Actions:

The elective waiting list has decreased by 9% from December 24 to April 25. This aligns with the downward trend and indicates that most patients treated or discharged had been waiting for under 18 weeks.

Elective admissions (IP & DC) per clinical WTE



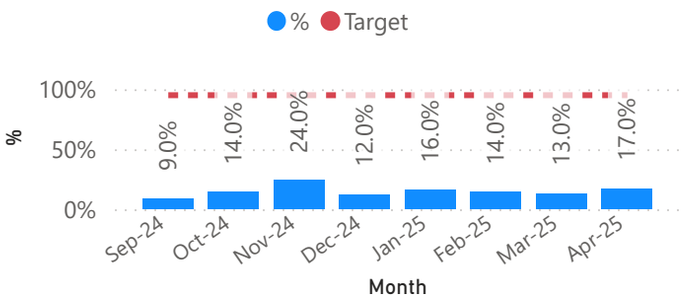
Technical Analysis:

Special cause variation of improving nature has been observed with performance of 1.83 admissions per Clinical WTE (1592.89)
Increase from April 2024 rate at 1.66 with an extra 9.7 admissions per working day in April 2025 with 40 WTE's less.

Actions:

The number of elective admissions has steadily increased over the last 12 months. A further increase is anticipated following the development of specialty-level clinical productivity plans for 2025/26. Plans will be presented in May 2025.

% 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 April 2025 is 17% against a target of 95% which is an increase from performance of 13% in March 2025.

Actions:

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

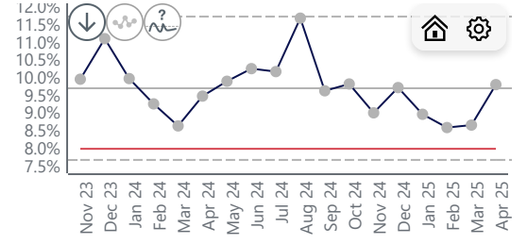
Integrated Performance Report | May 2025

Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

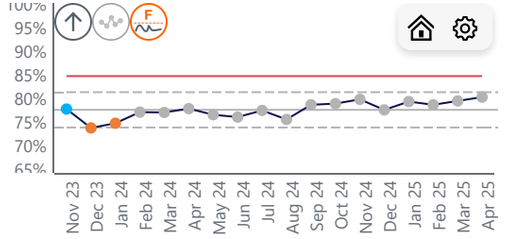
% Was Not Brought Rate (All OP: New and FU)

Target: Internal



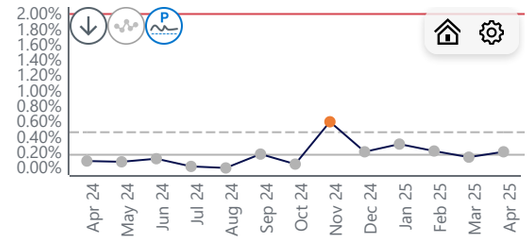
Theatre Utilisation (Capped Touch Time)

Target: Internal

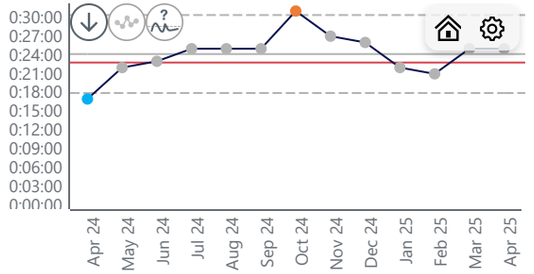


% of ED attends over 12 hours

Target: Statutory

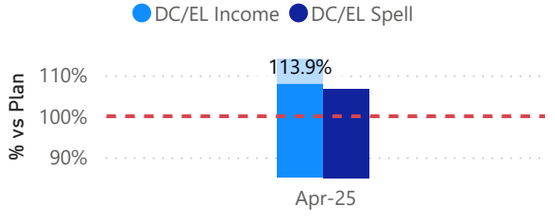


Average Ambulance Handover Time



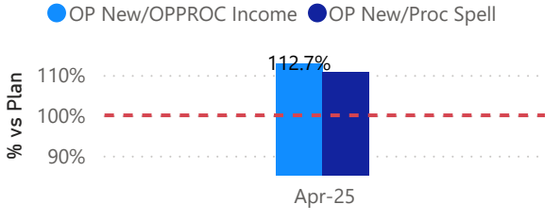
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

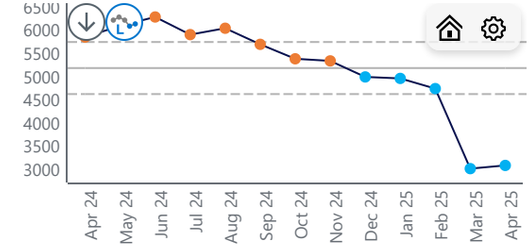


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

SLAM Performance

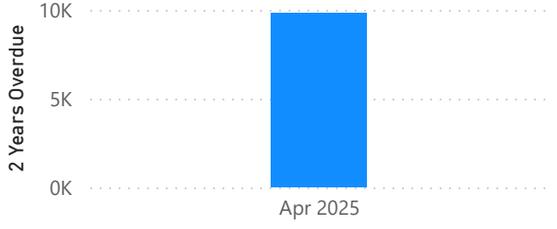


Volume of active outpatient follow up waits - 2 Years & Overdue



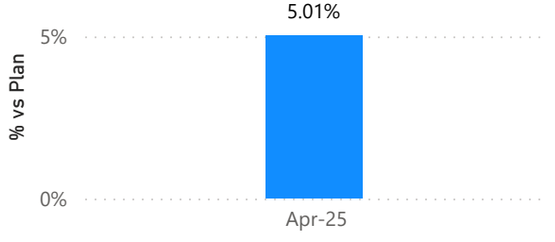
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

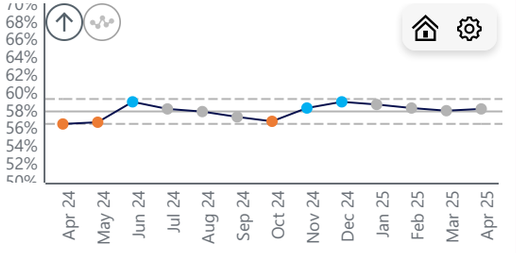


% follow up waiting list on PIFU

New WL Snapshot

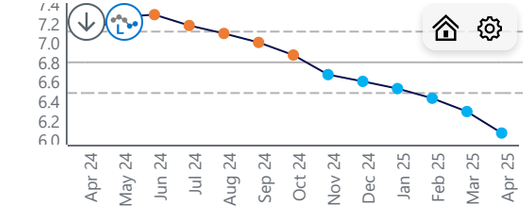


Time to first attendance, waiting for first event and of those waiting less than 18 weeks.



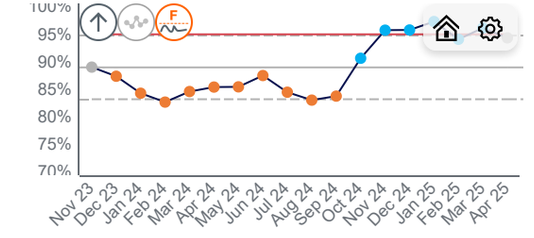
Estimated months it would take to clear the waiting list if no new patients were added

Outpatient RTT Only



Diagnostics: % Completed Within 6 Weeks of referral

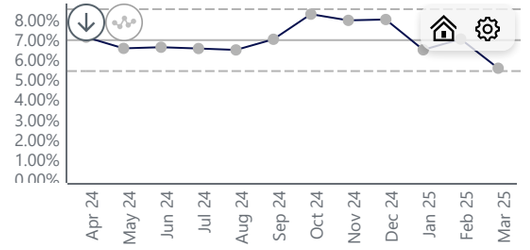
Target: Statutory



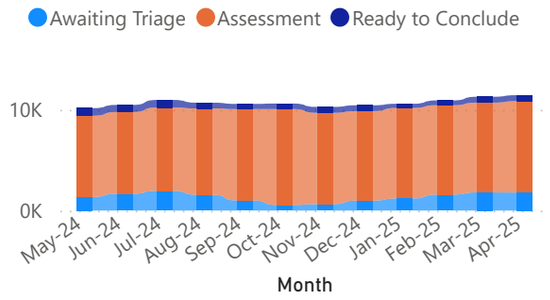
Alder Hey Children's NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

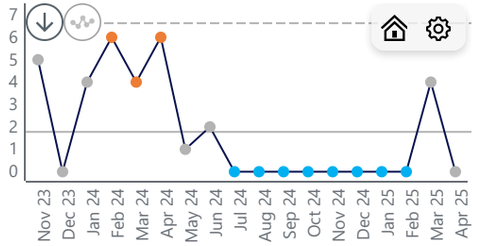
Percentage of patients admitted as an emergency within 30 days of discharge



ADHD/ASD Diagnosis Status



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

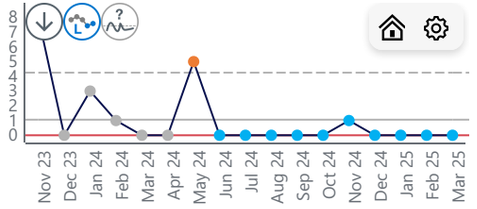


Annual change in the number of children and young people accessing NHS funded mental health services - In Development

Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours - In Development

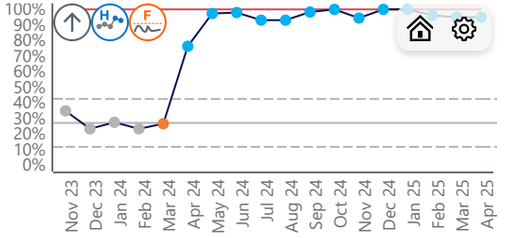
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



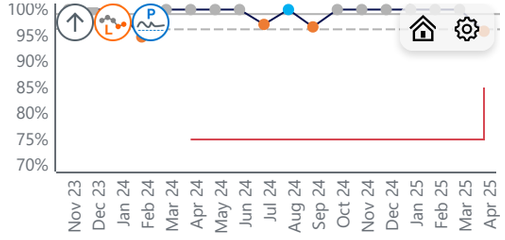
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



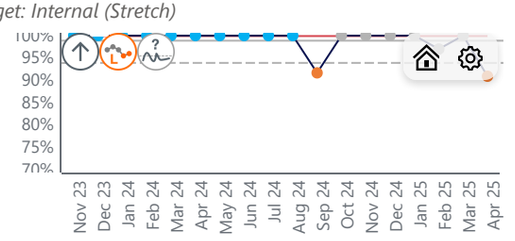
Cancer: Faster Diagnosis within 28 days

Target: Statutory



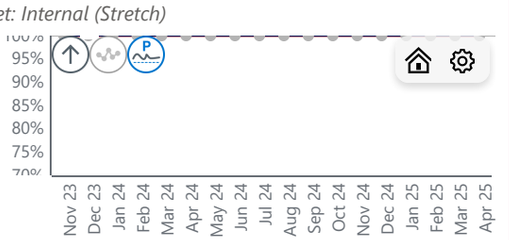
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)



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

Target: Internal (Stretch)



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

- Mandatory training completion remains over 90%
- PDR completion across the Trust achieved 90% at the end of March 2025 (this is a rolling figure).

Areas of Concern:

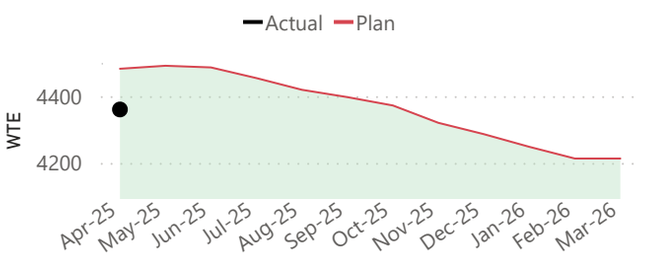
Whilst reporting a positive position in April 2024, (plan: 4481.85; actual: 4360.36), there is significant CIP required throughout the year. Improvement measures are reviewed via the Organisation Design, and Workforce Efficiencies programmes.

Forward Look (with actions)

• Sickness absence levels are challenging, with a detailed paper on sickness absence management due to be presented to the July People Committee, including a refresh of return to works and opportunities with the new occupational health contract • B7+ PDRs reset from 1st April 2025, due for completion by the end of July, with the rate of completion expected to increase through the summer.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

Total workforce for the end of April 2025 was 121 WTE below plan. Actual WTE was 4360 against a reduced plan of 4482.

Actions:

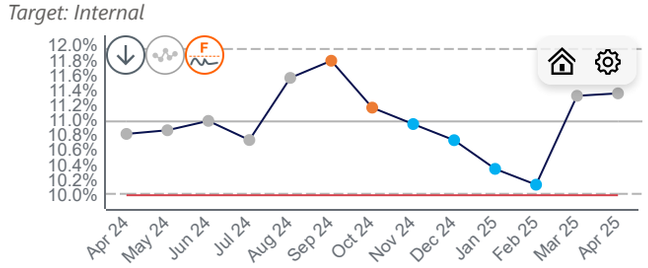
Bank and agency spend and WTE both reduced into April 2024. Usage is reviewed weekly and has come down significantly from March to April 2025 (the lowest in the previous 12-month period):

• Bank usage in April: 101.17 WTE (March 2025: 140.71 WTE)

• Agency usage in April: 6.49 WTE (March 2025 usage: 8.1 WTE).

Staff Turnover

Target: Internal



Technical Analysis:

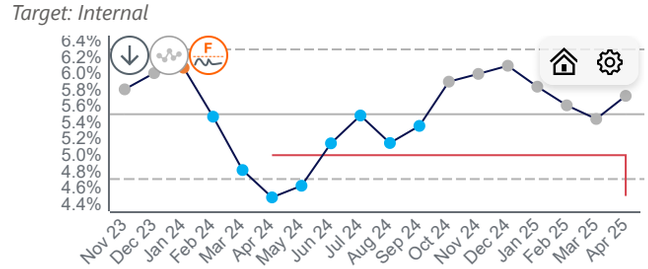
Common cause variation observed with performance of 11.4% in April 2025 against an internal target of 10%. Slight increase from March performance of 11.3%.

Actions:

Having seen a steady decline, staff turnover has recently increased due to the end of a group of fixed term contracts, and transfer of the digital team.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in April 2025 is 5.73% which is above the 5% target and is increase from March 2025 at 5.44%. April 2025 performance comprises STS at 1.78% and LTS at 3.95%. LTS highest rate since January 2024. Still demonstrating common cause variation, 11th consecutive month above the target which is now 4.5% in 2025/2026.

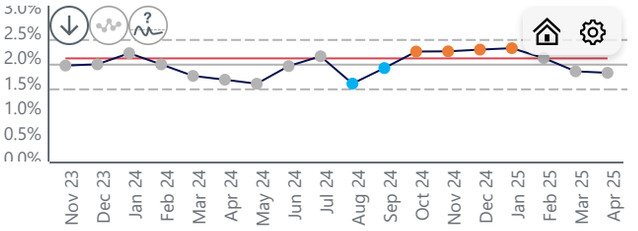
Actions:

Sickness absence levels are challenging, with a detailed paper to the July People Committee. In addition, a new occupational health provider has been confirmed, commencing in May 2025. Post initial implementation, this provides an opportunity to review the provision and how it is best utilised to support our people

Supporting Our People - Watch Metrics

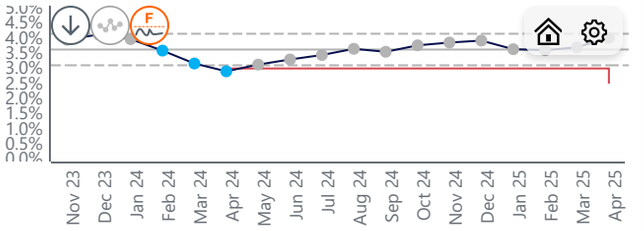
Short Term Sickness

Target: Internal



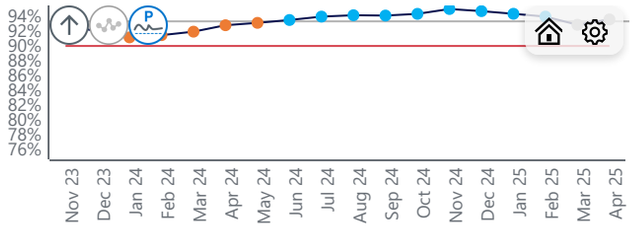
Long Term Sickness

Target: Internal



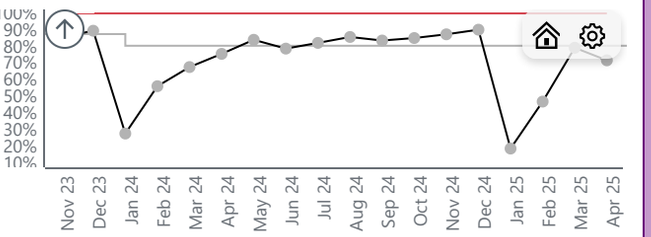
Mandatory Training

Target: Internal



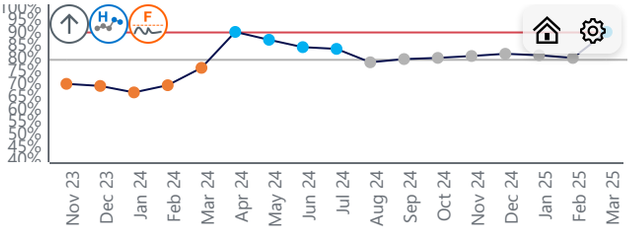
Medical Appraisal

Target: Internal

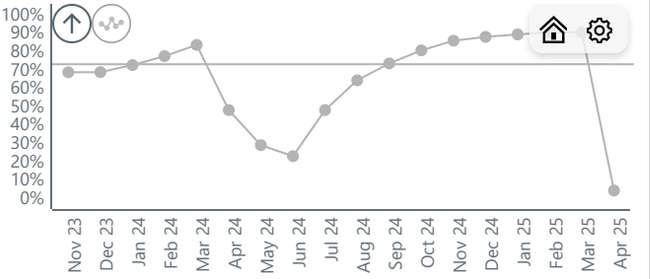


% PDRs Completed (Rolling 12 Months)

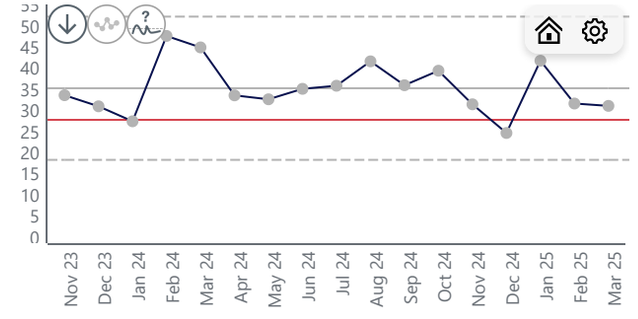
Target: Internal



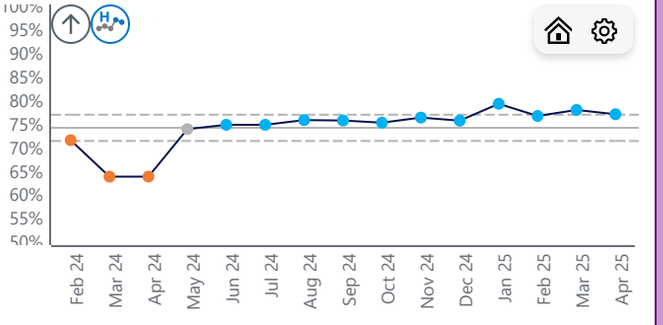
PDR B7+ Completed (Rolling 12 Months)



Average Time to Hire



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:

• The Paediatric Open Innovation Zone commenced from 1st April with agreement with Combined Authority being finalised • External funding applications in progress during April include a joint NIHR capital application with the University of Liverpool (£1.5m), an MRC Neurosciences application led by LSTM (£300k funding for AH including MRI scan costs) • Power Automate licences requested to boost RPA function • First Futures Management Board taken place in April bringing together Research, Innovation, Education and Digital (through linking with the AI, Digital and Data Collaborative)

Areas of Concern:

• MRI business case off track and under review
• RPA business case off track and under review

Forward Look (with actions)

• CHORAL (Child Health Outcomes Research at Leeds) visiting to identify potential partnerships on 9th May • International Clinical Trials Day will be used to promote research and innovation including the Mobile Research Unit on 21st May • Research, Innovation and AI sessions plans for Learning at Work week on 14th May

Number of innovative treatments and diagnostics deployed to care - In Development

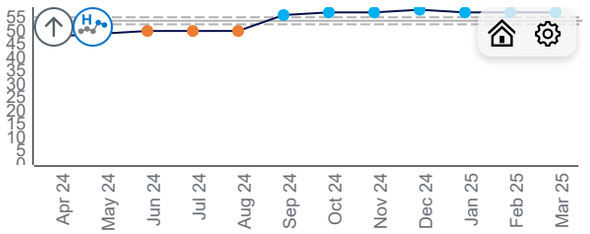
Technical Analysis:

Metric is under development

Actions:

Metric is under development

Number of AH Chief Investigators (substantive or honorary) leading NIHR portfolio studies (externally funded and peer-reviewed)

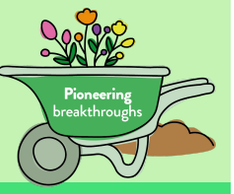


Technical Analysis:

Metric updated for 25/26 to capture number of Chief Investigators leading NIHR portfolio studies as this is a better marker of research quality

Actions:

Number of Chief Investigators remains stable and work is ongoing to use capacity and capability funding to support investigators to develop high quality external funding applications

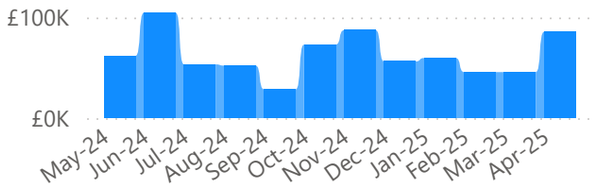


Integrated Performance Report | May 2025

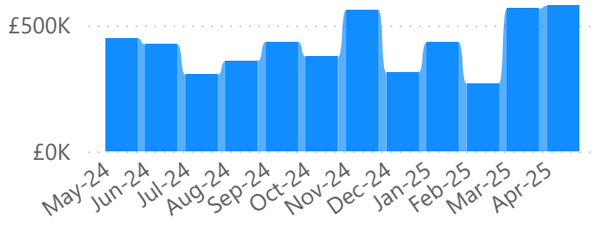
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

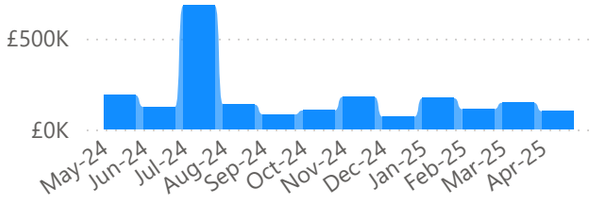
External innovation income received by month (commercial and non-commercial)



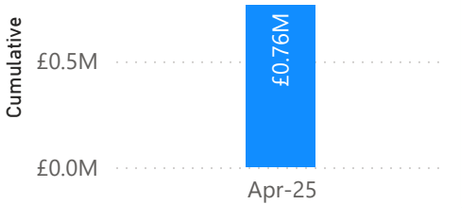
External research income received by month (commercial and non-commercial but excluding NIHR)



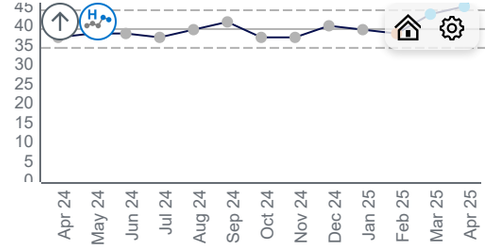
NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)



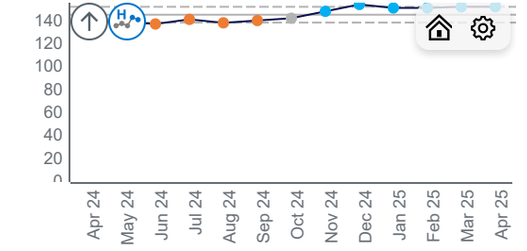
External income received by month across Research and Innovation (YTD Cumulative)



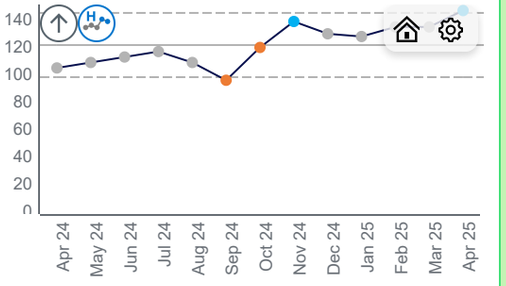
Number of open commercial studies (recruiting and in follow up)



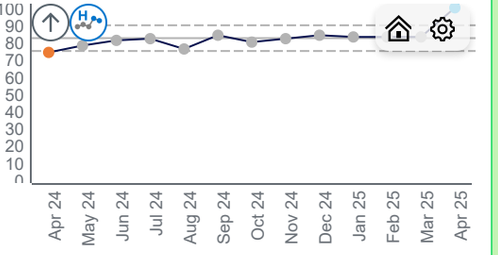
Number of open non-commercial studies (recruiting and in follow up)



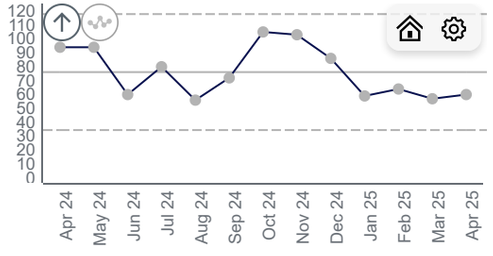
Number of participants recruited to all studies



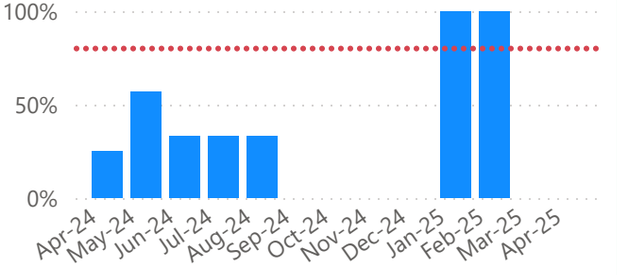
Number of participants recruited to all NIHR portfolio studies



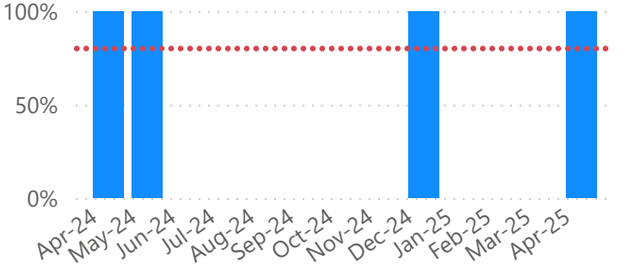
Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



Recruitment to time and target (RTT)



Recruitment to time and target (RTT) sponsored studies only



Integrated Performance Report | May 2025

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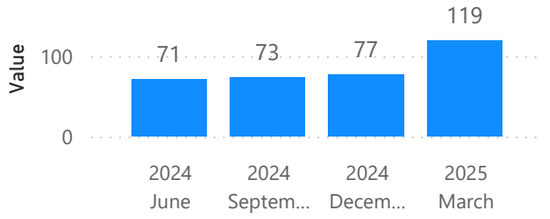
Pioneering Breakthroughs

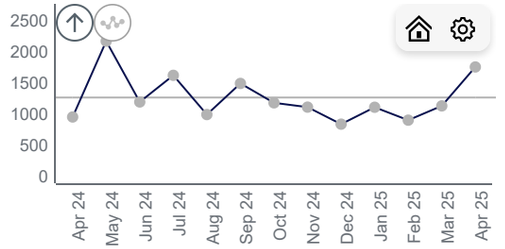
Number of publications with AH author by quarter including journal impact factor

Quarterly



Number of businesses supported by POIZ

Manual hours released from automation/AI solutions - Monthly



Number of staff trained in innovation methods

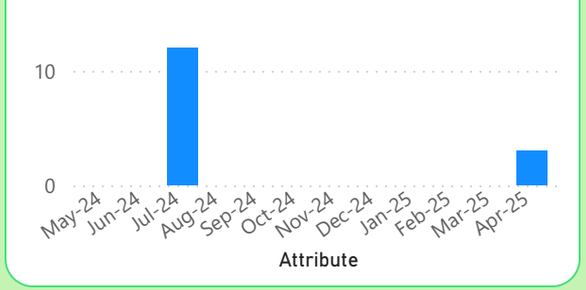
Number of staff trained in research methods

Number of externally funded fellowships (R and I) cumulative

New metric awaiting data

Number of AH-hosted jobs created through new external funding (POIZ metric)

Number of capacity building awards (funded through AH Charity, RCF and commercial capacity building funding)



Number of higher-level degree projects hosted by AH

New metric awaiting data

Number of primary and secondary schools engaged with Futures activities

New metric awaiting data

Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

In April (M1), the Trust is reported £1.165m deficit, which is in line with plan. CIP is £0.7m away from plan in M1. Overall, £3m CIP has been transacted in year with £7.2m in progress and £13.3m opportunity. On track to deliver subject to amber and red schemes. Cash has remained high in line with plan & capital is behind plan due to phasing of budget.

Areas of Concern:

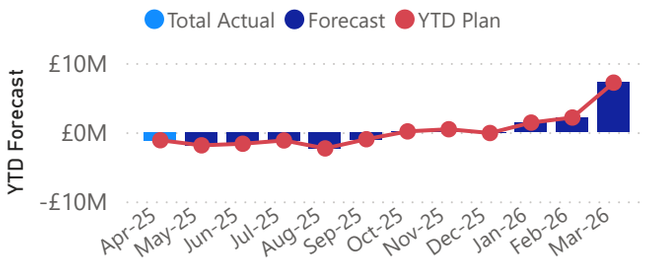
Work is ongoing to deliver full savings of £22.7m and Significant work is ongoing through the Financial Improvement Programme (FIP). Forecasting to achieve £7.160m surplus which is in line with the plan set at the start of the year, plus additional ICB stretch, so delivery of CIP is essential. It is recognised that capital allocation is unlikely to be sufficient to complete all capital requirements. A Capital Prioritisation Workshop will be held to manage this risk.

Forward Look (with actions)

Continued cost control to reach the year end position, with specific focus on non-clinical posts/10% target. Continued focus required on achievement of £22.7m efficiency target. Continued prioritisation of capital programme.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

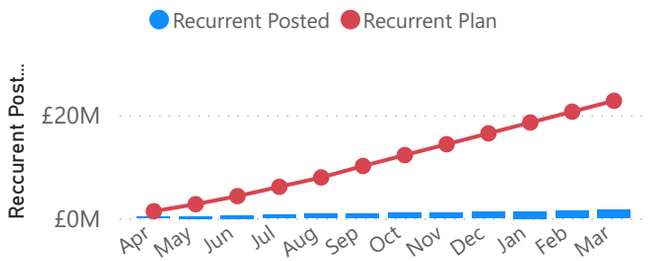
Risks to delivery of this is linked to achievement of CIP still in progress and management of in year pressures.

Actions:

Continue to monitor efficiency schemes in progress and cost control for arising pressures to be managed through FIP, SDG meeting and divisional deep dives.

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



Technical Analysis:

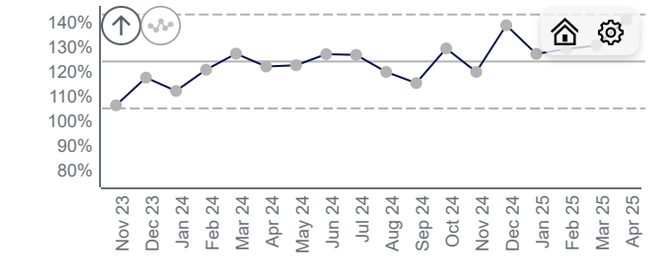
Recurrent CIP identified and in progress is £7.2m.

Actions:

Significant work is ongoing to support the delivery of efficiency targets across the Trust through the FIP.

% ERF Value (Income)

Target: Internal



Technical Analysis:

April performance estimated at 141%.

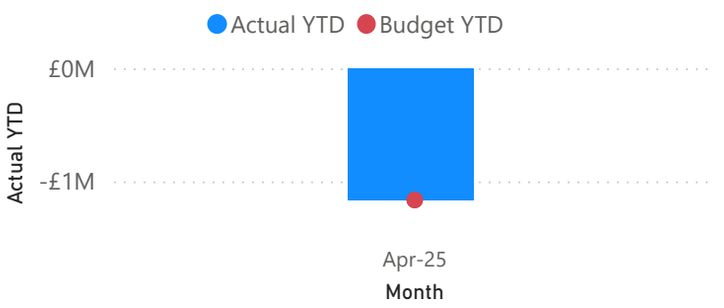
Actions:

Continue to monitor all areas. Likely Commissioners will expect trust to manage back to plan.

Financial Sustainability: Well Led - Watch Metrics

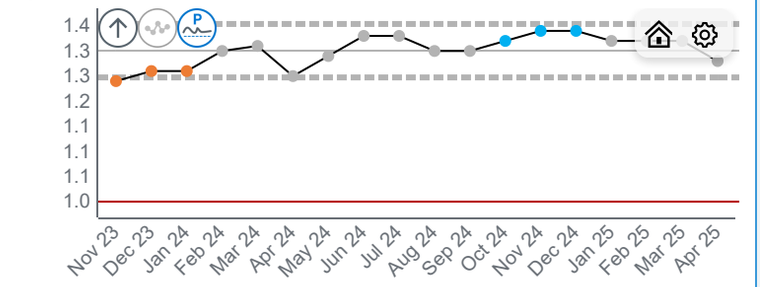
I&E distance from target (cumulative YTD)

Target: Internal

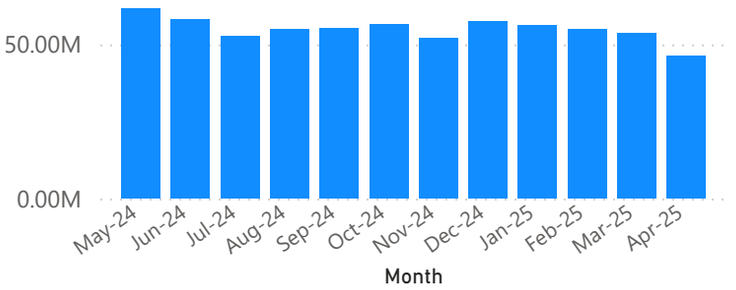


Liquidity

Target: Internal

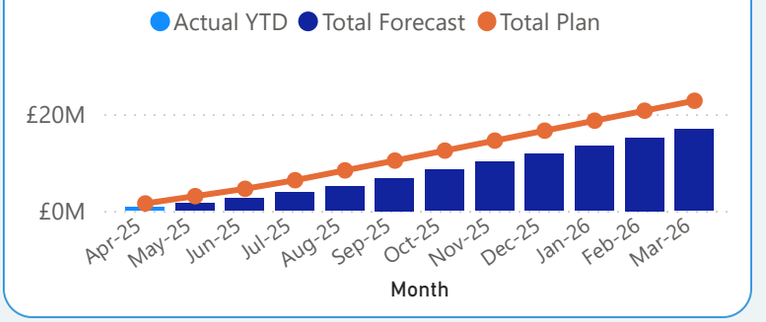


Cash In Bank



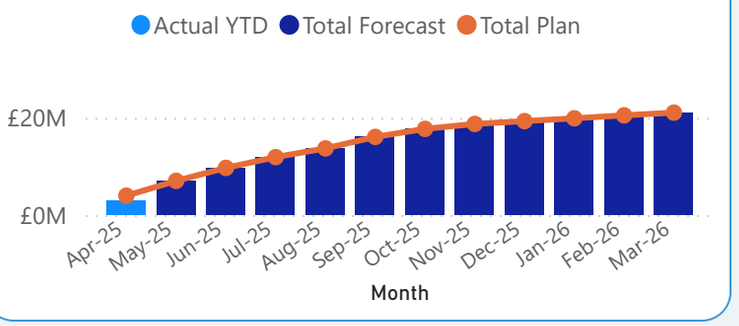
In Year CIP – forecast against plan

Target: Internal



Capital – YTD spend and forecast against plan

Target: Internal



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

Excellent face to face meeting with digital team to review risk approval process and all digital risks realigning scores and risk owners/managers.
Actions already in place to address the x1 recommendation from MIAA Risk Management audit (Substantial assurance)

Areas of Concern:

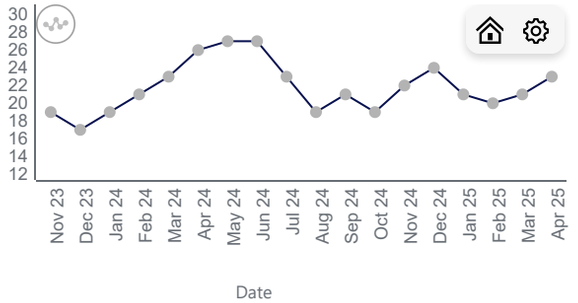
Risks without ongoing actions and agreed actions plans still need continued oversight and monitoring. Discussed at Risk Management Forum with Divisions

Forward Look (with actions)

Monthly F2F meeting with digital team to support risk management with team members plus review overdue incidents open >28 days aligned to digital team

C&MH divisions presenting findings of Risk Appetite work at ARC June 25

Number of High Risks (scored 15 and above)



Technical Analysis:

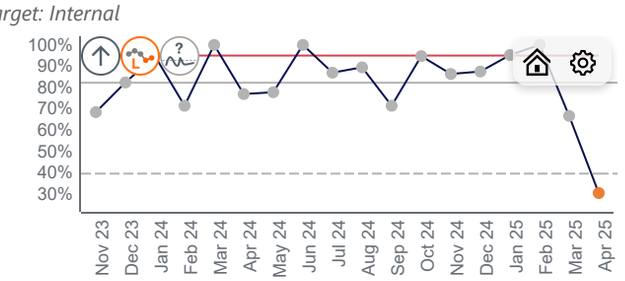
23 high risks on risk register as of end April 2025. Slight increase from 21 reported end of March 2025

Actions:

23 high risks on risk register as of end April 25

% of High Risks within review date

Target: Internal



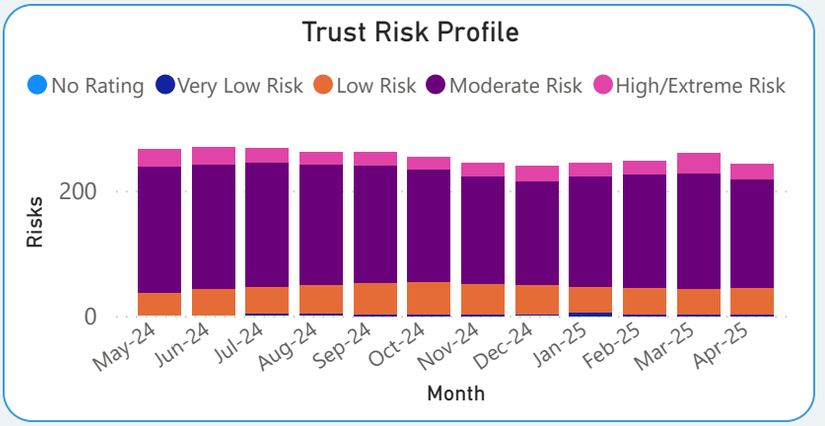
Technical Analysis:

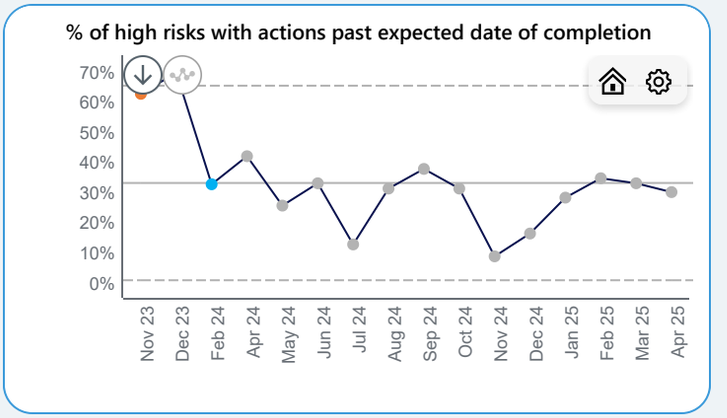
30.4% high risks within review date showing a declining position from last month's position of 67%. 2nd consecutive month below target following two month's achieving target.

Actions:

95.6% of high risks within review date (1 overdue) risk owner has updated at time of reporting. 30.4% of high risks with actions past expected date of completion (7 / 23) high risks with actions past expected date of completion) Risk owners informed, and risks updated.

Well Led - Risk Management





Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Sefton CAMHS awarded GOLD in ward accreditation inspection

• Appointment to Clinical Lead of Neurodevelopmental Pathway

• No patients waiting over 52 weeks in Community Paediatrics or Community Therapies

• 95% of Initial Health Assessment reports completed within 20 days of referral

• Complaint response times improved in April to 100% within 25 working days

Areas of Concern

• Increased incidents of reported restrictive intervention relating to patient in Sunflower House. Unit also has higher levels of sickness absence, support has been provided by corporate teams including Estates, safe staffing and continued focus on incident reporting, debrief and introduction of additional standby shift to ensure appropriately trained staff are available

• PALS responses within 5 days remain a challenge with performance at 73% for April.

• Proportion of clinic letters completed within 10 working days has significantly reduced and risk has been escalated within Division and shared with corporate teams to understand drivers and agree improvement actions

Forward Look (with actions)

• Preparation underway for move to Alder Park planned for early June. Teams relocating to Alder Park are Sefton SALT, Physiotherapy and Occupational Therapy as well as new Eating Disorder Day Unit

• Learning review with estates and development team to understand actions required to address any environmental risk factors at SFH following recent admission.

• Introduction of Matron of the Day rota to support PALS and complaints response with aim of resolving more issues at informal stage.

• Review of clinic letter compliance metric cross divisionally and with Digital team to agree improvement actions

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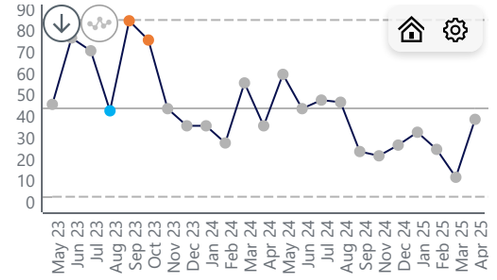
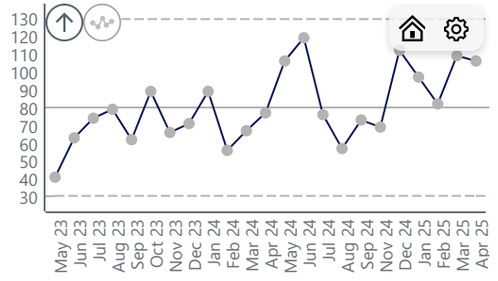
Divisional Performance Summary - Community & Mental Health

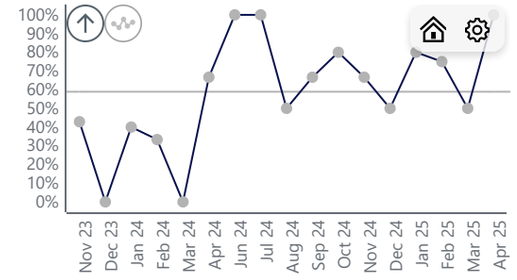
Patient Safety Incidents rated Low Harm & Above



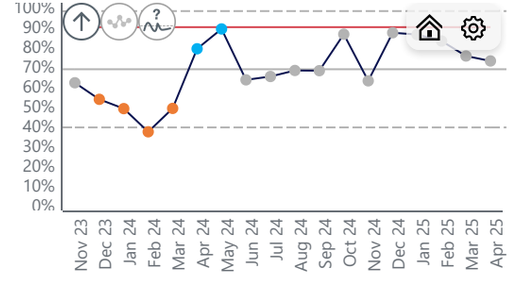
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

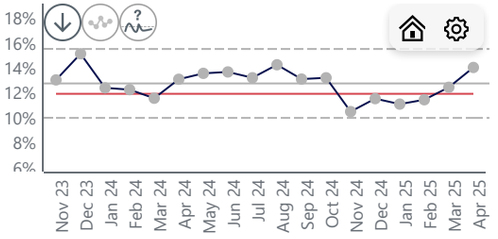


% PALS Resolved within 5 Days

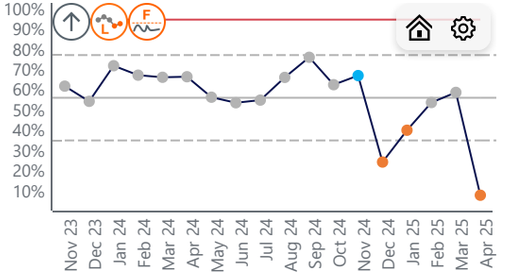


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

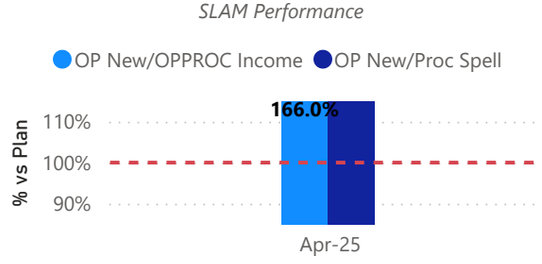


% of Clinical Letters completed within 10 Days

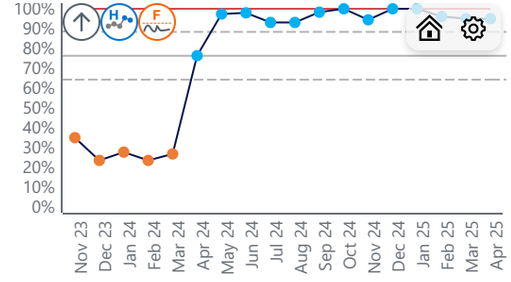


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

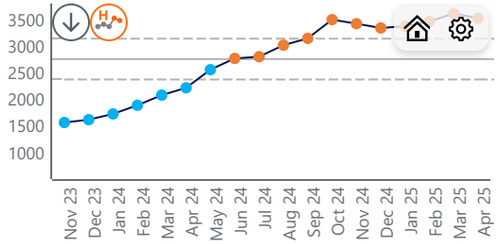
SLAM Performance



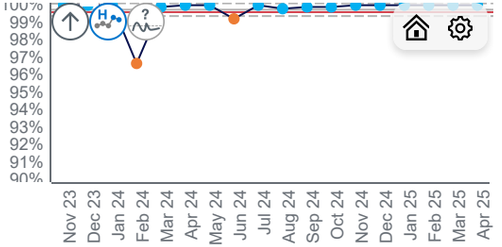
IHA: % complete within 20 days of referral to Alder Hey



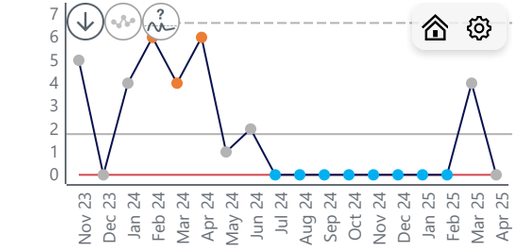
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



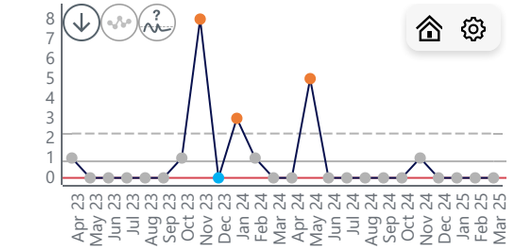
Percentage CYP suspected autism with contact under 13 weeks



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



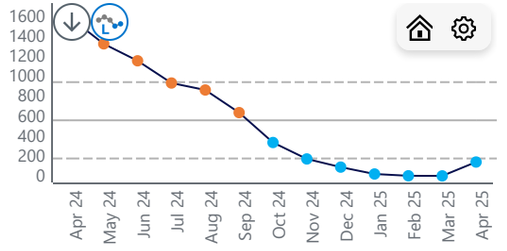
Number of Paediatric Community Patients waiting >52 weeks



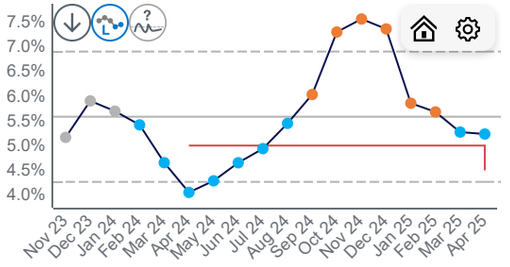
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

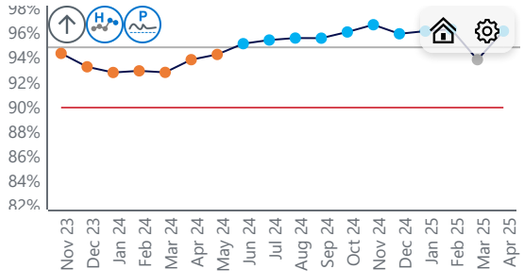
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



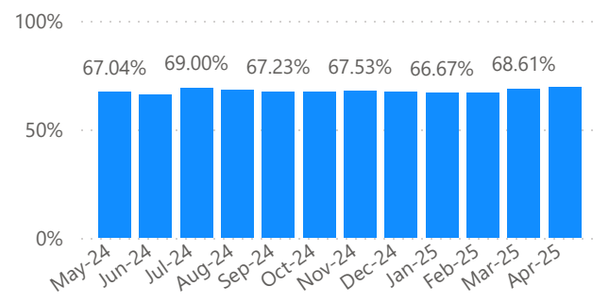
Sickness Absence (Total)



Mandatory Training

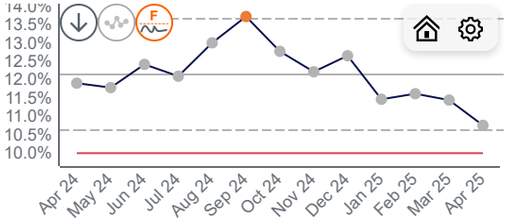


Workforce Stability

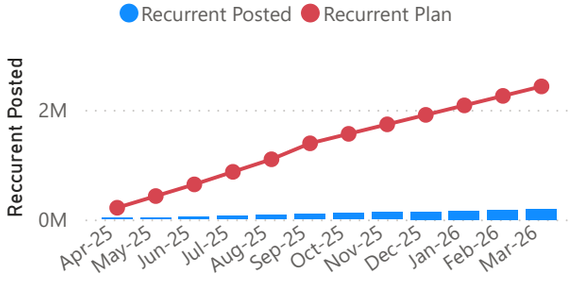


Staff Turnover

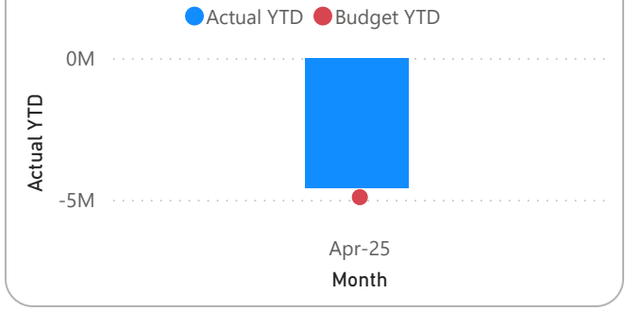
Target: Internal



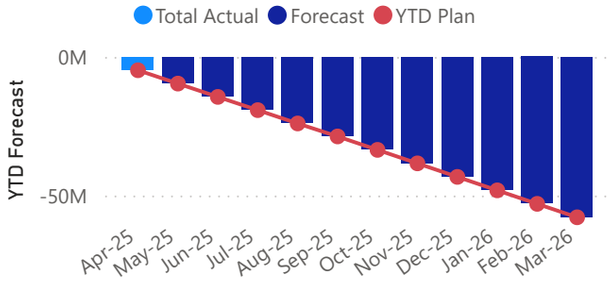
Recurrent Efficiency Plans Delivered (Forecast)



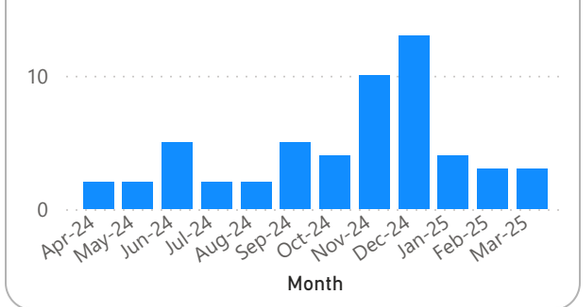
I&E distance from target (cumulative YTD)



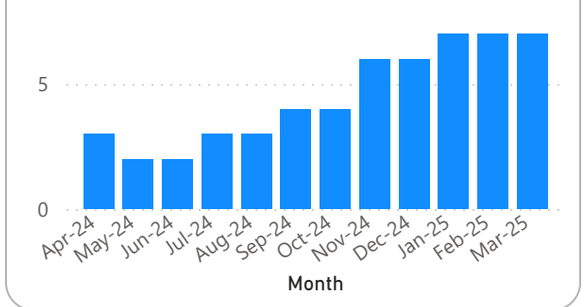
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• The haematology and transfusion laboratory team received the recommendation to be re-accredited by UKAS during a follow up visit having lost the accreditation in January 2025. UKAS recognised the significant volume of work which has taken place over recent months.

• Second consecutive month where both targets for Sepsis were achieved for children treated in ED and on the ward

• Improvement in all ED performance measures, 4hour standards, 12 hours within the department, median time to triage and time to clinical assessment

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

• 100% compliance in PALS

• 0 patients waiting over 65 weeks for treatment

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

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. The division continue to monitor closely in line with the impact of drug prescribing

• Theatre utilisation with limited improvement seen over recent months despite heightened efforts

• Financial challenges facing the year ahead, 1.4M cost pressure to mitigate within the division in addition to the delivery of CIP targets

Forward Look (with actions)

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

• Focused improvement of theatre utilisation with a review of list allocation and the booking and scheduling of patients, redistribution of lists confirmed with measures in place to attempt to increase utilisation

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

• Review of Interventional Radiology escalation SOP and interim measures when service provision is not available remain a focus with collaboration required with external partners

• Increase in hospital-initiated cancelations within 6 weeks, review under way to establish reasons with collaboration with the clinical collaborative for re-imagining elective care

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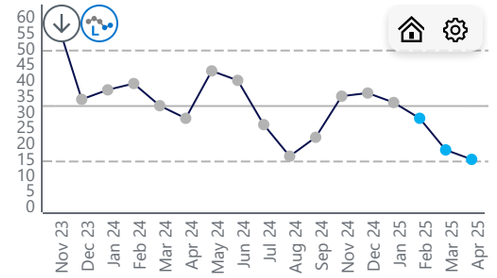
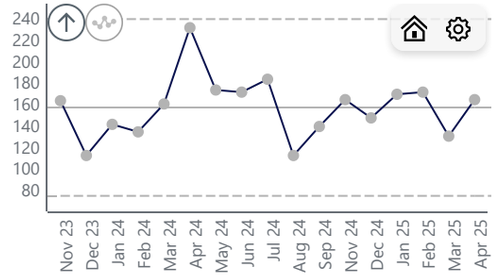
NHS Foundation Trust

Divisional Performance Summary - Medicine

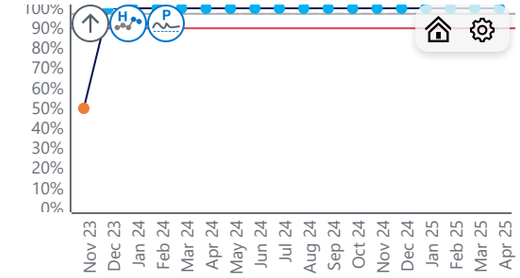
Patient Safety Incidents rated Low Harm & Above



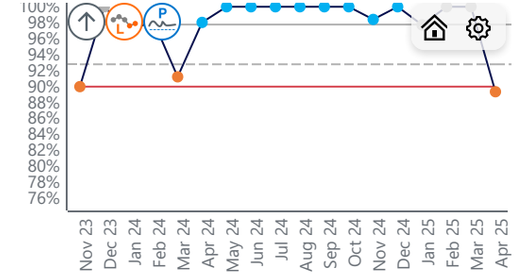
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

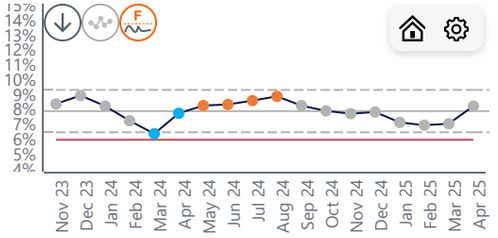


% PALS Resolved within 5 Days

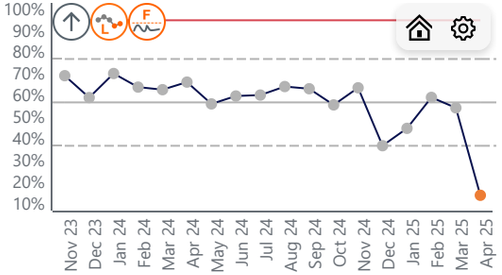


% Was Not Brought Rate (All OP: New and FU)

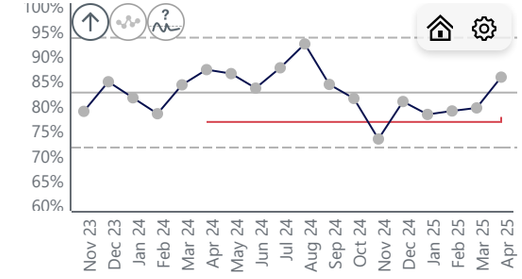
Target: Internal



% of Clinical Letters completed within 10 Days

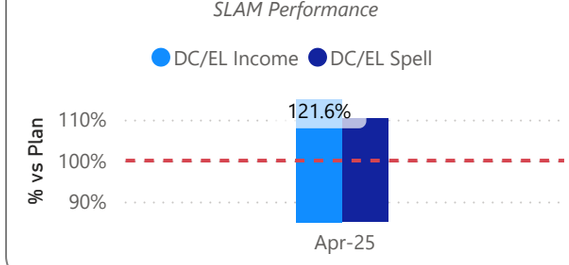


ED: % treated within 4 Hours



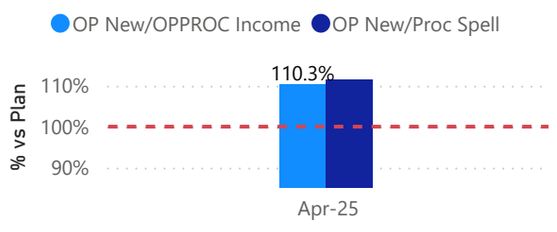
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

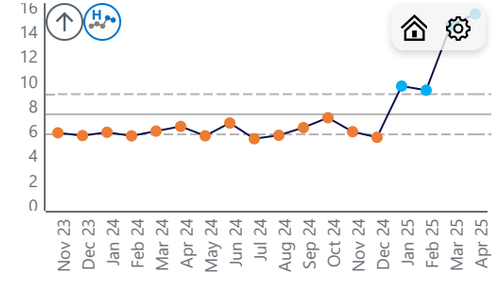


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

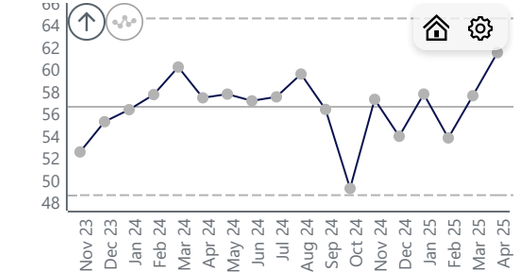
SLAM Performance



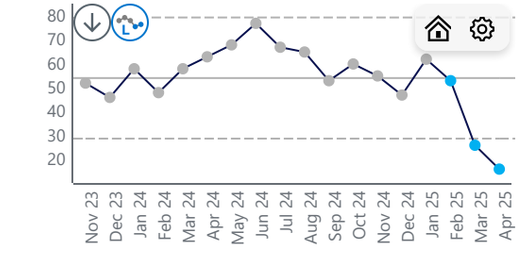
Inpatient Discharges per working day



Day Cases per working day



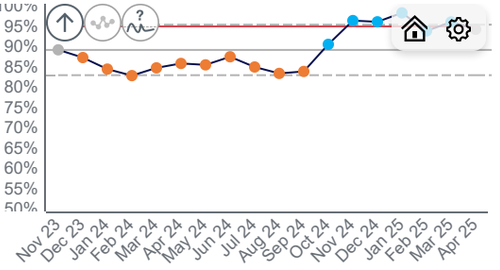
Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



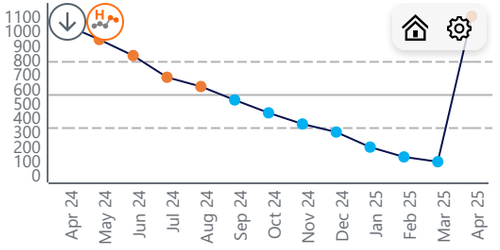
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

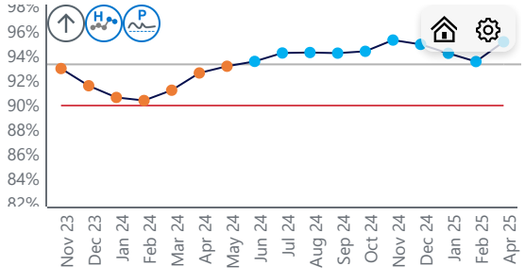
Diagnostics: % Completed Within 6 Weeks of referral



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

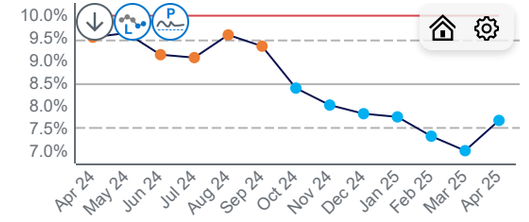


Mandatory Training

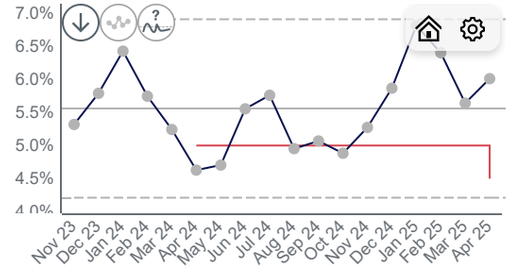


Staff Turnover

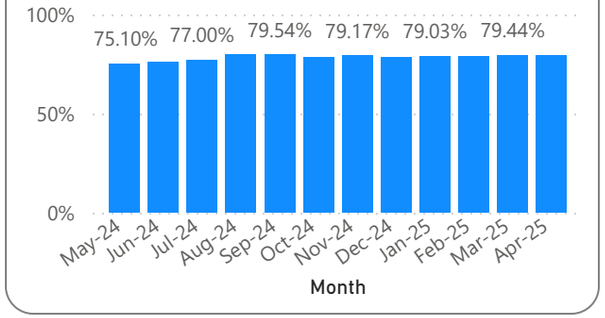
Target: Internal



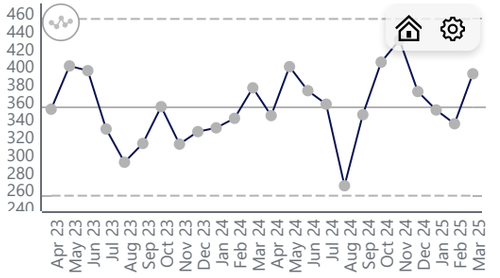
Sickness Absence (Total)



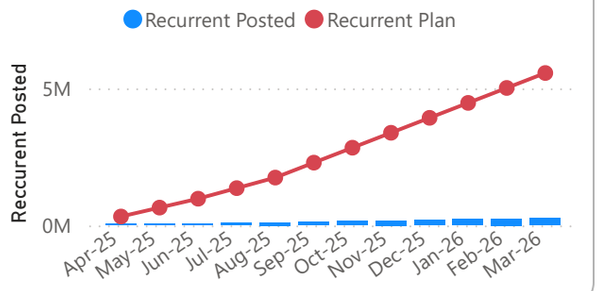
Workforce Stability



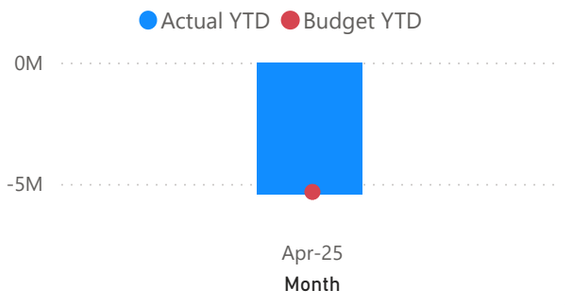
A&E Attendances per ED Consultant WTE



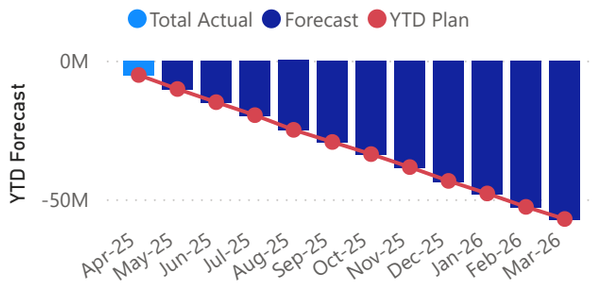
Recurrent Efficiency Plans Delivered (Forecast)



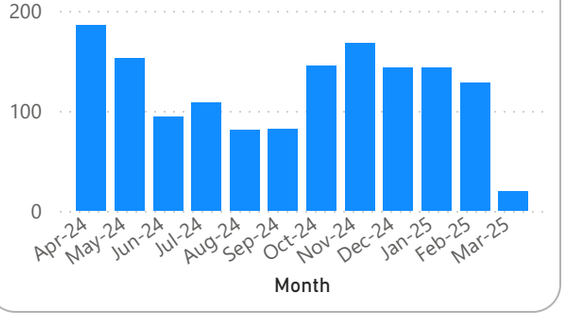
I&E distance from target (cumulative YTD)



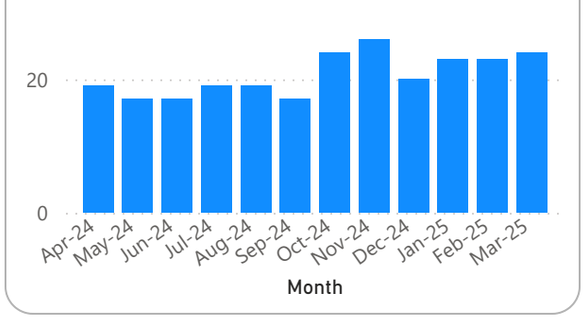
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Retained strong compliance with response rate to PALS and formal complaints

• Income and spells in M1 exceeded the plan for Elective & Daycase (110%) and Outpatient New and Procedures (106%).

• DM01 performance remains above the 95% target

• Mandatory training compliance remains above trust target

Areas of Concern

• The increase in patients waiting over 52 weeks is primarily driven by ENT and Dentistry. The main factors, include staff vacancies, reduced activity due to half term and long-term sickness throughout April.

• WNB remains above trust target

• Overdue FU remain a challenge despite reduction over previous months

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

Forward Look (with actions)

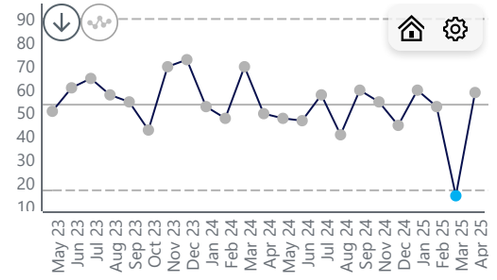
• Ongoing work with specialties to reduce overdue FU. Actions plans in place and targets reset for 25/26.

• Overbooking of clinics with a high WNB rate began in May 2025. An alternative solution of contacting families who WNB and conducting appointments virtually has received a positive response and will be implemented where feasible.

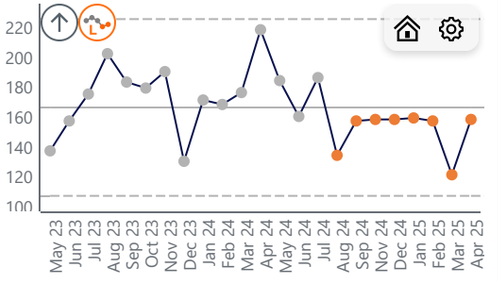
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

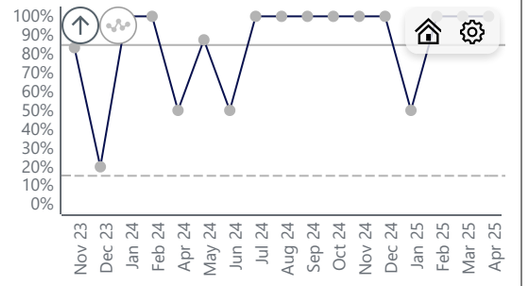
Patient Safety Incidents rated Low Harm & Above



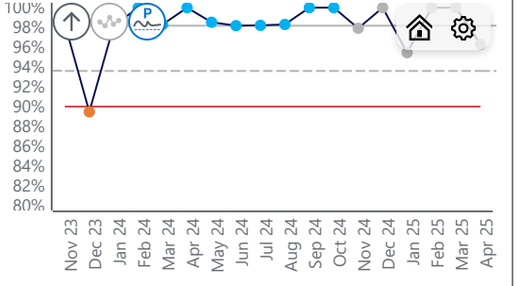
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

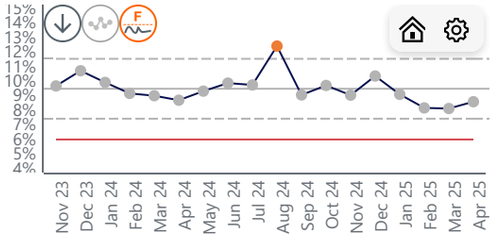


% PALS Resolved within 5 Days

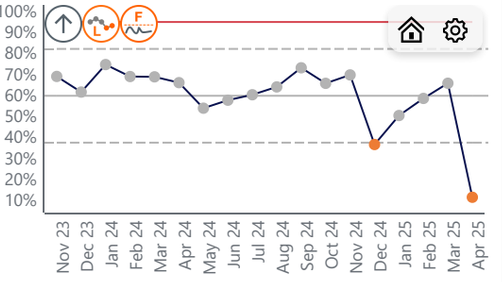


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

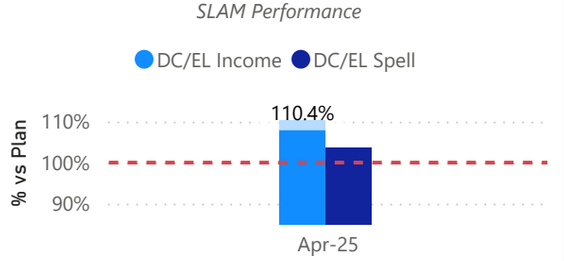


% of Clinical Letters completed within 10 Days



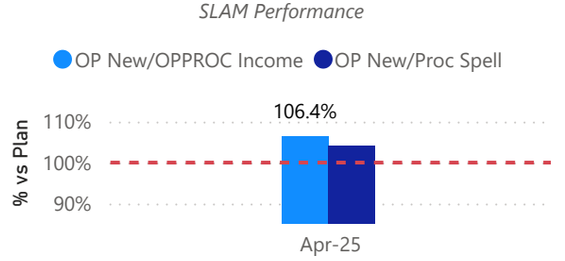
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

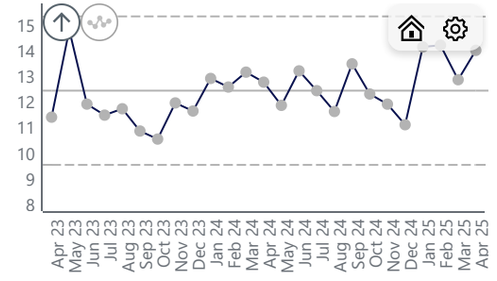


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

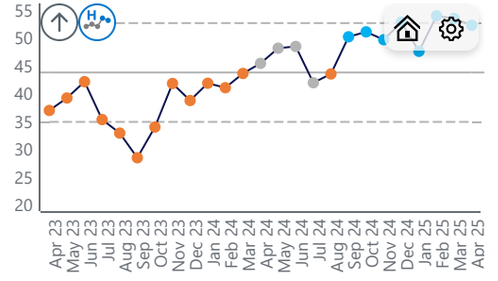
SLAM Performance



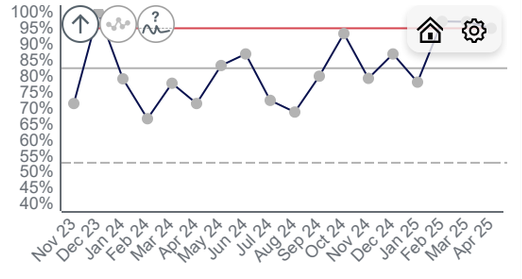
Inpatient Discharges per working day



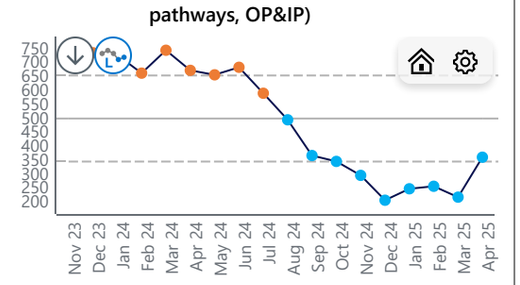
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



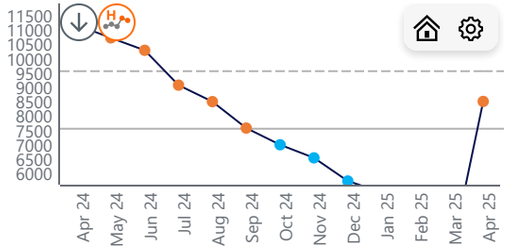
Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



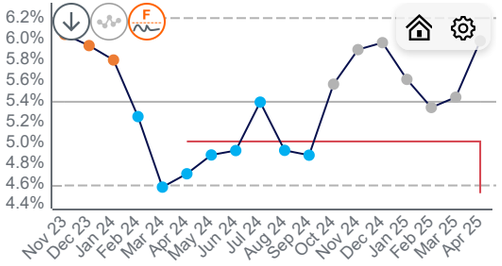
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Surgery

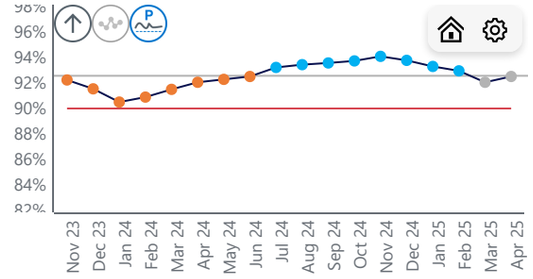
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2025



Sickness Absence (Total)

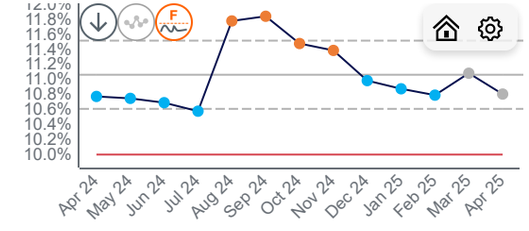


Mandatory Training

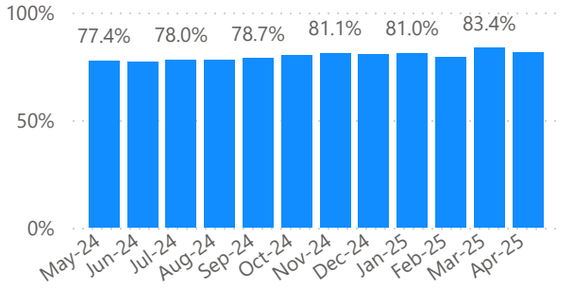


Staff Turnover

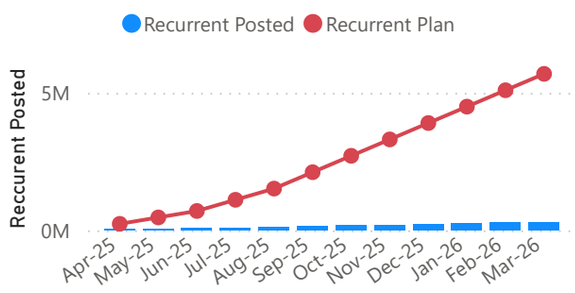
Target: Internal



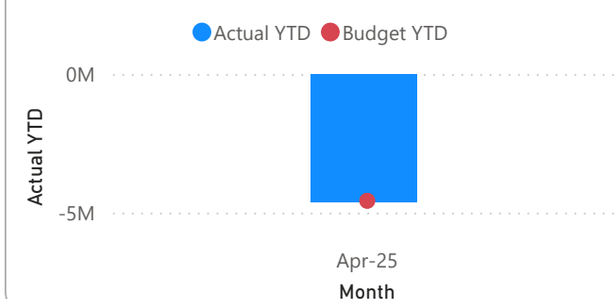
Workforce Stability



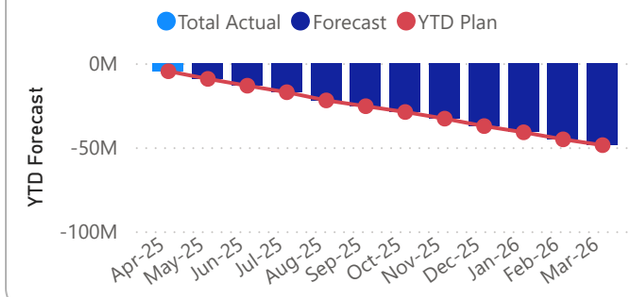
Recurrent Efficiency Plans Delivered (Forecast)



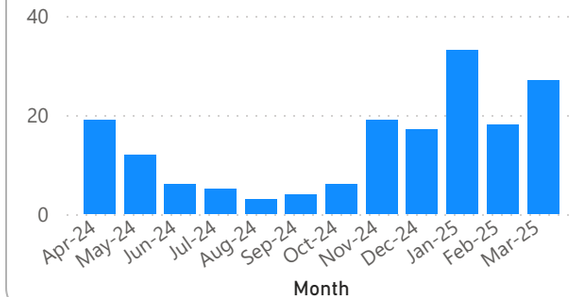
I&E distance from target (cumulative YTD)



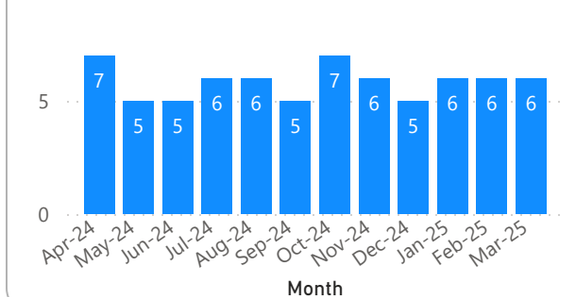
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• Workforce metrics all on track, data issues for RTW being addressed but no concerns with line manager completion

• Extension of IPR metrics to increase visibility of externally driven research targets

• External funding applications in progress during April include a joint NIHR capital application with the University of Liverpool (£1.5m), an MRC Neurosciences application led by LSTM (£300k funding for AH including MRI scan costs)

• First Futures Management Board taken place in April bringing together Research, Innovation, Education and Digital (through linking with the AI, Digital and Data Collaborative)

Areas of Concern

• MRI business case off track and under review

Forward Look (with actions)

CHORAL (Child Health Outcomes Research at Leeds) visiting to identify potential partnerships on 9th May

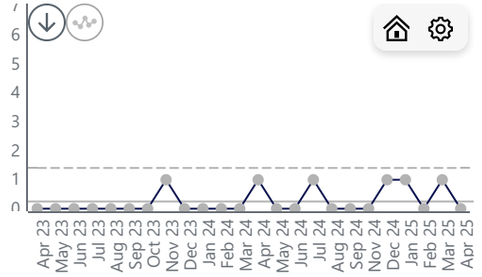
International Clinical Trials Day will be used to promote research and innovation including the Mobile Research Unit on 21st May.

Research education session planned for Learning at Work week on 14th May

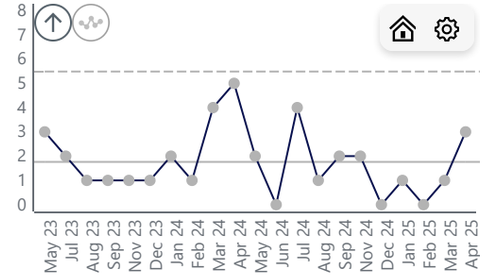
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

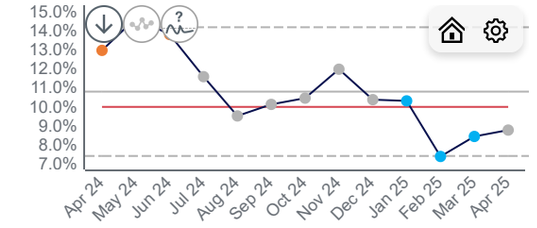


Patient Safety Incidents rated No Harm

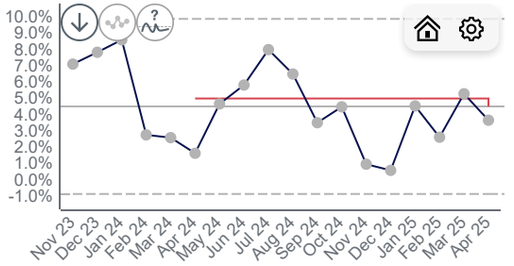


Staff Turnover

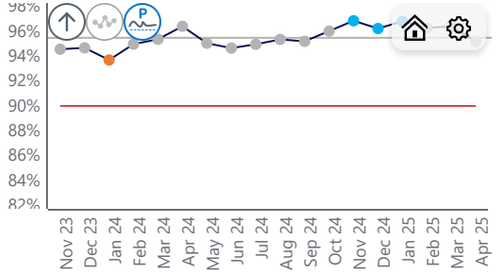
Target: Internal



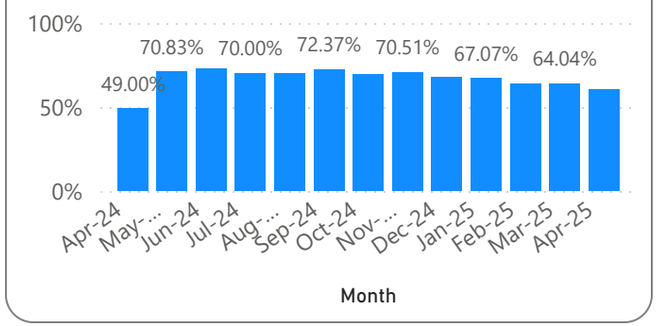
Sickness Absence (Total)



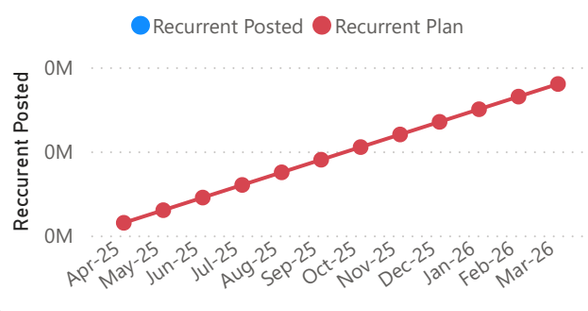
Mandatory Training



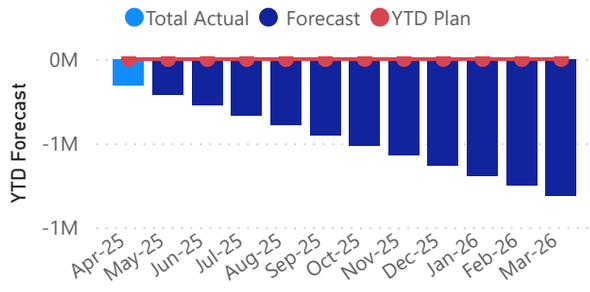
Workforce Stability



Recurrent Efficiency Plans Delivered (Forecast)

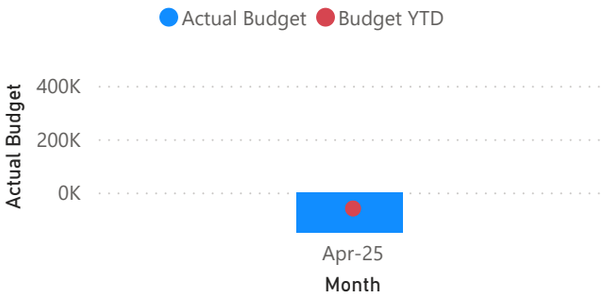


I&E Year End Forecast



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 May 2025. Highlights from the April data include:

- Mandatory training remains above Trust target at 91%.
- Short term sickness absence remains within Trust target at 2%.
- CIP achieved in year.
- Overall PDR compliance 95%.
- 94% of risks within review date.

Areas of Concern

- Overall sickness remains above Trust target at 5.7% (previously 5.5%)
- Corporate incidents open over 28 days = 207
- 54 corporate policies overdue

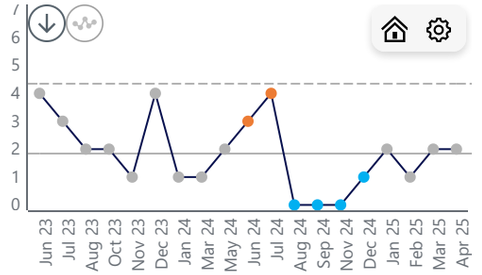
Forward Look (with actions)

- Star Chamber to be held to discuss cost pressures in detail.
- Continued focus on financial position, system finance and internal controls/opportunities including WTE.
- Divisional scrutiny at SQAC regarding overdue policy position.

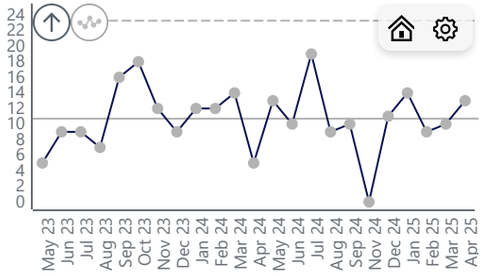
NHS
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Corporate

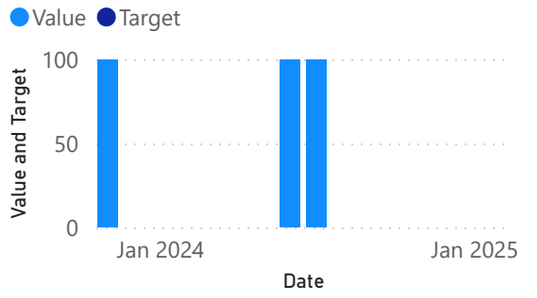
Patient Safety Incidents rated Low Harm & Above



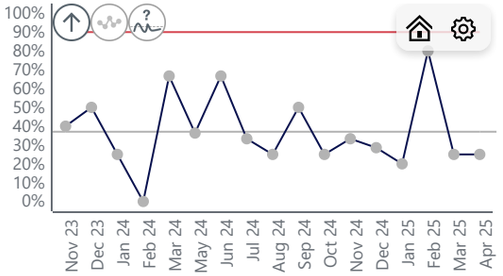
Patient Safety Incidents rated No Harm



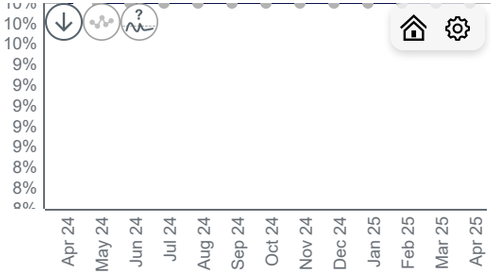
% Complaints Responded to within 25 working days



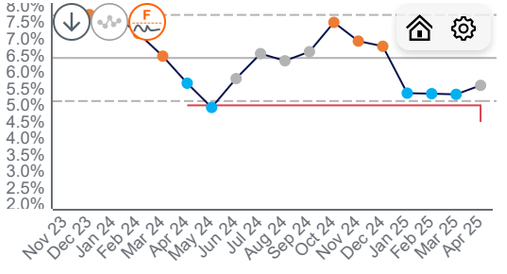
% PALS Resolved within 5 Days



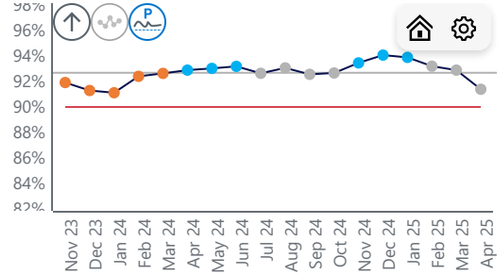
Staff Turnover



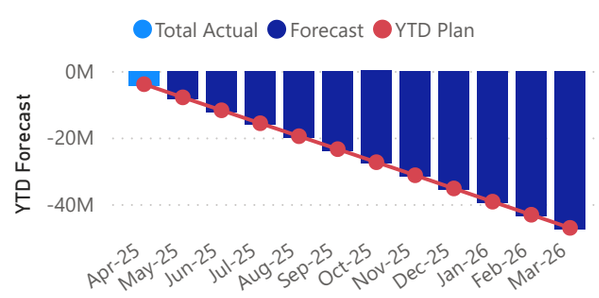
Sickness Absence (Total)



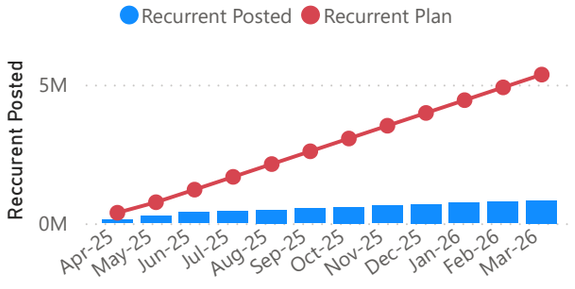
Mandatory Training



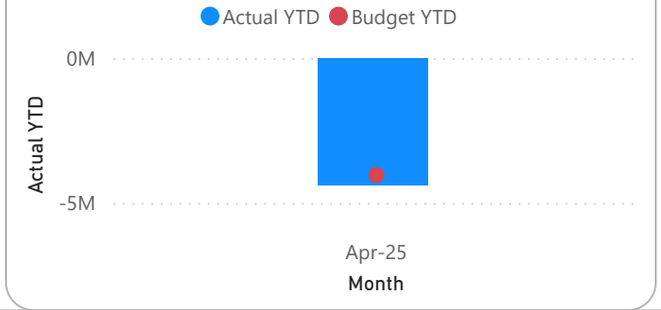
I&E Year End Forecast



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
April 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	Jan-25	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	98%		98%		80	24.7	12.28	0.30	1.80%	0.00	0%	0.00	0.00%	0.00	0.00%	37.00	7.20%	0.00	0.00%	5	5	0	0	1	100%	1	0
HDU	68%	60%	64%	50%	192	35.2	28.46	-4.48	-6.00%	3.33	62%	0.00	0.00%	0.00	0.00%	197.81	9.17%	0.00	0.00%	4	27	0	0	0	0%	0	1
ICU	80%	104%	81%	93%	383	42.3	37.75	0.20	0.10%	0.83	20%	0.00	0.00%	0.00	0.00%	308.71	6.34%	5.00	3.33%	8	31	0	0	1	100%	1	0
Ward 1cC	90%	83%	85%	82%	539	12.7	12.49	4.56	8.00%	0.30	6%	0.00	0.00%	0.00	0.00%	204.52	10.82%	21.80	14.46%	6	20	11	30	9	89.00%	0	0
Ward 1cN	72%	0%	84%		199	17.5	19.22	-4.57	-13.00%	1.63	67%	0.61	2.01%	0.00	0.00%	63.99	6.83%	0.00	0.00%	1	12	0	0	3	100%	0	0
Ward 3A	94%	79%	95%	147%	655	11.9	10.42	5.78	12.00%	3.23	20%	0.00	0.00%	0.00	0.00%	126.93	7.95%	90.79	23.69%	5	26	2	7	31	94.00%	0	0
Ward 3B	97%	82%	97%		359	15.2	16.06	-0.09	-0.20%	0.52	10%	0.00	0.00%	0.00	0.00%	94.88	7.19%	3.68	2.58%	3	12	0	0	1	100%	1	1
Ward 3C	78%	65%	76%	67%	657	11.2	10.88	-0.55	-0.80%	8.43	44%	0.00	0.00%	0.00	0.00%	129.51	6.92%	59.80	20.14%	11	60	1	1	2	100.00%	0	0
Ward 4A	90%	50%	88%	67%	767	10.6	10.65	0.91	1.30%	0.92	16%	0.00	0.00%	0.00	0.00%	170.77	8.30%	18.40	12.81%	6	21	0	1	23	100%	3	0
Ward 4B	54%	84%	60%	105%	526	15.0	11.84	7.69	26.00%	10.20	22%	0.00	0.00%	0.00	0.00%	100.41	9.13%	62.08	5.64%	11	40	1	5	6	100%	0	0
Ward 4C	91%	51%	94%	63%	521	12.2	10.7	1.34	2.00%	1.48	13%	0.00	0.00%	0.00	0.00%	113.61	6.26%	33.60	9.99%	7	32	0	1	10	100.00%	0	1

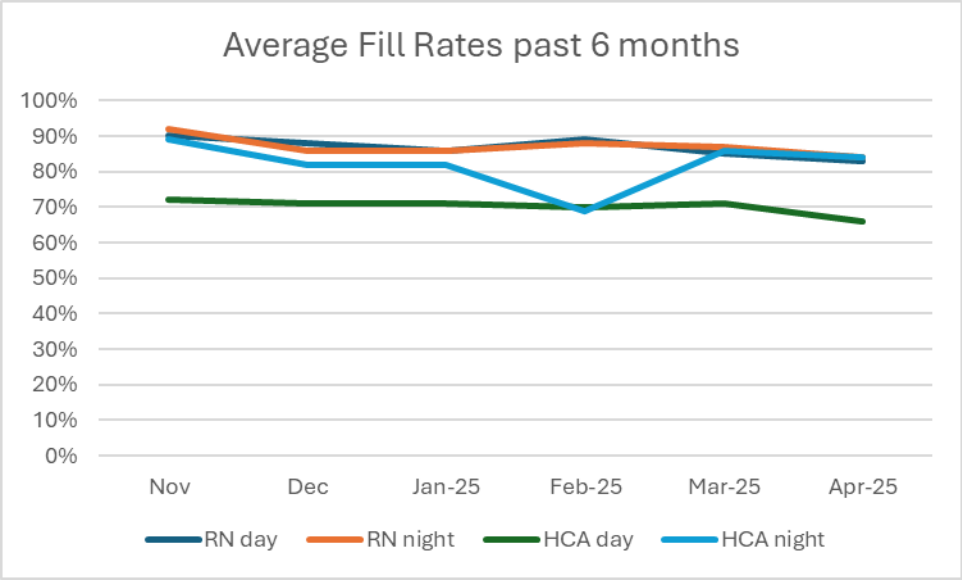
The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Fill rates are produced by setting out the planned number of hours required for Registered Nurses (RN) across days and nights and the same for Health Care Assistants (HCA) for a full month period and is captured daily. The electronic roster produces the percentage fill for the month and accurately reflects the hours worked against the planned number. The percentage fill rates include any hours worked by bank staff. The benchmark for CHPPD for the above tables is based on January 2025 data, which is the latest information available from the model hospital. Those areas highlighted red (1C Neo and 3B) fall below this reported benchmark.

3B: Despite a high fill rate for both registered nurses and care staff CHPPD rate is lower than the benchmark. This correlates with both capacity which has been reported above 100% for April and high acuity patients.

1C Neo: Ward 1cNeo staffing is supported by the Liverpool Neonatal Partnership, with nurses being deployed from LWH when required to ensure staffing levels are optimum and standards are met. No staffing incidents were reported in April.

Summary

Data for Ward 4B is not a true representation as the model has been realigned. The health roster has been realigned to reflect this, there is however a delay as the changes could only take effect for those rota's that had not been approved.
There are vacancies within HCA's in most departments which impacts on the fill rate reported.



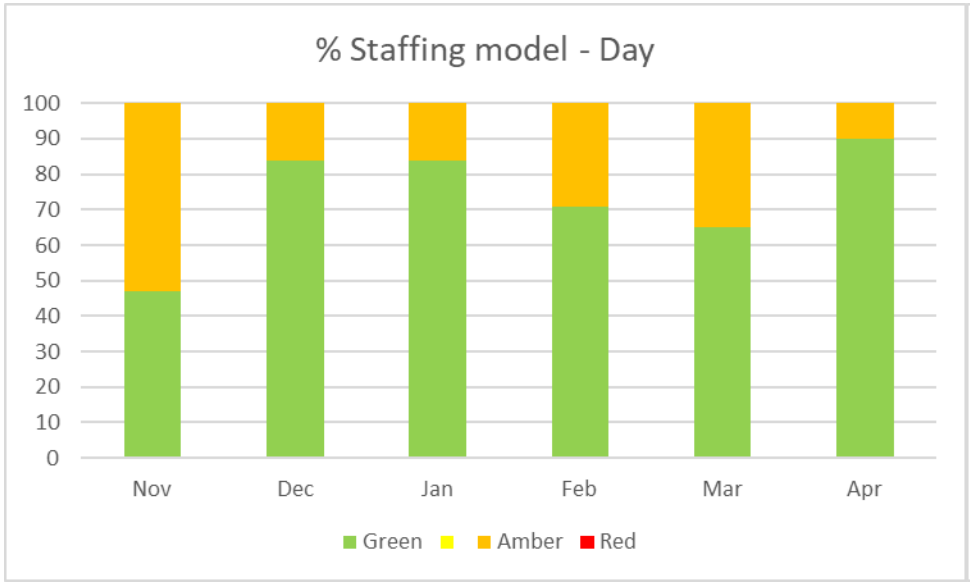
Nursing and care staff average fill rate April 2025	
Day and Night average fill rate	
Registered (%)	**Care Staff**
84%↓	**75%**↓

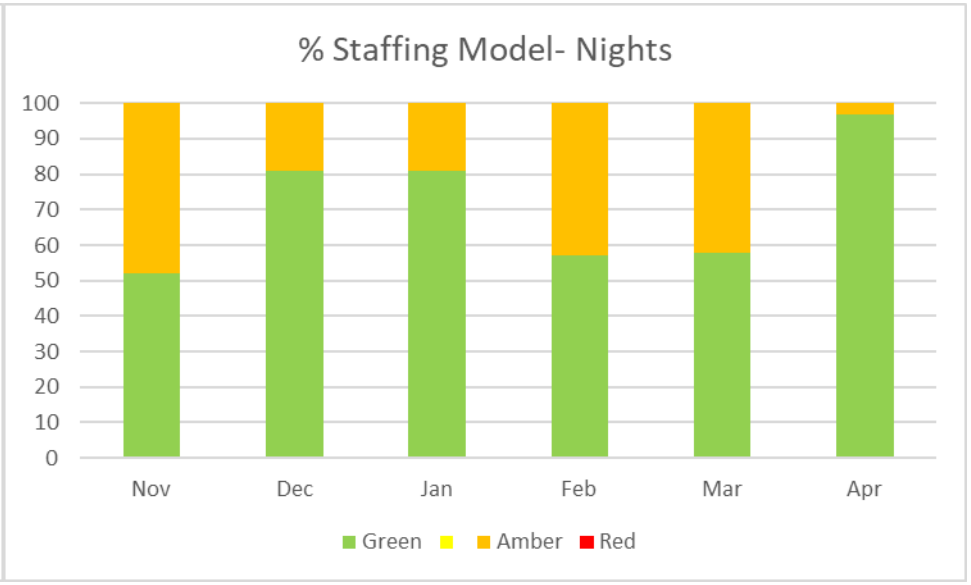
There has been a slight reduction in fill rate for both registered nurses and HCA's.However to note we have experienced reduced capacity throughout the trust in April and nurse/patient ratios have been safe. There are vacancies within HCAs across the trust which impacts on the fill rate reported in some areas, in addition an increase in 1:1 patients reports fill rates of over 100% therefore impacts on average.

Summary of Staffing models November 2024 – April 2025

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

April demonstrated a significant improvement in staffing status across both day and night shifts with a green staffing model being reported in over 90% of shifts. This correlates with a lower bed capacity and acuity of patients.



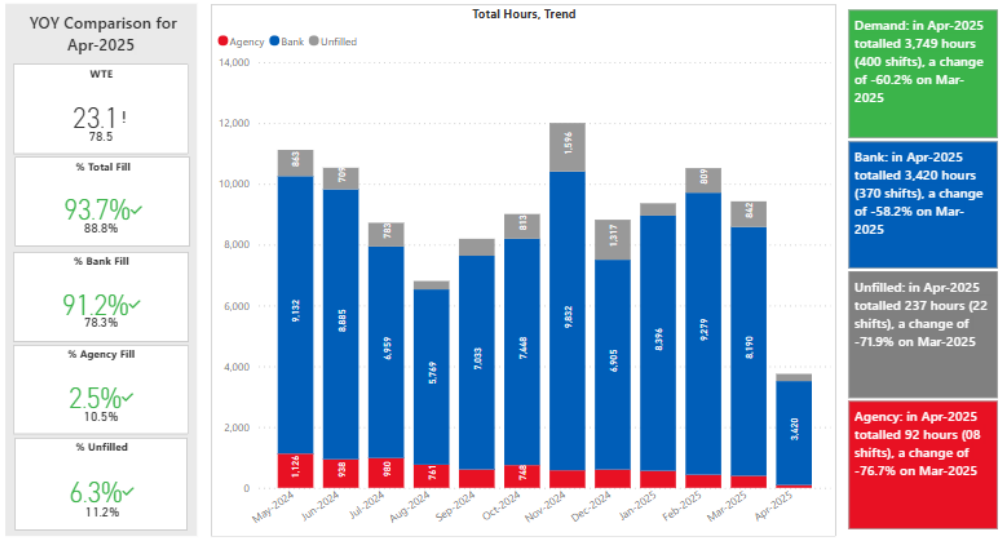


NHSP Bank Spend April 2025

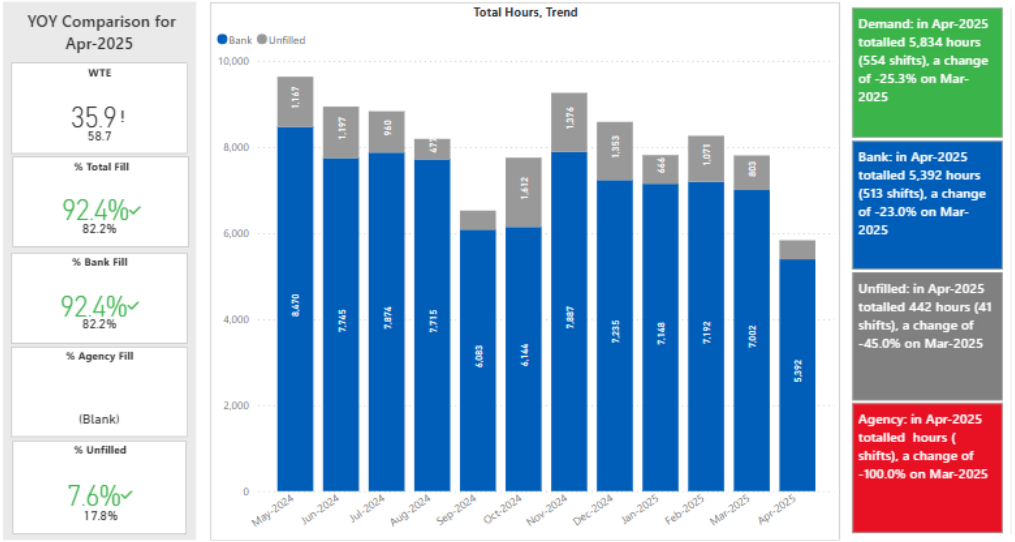
Temporary staffing is monitored closely with weekly oversight from Workforce Efficiencies group attended and represented by senior staff from various disciplines including nursing. This group developed trust and divisional dashboards to support the monitoring of bank and agency use across all areas and has oversight from executives. Weekly monitoring of bank and agency occurs in each division as well as daily oversight from Safe Staffing Chair and Senior Clinical Site Practitioner out of hours. As an additional measure for the month of March Director of Nursing and Associate Chief Nurses attended the daily safe staffing meeting allowing greater scrutiny over the present processes when booking NHSP shifts. To note there was assurance from this meeting that correct processes were being followed consistently and there was evidence of grip and control over temporary spend. Overall, we have seen a significant reduction in bank and agency. Registered Nurse bank in April totalled 3,420 hours (370 shifts) a change of -58.2% on the previous month.
Unregistered Nurse Bank for the month of April has reduced by 23% compared to the previous month despite continued gaps in substantive HCA roles Recruitment for HCA is in progress and in the month of March Alderhey attended a Health and Social Care Recruitment event in Liverpool. This was the first of its kind and gave us the opportunity to extend the scope of our recruitment including both adults and paediatrics with many potential candidates already having the care certificate qualification. A number of appointments were made on the day and there continues to be ongoing recruitment with further interested candidates who attended. It is positive that 3C who have had substantive vacancies for a significant period will see 8 new staff join their team in July.

As a result of the active recruitment to vacant substantive posts we should see a further reduction in our HCA temporary bank spend over the next couple of months.

Registered Nurse Bank Spend



Unregistered Nurse Bank Spend



KPI E-Roster
Period covered 31st March-28th April 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 **(31st March - 27th April)**	% 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)	44	25.15%	80.00	-78.35	0.00%	0	1	24.84%	13.21%	8.47%	0.00%	3.02%	0.00%	24.70%
Accident & Emergency - Nursing (912201)	42	19.00%	720.00	176.03	0.44%	43	0	18.70%	13.61%	2.68%	0.31%	5.59%	9.17%	31.62%
Burns Unit (915208)	44	22.63%	140.00	172.75	0.58%	11.5	0	12.91%	8.10%	1.77%	0.00%	8.30%	5.31%	23.94%
Critical Care Ward (913208)	44	20.77%	1200.00	1083.99	3.26%	615.5	4	19.29%	13.12%	2.63%	0.53%	6.73%	4.96%	27.97%
High Dependancy Unit (HDU) (913210)	44	34.03%	640.00	358.61	6.23%	450.5	1	36.14%	13.06%	4.63%	0.88%	10.63%	7.50%	36.71%
Medical Daycase Unit (911314)	48	19.23%	50.00	-4.88	0.00%	0	10	22.50%	21.73%	1.86%	0.00%	2.65%	0.00%	26.24%
Outpatients (916503)	48	30.99%	420.00	-141.74	3.21%	137.25	0	37.23%	18.27%	0.51%	0.95%	9.68%	3.64%	34.90%
Sunflower House (912310)	44	54.83%	190.00	-81.75	38.09%	1965.52	31	13.94%	15.07%	5.55%	1.90%	7.91%	3.45%	35.25%
Surgical Daycase Unit (915418)	27	39.24%	85.00	228.83	0.55%	14.5	6	27.98%	10.61%	1.35%	0.41%	11.21%	4.05%	27.62%
Theatres - Cardiac & Cardiology (915405)	44	13.83%	130.00	-15.21	0.00%	0	6	17.65%	15.36%	0.00%	0.06%	5.97%	5.81%	27.20%
Theatres - Emergency (915420)	44	23.47%	230.00	-15.12	2.32%	49.5		1.54%	13.58%	2.86%	0.00%	2.17%	0.00%	18.60%
Theatres - IP Anaesthetics (915423)	44	23.65%	82.00	75.83	1.71%	58.75	4	4.24%	14.28%	0.22%	1.94%	7.88%	0.00%	24.32%
Theatres - IP Porters (915435)	44	39.88%	101.00	10.07	20.62%	280		13.23%	12.44%	0.00%	1.60%	17.80%	0.00%	32.46%
Theatres - IP Recovery (915422)	44	25.64%	103.00	-1.7	4.18%	57.75		10.05%	14.62%	1.55%	6.64%	11.85%	0.00%	34.65%
Theatres - IP Scrub (915424)	44	16.36%	128.00	-3	1.24%	22		7.40%	14.66%	0.84%	0.00%	4.00%	6.01%	29.68%
Theatres - Ortho & Neuro Scrub (915436)	44	36.03%	37.80	0.75	2.70%	61.25		8.81%	18.29%	2.36%	0.73%	6.10%	7.79%	40.86%
Theatres - SDC Anaesthetics (915429)	44	55.26%	58.40	-21.5	40.70%	406.25		15.76%	17.80%	3.10%	6.94%	1.93%	15.26%	45.04%
Theatres - SDC Recovery (915430)	44	17.65%	177.30	-11.52	1.46%	18		21.86%	14.39%	2.14%	3.36%	8.94%	7.37%	36.20%
Theatres - SDC Scrub (915421)	44	32.40%	532.00	-253.79	0.71%	15.5		22.66%	19.37%	0.12%	1.75%	19.61%	0.00%	40.84%
Ward 1C Cardiac (913307)	26	20.25%	361.00	161.21	1.69%	110.5		14.56%	12.31%	2.21%	2.16%	13.40%	4.42%	34.78%
Ward 1C Neonatal (913310)	47	44.87%	556.00	1113.99	0.00%	0		27.87%	12.01%	5.71%	0.70%	6.86%	4.72%	35.71%
Ward 3A (915309)	44	28.65%	371.00	99.36	17.12%	1277.75	3	11.72%	11.93%	2.70%	4.32%	12.06%	7.22%	38.23%
Ward 3B - Oncology (911208)	45	13.86%	555.00	252.42	1.43%	72.5	31	14.87%	12.04%	2.05%	1.09%	9.48%	4.11%	30.79%
Ward 3C (911313)	44	22.52%	607.00	14.54	2.03%	148.5	13	27.72%	11.21%	3.45%	1.77%	9.42%	6.32%	34.19%
Ward 4A (914210)	18	21.79%	634.00	513.45	4.81%	369.5	27	19.53%	11.33%	3.21%	0.48%	10.95%	2.68%	31.71%
Ward 4B (914211)	45	38.09%	533.00	179.49	11.95%	1021	8	26.94%	15.19%	2.92%	2.76%	8.39%	5.48%	34.76%
Ward 4C (912207)	45	31.91%	280.00	126.47	0.19%	11.5	5	17.59%	9.90%	4.35%	4.07%	6.20%	5.19%	33.16%

Trust Summary

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

- Lead time 42 days (KPI 42 Days)
- Net hours have increased from 3360 to 3939 but remain within the KPI of 9001 (KPI 9001 to allow for up to a day to owe or be owed)
- Bank/Agency has decreased further from 11191 hours to 7218 Hours

- Additional duties have increased slightly from 120 shifts to 150 shifts. To note 3B Oncology Day Case have had to extend their opening at a weekend for a number of patients who required chemotherapy during the month of April and required specialist trained staff resulting in additional shifts being created.
- Sickness continues and remain high at 8.5%.
- Annual leave 14% (11%-17%) & other Leave 1.7% (<5%) all within the agreed KPIs.

BOARD OF DIRECTORS
Thursday, 5th June 2025

Paper Title:	**Compliments, Complaints and PALS report – Q4 and Year End 2024/25**
Report of:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	To provide update and assurance on the performance against complaints and PALS targets in Q4 2024/25 and the full year of 2024/25: • 3 day acknowledgement of formal complaints: average 88% compliance in Q4; average 88% compliance in year • 25 working day response to formal complaints: average 82% compliance in Q4 and average 83% compliance in year • 5 working day response to informal PALS concerns: average 92% compliance in Q4 and average 91% in year. The main themes continue to be treatment and procedure, access to appointments and communication
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	

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

Risk Number	Risk Description	Score

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

Compliments, Complaints and PALS Report – Q4 and Year End 2024/25: Trust Board 5th June 2025

Purpose	To provide update and assurance on the performance against complaints and PALS targets in Q4 2024/25 and the full year of 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 1a: Complaints received in Q4 by Division

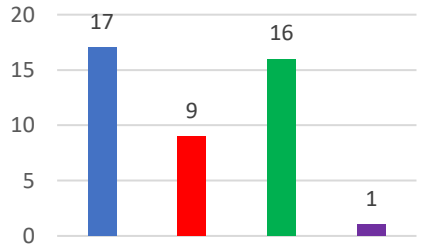


Figure 1b: Complaints received in 24/25 by Division

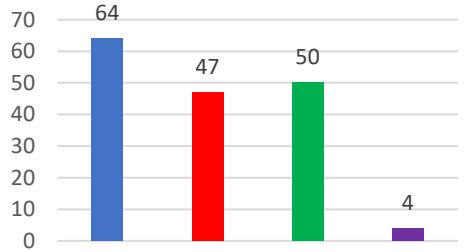


Figure 2a: Number of complaints rolling 12 months

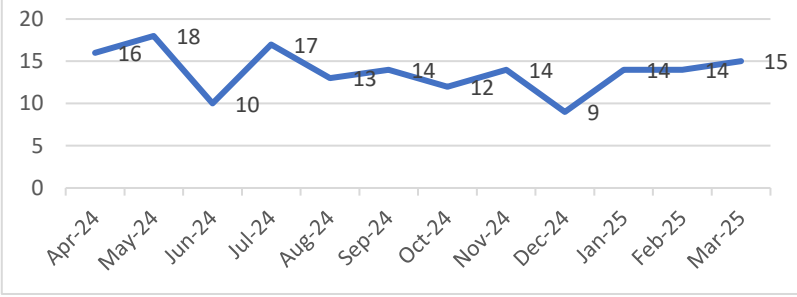


Figure 2b: Number of complaints per year since 2016/17

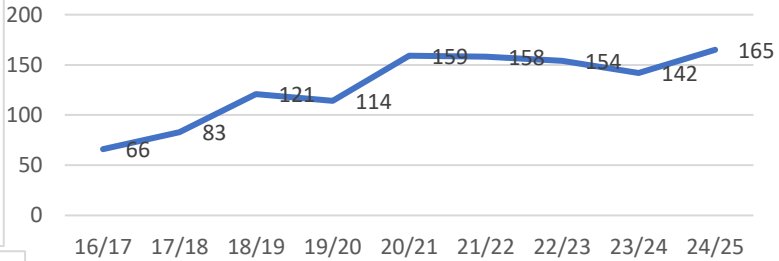


Figure 3a: Primary category of complaints in Q4

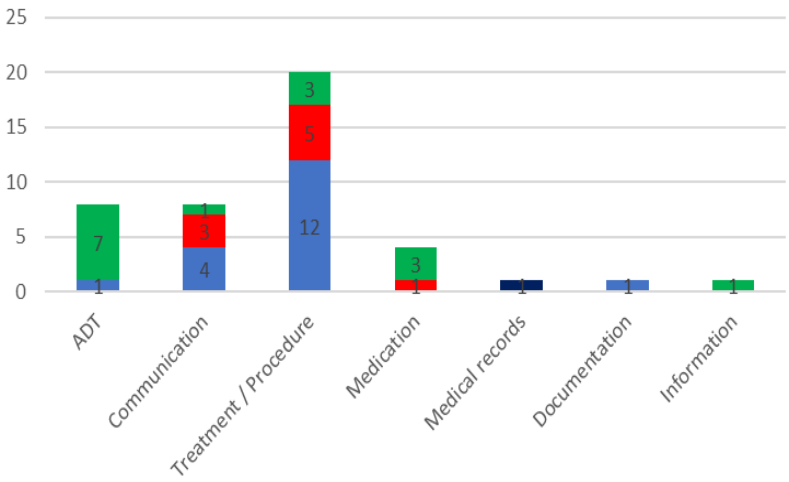
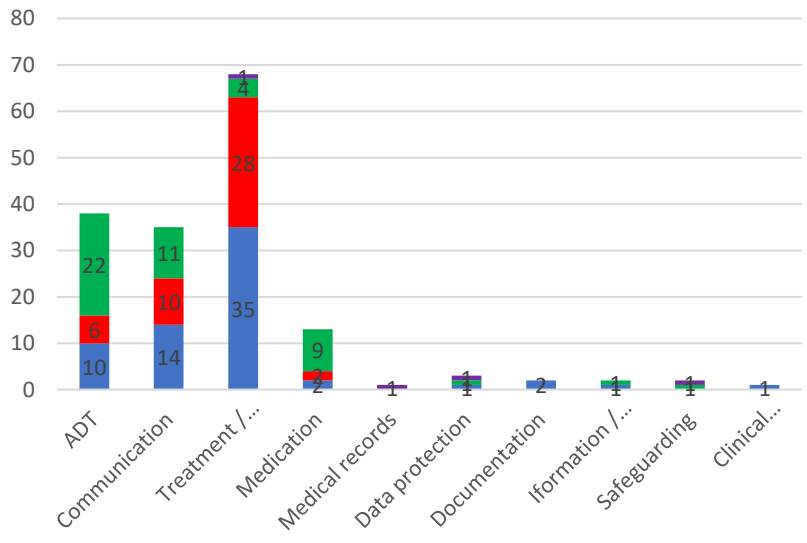
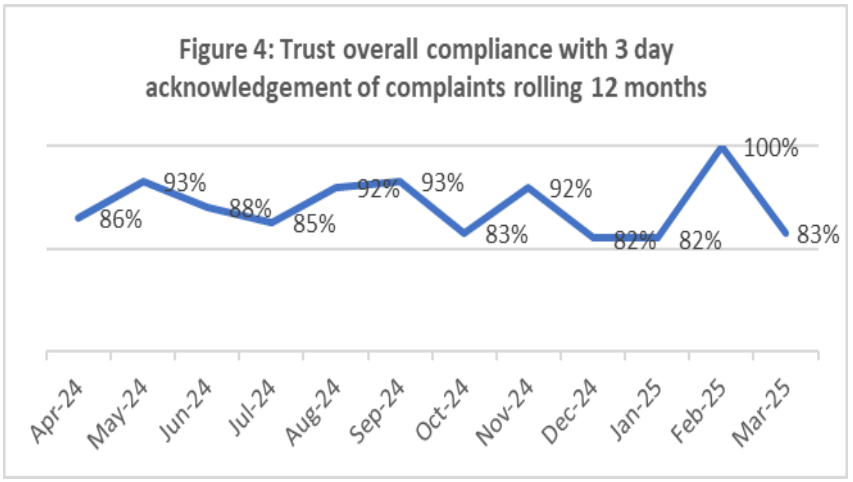


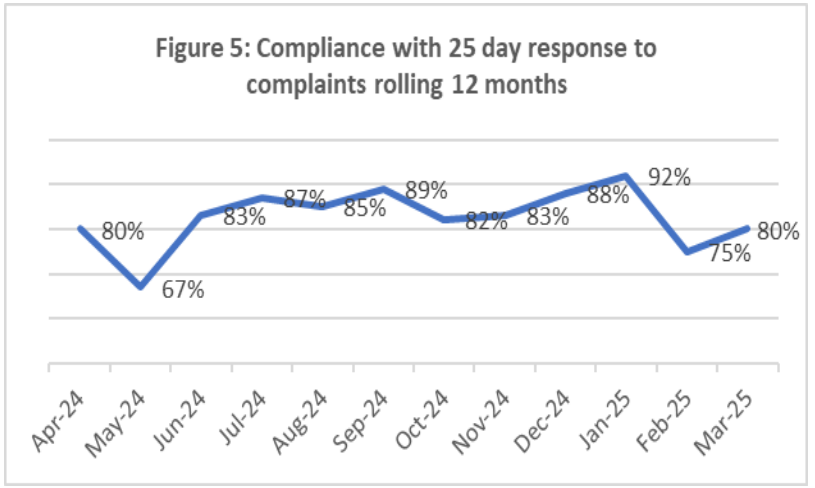
Figure 3b: Primary category of complaints 24/25

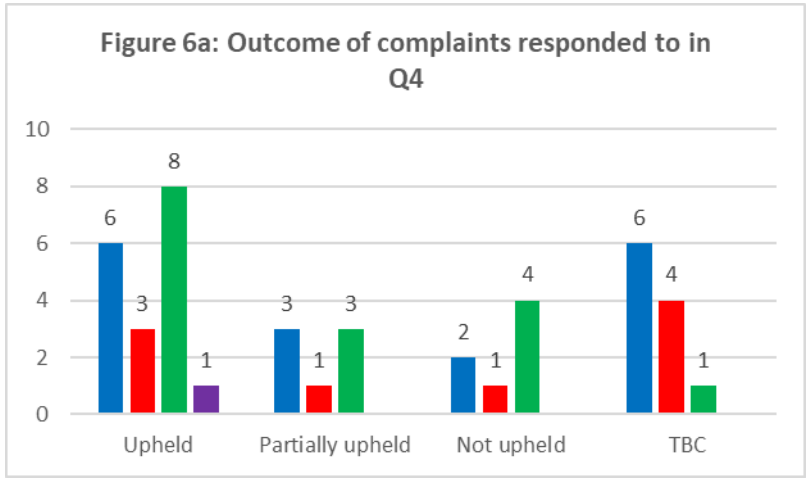


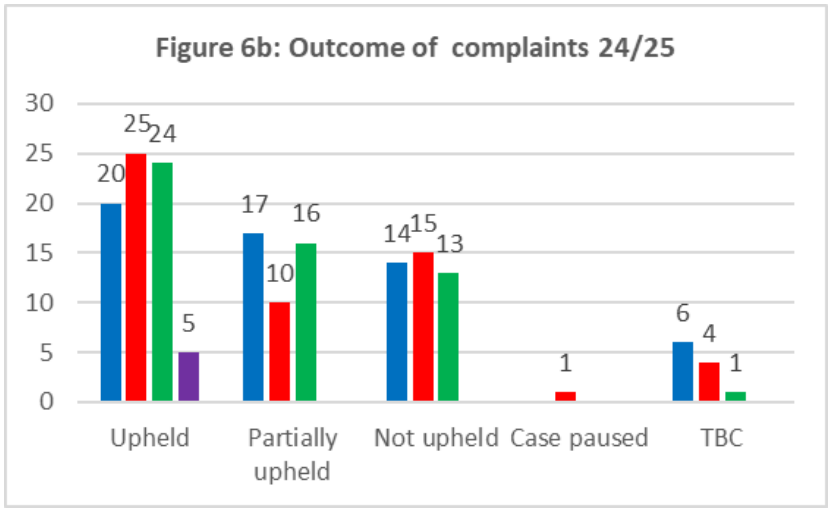
Complaints: In Q4, 43 complaints received. 4 second stage complaints received in Q4. Main reason continues to be treatment and procedure accounting for 46% of complaints received.

Compliments, Complaints and PALS Report – Q4 and Year End 2024/25









Percentage compliance with 25 day response by Division				
Division	**Q1**	**Q2**	**Q3**	**Q4**
Medicine	100%	100%	100%	100%
Surgery	71%	100%	100%	75%
Community & Mental Health	75%	50%	70%	90%
Corporate Services	100%	100%	0%	0%

Complaints: Trust overall not compliant with the 3 day acknowledgement; average 88% compliance in Q4 and 88% compliance in year. 43 complaints investigated and responded to

Trust overall not complaint with the 25 working day response; average 82% compliance in Q4 and 83% compliance in year as shown in Figure 5. The table demonstrates the excellent performance within the Divisions; it should be noted that these figures are based on information from BI and also the Divisions where data from the two sources may differ. Extraction of data from the relatively new InPhase complaints system relating to complaints and PALS continues to be a challenge.

PHSO: No new cases opened in Q4 and none closed. One case ongoing in the Division of Surgery. Three new enquiries were made by the PHSO (one in Division of Surgery and one in Community and Mental Health Division); information requested has been shared with the PHSO

Compliments, Complaints and PALS Report – Q4 and Year End 2024/25

Figure 7a: PALS received in Q4 by Division

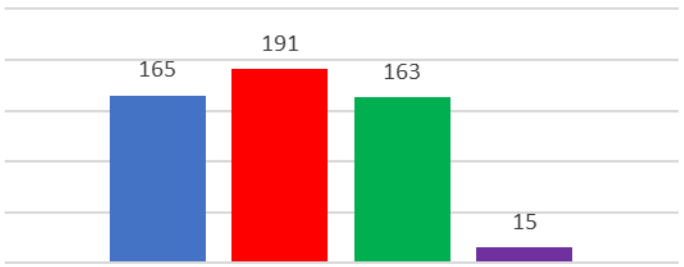


Figure 7b: PALS received in 2024/25 by Division

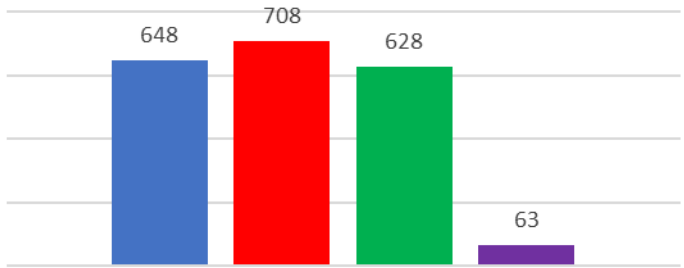


Figure 8a: Total number of PALS rolling 12 months

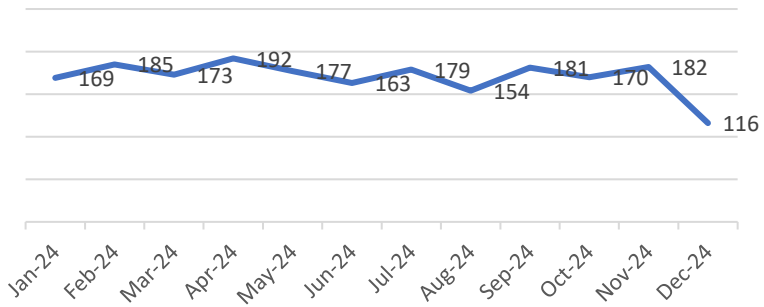


Figure 8b: Number of PALS per year since 2016/17

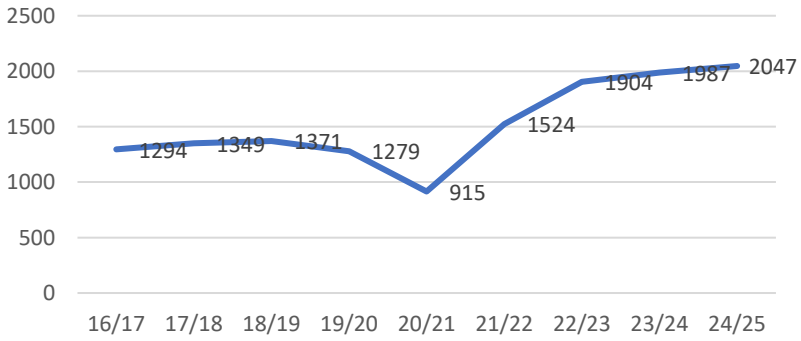


Figure 9: Category of PALS

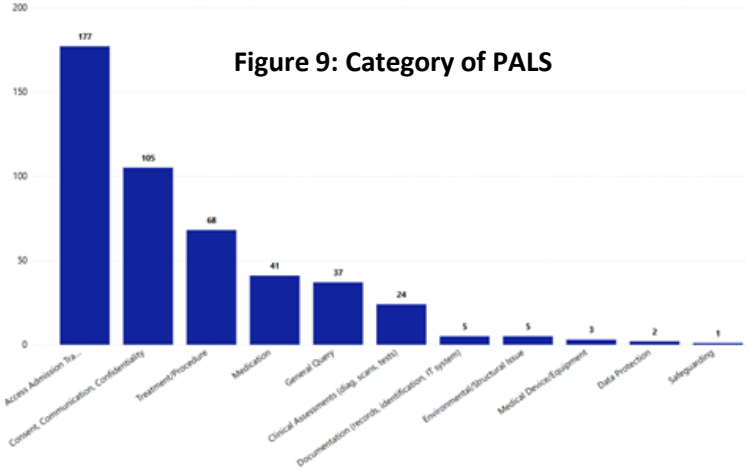
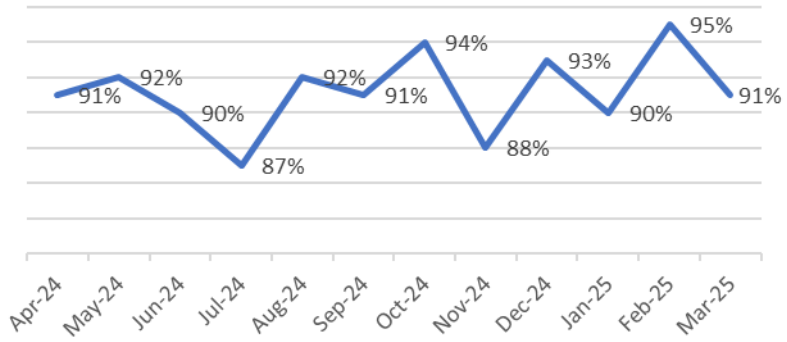


Figure 10: Trust overall compliance with 5 day response to PALS rolling 12 months



Percentage compliance with 5 day response by Division				
Division	**Q1**	**Q2**	**Q3**	**Q4**
Medicine	99%	100%	99%	98%
Surgery	99%	99%	99%	98%
Community & Mental Health	79%	73%	82%	83%
Corporate Services	55%	56%	35%	43%

PALS: In Q4, 534 PALS concerns were received which is a significant increase from Q3 (467). In year, 2047 PALS concerns were received which is a continued increase on the annual figure; this increase is associated in the main with access and waiting times. The main themes continue to be access to appointments and communication. Sustained improvement in compliance with the 5 working day response; average 92% compliance in Q4 and 91% in year. Corporate services compliance is now reviewed on a monthly basis by the Corporate Collaborative.

Compliments, Complaints and PALS Report – Q4 and Year End 2024/25

Learning from complaints and PALS: Alder Hey is a learning organisation and uses complaints as a mechanism for taking forward improvements and changes in practice. Lessons learned and actions taken, because of formal complaints and informal PALS concerns during the year include the following:

Lessons Learned

- The importance of all dressings being fully removed to enable a full assessment of any potential wound or tissue damage
- Communication is vital to ensure children, young people and families are fully aware of Trust processes and who they should contact if they need assistance
- The use of One Drive may cause delay in recording patient information and duplication with the electronic health record
- The Trust should have a blended diet policy
- The Trust would benefit from an increased number of safe space beds.
- The referral process should be clearly communicated to patients and their families to reduce any anxieties.
- Training on learning and disability care should be available to all Emergency Department staff.
- Face to face training for school staff may still be required rather than virtual school training
- Staff / patient concerns not always recorded on the Paediatric Early Warning System (PEWS)
- It is important to ensure collaboration between the young person, the family and Alder Hey throughout an inpatient's stay.
- All relevant therapeutic notes should be available to CAMHS Crisis Care to support more holistic review
- The CAMHS Crisis Care service offer needs to be more available to children and young people in Sefton.
- Team to be aware of and adhere to agreements for treatment / assessment relating to community physiotherapy access
- Explicit consent for attendance and involvement in appointments for student physiotherapists must always occur.

Actions

- Confirm at weekly PCO meeting that all answer machines are being checked and that all queries are responded to within 2 working days.
- Orthopaedic team to consider additional training for prescribing of blood products for all new starters as part of the departmental induction
- Weekly access meetings have been implemented to discuss the EPPF reports to ensure all pended appointments are made and sent out.
- Department to engage with digital team to review all electronic pathways to ensure that they meet the requirements of the service and ensure adequate record keeping in real time.
- A blended diet policy has been devised
- Business case submitted for the provision of more safe space beds
- Ward staff updated on how to order specialist commodes
- Education and training sessions arranged for all staff in the Emergency Department with the support of our Learning and Disability Team.
- Deliver face to face training to the staff at the school.
- Staff reminded of the criteria for referring patients to UTC.
- Ward staff have been reminded to record any concerns they have, or any concerns raised by the parent, in the patient notes.
- A business case has been submitted to purchase a blood gas machine.
- Revisit values-based learning package with all the team, including equality and diversity and the importance of demonstrating our Trusts values in our everyday practice
- Review of training compliance for Information Governance and share learning within monthly governance meeting
- The service is embedding a new welcome meeting, which will take place within 5 days of the young person's admission to Sunflower House. The aim of this meeting is to work collaboratively with the referrer, family and wider agencies from the start of the admission.
- Further Safeguarding training undertaken in Booking and Scheduling teams and referral teams regarding processes and who to follow.
- Review of CAMHS Crisis Care offer to children and young people attending other hospital ED to ensure that face to face assessment is provided if clinically appropriate
- All therapists to be reminded of requirement to gain consent for student physiotherapists to be present and to participate in patient contact. Records to be updated in relation to agreements for access to treatment and assessment

Compliments, Complaints and PALS Report – Q4 and Year End 2024/25

Figure 11a: Compliments recorded in 2024/25 by Division

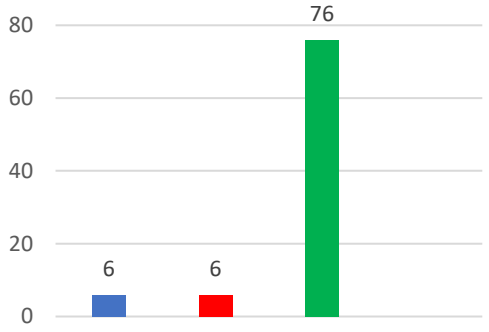
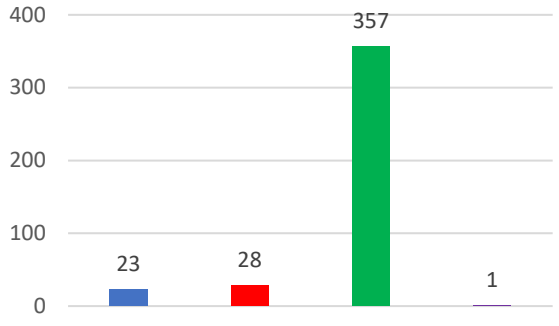


Figure 11b: Compliments recorded in 2024/25 by Division



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

Success Highlights	• 82% of formal complaints responded to within 25 working days in Q4 and 83% in year however there is potential room for improvement to ensure families receive a response in a timely manner • 92% of informal PALS concerns responded to within 5 working days in Q4 and 91% • 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
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 • Plan to meet with PALS and Complaints Officers and BI team to review and reconcile data which can look different

BOARD OF DIRECTORS

Thursday, 5th June 2025

Report of:	Nathan Askew Chief Nurse
Paper Prepared By:	Pauline Brown Director of Nursing The following staff are acknowledged and thanked for their support in compiling this paper: • Jennie Money Associate Director of Workforce, Education and Quality • Cathy Wardell Associate Chief Nurse Medical Division • Vikki Hughes Head of Nurse Education and Support Worker Development • Lisa Westley Lead Nurse for Retention • Alison Mellor Workforce Systems and Information Manager • Jo Gwilliams Trust Risk Manager
Subject/Title:	**Nursing Workforce Report 2024/2025**
Background Papers:	• Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals: National Quality Board, November 2017 • Safe, Sustainable and Productive Staffing: An improvement resource for neonatal care: National Quality Board, November 2017 • How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers: Royal College of Nursing, 2013 • Quality Standards for the Care of Critically Ill Children: Paediatric Intensive Care Society, December 2015 • Categories of Care: British Association for Perinatal Medicine 2011 • Quality Network for Community CAMHS Standards for Services: Royal College of Psychiatrists, 2020 • Developing Workforce Standards: Supporting providers to deliver high quality care through safe and effective staffing: NHSI, 2018 • NHS Long Term Workforce Plan, June 2023
Purpose of Paper:	This report aims to provide assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the

	demand for front line nurse staffing in accordance with NQB guidance To inform the Board of Directors of nursing workforce activity and progress in 2024/25 and proposed workforce improvements in 2025/26
Action/Decision Required:	The Board of Directors are asked to approve the following: The content of the report and assurance that appropriate information is being provided to meet national and local requirements. • The information on safe staffing and the impact on quality of care • Recommendations
Summary/Supporting Information	• Annual staffing report
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Provider of 1st choice • Deliver clinical excellence
Resource Impact:	none

Does this relate to a risk? Yes ☐ No x☐

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

Executive summary

The aim of this paper is to provide assurance to the Trust Board of Directors that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff.

Since the previous annual *Nurse Staffing Report for 2023/24* received in June 2024, and the *mid year Nursing Workforce report for 2024/25* received in December 2024, the senior nurse / AHP leadership team have successfully implemented the *Alder Hey Nursing and Health Care Support Worker Workforce Plan 2021-2025* and continue to make workforce improvements.

The recruitment action plan has continued in order to provide safe staffing levels. Alder Hey has demonstrated continued success in this highly competitive regional and national market, and of the 101 employment offers that were made for Band 5 recruitment, only 16 did not move through to full recruitment and commence in post. This represents a sustained reduction in attrition rate of 16% (was 8.5% in 2023/24 but 30% and above in previous years; this is associated with the introduction of the revised recruitment pathway.

From April 2024 the Trust has successfully recruited 85 nurses via the national recruitment route. 53 WTE Band 5 Registered Nurses left the organisation in the last year. This is a continuing downward trend from 2023/24.

The Trust successfully recruited to other key senior nursing leadership posts in 2024/25, including the appointment to the Associate Director of Workforce, Education and Quality.

In year, nursing vacancy rates continue to be below 2%, which is significantly lower than the national average of 10% as reported by NHSE. As of March 31st, 2025, the Trust had 0 vacancy for RNs, with a positive variance of 40 WTE over our funded establishment in line with additional funded establishment to cover maternity leave. Staffing pressures are therefore largely due to staff availability to work due to sickness absence and maternity/paternity leave, and other absences reasons. This is referenced in Appendix 3.

The Trust's mandated monthly submission of staffing levels to the Strategic Data Collection Service was 79% for RNs and over 90% for non-registered nurses which is a sustained position. This referenced in Appendix 1.

Staffing RAG data has continued to show a sustained position with zero red shifts in the Trust over the last financial year. The Trust benchmarked positively with comparator organisations for Care Hours per Patient Day (CHPPD).

The Trust extended the role of Lead for Nurse Retention for a second year to support a reduction in Registered Nurse leaver rates.

The report details the proposed workforce improvements for the next five years in the new combined *AHP and Nursing Workforce and Education Strategy 2025–2030* which is under development.

1. Introduction

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

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

This report will outline the key national guidance and regulatory requirements related to nurse staffing, a summary of achievements in 2024/25, compliance with workforce standards, and provide assurance on safer staffing requirements as set out in the National Quality Board (NQB) guidance; meeting NQB guidance is key to compliance with the CQC fundamental standards on staffing.

The report details proposed workforce improvements in 2025/26 which include implementation of the proposed *Allied Health Professional and Nursing Workforce and Education Strategy 2025-2030.*

2. National context and regulation

Trusts are expected to comply with the CQC fundamental standards on staffing; key to compliance is meeting NQB guidance including *Developing Workforce Safeguards* (NHSI, 2018).

There are a number of tools available to support in determining safe staffing levels. The Trust is in Year 2 of implementing the NHSE Children and Young People Safer Nursing Care Tool (SNCT) and Year 1 of implementing the Emergency Department SNCT and the Mental Health Optimal Staffing Tool (MHOST) on Sunflower House. The SNCTs support Trust's to determine optimal nurse staffing levels by measuring patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce.

The tools currently used at Alder Hey are Royal College of Nursing standards nurse to patient ratio, skill mix review, patient acuity and dependency assessment using SNCT data, professional judgement, and triangulation with nurse sensitive indicators.

Additional specialised guidance for staffing in paediatric intensive care and high dependency settings is set out by the Paediatric Intensive Care Society (PICS 2015). The British Association for Perinatal Medicine lay out standards for care of neonates (BAPM, 2011). The Royal College of Psychiatrists set out CAMHS standards (RCP, 2020).

The National Quality Board (NQB, 2017) set out improvement tools specifically for the care of children and neonates based on their expectations of safe, effective, caring responsive and well led care, on a sustainable basis, that ensures the right staff with the right skills are in place the right place at the right time.

A specific workforce statement is provided in the annual governance statement which is monitored by NHSE. Implementing the recommendations and strong, effective governance,

provides Trust Board assurance that workforce decisions promote patient safety and comply with the Care Quality Commission's (CQC) fundamental standards, NHSI compliance and the Board's statutory duties.

In June 2023, the *Long-term Workforce Plan* was published setting out an ambitious plan to recruit 170,000 more nurses to support safer staffing. The model proposes to train, retain, and reform the workforce to ensure the NHS has the right number of staff with the right skills and competencies in the right place to deliver safe, effective patient care within an affordable budget.

3. Workforce developments and achievements in 2024/25

The overall impact of the success of the nursing workforce strategy, including a reduction in vacancies, development opportunities, retention strategy and other initiatives to support safe nurse staffing are as follows:

3.1 Recruitment

i. 85 WTE Band 5 nursing staff recruited in 2024/25; only 16 from 106 WTE nurses offered a post at Alder Hey did not commence in post.
ii. Vacancy rate less than 2%, at many points in the year it was 0.
iii. A responsive recruitment culture with evidence of strong partnership between senior nurses, and human resource staff, notably working together on successful national recruitment days, plus, a comprehensive induction and preceptorship programme for new nursing staff.
iv. A continuance of our 'one stop' recruitment event in 2024/5, with all candidates being interviewed on the same day, and if successful the recruitment team undertake an admin appointment at the same time. This is completed across a whole day, with the interviewing of candidates who have been successful in their medication assessments. This process is completed in partnership with our divisional nursing teams, and the organisational recruitment team.
v. Recruitment strategy partnership working with Higher Education Institutes to attract potential student nurses from diverse backgrounds and wider work to engage with the student workforce to provide a clear offer to encourage their choice for Alder Hey to be their preferred work option.
vi. The Trust preceptorship framework has recently been reviewed and updated, and the Trust has been awarded the interim quality mark (IQM) from NHSE. The framework enables regular engagement with a PNA, group and individual restorative clinical supervision.
vii. Continued work on our Health Care Support Worker (HCSW) programme in partnership with NHSP to achieve the NHSE zero vacancy target; increase in vacancies is largely associated with changes in nursing models on some wards (for example Ward 4B) where the registered nurse requirement has been reduced.
viii. In March 2025, the Trust attended a Health and Social Care Recruitment event in Liverpool. This was the first of its kind and gave us the opportunity to extend the scope of our recruitment including both adults and paediatrics with many potential candidates already having the care certificate qualification. A number of appointments were made on the day and there continues to be ongoing recruitment with further interested candidates who attended.

3.2 Strong and effective leadership

i. Completion of the Trust *Nursing and Health Care Support Worker Workforce Plan 2021-2025* underpinning our clear vision to be a national leading centre in the training, education, and of paediatric nurses and HCSW's.
ii. Extended the role of Lead for Nurse Retention for a second year to support a reduction in Registered Nurse leaver rates
iii. Opportunities for staff to develop, grow and progress in the organisation.
iv. Developed a clear structure for advanced and enhanced practice
v. Successful recruitment to the Associate Director of Workforce, Education and Quality
vi. Internal promotion to Band 7 Ward Manager positions and Band 6 Ward Sister/Charge Nurse positions.
vii. Continued implementation of relevant Safer Nursing Care Tools with senior leadership and validation of data collection
viii. In October 2024, the Trust took part in a nursing workforce review with NHSE and ICB leads; the review was attended by the Chief Nurse and senior colleagues from nursing, HR and Finance. Positive feedback and assurance was received from NHSE and ICB partners.

3.4: Educational developments

i. Review of our Nursing preceptorship framework to align with new national guidance and ensure post pandemic requirements are being met.
ii. Optional rotation pathway continues for all newly qualified nurses; facilitates the development of a wider skill set; access to a wider experience in medical, surgical and specialist fields.
iii. Introduced the national Band 5 children and young people nursing competencies Embedded the Band 5 development framework, which offers clear guidance through the initial first 2 years post recruitment identifying the range of learning available and expected. The introduction has provided a 24 month progression framework for all Band 5 nurses within the organisation. The existing Band 5 framework can be used to further support this in addition to local progression pathways to meet each areas patient and family needs to support a standardised baseline of knowledge and skills to our Band 5 nursing workforce.
iv. Band 6 Development programme: The Trust has established a bespoke group of senior leaders to fully explore opportunities to support the Band 6 workforce. The intention is to utilise a range of learning opportunities, to meet each individuals needs.
v. Supporting internationally educated nurses in their progression within the organisation.
vi. Ongoing partnership working with our HEI partners to ensure full utilisation of existing placement capacity, and the opening of new placement opportunities linked to research and management.
vii. Delivery of a fully structured student engagement programme, with annual engagement days for all nursing students, focusing on key skill development and enhanced knowledge building.
viii. Implementation of a multiprofessional forum, which provides a learning hour and listening hour for all learners within the organisation to come together.
ix. Ongoing support of our 7 students on the Registered Nurse Degree Apprenticeship (RNDA 4) who are progressing well and will graduate in June 25.

x. Ongoing delivery of the Supportive Coaching in Practice (SCiP) model, to support our learners onsite. Now sharing this development via national events and regional groups.
xi. Completion of phase 1 of an IV pilot project, enabling final placement nursing students the opportunity to administer IV medication under direct supervision.
xii. Supported 24 nursing staff to undertake the Professional Nurse Advocate (PNA) training with 10 now successfully completed.
xiii. Ongoing support of PNA forum and the overall PNA organisational strategy to ensure full utilisation of this role to support the nursing workforce. Supported via CPD funds and tracked via the Trust risk register. There are now 25 qualified PNA's supporting the nursing workforce across 12 clinical areas. Work continues to ensure PNA representation across all clinical nursing areas as we move towards achieving the NHSE ask of 1:20 PNAs to nurses. The role continues to be further embedded across the Trust and is fully integrated into the Trust preceptorship and wellbeing offers. The PNA organisational strategy continues to provide a basis to ensure full utilisation of the role across the Trust. Additional work is also occurring to ensure representation of the PNA role across Trust policy
xiv. Fully embedded the Practice Education Recognition Certificate (PERC). This enables those student nurses who demonstrate consistent exceptional practice, to be identified. Ward / Departmental Managers are able to offer a recruitment opportunity for any vacancies they have, to final year students to their area in recognition of exceptional practice via this process.
xv. Continued to support senior nurses and aspiring nurse leaders to undertake the MSc programme in leadership enabling staff to gain the necessary skills and competencies to successfully fulfil senior nurse roles. Maintained and supported 3 senior nurses per year to participate.
xvi. Practice Education Facilitators and Clinical Practice Educators continue to ensure required internal and external placement quality standards are met, address organisational education requirements, and provide a streamlined approach to a wide variety of staff development opportunities.
xvii. CSWD programme: Continues to be delivered in partnership with NHSP. The Trust is also reviewing all regional recruitment opportunities, including engagement with Liverpool City Council events and the possibility of organisational open days. A steering group has been established to fully consider all aspects of recruitment and induction for the HCA workforce with any changes to be implemented in 2025/26.

3.5: Quality metrics

i. Continued monitoring of different aspects of practice using the Tendable Audit Tool across all the wards; audits on InPhase from March 2025.
ii. The Ward / Departmental Accreditation programme has been further developed to include additional departments, with 25 wards and departments included in the programme.
iii. The ward accreditation measures have been mapped across to reflect the CQC self-assessment framework and all assessments are now carried out using this tool, with the scoring reflective of the CQC assessment framework. All areas assessed in 2024/25 successfully achieved either Gold, Silver or Bronze
iv. E-roster system fully in place and monitored across wards, with KPI's reviewed updated and performance monitored.

v. Local challenge boards continue to monitor staffing at Divisional level providing information for recruitment events. They also provide assurance around key performance indicators reporting into Trust wide committees.
vi. Patient Safety Meetings continue to provide assurance around our safety culture.
vii. Quality Ward Rounds undertaken with a range of quality topics reviewed. Involvement from the CYP adds significant value to the process. Associated action plans are monitored via Divisional Governance committees. The quality rounds are undertaken by the senior nursing / AHP team and provide visibility and drive improvement work across all areas.
viii. CNIO supporting digitally enabled quality improvements and solutions.
ix. Monthly Safer Staffing report provides an update on quality metrics.

3.6: Retention

i. The Internal Transfer Process (ITP) offers existing Alder Hey Band 5 nurses the opportunity the relocate within the organisation. The ITP creates a framework for Band 5 nurses to identify a new area they would prefer to work, and for us as an organisation to support these relocations were possible, without the need for formal recruitment processes.
i. 2024/2025 showed a slight increase in total RN leavers from 92.15 WTE (2023/2024) to 94.7 WTE. However, when looking specifically at our Band 5 leaver data this continues to demonstrate a steady decline. In 2023/2024 there were 59.62 WTE leavers compared to 53.16 WTE in 2024/2025. This can be attributed to the package of support on offer within early careers (1 – 2 years). However, recent data does suggest a decline in leavers across all bands (Appendix 3).
ii. Retention data specific to Alder Hey continues to be tracked and comparable to regional and national data thus enabling targeted intervention with improvement being demonstrated. Recent data clearly shows a reduction in leaver rate. specifically, within the preceptee phase (first 12 month). However, leaver rates across all Bands demonstrate a reduction (Appendix 3). This can be attributed to the expansion of retention initiatives across all Bands within the nursing workforce.
iii. The Professional Nurse Advocacy programme led by the Lead for Nurse Retention, continues to grow with 25 PNAs now delivering Restorative Clinical Supervision and wider aspects of the A-Equip model across the nursing workforce. CPD funding continues to support ongoing training enabling a targeted approach to ensure PNA representation across all clinical nursing areas.
iv. Work has been undertaken to create a developmental framework for all Band 5 nurses within the organisation, this is inclusive of the preceptorship period and also details the opportunities available to staff in addition to the expectations of the organisation at designated points being clear.
v. All nurses are supported to complete the organisational Standards for Student Supervision and Assessment (SSSA) training enabling them to meet the Nursing and Midwifery Council (NMC) requirements to support and assess student nurses. As part of SSSA training we now also provide education in relation to the preceptor role and an introduction to coaching.

4. Nurse staffing model

4.1: Ward establishments

The staffing model is fundamentally based on achieving compliance with national requirements, local patient acuity, professional judgement, benchmarking using the NHSE Model Health System, and review of compliance with key quality metrics including key performance indicators, outcomes and incidents as core components of safe staffing principles. 100% of ward establishment reviews were undertaken in 2024 using a multi disciplinary team approach including Finance and HR. Analysis was shared with the senior nurse / AHP team and the Executive team.

Significant progress was made in 2024/25 in the introduction and implementation of evidence-based acuity tools to support workforce planning and establishment setting and the Trust is now in Year 2 (2025/26) of implementation of the relevant NHSE Safer Nursing Care Tools (SNCT); it is considered to take a minimum of three years to implement the tools in full. The following SNCT are available and applicable to wards and departments at Alder Hey:

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

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

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

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

Patient acuity data was collected twice in Year 1 (February 2024 and July 2024) for 20 days for all patients on the ward in line with SNCT guidance on all inpatient wards who met the criteria for the CYP SNCT (as shown in Table 1). Data was validated by senior staff who are

not the budget holder for that ward. NHSE guidance regarding the number of days to collect data changed at the end of 2024 and as such data collection for was undertaken for 28 days in Year 2 (February 2025 and planned for June 2025). Sunflower House and ED undertook their first data collection in February 2025 and the second is planned for June 2025.

The patient acuity data can be used as part of establishment setting by populating the CYP SNCT Ward Multipliers tool, however it is recommended that the data is collected a minimum of three times before it is used to set establishments, therefore the senior team used the data during the 2024 round of establishment reviews in shadow form. It is planned to use the CYP SNCT data collected for forthcoming establishment reviews planned for July and August 2025 in line with the annual planning cycle for Trust budget setting planning. The Safer Staffing Faculty at NHSE have been extremely supportive and on hand to assist the team with any questions to support our phased implementation.

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

4.2: Safer staffing levels

Trusts are mandated to provide nurse staffing information on a monthly return via the Strategic Data Collection Service and publish this data at ward level; the Trust is compliant with submitting data.

The Trust produces a monthly *Safe Staffing and Patient Quality Indicator Report* to provide a summary of overall Nursing and HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Data can be compared and benchmarked with CHPPD figures from comparative wards enabling investigation to understand any significant variation and to make sure the right staff are being used in the right way in the right numbers. CHPPD includes total staff time spent on direct patient care including clinical time such as preparing medicines, documentation, and safeguarding.

The staffing levels reported are the head count on each shift which does not analyse skill mix or the impact of temporary staff on a shift. A monthly ward fill rate of 80% and over is considered acceptable nationally. Fill rates for 2024/25 demonstrated that the average overall staffing level was 85% for the year as shown in Appendix 1. Broken down further we find the overall RN reported staffing levels are at an average of 88%, with the HCA fill rate was 82%. There are vacancies within HCA's in most departments which impacts on the fill rate reported.

Appendix 2 shows the CHPPD benchmarking data by ward for 2024/25. An analysis of the CHPPD benchmarking demonstrates that majoritively the Trust provides a similar or slightly higher than average care by patient hours. The benchmarking data used for HDU is the same comparator as for PICU therefore it is appropriate that this figure is lower. Where benchmarking data is lower, this is subject to review and analysis, and reported on a monthly basis through the *Safe Staffing and Patient Quality Indicator Report.*

Safer Staffing meetings were held twice per day Chaired by a Head of Nursing where plans were made for the day and night in line with the *Standard Operating Procedure (Nurse Staffing Escalation Ward and Departmental Optimal and Minimum Staffing Levels*. The

overall staffing status (Green; Yellow; Amber; Red) was escalated to the Daily Operational meeting and to the Chief Nurse by exception in line with the escalation process. The red model has not been invoked since late 2022.

A breakdown of the status of day and night shifts in year is shown in the graphs below which shows there has been no escalation to red status in this reporting period. The data also demonstrates the effective management across the 24-hour period with staffing comparative on day and night shifts in line with activity.

As at March 2024 the Trust had no vacancies and the additional 40 WTE posts to cover maternity leave were all filled.

5. Workforce challenges

5.1: Leavers

Detailed leaver data is supplied in Appendix 3 and demonstrates the continued improvement in the Trusts position when compared nationally.

The main reasons for leaving the Trust in the last 12 months have been voluntary resignation for work life balance and voluntary resignation for relocation. The data also highlights that a number of staff left the organisation citing the reason for leaving as

promotion. This suggests that there is a potential lack of opportunity for progression. This is primarily demonstrated within Band 5 & Band 6 and mirrors the data from 2023/2024

Leaver rates from our internationally educated nurses demonstrate a slight increase in leaver data when compared to 2023/2024. A high proportion of those leavers (60%) either cite voluntary resignation for relocation or voluntary resignation for promotion as the reason for leaving.

Focused support has continued and expanded within our preceptee cohorts, resulting in a significant decline in preceptee leaver rates. Documentation in the form of the Trust preceptorship policy and updated preceptorship paperwork have strengthened our preceptorship offer with 2025 currently demonstrating no preceptee leavers to date.

The appointment of the Lead for Nurse Retention role has continued past the initial pilot and is confirmed until March 2026. The role continues to work to support the Trust wellbeing offer and alongside the quality improvement team to support delivery of the Trust People plan. The Lead for Nurse Retention role links in with regional and national workstreams whilst contributing to internal and external reporting requirements.

5.2: Age profile of RN and Band 5 nursing staff

Age profiling and the potential for retirement is an integral part of effective workforce planning, thus enabling predicted future requirements to be identified and factored into the Trust's recruitment strategy.

The nursing age profile chart identifies 40 (5.5%) Band 5 nurses are able to retire at aged 55 years, an increase of 10 to the previous year, and 142 (9.5%) of all Registered Nurses can retire at aged 55 years, a decrease of 54 compared to the previous year.

Partial retirement options have been introduced and have encouraged a number of nursing staff to take their pensions but return to work.

Information relating to retirement intention is only available through staff sharing information voluntarily, therefore this poses a risk to the organisation. In order to impact assess and mitigate the risk of future gaps in the nursing workforce, work will continue to seek staff intentions over the coming years. This will take the form of 'stay interviews' which can occur anytime but mainly as part of the appraisal process.

5.3: Maternity leave

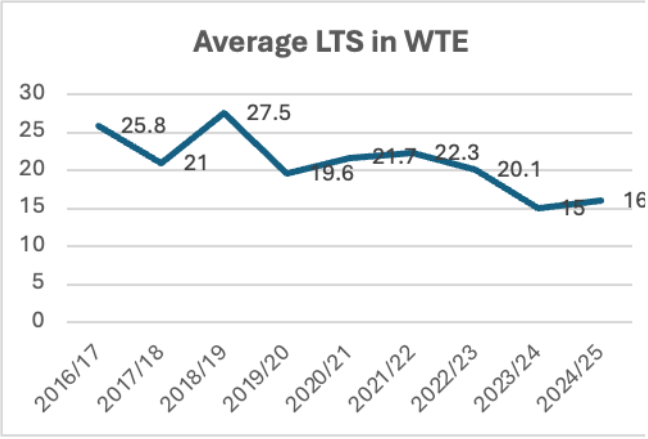
Maternity leave cover is not included within the calculated ward establishments for any of the wards. In 2017/18, in recognition of the average maternity leave figure of 40 WTE, the Trust Board supported an increase to the overall funded nursing establishment of 40 WTE in order to further improve resilience in providing maternity leave cover.

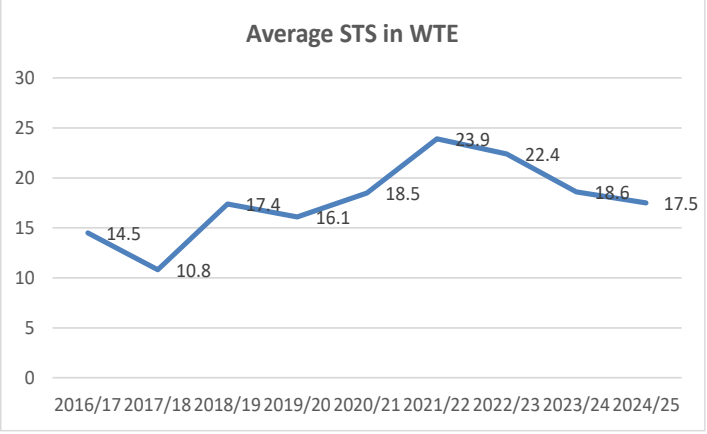
60% of maternity costs are recovered from central government across the duration of a period of maternity leave absence, the remaining 40% is the Trust's internal challenge, which is valued in the region of £480,000 per annum.

5.4: Sickness

There has been sustained improvement in the average long-term sickness this year compared to previous years, reflecting the significant investment in wellbeing and other support programmes to aid staff recovery and earlier returns to work.

Short term sickness remains above the Trust target however has seen a continued downward trajectory from last year. Ward Managers continue to work in collaboration with HR to support the physical and mental health and wellbeing of staff and hold regular wellbeing days on their wards and departments.





5.5: Enhanced Therapeutic Observations and Care

The Trust continues to care for a significant number of patients who require 1:1 nurse to patient ratio of care outside of PICU and HDU areas. Oversight on a daily basis is provided

through the Safer Staffing Meeting in line with the Standard Operating Procedure for one-to-one care (Developing Workforce Safeguards, NHSI 2018). Ward 4B model of nursing has been reviewed to consider this need.

NHSE recognise 1:1 care as Enhanced Therapeutic Observation and Care (ETOC), and in August 2024 they launched the ETOC programme to support Trusts to make local, clinically led, and patient centred approaches that improve their care provision based on the following four pillars:

1. Effective leadership and oversight – including governance, data, local assurance, clinical policy making.
2. Effective person-centered and safe therapeutic care – including identifying the need for ETOC, monitoring and stepdown.
3. Effective education and training – ensuring that that staff are trained in reviewing, providing and overseeing ETOC.
4. Effective workforce planning and deployment – planning for levels of ETOC, ensuring that ETOC is considered during safe staffing establishment setting processes.

The Trust is part of the Cheshire and Mersey ETOC working group and is working on reviewing and aligning our policies and procedures to meet the standards. In support of the national programme to understand the demand for ETOC, monthly data will be submitted via the PWR in 2025/26

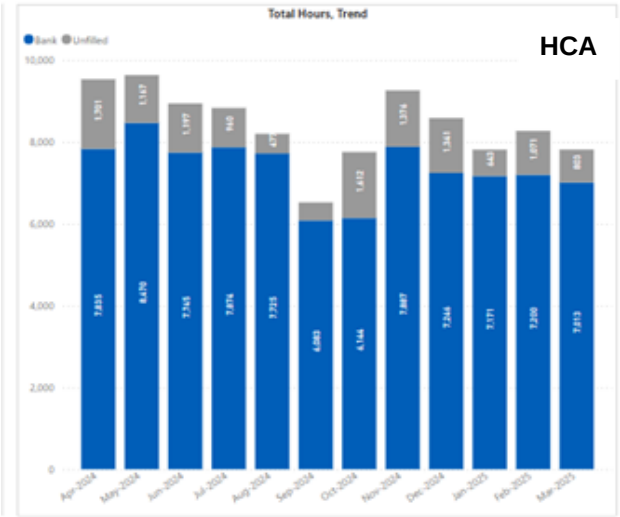
5.6: Temporary staffing: NHSP and agency

The Chief Nurse has led a continued drive to reduce the use of bank and agency staff.

Senior nursing staff are members of the Workforce Efficiencies Group where temporary staffing is monitored closely on a weekly basis, with executive oversight. Temporary spend is also reviewed and managed within Divisions and daily at the Safe Staffing Meeting and by the Senior Clinical Site Practitioner out of hours. The efficacy of this process has been observed and reviewed by the senior nurse team with a high level of assurance gained in regard to the application of scrutiny and management of temporary staffing requirement.

The Trust has seen a reduction in the overall bank and agency usage of Registered Nurses and HCAs in year as shown in the graphs below.

RN



HCA

The use of additional temporary spend remains a Trust priority. To support Ward Managers to manage their budget, in March 2025 it was proposed and approved that ward nursing budgets be realigned across substantive and bank lines, to reflect that some bank shifts are required to cover sickness and other short-term absences. It is anticipated that by setting a more realistic budget, ward managers will be in a better position to manage financial resources appropriately. It has been proposed and approved that a proportion of the 23% uplift (8% for most wards) is aligned from the substantive budget to an NHSP budget for each ward for Registered Nurses (Band 5; Band 6 is nominated wards) and HCAs. This proposal will not lead to a reduction in total allocated budget but will support a reduction in expenditure run rate and reduce the level of over-spending against agreed budgets.

5.7: Staffing risks and incidents reported

There were a total of 79 staffing related incidents and near misses reported in 2024/25 comparable with 76 in 2023/24 and a sustained reduction compared to 145 incidents in 2022/23. Where staffing related incidents occur, these are recorded on the Trust incident management system.

The main reported themes relate to staffing issues due to staff shortages and concerns regarding skill mix and suitably trained staff. Ward 1C Cardiac reported the highest number of incidents as shown in the graph below, mainly relating to staffing number and patient acuity in HDU commissioned beds.

Examples of action taken to address and reduce staffing incidents are as follows:

- The Safer Staffing Huddle has been embedded to ensure a clear and agreed daily staffing; appropriate redeployment of staff from other areas following assessment and review.
- Use of temporary staffing following risk assessment
- Weekly forward look of TCIs to plan staffing requirement.
- Clinical Educator working alongside new nurses and student nurses.

There are currently 12 open risks on the Risk Register relating to staffing in Wards and Departments (does not include specialist nursing teams) with risk scores ranging from 6 to 12 (2 of the 12 are legacy risks that were not reported on in the last annual report). All have appropriate control measures and associated actions. 5 staffing risks relating to Wards and

Departments were closed on the Risk Register in 2024/25. An overview of the risks is shown in Appendix 6.

6. Proposed workforce developments for 2025-2030

i. A new combined *AHP and Nursing Workforce and Education Strategy 2025–2030* is under development, which includes 4 commitments across these workforce groups and aligned activity to support delivery over the next few years.

ii. Commitment 1: Support a thriving workforce with a shared sense of value and belonging

   a. Continue to maximise high quality practice learning capacity to support a pipeline of newly qualified nurses with paediatric skills and interest.
   b. Ensuring we have HCAs and nurses with the right skills to care for our increasingly complex children and young people by exploring and developing innovative models of recruitment and working to ensure we attract and retain talented people.
   c. Continue to access relevant apprenticeship opportunities to help support a sustainable future paediatric HCA and nursing workforce to access careers and widening participation of our local population.
   d. Led by the Lead Nurse for Retention, key projects have delivered a significant improvement in nurse retention over the last few years. We will continue to broaden and strengthen our retention focus to grow and improve our preceptorship offer, enhance support for those at early career, new to role and transitioning.
   e. Continued reduction in use of temporary staffing: Continue to review ways of reducing the use of temporary staffing, including workforce reviews and reduction of agency spend. This will include reducing nursing bank rates in line with other Cheshire & Merseyside organisations, ensuring all bank shifts are paid at the level of the Band of nurse required.

iii. Commitment 2: Develop and strengthen compassionate and inclusive leadership

   a. Develop and empower our nursing workforce by providing training, support and resources to build confidence in EDI and Allyship, including a tailored development plan for our internationally recruited colleagues.
   b. Continue to grow the professional nurse advocacy role, developing and expanding restorative clinical supervision offer to nurses.
   c. Continuing to develop and improve the diversity of our nurses, ensuring we have an effective training and education plan and succession planning.

iv. Commitment 3: Design and develop our future workforce, ready to embrace new ways of working

   a. Continue to build our advanced practice workforce, and grow the enhanced practice offer for our nurses, supporting work across the 4 pillars of practice.
   b. Refine career pathways, supported by the Development Hub (a multi-professional resource launched on the intranet which includes a career pathway from HCA to senior nurse).
   c. Ensure compliance with regulatory guidance and safer staffing, including continued use of the relevant Safer Nursing Care Tools.

v. Commitment 4: Inspire excellence in research, innovation, digital and education
   a. Continue to support our nurses to be research literate, informed and to facilitate evidence-based practice within their services through access to relevant training, advice and opportunities.
   b. Continued partnership with local HEIs to explore options to grow clinical research and academic careers: strengthen and grow continuing professional development opportunities; and ensure positive learner experiences for all our nursing workforce.

7. Conclusion

A firm foundation has been successfully built to support ongoing workforce management and further development. Following successful implementation of the Trust Nursing and Health Care Support Worker Workforce Plan 2021-2025, the senior nursing / AHP team will commence implementation of the proposed new combined AHP and Nursing Workforce and Education Strategy 2025 – 2030. In addition, the team will continue to respond to the national picture, including emerging risks, national and local developments, and changes, and identify opportunities to transform and enable effective new ways of working.

The Trust Board of Directors are asked to note and approve the contents of this report.

Appendix 1: Staffing availability report 2024/25

Ward Safer Staffing 2024/25	Day RN	Day HCA	Night RN	Night HCA	Overall staffing		
					Average RN	Average HCA	Overall
April 24							
May 24	88%	92%	87%	112%	87.5%	102%	94%
June 24	88%	78%	87%	102%	87.5%	90%	88%
July 24	88%	72%	87%	94%	87.5%	83%	85%
August 24	88%	70%	87%	94%	87.5%	82%	85%
September 24	90%	68%	90%	94%	90%	81%	86%
October 24	92%	69%	92%	96%	92%	82%	87%
November 25	90%	72%	92%	89%	91%	80%	86%
December 25	88%	71%	86%	82%	87%	76%	82%
January 25	86%	71%	86%	82%	86%	76%	81%
February 25	89%	70%	88%	69%	88%	69%	79%
March 25	85%	71%	87%	86%	86%	78%	82%
Total compliance 2024/25	88%	73%	88%	91%	88%	82%	85%

*the above does not reflect ward occupancy and is a measure of % fill rate against roster template.

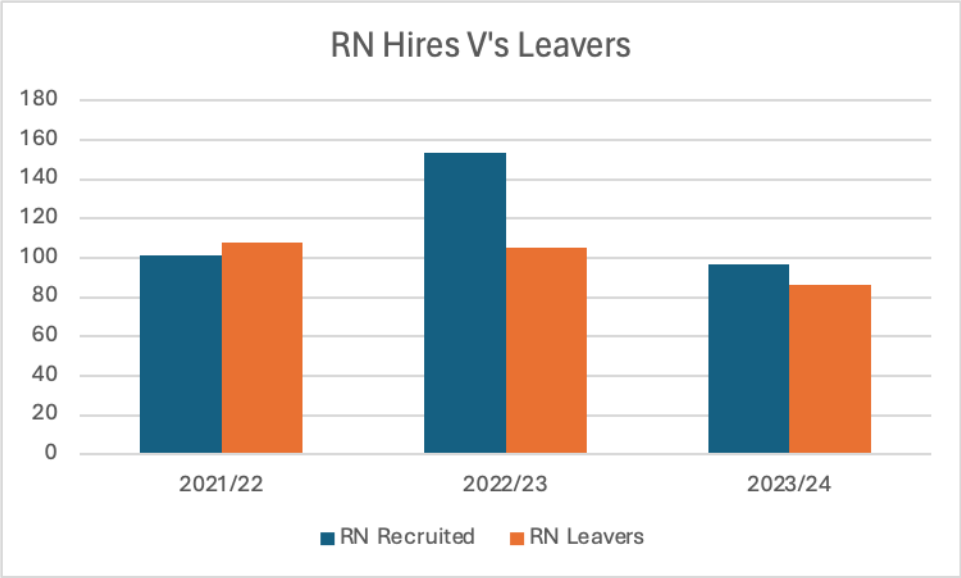
Appendix 2: Care Hours per Patient Day (CHPPD) report April 2024 to March 2025

	April 24		May 24		June 25		July 24		Aug 24		Sept 24		Oct 24		Nov 24		Dec 24		Jan 25		Feb 25		Mar 25	
	AH	BM	AH	BM	AH	BM	AH	BM	AH	BM	AH	BM	AH	BM	AH	BM	AH	BM	AH	BM	AH	BM	AH	BM
Burns	10.1	13.5	26.5	13.5	16.7	16.7	15.9	15.9	21.6	15.9			21.2	21.6			21.6	13.5	19.2	13.5	18.1	13.5	20.7	13.5
HDU	24.5	30.9	27.8	30.9	34.1	31.7	39.9	37.8	38.1	37.8			31.2	37.5			25.9	27.3	25.3	27.3	24.6	27.3	24.1	27.3
ICU	31.2	30.9	27.1	30.9	26.8	29.2	31.4	33.5	35.8	33.5			36.1	36.4			37.6	27.3	37.9	27.3	36.3	27.3	37.2	27.3
Ward 1CC	8.7	13.2	12.5	13.2	13.3	13.3	12.4	12.4	14.6	12.4			13.1	14.6			11.5	12.4	12.5	12.4	11.5	12.4	12.6	12.4
Ward 1CN	17.3	19.4	14.7	19.4	18.7	18.7	17.3	17.3	18.6	17.3			19.3	18.6			17.7	15.1	19.2	15.1	17.4	15.1	17.9	15.1
Ward 3A	10.1	10.8	9.2	10.8	9	9.3	9	9.3	12.7	9.3			10.1	12.6			10.1	10.2	10.4	10.2	9.2	10.2	9.7	10.2
Ward 3B	16.9	11.9	13.9	11.9	15.2	15.2	14.7	14.7	15.4	14.7			16.7	15.4			15.9	10	16.1	10	14.5	10	14	10
Ward 3C	12.2	10.1	13.1	10.1	12.8	11.5	13	12	12.9	12			11.4	12.8			10.5	8.6	11.1	8.6	9.7	8.6	9.4	8.6
Ward 4A	10.2	10.8	11	10.8	10.1	9.75	10.7	10.3	12.1	10.3			10.3	12.3			11.3	10.2	10.7	10.2	10.3	10.2	10.1	10.2
Ward 4B	14.3	11.3	13.2	11.3	15.9	15.9	15	14	15.7	14			13.8	15.3			12.2	11.9	12.2	11.9	11.6	11.9	12.2	11.9
Ward 4C	10.2	12.4	10.3	12.4	10.3	10.3	11.1	11.1	14.3	11.1			15.1	14.3			11.7	11.8	10.7	11.8	9.8	11.8	10.2	11.8

AH = Alder Hey
BM = Benchmark

Appendix 3: RN workforce data

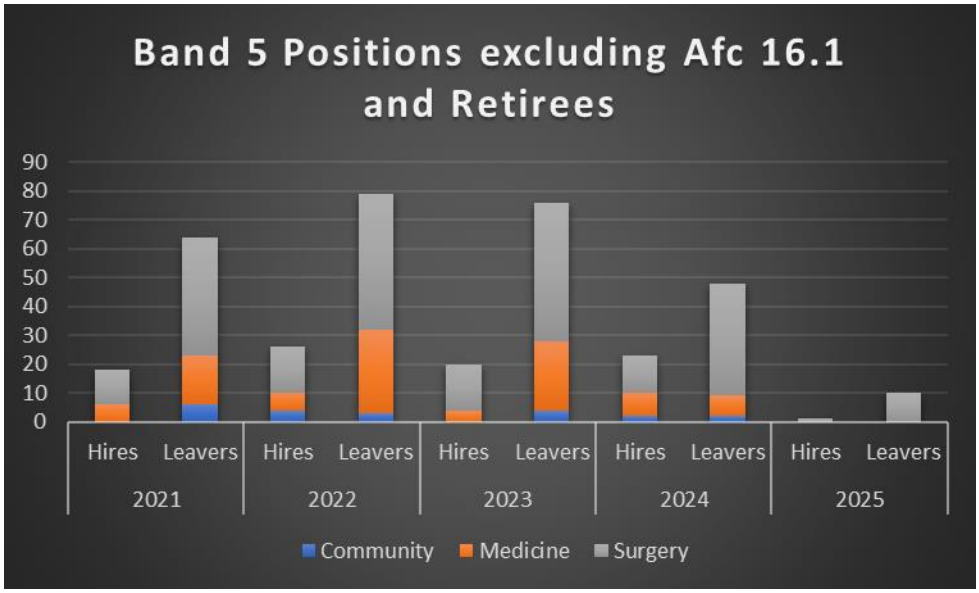
A3.1: Hires compared to leavers



A3.2: Preceptee leavers 2021 to 2025

AfC 16.1 (Early Career Nurses)										
	2021		2022		2023		2024		2025	
	Hires	Leavers	Hires	Leavers	Hires	Leavers	Hires	Leavers	Hires	Leavers
Community	7	0	6	1	3	0	4	0	3	0
Medicine	28	4	20	5	25	8	23	4	16	0
Surgery	39	6	37	9	53	6	56	3	17	0

A3.3 Band 5 leavers excluding preceptees/ retirees



Band 5 positions excluding AfC 16.1 and Retirees										
	2021		2022		2023		2024		2025	
	Hires	Leavers	Hires	Leavers	Hires	Leavers	Hires	Leavers	Hires	Leavers
Community	0	6	4	3	0	4	2	2	0	0
Medicine	6	17	6	29	4	24	8	7	0	0
Surgery	12	41	16	47	16	48	13	39	1	10

A3.4 National Band 5 Comparator leaver data

A3.5 National Band 5 Comparator leaver data

Appendix 4: Risk Register staffing risks

A4 1: Open risks 2024/25

Ref	Division	Dept	Date reported	Risk Title and Description	Risk Score
2029	Surgery	3A	December 2019	Patient safety and delivery of care on ward 3A associated with funded establishment. Current nursing establishment does not match acuity of complex surgical patients or meet RCN safer staffing recommended guidelines.	9 =
2416	Medicine	3B	July 2021	There will be increased pressure on staff well being and ability to provide requirements for safe and effective patient care if current skill mix regarding numbers of chemotherapy trained staff continue to not address the increased acuity of care and activity (due to high numbers of less experienced nurses)	6
2581	Medicine	Palliative	April 2022	If the Paediatric Oncology Outreach Nurses don't have an adequate number of nurses, then the families we support will not receive the best quality care	9 =
2556	Community & MH	OPD	March 2022	Inability to safely staff Catkin and Community Clinics. There maybe reduced support to the Clinical teams, both in Catkin and the Community clinics due to workforce vacancy, sickness within the team and historical working patterns	12 =
2469	Community & MH	OPD	October 2021	Inability to safely staff waiting list initiative (WLI) clinics in OPD. Due to the COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. The OPD nursing workforce are contracted to provide a service Monday to Friday, with the introduction of weekend and evening WLI clinics nursing staff are offered the opportunity to work overtime to cover these extra shifts. However, due to the size of the nursing workforce we have limited staff signing up for overtime with the potential that safe staffing levels will not be reached.	12 =
2703	Community & MH	DJU	November 2022	Risk of not meeting required safe staffing numbers on the Unit for all shifts. Number of staff going onto maternity leave and leaving for new higher Banded positions in community / resignations / retirements.	12 ↑
2759	Community & MH	OPD	March 2023	Inability to safely staff Outpatient Clinics due to short and long term sickness and vacancy gaps (clinical and administrative staff). Due to short and long term sickness within both the	6

				registered and unregistered workforce there are gaps in the rota. In addition there are vacancies in reception and nursing roles.	
112	Medicine	3C	November 2023	Inadequate Staff Nurse skill mix on 3C	6 ↓
245	Medicine	Renal	September 2024	Financial risk to Renal transplant service. There is a risk that the renal transplant service will be decommissioned if the transplant nurse specialist post is not funded permanently.	6
265	Community & MH	Sunflower House	September 2024	Inpatient Occupancy Levels. Risk of reduced skills and experience of workforce and potential re deployment.	8
268	Medicine	3B	September 2024	Lack of senior nursing staff who are APLS trained. There are not enough APLS trained nurses on 3B. There should be at least one trained per shift as per Hospital guidance.	6
326	Medicine	4B	February 2025	Unable to fully implement a new workforce model on 4B. New working model for 4B requires increase in HCA workforce to support a 1:5 Registered Nurse Model (reduced RN) . The reduction in RN workforce has been successful but at the same time the necessary increase in HCA workforce has not been achieved This could lead to a reduced oversight of the ward activity as RNs are pulled away to undertake 1:1 care when HCA support is not available Additional pressure due to 3 bed allocated from PAU over spill agreement, these 3 beds can not be included in 1:5 model (patient need 1:3) this over spill due to last until Feb 2026.	8
All risks will be reviewed following the 2025/26 establishment review					

A4 2: Closed risks 2023/24

Closed risks				
Ref	**Division**	**Dept**	**Title**	**Risk Score**
2001	Medicine	4B	Reduced availability and resources on Ward 4B to deliver staff training in invasive and non-invasive ventilation and sleep study management resulting in the cancellation or delay in admissions to Ward 4B and potential harm to patients and delay in treatment	8
2564	Surgery	1CN	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	4
41	Community & MH	Learning Disability Service	Reduced staff / service capacity (LD / ASD team)	9
100	Medicine	4C	Reduction in skilled workforce on Ward 4C	9
142	Community & MH	ICCNT	Community Liverpool Matron Service	9

BOARD OF DIRECTORS

Thursday, 5th June 2025

Report of:	Nathan Askew, Chief Nursing, AHP and Experience Officer
Paper Prepared By:	Nathan Askew
Subject/Title:	**CQC Children and Young People's Survey 2024**
Background Papers:	Full report available at https://www.cqc.org.uk/provider/RBS/surveys/103
Purpose of Paper:	This report provides an executive summary to the board of the CQC Childre and Young People's survey 2024 for information.
Action/Decision Required:	The Board of Directors are asked to note the contents of the report
Summary/Supporting Information	Overall the Trust performed well in the survey which was based on 221 responses. The results, when compared to other NHS Children and Young People services were about the same, or better than expected in a range of areas. The report will be shared with the Patient Experience Board for further actions to assist in improving the experience of our children, young people and families.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Outstanding experience.
Resource Impact:	none

Does this relate to a risk? Yes ☐ No x☐

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

Executive Summary of CQC Children and Young People's Survey 2024

Introduction

This report provides an executive summary to the Trust Board of the CQC Children and young People's Survey which was published on 22nd May 2025. Data was collected through a survey undertaken by the CQC between August – December 2024 in which 221 responses were received for Alder Hey. The full report and detailed findings is available at https://www.cqc.org.uk/provider/RBS/surveys/103

Background

The survey assessed patient and carer experiences across several domains, including waiting areas, hospital wards, communication, procedures, and discharge. Responses were scored out of 10 and benchmarked against other NHS trusts.

Unfortunately, previous survey results are not provided on the CQC website for comparison, however the survey provides comparison to other hospitals providing children and young people services.

Key Findings

Overall Summary findings:

Domain	CYP	Parents and carers
The waiting area	7.2	7.9
Hospital ward	7.7	9.7
Taking to hospital staff	9	9
Being looked after in hospital	8.9	9.9
Hospital Food	7.5	7.1
Facilities	7.1	7.9
Pain	9.3	8.6
Operations and procedures	9.3	9.3
Leaving Hospital	8.6	9.1
Overall Experience	**9.5**	**9.1**

Key
About the same
Better than expected
Much Better than expected

Overall, the trust performed better than expected or above in comparison to other units. The following three areas were rated about the same and will form the basis for improvement work aligned to the patient experience strategy.

The waiting area – Parents and carers' reports (0 to 7 years)	Patient Response	Compared with other trusts
	7.9 / 10	About the same
Reasonable waiting times Children experiencing reasonable waiting times in waiting areas	7.0 / 10	About the same
Noise while waiting Children not being disturbed by noise from other patients in waiting areas	9.5 / 10	About the same
Enough to do while waiting Children having enough to do in waiting areas	8.7 / 10	About the same
Food and drink while waiting Children having enough food and drink in waiting areas	8.3 / 10	About the same
Informed while waiting Children being kept informed while in waiting areas	8.6 / 10	About the same
Feeling bothered while waiting Children not feeling bothered by anything in waiting areas	5.5 / 10	About the same

Pain - Parents and carers' reports (0 to 15 years)	Patient Response	Compared with other trusts
	8.6 / 10	About the same
Pain management Staff providing effective pain management for children and young people	8.6 / 10	About the same

Facilities - Children and young people's reports (8 to 15 years)	Patient Response	Compared with other trusts
	7.1 / 10	About the same
Hospital Wi-Fi Children and young people finding the hospital Wi-Fi meets their needs	7.1 / 10	About the same

Areas for attention relating to the waiting room highlight waiting times and feeling bothered while waiting. Relating to pain management the overall score is good, and CYP scored Wi-Fi low which is likely to be attributed to the restrictions we have in place to safeguard children and young people of all ages.

Areas of better performance relate to CYP talking to hospital staff, the overall experience of CYP and the experience of operations and procedures, both from CYP and parents' perspective.

Summary

Overall, the Trust performed well in all areas of the survey, with the minimum domain score being in line with other similar providers. The Patient Experience Board will develop actions to address lower scores in line with the experience strategy.

Recommendations

The Trust board are asked to:

- Note the contents of this report

BOARD OF DIRECTORS

Thursday, 5th June 2025

Paper Title:	**Digital, Data and Artificial Intelligence Update**
Report of:	**Kate Warriner – Chief Transformation and Digital Officer**
Paper Prepared by:	**Kate Warriner – Chief Transformation and Digital Officer; Ian Gilbertson – Deputy Chief Digital and Information Officer**

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

1. Executive Summary

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

Key headlines include:

- Digital Maturity Assessment Update
- Artificial intelligence strategy approved
- Good progress with Digital, Data and AI programmes within Vision 2030

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

2. National and Regional Updates

2.1 National Digital Maturity Assessment (DMA) 2025

The DMA process at Alder Hey has now been completed submitted. The questionnaire has been answered in full by a range of multi-disciplinary teams.

Each Trust was also paired with another organisation as part of the DMA peer review process. Alder Hey were matched with Liverpool Women's Hospital for the provider peer review which will be scheduled for June. Next steps, include awaiting the publication of the data in September, before reviewing this collaboratively with other providers across the ICS.

2.2 Cheshire and Merseyside - Digital and Data Strategy Collaborative

Alder Hey, is a core participant in the C&M Digital & Data Strategy Collaborative (LDDSC), which includes ICB representatives and is attended by AH Chief Transformation and Digital Officer. The group is tasked with aligning digital strategies across providers and commissioners, reinforcing Alder Hey's role in shaping regional digital priorities.

2.3 Cheshire and Merseyside – AI Strategy Development

Alder Hey are playing a key role in contributing to the development of the AI strategy across C&M. The team are regularly attending all workshops ensuring alignment across the region which should enable delivery at scale on certain solutions. There has been particular focus on the pilot of Alder Hey's ambient AI solution which other providers within the region are now assessing.

2.4 North West Skills Development Network

Alder Hey participated in the annual Skills Development Network event in May. One of the main focuses was the Trusts presentation of their journey with Ambient AI which was extremely well received. Alder Hey also supported the hosting of a round table discussions with senior digital leaders and colleagues from NHSE.

3. Vision 2030 – Digital, Data and AI Collaborative Update

Since the last Board report significant progress has been made in development and ratification of Alder Hey's Artificial Intelligence Strategy. The development of the strategy has been a structured and iterative process, aligned with the Trust's overarching 2030 vision.

The AI Strategy has been supported by Futures Committee and now formally approved by the Board of Directors. Supporting mobilisation and investment plans are now being developed and will be shared through the relevant committees. Wider work is also in progress to refresh the Digital and Data strategy and ensure it integrates with the AI plan.

The Digital, Data and AI Collaborative Group, underpinning the delivery of the strategy, is now established and meeting weekly. The group will be overseeing the following workstreams.

Improvements have been made to the Community and Mental Health service elements of the EPR. Key actions included the development and deployment of new digital widgets to improve visibility of high-risk information and safeguarding status, optimisation of summary pages for CAMHS and crisis care, and enhancements to caseload functionality. These changes were delivered at pace, with several going live in April 2025 and receiving positive feedback from clinical teams

3.1 Enhancing Safety Through Digital

The project to integrated observations directly into the Electronic Patient Record is making good progress, with the design and processes now formally signed off. The project is currently in the testing phase, with a view to a Pilot in June and a Trust-Wide roll out in July.

ICNet is a digital infection prevention and control (IPC) surveillance system being implemented at Alder Hey to enhance patient safety and reduce healthcare-associated infections. The integration with EPR is under development and the solution is aiming to launch in August.

3.2 Optimising Systems

Work is underway to scope out the upgrade of the EPR system to Version 2.2. A supporting business case is in development which will outline the investment required and intended benefits of moving to the latest platform. This will be shared with the relevant committees in July.

Patient Demographic Service, which aims to integrate national demographic data directly into Alder Hey's Electronic Patient Record (EPR) system, is due to go live in June. This will ensure that patient information such as name, address, NHS number, and contact details are accurate, up-to-date, and consistent across systems.

The Office 365 review at Alder Hey is in progress and currently focused on optimising licensing, reducing costs, and aligning usage with operational needs. A dedicated

Microsoft 365 Working Group has been established, to oversee optimisation efforts. The multi-disciplinary group is reviewing usage patterns, gathering feedback, and tracking actions to ensure the platform is being used effectively across the Trust.

3.3 Data Driven Care

Federated Data Platform Theatres module and Patient Booking Management (PBM) are now live across all 18 surgical specialties. Over 2000 bookings have now been made via the system which is supporting improved utilisation in theatres. Alder Hey are finalising plans to implement further applications.

The Data Warehouse and Platform project at Alder Hey is a major digital transformation initiative aimed at replacing the Trust's outdated on-premises Server infrastructure with a modern, cloud-based solution. This new platform is designed to support real-time analytics, advanced AI capabilities, and secure data governance, aligning with the Trust's Vision 2030 and strategic goals around insight-led decision-making and population health improvement.

As of May 2025, the platform infrastructure has been built, the DPIA has been signed off, and data ingestion is underway. The project is expected to go fully live by June 2025. Key benefits include faster access to data, improved staff experience, and compliance with NHS data standards.

3.4 Broadening Virtual Care Offers

The Patient Portal project at Alder Hey is progressing through a phased implementation, with the goal of delivering a secure, user-friendly platform that enhances access to care for children, young people, and their families. The portal is designed to integrate with existing systems enabling patients and carers to view and manage appointments, access correspondence, complete waiting list validation questionnaires, and interact with clinicians. A phased implementation plan is currently being developed in collaboration with the Trusts 3 Divisional Leads, with the first phase aiming to go live in October 2025.

3.5 Advancing AI

The Microsoft 365 Co-Pilot project at Alder Hey has progressed from planning to early implementation, with a clear focus on piloting, training, and benefit realisation. Training workshops were held in April 2025, supported by Microsoft, to familiarise users with Co-Pilot's integration across Teams, Outlook, Word, Excel, and PowerPoint.

Bi-weekly feedback sessions were also launched to capture user insights and refine implementation. As of mid-May, licences have been assigned and users are beginning to explore Co-Pilot's capabilities, including summarising meetings, drafting documents, and automating routine queries. While uptake is still in its early stages, the project is being closely monitored, with plans to align future rollout with the broader data platform and AI strategy.

Ambient AI project at Alder Hey continues to progress steadily, with a focus on scaling adoption, improving integration, and refining workflows. As of late May 2025, 144 users

have been onboarded. The project remains on track to reach its target of 350 users by July, onboarding approximately 50 users per month. Integration with Meditech remains a key priority.

Feedback from the proof-of-concept phase has been positive, however, further evaluation is planned to validate these benefits at scale. Training and communication strategies are being refined to support both new and existing users.

4. Digital Centre of Excellence and Performance

2 Business Cases are currently being developed to support the refresh of the Trusts EPR and Core Data Centres. Both data centres require a refresh due to the age of the equipment and given its criticality on supporting the hospitals digital systems.

The Windows 11 project at Alder Hey is a Trust-wide initiative to upgrade all devices from Windows 10 and is on track to deliver before Microsoft's end-of-support deadline on 14 October 2025. Initial testing has been positive with all System Owners and Pilot users in the process of reviewing and approving the build.

Cyber Improvement work is underway with the Trusts regional exposure scores improving. A Cyber Tabletop exercise is scheduled for June in collaboration with the Trusts EPRR team with a view to rehearsing, learning and improving any future response to a Cyber incident.

Data Protection and Freedom of Information performance levels remain steady with robust plans in place via Audit Committee to drive forward continuous improvement. Annual Data Security and Protection Toolkit assessment is underway, with the criteria widening this year making it more difficult for Trusts to attain higher levels of assurance. On track to complete the final submission by June 25 with the results expected later on in the year.

5. Summary and Recommendation

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

Board of Directors is asked to note progress to date.

Trust Board Committee
Thursday 5th June 2025

Paper Title:	Infection Prevention & Control Quarterly Report January – March 2025
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 January – March 2025
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☐
Resource Implications:	N/A

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score
2749	Lack of advanced data skills within the IPC team resulting in inability to monitor and recognise IPC standards and trends. Lack of real time data	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 Q4 period (1st January – 31st March 2025) ensuring the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice.

The Trust recognises that the effective prevention and control of healthcare-associated infections (HAIs) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently by everyone working directly with patients to ensure their safety. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

2. Background and current state

During Q4, the IPC committee received reports from the following subgroups.

Clinical Advisory Group: No meetings held in Q4 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 Q4, 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: During Q4 the group met on 18.03.25 and welcomed a new Chair. 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

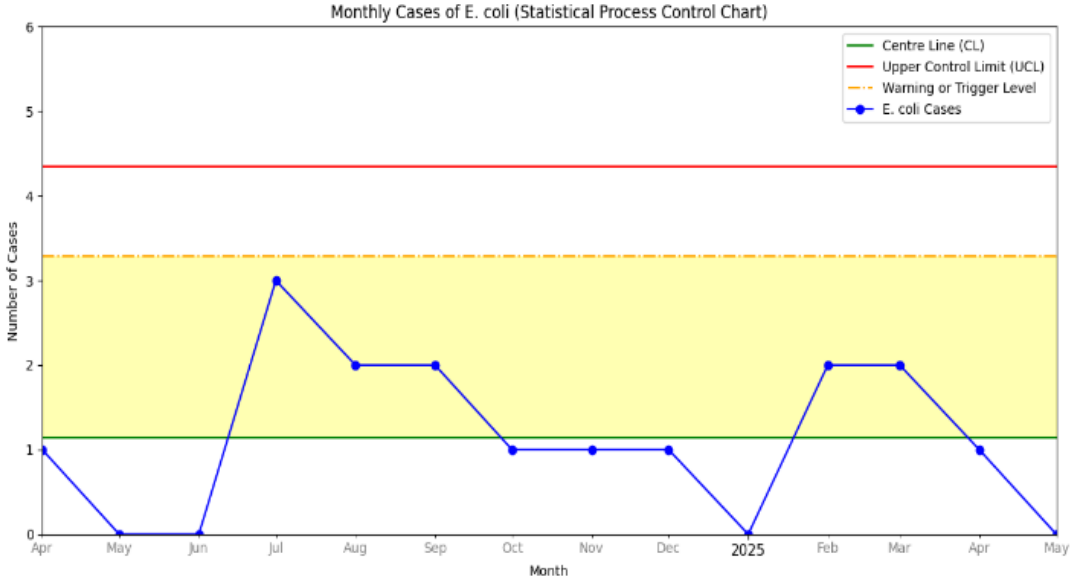
A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA (UK Health Security Agency) is shown below. During Q4, 14 patients had healthcare-associated Gram-negative blood stream infections. Cases were identified in Neonatal (3), Renal (1), Oncology (6), Cardiac (1), HDU (1), and Critical Care (2)

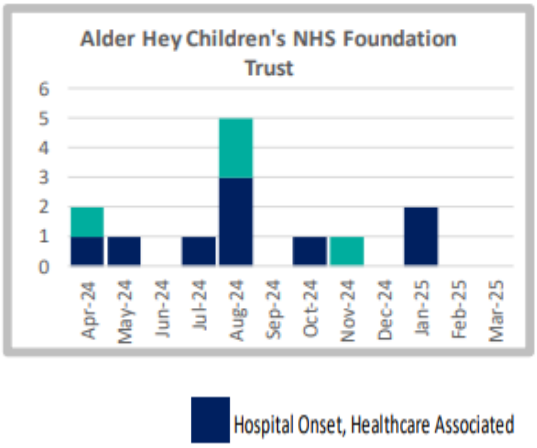
The post-infection reviews (PIR) of these cases identified previous antibiotic exposure, critical illness, and significant patient comorbidities as predisposing factors, which are well known high-risk factors for Gram-negative blood stream infections.

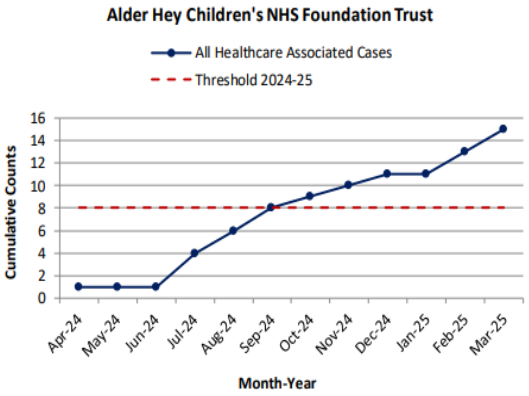
The workplan to reduce Central Line Related Line Infections (CLABSI (Confirmed central line associated bloodstream infection)) across the Trust has continued during Q4, with a closer collaboration between IPC and the Microbiology laboratory to include in our PIRs all significant blood stream infections (not just those subject to mandatory UKHSA reporting such as *E. coli, Pseudomonas aeruginosa* or *Klebsiella spp.*) to engage with all stakeholders in the development of the CLABSI steering group.

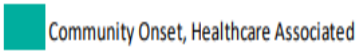
In preparation for the ICNET roll out, we have started to monitor our HAIs occurrence with Statistical Process Control Charts (SPC charts), to better understand the trends over time.

E. coli bloodstream infections

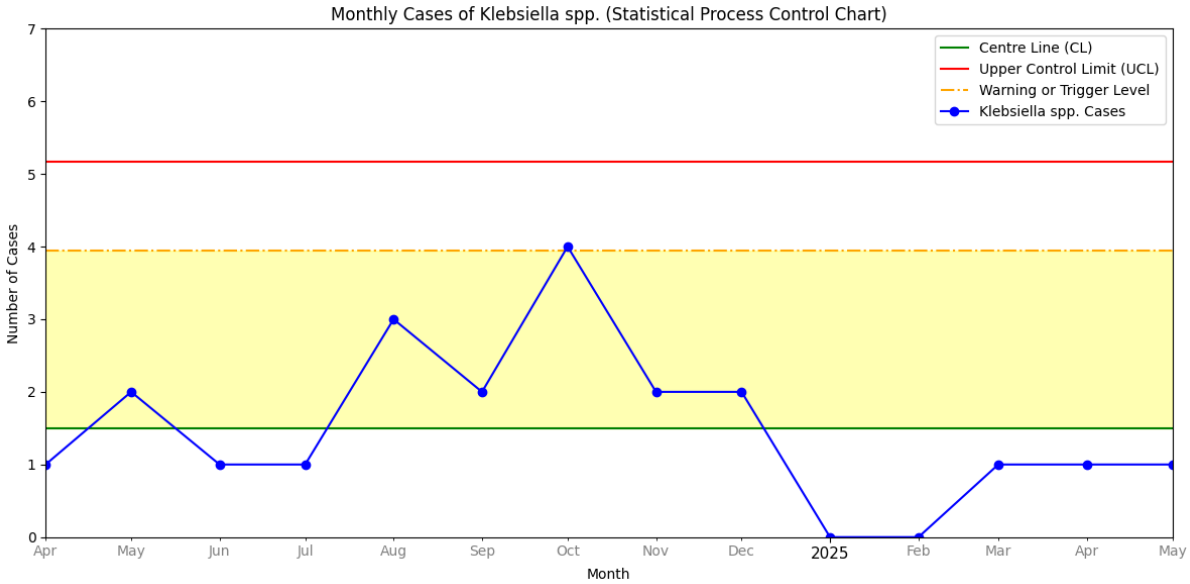


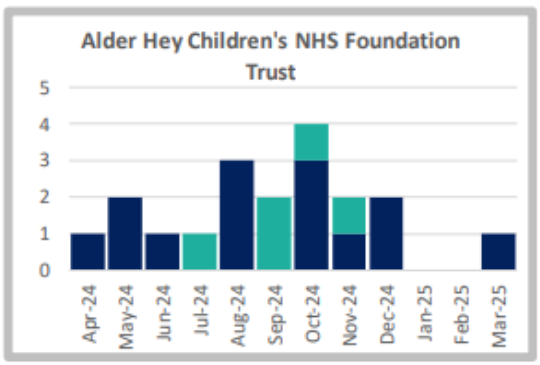


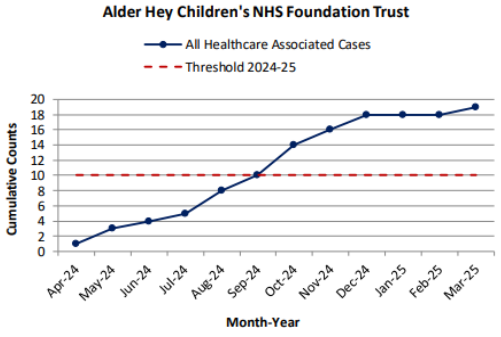


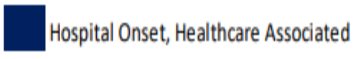


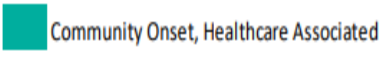
Klebsiella spp. bloodstream infections



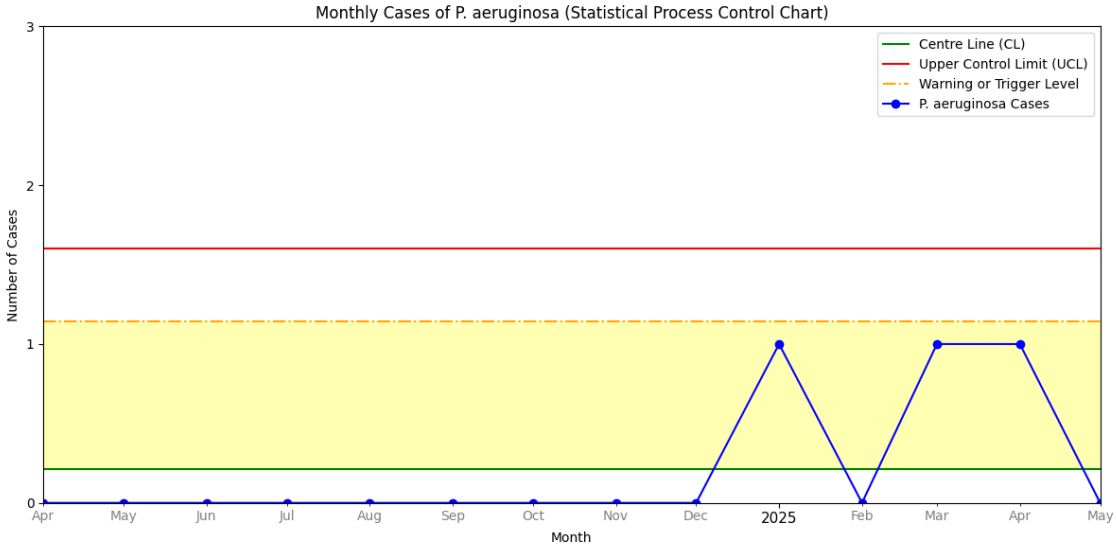


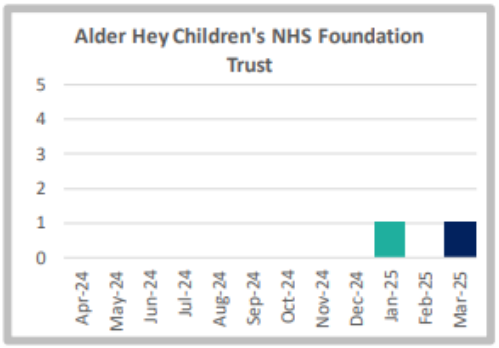


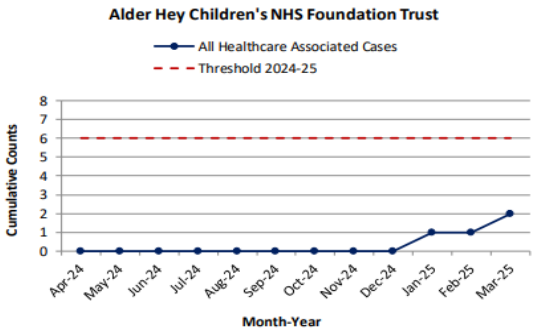




P. aeruginosa bloodstream infections







Hospital Onset, Healthcare Associated

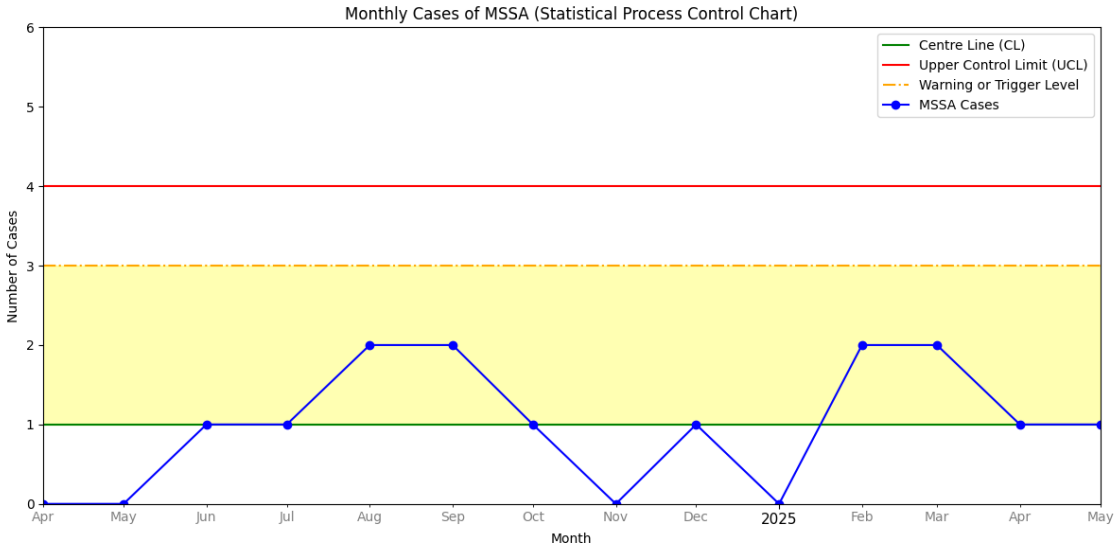
Community Onset, Healthcare Associated

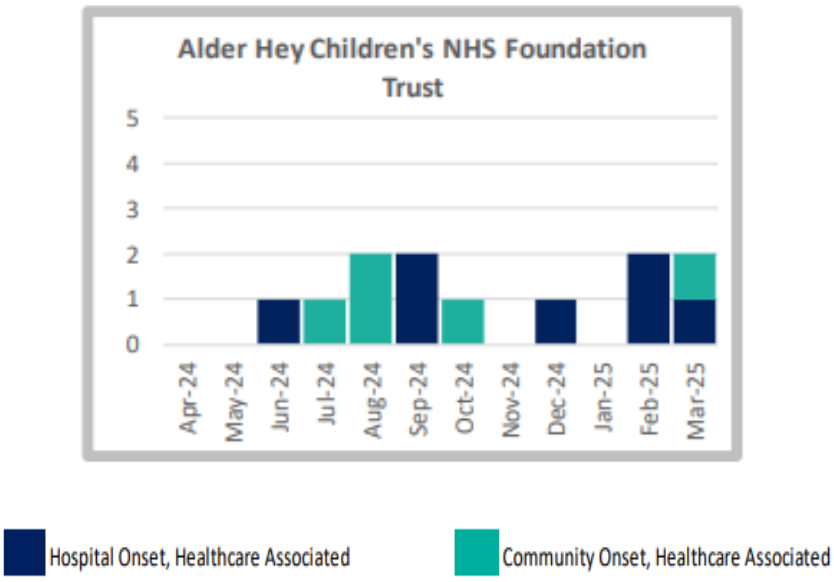
UKHSA HAIs monthly tables for Gram-negative bloodstream infections.

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).

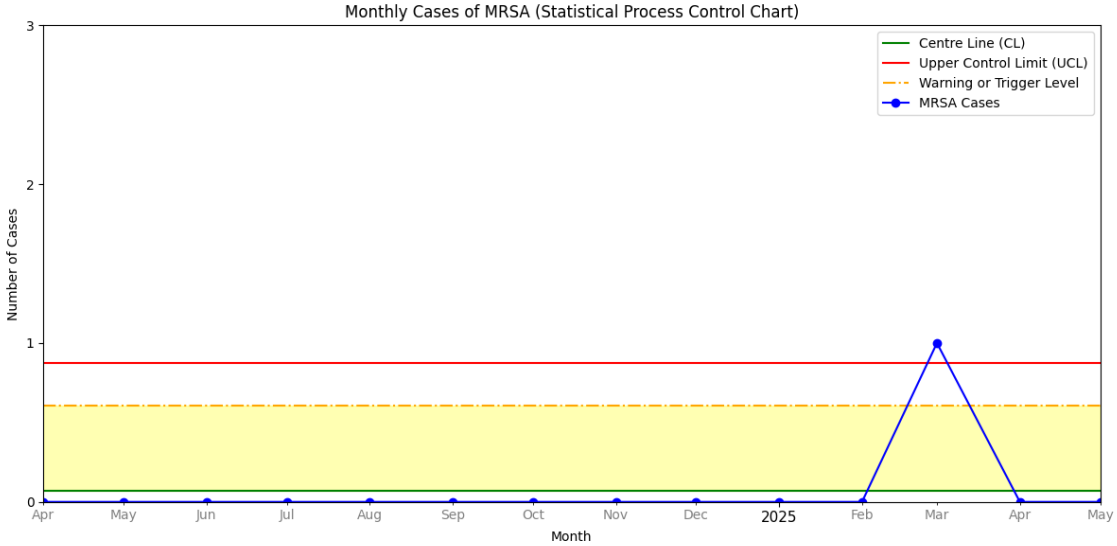
3.1.2 Healthcare-associated *Staphylococcus aureus* bloodstream infections

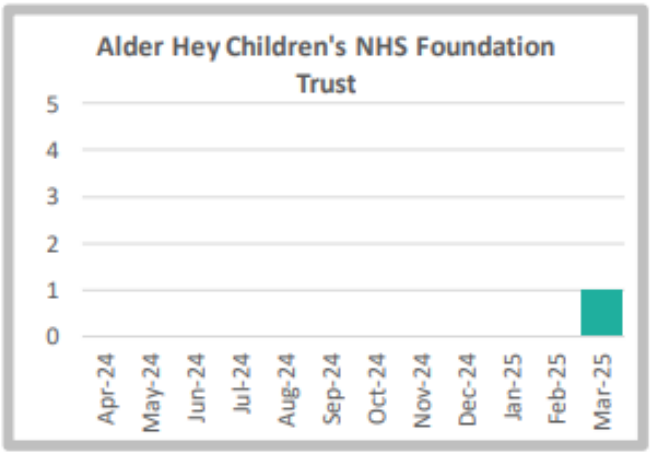
During Q4, 3 patients had a healthcare associated MSSA blood stream infection. The cases were identified in Critical Care (1) and Cardiac (2). The post-infection review (PIR) prompted a review of ANTT processes for dressing changes.





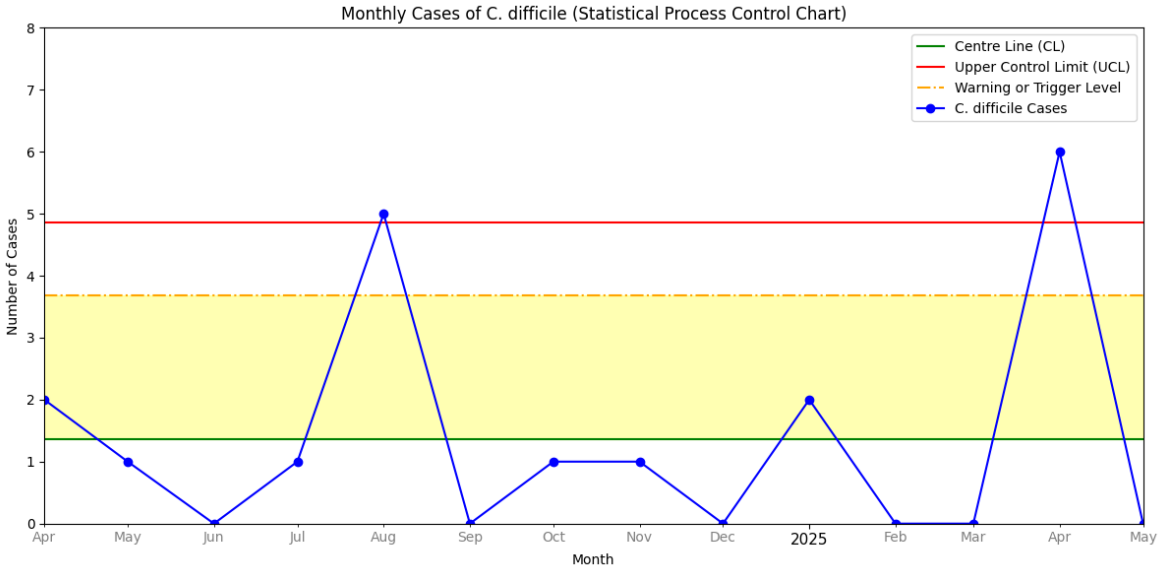
During Q4, a single case of community-onset healthcare-associated (COHA) methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection was reported in 3B. This finding underscores the importance of continued surveillance and strict infection control protocols to prevent further occurrences. Identifying even one case of COHA MRSA is significant, as it highlights the need to evaluate current measures, educate staff, and reinforce best practices to mitigate risks and ensure patient safety.

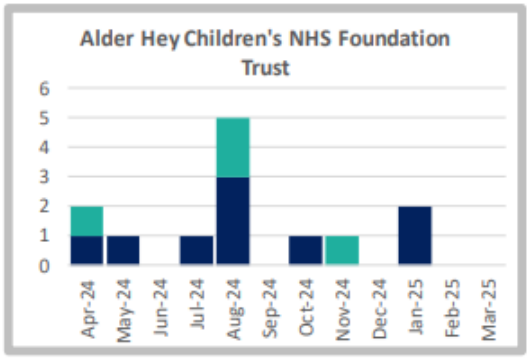

Monthly Cases of MRSA (Statistical Process Control Chart)
Centre Line (CL)
Upper Control Limit (UCL)
Warning or Trigger Level
MRSA Cases
Number of Cases
0
1
2
3
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2025
Feb
Mar
Apr
May
Month

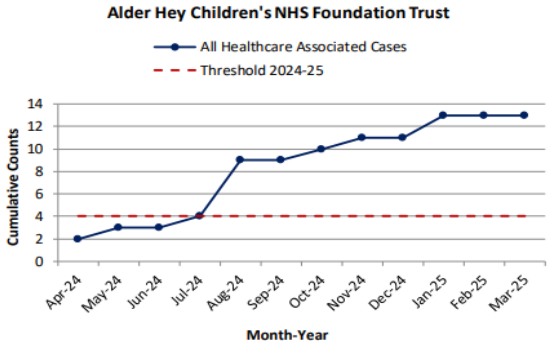

Alder Hey Children's NHS Foundation Trust
5
4
3
2
1
0
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25


Hospital Onset, Healthcare Associated
Community Onset, Healthcare Associated

3.1.3 *C. difficile* Infection



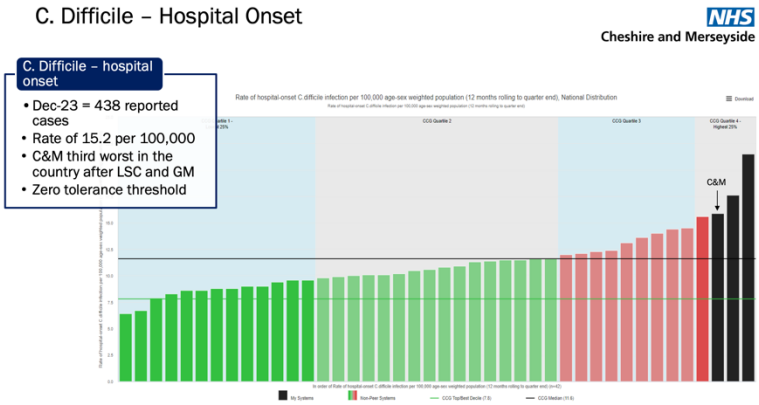




In Q4 there was 2 hospital-onset healthcare associated and 1 community-onset healthcare associated *Clostridioides difficile* infections identified within Oncology. Post Infection reviews confirmed that no lapses in care were identified. The affected individuals were long-term inpatients with prior exposure to multiple antibiotic treatments before developing C. diff infections. No common patterns emerged, as there were no additional cases on the ward and no evidence of transmission to other patients or staff.

Learning from PIRs - Emphasize thorough and appropriate documentation of patient stool/output in records, utilizing the Bristol stool chart.
Actions Taken: Tailored education sessions have been provided to small staff groups to reinforce best practices.

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 Q4, a significant portion of positive respiratory viral tests analysed in the microbiology laboratory were from patients who had been admitted for more than three days, indicating healthcare-acquired viral infections. Additionally, we continue to report instances of inappropriate viral respiratory testing to the ED team to promote the effective 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 Q4, an outbreak of healthcare-associated Norovirus was declared, with two confirmed cases. The outbreak resulted in exposure for eight patients and two staff members.
Given its rapid transmission, infection prevention measures were promptly implemented to contain the outbreak and minimize further spread.
Efforts included enhanced infection control protocols, such as strict hand hygiene enforcement, thorough environmental cleaning, and isolation precautions for affected individuals. Staff were advised on best practices to prevent cross-contamination, and patient monitoring was intensified to identify any additional cases early.
Norovirus outbreaks have been increasing globally, with recent reports indicating a surge in cases.

3.3 Other Notable Infections

3.3.1 Group A *Streptococcus*

0 cases of healthcare associated Group A *Streptococcus* identified during Q4.

3.3.2 Measles

There was 0 positive measles case reported during Q4. 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

Throughout Q4, the Infection Prevention and Control (IPC) department has consistently upheld a heightened level of visibility across the Trust. This was achieved through the diligent execution of daily isolation ward rounds and the regular coordination of monthly steering group meetings. Despite facing challenges associated with limited staffing, the IPC team demonstrated resilience and commitment by closely collaborating with the Director of Infection Prevention and Control (DIPC) and the Deputy Director of Allied Health Professionals (AHP).
In addition to fulfilling their core responsibilities, the IPC team actively contributed to the Trust's response to outbreak incidents, showcasing their adaptability and dedication to safeguarding health standards. Their ability to manage routine activities while responding to emerging challenges underlines their pivotal role within the organization. These efforts reflect the team's unwavering focus on maintaining infection control measures and supporting the Trust's overall objectives.

Recruitment update:

- Band 7 Data Scientist Apprenticeship – Successfully recruited and joined the team in March.
- Band 5 IPC Clinical Audit and Hand Hygiene Lead – Successfully recruited and joined the team in April.
- Band 6 IPC Specialist Practitioner – Successfully recruited and will be joining the team in October.

Governance within the IPC Committee has been enhanced through the oversight and approval of revised IPC policies and the associated IPC Assurance Framework workplans.

These workplans guide the operational groups that report directly to the IPC Committee. Additionally, the DIPC actively participates in the monthly subdivision IPC committees, which provide further updates to the overarching IPC Committee.

Funding for ICNet has been successfully secured, with implementation planned for the upcoming financial year. However, risks remain relatively unchanged due to ongoing staff absences and the continued prioritization of clinical care and patient 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.

00002715	2749	Lack of advanced data skills within the IPC team resulting in inability to monitor and recognise IPC standards and trends. Lack of real time data	12	3	9		Funding secured for ICNet. Action closed. New action for the implementation of ICNet with go live date May 2025 is on track. Data Scientist in post in March 2025. Risk score static until user testing and implementation complete.
00002710	2744	Non delivery of IPC standards due to insufficient IPC staffing levels	12	6	9		IPC practitioner posts are fully recruited but awaiting start date for 1 candidate. Data Scientist started in post March 2025. Recruitment in progress for clinical audit and hand hygiene role. Service remains safe. Score to be reviewed with intention of reducing when posts holders in place.

BOARD OF DIRECTORS

Thursday, 5th June 2025

Paper Title:	Use of the Mental Health Act
Report of:	Lisa Cooper, Director Community & Mental Health Services
Paper Prepared by:	Dr Barry Mullan, Consultant Psychiatrist & MHA Lead

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	Previous annual 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:	

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

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

1. Executive Summary

The purpose of this paper is to provide assurance to Trust Board regarding activity in relation to use of the Mental Health Act (MHA) for the reporting period 01 April 2024 – 31 March 2025.

2. Background

There are several different legal frameworks under which Alder Hey treats children and young people aged 0-18 years, which have been determined by Statute and Case Law.

Most children with physical disorders are treated under their own consent if they are Gillick Competent, that is if they have enough intelligence and understanding of the decision to be made; or under Parental Consent if the decision is within the Scope of Parental Responsibility and if parents are believed to be acting in the best interests of the child.

The Scope of Parental Responsibility has some limitations clarified by the Mental Health Act Code of Practice and some limitations clarified by Case Law. Otherwise, there must be a decision made over whether the consent is 'a decision that a parent should reasonably be expected to make' in relation to medical care of their child.

In practice children and young people are detained under the Mental Health Act if they have a mental disorder and require hospital treatment and:

1. Require deprivation of their liberty significantly beyond age-appropriate levels of parental supervision such as the use of a seclusion room or restraint to prevent absconsion.

2. Require deprivation of their liberty and the local authority has acquired 'parental responsibility', as the local authority cannot consent to a deprivation of liberty.

3. Refuse admission and/or treatment and are Gillick competent or aged 16+.

4. Require repeated intrusive treatments such as restraint for intramuscular injections if they are extremely agitated and putting themselves and others at risk and after all alternative interventions have failed or such as requiring restraint for nasogastric feeding if they have an eating disorder.

Children and young people are detained for a period of assessment and treatment (Section 2: up to 28 days) or for a period of treatment (Section 3: up to 6 months then can be extended for up to a further 6 months, and yearly thereafter). Children and young people can challenge any of these decisions by appealing to a Mental Health Tribunal or to the Independent Associate Hospital Managers. Children and young people have access to the support of an Independent Advocate who will assist them to appeal.

Children and young people may be brought to the Emergency Department by Police under Section 136 of the Mental Health Act. The Emergency Department is a

designated place of safety for those children and young people who appear, to a police officer, to be suffering from a mental disorder and to be in immediate need of care or control. Once in the Emergency Department these children and young people will receive a mental health assessment which may result in detention under Section 2 or 3 of the Mental Health Act.

Children and young people may be detained to Alder Hey or from Alder Hey to another hospital on the recommendations of two doctors and an Approved Mental Health Practitioner (AMHP). If children and young people are being sectioned to another hospital, then the detention starts on arrival at that hospital, and they are recorded in the destination hospital's figures and not the Trust's.

Children and young people may be discharged from hospital on a Community Treatment Order (CTO) These are children and young people who have been detained on a Section 3 and the Section is put aside to allow discharge with some conditions. If those conditions are not complied with the section can be reinstated (recall for a period of assessment up to 72 hours and then revoked if deemed appropriate).

The Mental Health Act (1983 & 2007) authorises the Trust to deprive children and young people of their liberty to assess and treat a mental disorder. The Mental Capacity Act (2005) authorises the Trust to deprive adults (>18) of their liberty to manage a physical disorder. A Family Court or Court of Protection deprivation of liberty order authorises the Trust to deprive children and young people (<18) of their liberty to manage a physical disorder or to keep them safe. All qualifying children and young people have access to Independent Mental Health Advocacy (IMHA) in line with the Mental Health Act. The provider, "Real Advocacy" is a specialist Tier 4 Mental Health Advocacy Service that works in close liaison with the Tier 4 and Paediatric Wards when children and young people are detained under the Mental Health Act.

To support both the increase in young people detained under the Mental Health Act and ensure that the legal and statutory administrative processes related to the use of the Mental Health Act are followed correctly, a service level agreement with Merseycare NHS Foundation Trust is in place. This service level agreement supports the complex administration of the Mental Health Act, facilitates the review of appropriate Trust policies, and promotes effective staff training in relation to the Mental Health Act.

3. Detentions under the Mental Health Act

For the reporting period 01 April 2024 – 31 March 2025, the Trust had **15** children and young people detained under a section of the Mental Health Act. This is an increase compared to 2023/2024 when **10** children and young people were detained under a section of the Mental Health Act.

Table 1 shows the breakdown of children and young people detained under the Mental Health Act for the reporting period compared with previous years. The sections of the Mental Health Act used are shown in **Appendix 1**.

Table 1: Annual detentions under Mental Health Act

Location	2021/2022	2022/2023	2023/2024	2024/2025
Tier 4 Inpatient Unit	2	2	4	*6
Paediatric Ward	3	7	2	6
CTO	2	1 (Tier 4)	0	0
CTO recall	0	1	0	0
Section 136	5	6	4	3
Total	**12**	**17**	**10**	**15**

(Note: * Children's Tier 4 inpatient unit had a child on a section 5.4 which did not result in detention)

4. Deprivation of Liberty Order Safeguards

In relation to those aged 18 years or over, the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were introduced in April 2009, as part of the implementation of the Mental Capacity Act 2005, to ensure better legal and administrative protection for all those who may, for whatever reason, lack capacity to consent to the care they are receiving, including where they live and how they are cared for on a day to day basis.

Prior to the Mental Capacity Act, there was a lack of clarity about how the liberty and human rights of those lacking capacity to consent to their care arrangements, including where these restricted their movement and choices, should be protected. The bulk of people whom the Act was intended to help had serious disabilities including those arising from dementia, learning disabilities and serious mental health problems.

The DoLS regime only applies to hospitals (NHS or private) and care homes (registered with CQC). In any other type of placement, deprivation of liberty can only be authorised by an order from the Court of Protection. If there is no authorisation in place, then a deprivation of liberty is unlawful.

Three factors determine deprivation of liberty under Article 5 of the European Convention on Human Rights:

1. The objective element: i.e. that the person is confined to a particular restricted place for a non-negligible period of time
2. The subjective element, i.e. that the person does not consent (or cannot, because they do not have the capacity to do so) to that confinement
3. State imputability: i.e. that the deprivation of liberty can be said to be one for which the State is responsible.

The statutory framework of the Deprivation of Liberty Safeguards (DoLS) does not apply to those under 18 years of age. For under-18s, a legal framework must be placed around the arrangement to ensure that the deprivation of liberty is lawful.

A deprivation of liberty will be lawful if warranted under statute, for example, under

- Section 25 of the Children Act 1989 (placement in secure accommodation)
- Mental Health Act 1983
- Youth remand provisions of the Legal Aid, Sentencing and Punishment of Offenders Act 2012
- Custodial sentencing provisions of the Power of Criminal Courts (Sentencing) Act 2000

Where the deprivation of liberty is not authorised by statute, then the appropriate consent must be obtained, either from the Court of Protection or from the High Court exercising its inherent jurisdiction:

- Children/Young People Under the Age of 16 - the Mental Capacity Act 2005 does not apply to those under 16 years; therefore, application must be made for authorisation under the inherent jurisdiction of the High Court.
- Children/Young People Aged 16 and 17 - the Mental Capacity Act 2005 applies. An application must be made to the Court of Protection.

Table 2 below shows the number of Deprivation of Liberty Order Safeguards applications made for the reporting period compared to previous years.

Table 2: Applications for Deprivation of Liberty Order Safeguards

Applications	2021/2022	2022/2023	2023/2024	2024/2025
Urgent DoLS applications	11	4	1	6
Standard DoLS applications	2	11	6	4
Court of Protection	1	0	0	1
Total	**14**	**15**	**7**	**11**

5. Mental Health Act Training

Currently Mental Health Act training is required for the following areas on an annual basis: Specialist Mental Health Services, Ward 4C and Emergency Department. Training compliance for these identified areas within the Trust is shown in **Table 3** for the reporting period. All areas are compliant with the required training.

Table 3: Mental Health Act Training Compliance

Service/Ward	Mental Health Act Training Compliance
Specialist Mental Health Services	96.9%
Ward 4C	100%
Emergency Department	100%

In addition, to annual Mental Health Act training, Mersey Care provides training regarding Mental Health Act paperwork and administration to appropriate staff across the Trust as part of the service level agreement. During the reporting period specific training has been provided for Sunflower House and Ward 4C.

6. Incidents

For the reporting period, **8** incidents were reported in relation to use of the Mental Health Act. **Appendix 2** provides details of all incidents, action taken and learning identified/implemented.

Learning from incidents revealed challenges in using correct documentation when detaining a child due to other agencies employing Thalamos, a digital system. Implemented in 2022/23 for Mental Health providers and Local Authorities. Thalamos supports MHA documentation standards. The Trust aims to implement Thalamos during 2025/26 to eliminate confusion about completed documentation and make it easily accessible. This will ensure documentation is on the most current legal forms and reduce errors in hospital and user email addresses that could delay or invalidate detentions.

7. Independent Mental Health Advocacy Service

An Independent Mental Health Advocate (IMHA) is a specialist advocate. The right to an IMHA was introduced in 2007 under amendments to the 1983 Mental Health Act. This gave legal rights to IMHAs which are not available to other advocates. These rights mean that IMHAs may:

- Meet qualifying children and young people in private.
- Consult with professionals concerned with the child or young person's care and treatment.
- See any records relating to the child or young person's detention, treatment, or after-care, for the purpose of providing help to the child or young person and where the child or young person consents.
- Request access to records where the child or young person lacks capacity to consent, if accessing the records is necessary to carry out the functions as an IMHA.

IMHA services are independent, confidential, and free of charge to the child or young person and whilst they do not have to accept help from an IMHA they can change their mind at any time, as such this service should be promoted to children and young people detained under the Mental Health Act. Alder Hey commissions "Real Advocacy" to provide advocacy support to children and young people detained under the Mental Health Act within the Tier 4 Childrens Inpatient Unit and acute paediatric wards.

For the reporting period there were **6** children and young people referred for advocacy support from the Trust's Tier 4 Childrens Inpatient Unit and **5** children and young people referred from Ward 4C.

As detailed in Appendix 2, 1 young person on Ward 4C was not given details of an IMHA immediately following their detention. This was resolved and access to IMHA provided when the incident came to light.

Issues discussed with children and young people who required advocacy support included:

- Support for young people with IMAR process and meeting
- CETER representation
- Medication discussion
- Discharge planning
- Rapid tranquilisation
- Views on NG tube feeding Care Plan
- Request for increased outside time
- MHA rights
- Ward round attendance (4C)
- School change request
- Discharge date
- Home leave

The Advocacy service continues to meet monthly with Sunflower House staff. These have been very productive and have been expanded to include the Hospital Social Worker. "Talking to Young People about Advocacy" Staff learning session was delivered Sunflower House and on Ward 4C. The Advocacy service has published a "Easy read guide to the Mental Health Act" this was co-produced with young people and copies of this have been provided to Sunflower House.

There were no safeguarding incidents requiring involvement from the Advocacy Service during the reporting period and no formal complaints or concerns raised from the children and young people referred to the service. There were no complaints or compliments raised regarding the Advocacy provider during the reporting period.

During 2025/26, the provision of the current IMHA service will be reviewed to ensure it meets the requirements of the MHA.

8. Priorities for 2025/26

The following priorities have been agreed for 2025/26 in relation to the Mental Health Act across the Trust:

- Deliver ongoing training via Mersey Care to relevant Alder Hey staff
- Review the current IMHA service to meet MHA requirements
- Implement Thalamos system for accurate paperwork and built-in MHA training, used across Cheshire & Merseyside by NHS and Local Authority providers
- Enhance methods of recording Mental Health Act incidents
- Improve recording of all Mental Health Act assessment activities and outcomes, including those not leading to detention

9. Next Steps

The Trust Board are asked to note the contents of this report and to be assured that the Trust has in place robust arrangements to meet the appropriate requirements of the Mental Health Act and is responsive to the needs of children and young people for whom this applies.

Appendix 1: Definitions of sections of the Mental Health Act

Section of Mental Health Act	Definition
Section 2	The criteria for detention under Section 2 of the Mental Health Act 1983 (2007), is if a person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment and possibly medical treatment for a limited period of up to 28 days. The initial assessment for detention will be completed by 2 doctors and an Approved Mental Health Practitioner (AMHP). This section can only be extended if an application is made to the county court on specified grounds for a Nearest Relative to be displaced and / or an acting nearest relative to be appointed (s.29(4)) or if the patient has been AWOL and returned to the hospital before the section expires. Otherwise, a further assessment will take place for a Section 3 if treatment is still required and is not available in the community.
Section 3	The criteria for detention under Section 3 of the MHA is if a person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital. Alternative means of treatment must have been considered prior to the decision of detaining in hospital. The section is valid for up to 6 months and can be renewed by the Responsible Clinician (RC) for up to a further 6 months. After this, it can be renewed for a period of up to 12 months at a time however the RC has the power to discharge at any time.
Section 136	Section 136 is an emergency power which allows for the removal of a person who is in a place to which the public have access, to a place of safety and for detention there to allow for a MHA assessment. Alder Hey Emergency Department is a designated place of safety for children.
Community Treatment Order (CTO)	The purpose of a CTO is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles, in treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs.

Appendix 2: Incidents relating to use of Mental Health Act

Incident number	Date reported	Incident Location	Incident Details	Learning/Actions taken
11275	15 June 2024	Emergency Department	Young person brought to Alder Hey ED by Police on a Section 136. When contacting Liverpool Careline EDT young person had an out of area GP (Conwy North Wales). Conwy were contacted but did not respond, Liverpool Careline EDT stated that EDT do not cover children regarding the MHA only adults (this is incorrect). Delay in arranging the MHA assessment which led to the young person becoming frustrated and subsequently restrained Police and medicated by ED staff.	Alder Hey Safeguarding team shared incident with Designated Nurses for Safeguarding at St Helen's Place and Liverpool Place for discussion with Children's Social Care.
14817	29 October 2024	Sunflower House	Young person detained under MHA. Transferred to Alder Hey care via Prometheus. Section paperwork sent to MHA administrator who advised 1 form was completed on an outdated form and is invalid. This was completed by Oldham CAMHS during their assessment (2 doctors and an AMHP). This was escalated to the medical staff & Head of Service at Sunflower House. Oldham CAMHS and AMHP were contacted and advised of the incorrect form, and arranged a new MHA review, in accordance with the MHA.	Patient detained under section 5 (2) of the mental health act while awaiting a re-assessment. The Section paperwork for detention was completed correctly. Reflected on what current MHA forms look like. MHA training rolled out across the nursing team as a refresher Debrief and disclosure undertaken with the family and community team Incident forwarded to Pennine Care NHS Foundation Trust for investigation.
15291	17 November 2024	Sunflower House	MHA appeal paperwork completed for child. However, the 'uk' was missed off the email address.	MHA office rearranged for a tribunal through DHSC Incident shared with child and parents.

			The tribunal panel declined to accept the appeal, and DHSC were contacted to have the tribunal listed.	
15527	25 November 2024	Sunflower House	Young person detained under Section 2 MHA was granted Section 17 leave from Sunflower House. This was documented as escorted, but the young person was not accompanied, for 1 hour in total. Staff nurse let young person off the ward on leave with auntie to the local area. Young person was reported to utilise this leave appropriately and returned to the ward with no concerns. Further staff nurse let young person off the ward on leave with parents. Young person utilised leave in the local area and returned with no concerns. It was later established that a condition of young person's Section 17 leave was that staff were to escort, even when parents were there.	Section 17 leave form instructions not followed. Reflections were undertaken with staff involved (on one occasion it was reported that an escort had been provided but it had not been clearly documented. It was felt form could be clearer). A discussion was held with both nurses to advise that in cases in which they believe it is unclear then an escort can always be allocated from a safety point of view and to contact the on-call psychiatrist who can review the case and advise. MHA Lead informed of the incident and an improved Section 17 leave template developed and implemented.
16815	09 January 2025	Ward 4C	Young person detained under the MHA and was not offered access to an IMHA and therefore was not aware of their right to appeal their detention. This incident occurred prior to bank holiday, when reviewed following the bank holiday and situation realised young person and parent fully informed. Following further assessment of the young person their detention status was reviewed and rescinded, this was in a time period that would have been sooner than if the section had been appealed.	Ward staff signposted to current MHA paperwork policy for accepting MHA paperwork and the checklist which includes ensuring right to appeal and an IMHA are explained to the child or young person. Ongoing work by MHA Lead developing policy/pathway for children detained under MHA.
17223	22 January 2025	Tier 4 unit – outside of Alder Hey	Young person admitted to Tier 4 service in a different Trust under MHA, (Not from Alder Hey). Case manager was not informed of the CPA meeting.	Feedback provided to Tier 4 unit regarding importance of including community mental health team in meetings to support young person's discharge.

			Subsequently, there was no representation from community mental health team.	
17328	25 January 2025	Sunflower House	Nurse in charge discovered that young person had not been signed out or back in from Section 17 leave. Young person had been out with their parent for 5 hours. Young person was detained on Section 3 MHA.	Importance of completing documentation discussed with all staff and additional training provided regarding MHA and documentation.
17457	29 January 2025	Whiston Hospital	Young person detained under Section 2 MHA to different trust. Young person's CAMHS Consultant Psychiatrist agreed be the Responsible Clinician (RC) under MHA for the young person. This is not permitted and the Alder Hey Consultant Psychiatrist was not able to review this young person or been involved in their assessment and treatment during the period of detention. Mersey Care should have provided the RC role and were aware Alder Hey were providing this.	Consultant Psychiatrist involved undertook a reflective and learning exercise with Clinical Director Psychiatry. Training provided to Alder Hey Consultant Psychiatrists regarding role and responsibilities for RC role. Mersey Care advised they would review this policy relating to role of RC.

BOARD OF DIRECTORS

Thursday, 5th June 2025

Paper Title:	Use of Restrictive Physical Interventions Annual Report 2024/2025
Report of:	Lisa Cooper, Director Community & Mental Health Services
Paper Prepared by:	Andrea O'Donnell, Consultant Nurse Mental Health Jacqui Pointon, Associate Chief Nurse Tony Maguire, Specialist Nurse/Restrictive practice training coordinator Dr. Jenny Craske, Clinical Nurse Specialist, Pain & Sedation Service

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	Previous annual 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:	

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
*2800	A child may be harmed in the process of holding them to complete an intervention across the Trust.	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 assurance to Trust Board of activity in relation to the use of restrictive physical interventions across the Trust for the reporting period 01 April 2024 – 31 March 2025.
- Identify areas for improvement and actions for the Trust to take to support children and young people to access care safely.

2. Background

Children and young people receiving assessment and treatment from Alder Hey either within the Specialist Mental Health Services; acute hospital services (inpatient and outpatient) or wider community, may require the use of restrictive physical intervention or clinical holding. A safe, human rights based, and therapeutic culture should be provided for all children and young people receiving care and treatment including those who may present with additional sensory/behavioural challenges and those who are detained under the Mental Health Act (1983).

Alder Hey has in place robust policy guidance updated and published in 2023 – Overarching restrictive practices policy for use with children and young people (C73) which is further supported in the Trust's Tier 4 Children's Inpatient Unit by (MH2), which clearly recognises that therapeutic environments are most effective for promoting both physical and emotional wellness in line with best practice.

Restrictive physical intervention has increasingly replaced the term 'physical restraint'. This is any method which involves some degree of direct force to try and limit or restrict movement (Restraint Reduction Network, 2019 and updated July 2021 - Restraint Reduction Network Training Standards 2021).

[The intervention] should be necessary, proportionate, justifiable, and only used to prevent serious harm. Any use of planned or unplanned restrictive physical intervention should be carried out using the least restrictive interventions and for the minimum amount of time. The physical restriction or barriers which prevent a child or young person leaving, harming themselves, or causing serious damage to property are also included in the term restrictive physical intervention.

Clinical holding is a form of restrictive physical intervention and is using limited force to hold a child or young person still. It may be a method of helping children or young people, with their permission, to manage a health care procedure quickly or effectively. Clinical holding has been distinguished within restrictive physical intervention by the degree of force used, the intention of the hold and the agreement of the child (Bray et al., 2014) but should still be considered a restrictive physical intervention. Whilst some NHS settings use a range of mechanical devices (splints/mittens/bed rails), these are not currently used at Alder Hey.

The identified Executive Lead for the Trust is the Chief Nurse who is supported to discharge these duties via the Director of Community and Mental Health Services.

During 2024/25, there was key progress across the Trust with the implementation of the Informed Consent for Clinical Holding for Planned Procedures leaflet and of the Minimising Fear and Anxiety in Children Undergoing Diagnostic and Therapeutic Procedures policy (Minimising Fear and Anxiety in Children Undergoing Diagnostic and Therapeutic Procedures.docx (sharepoint.com) (updated October 2023) and remains in date/relevant.

The Trust's pain study days (10 in total) continue to include signposting to guidelines and discussing the principles of restrictive physical interventions. Staff confidence in relation to the term clinical holding. Work on documentation of clinical holding is ongoing with the digital team.

For those children and young people who are being cared for under the Mental Health Act, there is specific statutory guidance on different forms of restrictive intervention (and considerations for their use) detailed in the Mental Health Act: Code of Practice (2015). This was updated in October 2017 and included further guidance on implementing changes to police powers and places of safety provisions. These primarily focus on the police only being called to support if there is immediate risk to the child, young person or others around them that cannot be managed by our own resources ,it also limits the time that the police will remain with a young person detained under section 136 of the MHA, both of these factors serve to further highlight the importance of continuing the programme of training and awareness raising regarding safe use of restrictive practice. In addition, when providing care to young people aged over 16 years, staff should be aware of their professional obligations relating to the Mental Capacity Act (2005).

There are a number of publications regarding the use of restrictive interventions and clinical holding with children and young people (Mental Health Units (Use of Force) Act 2018 - GOV.UK (www.gov.uk) most recent update 2021, Quality statement 10: Review of restrictive interventions | Learning disability: behaviour that challenges | Quality standards | NICE RCN Guidance; DHSC), all of which clearly articulate the need for organisations to have a proactive approach to reducing the use of restrictive interventions but also to ensure that staff are appropriately trained and that there is a positive, transparent and collaborative culture when reporting on the use of restrictive interventions and clinical holding. The restraint reduction Network provide a thorough outline on the types of restrictive practices and supporting resources to aid staff https://restraintreductionnetwork.org.

3. Data regarding restrictive physical interventions

For the reporting period 01 April 2024 – 31 March 2025, the Trust reported a total of **419** incidents regarding the use of restrictive physical interventions of children and young people accessing services at Alder Hey. This is an increase in the number **(302)** reported 2023/24 and the number **(199)** reported during 2022/2023.

Tables 1 & 2 below show the recorded incidents involving restraint and clinical holding reported across the Trust per division for 2024/25 compared with previous years.

Table 1: Recorded incidents involving restraint

Division	2021/2022	2022/2023	2023/2024	2024/2025
Medicine	30	76	16	15
Surgery	23	19	6	3
Community & Mental Health	88	68	261	322
Total	**141**	**163**	**284**	**340**

Table 2: Recorded incidents involving clinical holding

Division	2021/2022	2022/2023	2023/2024	2024/2025
Medicine	4	14	14	70
Surgery	4	9	3	6
Community & Mental Health	3	13	2	3
Total	**11**	**36**	**18**	**79**

Whilst the decrease in reporting of incidents relating to the use of restraint within the medical and surgical wards may be attributed to the reduction in children and young people being admitted to the acute paediatric wards who have complex and challenging behaviour and the work between the Trust's Crisis Care Service and Emergency Department, the reporting of clinical holding incidents requires further review and work.

There is a significant increase in the reporting of restraint in the Community and Mental Health (Tier 4 Children's inpatient unit), which reflects the complexity and challenging presentation of the children admitted for significant periods of time.

The reporting of the use of restrictive interventions highlights the ongoing efforts across the Trust to ensure proper recording. This includes raising awareness about restrictive practices, providing training related to Positive Behavioural Support (PBS), and offering customised training sessions for departments such as PICU, Theatres, Outpatients, and Phlebotomy. In addition, PAMOVA physical intervention training is provided, and the Mental Health Liaison Team also undertakes targeted work on basic communication with children and young people who exhibit behavioural and/or mental health issues, as well as considerations for reasonable adjustments in the acute environment.

Further improvements regarding the reporting of restrictive physical interventions and clinical holding have been made to the Trust's incident reporting system, this included incorporating reporting in line with The Use of Force Act (2018) requirements. The latter relates solely to Mental Health Inpatient Units. Improvements in the reporting of incidents have been noted in relation to themes leading to restraint being needed within the Trust's Tier 4 Inpatient Unit which include rapid tranquilisation; increased observation; searching procedure; restrictive escort and nursing in isolation/use of segregation and seclusion needs.

All incidents must be reported within 24 hours, and both staff and young people should receive a debrief after restrictive interventions. The Restraint Reduction Network's debrief model is included in the Trust's Restrictive Interventions policy.

4. Data regarding restrictive intervention incidents reporting harm

For the reporting period 01 April 2024 – 31 March 2025, there were no moderate or serious harm incidents reported regarding the use of restrictive physical intervention and clinical holding in relation to children, young people, staff, or others (parent/carer/visitor).

A total of **30** incidents, involving low harm were reported **(Table 3)** which is a decrease from 2023/24 (**132**) and highlights improvements to safe management/reducing risks.

Of the **18** reported incidents involving harm to a child or young person, most were due to physical care needs being refused by the young person, requiring RPI. Only **1** incident involved a staff hold on the elbow. Additionally, **11** harms occurred to staff during the procedure or while preventing harm to others, with **1** incident involving patient-on-patient harm.

Table 3: Incidents reporting low physical harm 2024/25

Division	Total Incidents	Harm to child/young person	Harm to staff	Harm to other
Medicine	6	3	3	0
Surgery	2	0	2	0
Community & Mental Health	22	15	6	1
Total	**30**	**18**	**11**	**1**

The Trust continues to offer support and assistance to children, young people, and staff affected by restrictive physical intervention or clinical holding. This includes providing reflective practice, debrief sessions, and access to Health Psychology support. Additionally, the Mental Health Liaison Team, established in 2024, has continued to develop its services to address the needs of the acute site. This development involved a review with the established LD/ASD Liaison team and an agreement to merge services to enhance the clinical pathway offering. Addressing the needs of children, young people, and staff is fundamental in this area to ensure effective and transparent responses.

5. Staff Training

Education and training are crucial for promoting and facilitating change. Staff who may be required to use positive behaviour support, restrictive physical interventions, or clinical holding must receive specialised training, including bank staff and security personnel. The emphasis of this training is on avoiding the use of restrictive physical interventions and exploring alternatives.

Since 2015, Alder Hey has provided Positive Behaviour Support (PBS) training for clinical staff and formally integrated it into the Trust's Conflict Resolution training program in January 2019. This is reported monthly to line managers as part of the Trust's mandatory training matrix. During 2024, several reasonable adjustment training sessions were conducted across various wards and departments, with plans for a more formalised approach being considered.

In February 2024, the Trust's Tier 4 Children's Inpatient unit reviewed the RPI training provider, due to challenges in meeting the needs of the Tier 4 Inpatient service. To address the additional training requirements of Tier 4 staff, an alternative training provider was secured (PAMOVA), who commenced training in April 2024 and are BILD/RRN compliant. Evaluations of the new provider have been positive and to date 28 staff Tier 4 staff (plus 7 NHSP staff) have been trained.

In January 2024, the Community & Mental Health Division recruited a Nurse Specialist and, in March 2024, a Nurse Consultant to review the training provided and ensure a sustainable model for the future. This approach addresses the varied needs across the Trust.

Following consultation and thorough assessment with PAMOVA, along with a training needs analysis with key wards and departments, a new training program was developed, and PAMOVA was procured to meet all Trust requirements at different levels. A two-day training course was conducted between January and March 2025 to update those already trained in CALM techniques with PAMOVA theory and techniques.

6. Children's Tier 4 Inpatient Unit Restraint Reduction Programme

The Trust aims to minimise restrictive physical interventions within the Children's Tier 4 Inpatient Unit, ensuring these practices are appropriate and legally compliant. The Unit has fully adopted 'Safewards' in line with best practices for reducing restrictive interventions, being the first paediatric unit to do so.

The Trust's Mental Health Liaison Team train staff on reasonable adjustments to reduce restrictive interventions. This includes using communication profiles for children/young people. Ongoing work emphasises the importance of following these profiles to create a positive experience and reduce the use of restrictive physical interventions.

7. Priorities for 2025/26

The following priorities have been agreed for 2025/26 in relation to the use of restrictive physical interventions across the Trust:

- Provision of ongoing training for Alder Hey staff via PAMOVA and the Mental Health Liaison Team.
- All Trust staff should have access to breakaway training to understand the legal framework for conflict situations and learn basic escape techniques. By October 2025, an annual program for both new and refresher training will be established.

- Enhance recording methods for restrictive physical interventions incidents particularly for clinical holding.
- Undertake an audit of reported incidents to ensure debriefs are recorded in clinical records and Trust policy is correctly followed.
- Address difficulties in tracking staff harm by reviewing the reporting method and updating the InPhase form to ensure accurate capture of data.
- Establish a Trust-wide Restrictive Practice Forum for training, policies, and incident oversight.

8. Next Steps

The Trust Board are asked to note the contents of this report and to be assured that the Trust has in place robust arrangements regarding the use of restrictive physical interventions with children and young people who access services within the Trust.

Appendix 1: Recorded incidents involving restrictive physical interventions per division 2024/2025

Medical Division

Department	Number of incidents	
	Restraint	Clinical holding
Ward 4C	11	14
Ward 4B	1	0
Emergency Department	3	1
Renal (unit)	0	48
Nephrology	0	6
Radiology	0	1
Total	**15**	**70**

Surgical Division

Department	Number of incidents	
	Restraint	Clinical holding
Ward 3A	0	0
Anesthetics Department	1	1
Surgical Day Case Ward	1	4
Theatre surgical Day Case	1	1

Theatre In patient general	1	0
Total	**3**	**6**

Community & Mental Health Division

Department	Number of incidents	
	Restraint	Clinical holding
Tier 4 Children's Inpatient Mental Health Unit	322	2
Outpatients	0	1 (LD team)
Total	**322**	**3**

BOARD OF DIRECTORS

Thursday, 5th June 2025

Paper Title:	**Chair's Report from the Safety and Quality Assurance Committee meeting held on 21st May 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 21st May 2025, along with the approved minutes from the 30th April 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 and 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 30.04.25	Minutes Approved
Divisional updates	Reports x4 noted
Liverpool Neonatal Partnership Monthly update	Report noted
Patient Safety update and Annual Report	Report noted
Patient Safety Incident Investigation (PSII) report	Report noted
Cardiac Surgery Action Plan	Report noted
Never Event Retained Surgical Instrument Action Plan	Report deferred to June 2025
Unacknowledged Diagnostic notifications	Report noted
EPRR Quarterly update and Annual Assurance report	Report noted
Emergency Preparedness Resilience and Response Policy – M28	Policy Ratified
Mass Countermeasures Plan	Plan Ratified
CQC Mental Health Act compliance visit to Sunflower House	Report noted
PALS and Complaints quarterly report	Report noted
Patient & Family Feedback Quarter 4 2024/25 report	Report noted
Quarter 4 Children & young people engagement leads report	Report noted
Ward Accreditation 24/25 Annual Report	Report noted
Clinical Effectiveness and Outcomes Group Chairs Highlight report	Report noted
Board Assurance Framework	Report noted
Quality Account	Report noted
Quality Strategy	Report noted
Clinical Audit Assurance 24/25 Annual Report	Report noted

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

None – SQAC is sighted on the progress within Cardiac Surgery, and ongoing risks within the Neurology, Interventional Radiology and Haematology and Transfusion Lab services and on the actions being taken to address these areas of risk.

4. Positive highlights of note

- SQAC received a good level of discussion on a number of key items and noted positive improvements across a number of areas, whilst noting a number of ongoing challenges. SQAC noted the challenges regarding the current financial climate.
- SQAC welcomed the clarity regarding governance
- SQAC welcomed the Medicine monthly assurance report, noting some challenged services as above.
- SQAC welcomed the Community and Mental Health Division monthly assurance report, noting the challenging profile of patients currently in Sunflower House.
- SQAC welcomed the Clinical Research Division monthly assurance report.

- SQAC welcomed the Division of Surgery monthly assurance report noting some issues regarding cleanliness.
- SQAC welcomed the Liverpool Neonatal Partnership monthly update
- SQAC noted the PSII report and associated improvement plan
- SQAC welcomed the Patient Safety Strategy update
- SQAC welcomed the Patient & Feedback Quarter 4 2024/25 report
- SQAC welcomed the Quarter 4 Children & Young People engagement leads report
- SQAC welcomed the Quality Account and approved the contents. Comments were requested to be shared with Chief Nursing Officer by 30.5.25
- SQAC welcomed the Quality Strategy, SQAC Noted the contents and approved the Quality Strategy and associated work plans
- SQAC welcomed the Clinical Audit Assurance 24/25 Annual Report

5. Issues for other committees

None

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 30th April 2025
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing Officer	NA
	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	AB
	Lisa Cooper	Divisional Director	LC
	Ian Gilbertson	Deputy Chief Digital and Information Officer	IG
	Gerald Meehan	Non-Executive Director	GM
	Rachael Pennington	Associate Chief Nurse - Surgical Division	RP
	Laura Rad	Head of Nursing – Clinical Research	LR
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Veronica Greenwood	Director of Allied Health Professionals	VG
	Paul Sanderson	Chief Pharmacists	PS
	Jill Preece	Governance Manager	JP
	Peter White	Chief Nursing Information Officer	PW
25-26-06	Sarah Craigie	Patient Safety Incident Investigation Lead	SC
25-26-18	Susan O'Neil	Head of Neonatal Nursing, Liverpool Neonatal Partnership	SON
Apologies:	Alfie Bass	Chief Medical Officer	ABa
	Pauline Brown	Director of Nursing	PB
	Kerry Byrne	Non-Executive Director	KB
	Urmi Das	Divisional Director – Division of Medicine	UD
	Hilary Peel	Public Governor	HP
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health	JP
	Jackie Rooney	Associate Director of Nursing and Governance	JR
	Melissa Swindell	Chief People Officer	MS

25/26/01 Welcome and Apologies
The Chair welcomed everyone to the meeting and apologies were noted.

25/26/02 Declarations of Interest - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

25/26/03 Minutes of the Previous Meeting
The Committee members were content to **APPROVE** the minutes of the meeting held on 26th March 2025.

25/26/04 Matters Arising/Review of Action log
The action log was reviewed and updated.

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

25/26/05 Divisional Updates
Division of Medicine
CW presented the Medicine Division update and drew attention to a few key points from the report including:

Highlights:
- ED achieved 82.7% against four hour performance target for the full year April 2024-March 2025
- Ward 3C had been awarded Gold overall and Outstanding overall in the recent Ward Accreditation Assessment with robust leadership team in place within Ward 3C

- The Diabetes team had in excess of 70 patients awaiting diabetes pump, with a waiting list of over 6 months. This waiting list had reduced to such that the final patients outstanding will commence this month with no waiting list remaining
- Division are 100% compliant in responding to complaints within 25 working days

FB acknowledged the strong successes and commended the Division on the achievements
NA referred to EPRR and requested a target date for completion of EPRR updates be included within future Divisional reports.

Challenges:

- Division are facing significant challenges relating to access to interventional radiology services, both in and out of hours for vascular and non-vascular services. Executive Team colleagues are fully sighted on the ongoing challenges and any inability to provide the service is escalated to them. The risk is being regularly reviewed with weekly oversight and it remains on the Risk Register with a risk score of 16
- Sepsis compliance remains above 90% for patients receiving antibiotics within 60 minutes for both ED and inpatients
- Division have greater control with document management and oversight, current position at the end of March is just below 90%

NA commended the Medicine Division on the layout of the report and welcomed the 100% compliance rate regarding formal complaint responses.

NA discussed the need for a better understanding of the difference between IR preferred and IR required interventions and mentioned that this understanding should be broken down per procedure to determine whether it is a requirement or a preference and what the alternative provisions might be. NA suggested that this should be brought to the executive team within the next month. SQAC noted that the IR risk score is due to be reviewed on 1.5.25.

Surgery Division
Highlights:

- Successful outcome from the PASQAT review undertaken within the Audiology Service
- PICU had been awarded Gold in the recent Ward Accreditation Assessment
- New chest drains had now been implemented across the Trust, all training had been completed, this risk would be closed.

Challenges:

- Issues with procurement processes which has led to the establishment of a small Task force group within the division, reporting to the divisional finance meetings to improve and consolidate buying processes
- Incident Reporting: A minor increase in moderate incident reporting, which were then downgraded from moderate. The division plans to review these incidents to identify themes and provide supportive training or feedback to reporters
- EPRR (Emergency Preparedness, Resilience, and Response): The division is updating business continuity plans with a new impact analysis process. All teams are working through this, with reviews scheduled
- Sepsis Training: compliance with the sepsis pathway is at 100%, training levels are consistently at 85%, with ongoing efforts to reach over 90%
- Capital Risk: The major risk regarding capital remains at 16, as there is not sufficient assurance, an update is due to be provided to Risk Management and the Capital Group
- Guidelines Compliance: There is gradual improvement in compliance, with a focus on information leaflets, with the aim of achieving full compliance

FB referred to the challenges regarding procurement and sought clarity whether the issues being faced within the division could be managed internally or whether any support is required from wider teams. FB acknowledged the challenges raised by RP regarding procurement issues and emphasised the importance of identifying when procurement issues escalate to incidents that compromise patient care or safety.
RP stated that whilst the division is working with the procurement leads at the Walton centre there may be a need for broader organisational support to resolve procurement issues effectively.

NA advised the committee on the organisational Task force which is being formed to review procurement processes across the entire organisation.

FB sought clarity whether there is a way to define incidents where quality of treatment or safety is compromised. NA advised that this would be included as part of the review.

Clinical Research Division

Highlights:

- Research consent audit had commenced and is progressing well
- Trial of SAE recording via Inphase had commenced with oncology research team piloting new system of recording Study Adverse Effects (SAE's) via Inphase
- Division have had an increase in patient stories through the patient feedback platform
- Key performance indicators are positive with no significant issues reported
- Business Continuity plan was approved in March 2025 and an exercise is scheduled for June 2025 to test the plan

Challenges:

- CRF Fire Door misalignment - the division have ongoing issues with the fire door at the CRF entrance, the fire door is repeatedly being forced open causing misalignment. Division are working with MITIE to review a fix, and this issue had been added to the Risk register.
- The Essence Study is due to be discussed at the Risk Management Forum. Letters to sponsors were delayed due to annual leave but are now being sent out. 1 out of the 21 consent forms remains missing, with ongoing efforts to locate, Information Governance team had confirmed that no further action is required however IG are open to participating in discussions at Risk management Forum to agree on how to manage such cases in the future. LR advised that an update would be included in the May Divisional update regarding feedback from external sponsors and advised that this would be captured within the deep dive report presented to Risk Management Forum.

SQAC agreed that they would receive Essence updates by exception and that Risk Management would ensure oversight, with no formal action required at SQAC.

GM requested SQAC to receive an update report at the May 2025 SQAC meeting regarding the Fire door to ensure oversight. LR confirmed that an update would be included within the Divisional report in May 2025. SQAC acknowledged the importance of working with other Divisions to ensure clear messaging regarding the fire door.
Resolved: CRD May 2025 Divisional update to include an update on the CRF Fire door

Community and Mental Health Division

Highlights:

- CQC Inspection of specialist mental health services, ASD and ADHD services: The division received positive verbal feedback from the recent Care Quality Commission (CQC) inspection. The full report is awaited by June 2025
- CQC Annual unannounced Mental Health Act compliance inspection of Tier 4 Mental Health Service – initial verbal feedback received, full report to follow – with no immediate actions required, update would be provided at May 2025 SQAC meeting
- Outpatients Department had been awarded Gold in the Ward Accreditation Assessment

Challenges:

- Visibility of Risk assessment information and Safeguarding information in the EPR: Rapid improvement work is ongoing to enhance the quality and accessibility of safeguarding information and practices
- Achieving targets relating to completion of PALS and Complaints: There is a review of matron roles to improve the handling and resolution of Patient Advice and Liaison Service (PALS) and complaints, the aim to streamline processes and enhance communication to ensure that patients' concerns are addressed promptly and effectively

- Staffing capacity, resilience and well-being**:** Division are providing continuous support to staff to help them cope with demands of their roles this includes initiatives to promote mental health, reduce stress, and enhance resilience and well-being. LC advised on the current challenges in Sunflower House with regards to 2 challenging children which is impacting on staff, Division are seeking advice from IPC regarding these patients
- The Division had 15 Business continuity plans, 10 of which have had their annual review and update, 5 are expected to be completed by the end of May 2025.

FB welcomed the full CQC Sunflower House report in due course and welcomed an update regarding the impact of matron regarding PALS and complaints in due course.

SQAC **NOTED** the challenges experienced within the Division relating to the 2 complex inpatients and the impact this is having
Resolved: SQAC received and **NOTED** the Divisional Assurance Reports.

---- *Safe* ----

25/26/06 Patient Safety Strategy update

SC presented the Patient Safety Strategy update from the Patient Safety Board on 27th March 2025

- Workstream 1 - suite of safety metrics and driver metrics for safety are on target to achieve a 5% improvement in reporting no harm incidents and a 5% reduction in low harm and above incidents per 1,000 bed days
- Workstream 7 - Patient Safety Partners (PSPs): 40 PSPs had now completed the induction process and would start providing support. Various departments, including Pharmacy, Infection Control, and the Research Division, have identified projects for PSP involvement
- Workstream 10 - PSIRF (MIAA Audit) - MIAA audit on patient safety received substantial assurance, with two recommendations noted, actions are already in place to address these recommendations
- Workstream 17 - Antimicrobial Stewardship (AMS):The new AMS pharmacist took over in January 2025, new guidelines had been ratified, and nursing education is targeting wards. There had been successful collaboration with the Bright Stars team in the USA, resulting in a 30% reduction on inappropriate blood cultures in critical care

Challenges

- There is a disparity in the reported data for the number of Patient Safety Investigations and the number of never events for 2024-25, this issue has been escalated to the Business Intelligence (BI) team for review
- Workstream 8 - Education and Training on Patient Safety: There is a risk of learning responses being led by staff who do not meet the Patient Safety Framework (PSF) standards. Divisions had been asked to provide names of staff who will lead in these roles, and the central team will facilitate training and Continuing Professional Development (CPD). There is no centralized log of classrooms or staff who meet the PSF standards, the team are working with the Learning and Development team to consider building this into the Electronic Staff Record (ESR). An options paper remains in draft, following review the costings and benefits are required to be included.
- Workstream 10 - PSIRF there had been discussion and proactive plan to populate Level 2 Training on ESR following the MIAA report, the challenge exists as the training is currently on two platforms ESR and e-learning for healthcare
- Parity of Esteem: -There is a consideration for training to be put on ESR to encourage more involvement. There is also a risk of not knowing responsibilities when it comes to risk assessments, including ligature cutting and documentation
- Workstream 22 – Un-Acknowledgement Notices: There is a discussion about adding clinical incident data into the update. It was noted that if requests for imaging are cancelled and then reinstated, they do not get reported and uploaded to clinicians in Alder care, although they are reported on PACS. This issue was raised as an incident
- Key milestones going forward would include Deteriorating Patients decision document which is being received in May 2025 for 25/26 improvement programme of work and had been added to the workplan for 25/26 this would be part of the improvement workstream
- NATSIPPs & LocSSIPs update to report into improvement workstreams, both are included in workplan for 25/26

- World Patient Safety Day on 17th September is focussing on the theme of safe care for every newborn and every child

GM raised a concern about the presence of anaesthetists at cardiac arrests, particularly out of hours and highlighted the importance of having staff with advanced airway skills available during such emergencies and questioned whether this was a regular risk or an isolated issue.
NA responded to GM concern and clarified that the risk of not having an anaesthetist available at cardiac arrests out of hours is not common and advised that there is always a resident anaesthetist on-site, but if the anaesthetist is already in theatre, they might be unable to attend a cardiac arrest immediately. However, all members of the cardiac arrest team are trained in advanced paediatric life support, which includes intubation skills. Additionally, there is an on-call anaesthetist who can arrive within 30 minutes if needed. NA stated that the Trust are reviewing the provision of anaesthetic support out of hours to mitigate this risk further.

GM referred to the critical issue regarding the suitability of PSIRF leads' training and wanted to understand what specific competencies or elements were missing that were causing concern. NA explained that the issue was quite complex and clarified that the training for PSIRF is delivered in multiple levels and described the levels of training. NA highlighted that the training provided by HSIB (Healthcare Safety Investigation Branch) is of a very high standard. NA advised that the main challenge lies in the recording and documentation of this training and advised that process for the current system is cumbersome and inconsistent. NA assured GM that there are many people in the organisation who are fully trained and compliant, however the documentation and recording of this training is not centralized or streamlined. NA advised that focus moving forward is to simplify and centralize the recording process to ensure sustainability and consistency, this would involve identifying key roles that require this training and ensuring that the training assignments are automatically managed.

FB referred to the Data breach thematic review and noted that the review did not seem to raise any actions, other than a reminder of the need for all to be aware of risks involved. FB appreciated the value of the work completed and emphasised the importance of maintaining awareness regarding data breaches.

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

25/26/07 Sepsis Quarterly Report

DP presented the Sepsis Quarterly Report

- The sepsis team is working on finalising the sepsis dashboard with the IT team to ensure it is free of bugs. The key metric for inpatients is the administration of antibiotics within 60 minutes. The quarterly figures show a decrease last quarter but have since rebounded above the 90% target.
- Monthly data indicates fluctuations due to the small number of patients, with a notable decrease in February, returning to 100% compliance in March 2025
- The 90-minute target for antibiotics is used as a secondary measure for complex cases, and the trust had consistently met this target
- Training compliance had been a challenge, particularly due to delays in updating the sepsis training package with the new software acquired by the learning and development team. There is an ongoing effort to ensure that staff roles and sepsis training assignments are consistent and up to date. This involves reviewing 830 different roles within the trust to ensure appropriate sepsis training is assigned. The training compliance for medical staff remains below the 90% target, which is an ongoing issue.
- The ED and inpatient working groups are resuming their efforts to ensure data consistency and cross-cover arrangements
- The ED had maintained a high level of compliance with the sepsis pathway, consistently achieving above 90% for the administration of antibiotics within 60 minutes
- The retirement of vitals project is nearing completion, with a draft package ready for testing. This project aims to ensure accurate and timely recording of vital signs for sepsis patients
- Future Plans:-The sepsis team plans to address the remaining issues with the BI team. There is a focus on improving the consistency of sepsis training assignments and ensuring all relevant staff receive appropriate training
- Challenges and Mitigations include delays in updating the training package and ensuring consistent training assignments across all staff roles. The team is working closely with the learning and development team to overcome these challenges and improve overall compliance

Discussion took place regarding the additional day leave and the impact that this had made on increasing training compliance suggested that if the data showed a substantial improvement in training compliance due to this incentive then the Executive Team should consider whether to implement this strategy again.
Resolved: FB requested NA to follow up the impact of the extra day of leave on overall training compliance across the Trust and to consider the possibility of continuing this practice.

Resolved: IG agreed to liaise offline with DP to enable any future learning for colleagues from the Sepsis dashboard process to enable any improvements in data sets in the future.

FB acknowledge the clear and reassuring note of the Sepsis report and highlighted the importance of the exercise regarding the assignment of mandatory sepsis training, and the valuable lessons to be learned from this exercise which could be applied to other training areas across the Trust.
Resolved: SQAC received and **NOTED** the Sepsis Quarterly Report

25/26/08 **Drugs & Therapeutics Committee Quarterly and Annual Report**

PS presented the Drugs & Therapeutics Committee Quarterly and Annual Report

- A new risk related to the supply of Total Parenteral Nutrition (TPN) was added due to several incidents in the aseptic suite. A thematic review addressed this risk.
- The risk relating to the reporting of valproate in pregnancy was successfully closed after significant efforts in collaboration with the region and the Integrated Care Board (ICB)
- Medicines Management Operational Committee (MMOC): Continues to process substantial work, but faces challenges with out-of-date medicines-related documents
- Medicines Safety Committee: Reported a reduction in incidents of harm and an increase in near-miss reporting, indicating a strong reporting culture.
- Controlled Drugs (CD) and Incident Reporting: An incident involving the diversion of propofol highlighted the need for improved processes in reporting and managing such incidents.PS is also the Controlled Drugs Accountable Officer (CDAO), emphasised the importance of him attending patient safety meetings, Trust Board meetings, and "Ask the Execs" sessions to discuss CD incidents and ensure staff understand their responsibilities
- Shortages and Supply Management: The trust continues to face challenges with medication shortages, but improvements in managing these shortages had been noted. Future reports will include a 12-month graph to show how shortages are being managed.
- Leadership and Structural Changes: The senior leadership team in pharmacy had been restructured, with the appointment of a permanent deputy and an associate chief pharmacist for clinical services.
- The first meeting of the newly structured Drugs and Therapeutics Committee is scheduled for week commencing 6th May 2025, with support from the Chief Nursing Officer.

Challenges and Mitigations:

- Out-of-Date Medicines Documents:There is a need to catch up on the backlog of out-of-date medicines-related documents.
- Controlled Drugs Incident: The incident involving propofol highlighted the need for better communication and processes in managing potential drugs of abuse. Actions include attending patient safety meetings, board meetings, and ensuring staff understand their responsibilities regarding controlled drugs.
- Medication Shortages: While management of medication shortages has improved, it remains a challenge requiring ongoing attention. Future reports will include a 12-month graph to show the management of medication shortages.

FB emphasised the importance of learning from the CD incident involving the diversion of propofol and highlighted the need to agree on the escalation of actions and their implementation. FB requested NA to ensure that the learning from the CD incident is shared with the committee. FB also referred to the impact of financial decisions on patient safety and access, suggesting that this would require some modelling regarding waiting times and other factors.

NA noted a theme of incidents relating to controlled drugs over the last six weeks, all of which had been individually responded to, and advised that there is a need to bring this together. NA and PS agreed to discuss offline during the week commencing 6 May 2025.
GM sought clarity regarding resilience across the hospital regarding medical supplies. PS acknowledged the concern and stated that while it is difficult to predict the exact impact of global changes on the pharmaceutical market, the hospital is currently in a strong position with a very good

process for managing shortages. PS advised that there are a couple of long-term vacancies within the procurement team, but job descriptions have been approved, and these posts are due to be advertised. PS expressed confidence that with the extra staff and the improved process, the hospital would be well-placed to manage any potential issues.

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

25/26/09 Review of SQAC Terms of Reference

FB advised that the amendments to the Terms of Reference primarily focus on aligning the membership with the reporting structure that had been evolving over the last two years. This ensures that the lead for each subcommittee is part of the SQAC membership.

FB stated that an addition was made to allow the relevant executive lead to present updated policies by exception to SQAC, which means that policy owners need not attend the meeting if their policies had already been scrutinised at one or more committees before reaching SQAC. FB advised that this change aims to improve efficiency. FB requested any comments or questions regarding the Terms of Reference, no questions were raised.

Resolved: SQAC received, **NOTED** and Approved the SQAC Terms of Reference

25/26/10 SQAC Annual workplan

FB advised that the SQAC workplan ensured that reports presented to SQAC would have been through one of the subcommittee and follows a pre-established cycle and allows people to know when their reports are due and ensured a clear reporting pathway. FB requested whether the committee had any questions regarding the workplan and whether they were content to approve.

SQAC were happy to approve.

Resolved: SQAC received, **NOTED** and Approved the SQAC Annual workplan

25/26/11 SQAC Annual Report

FB presented the SQAC annual report and expressed her thanks to those colleagues who had contributed to the Annual Report. FB queried whether there were any matters of accuracy or areas that required further attention, to which there were none. FB emphasised the importance of continuous improvement and encouraged members to speak up if they thought their reports or other reports could be further improved.

Resolved: SQAC received, **NOTED** and endorsed the SQAC Annual Report

25/26/12 Patient Experience Group Terms of Reference and workplan

NA presented the Patient Experience Group Terms of Reference and workplan advising that this year is a transitional period for patient experience. NA advised that the functional aspects of patient experience management would continue to be managed by the Director of Nursing, whilst the Director of Allied Health Professionals would take responsibility for managing the delivery of the strategic vision, throughout the year these two elements would align similar to Patient Safety Board.

Resolved: SQAC received, **NOTED** and Approved the Patient Experience Group Terms of Reference and workplan

25/26/13 Clinical Effectiveness Group Terms of Reference and Workplan

NA Presented the Clinical Effectiveness Group Terms of Reference and Workplan and advised that from May 2025 the Clinical Effectiveness and Outcomes Group would transition to a Board structure similar to the Patient Safety Strategy Board. This change aims to improve the reporting process and align it with the new structure, with reports being presented in an A3 style as the year evolves.

NA acknowledged the significant work undertaken by the Associate Director of Nursing & Governance and the Chair of CEOG in realigning the process to the new structure and advised that their efforts had been instrumental in ensuring a smooth transition and setting up the group for success in the coming year.

Resolved: SQAC received and **NOTED** the Clinical Effectiveness Group Terms of Reference and Workplan

25/26/14 Clinical Effectiveness and Outcomes Group Chairs Annual Report and Highlight report

NA presented the Clinical Effectiveness and Outcomes Group Chairs Annual Report and Highlight report. NA advised that there is continued focus regarding improving compliance of information leaflets, policies guidelines and SOPs, currently noncompliance of less than 90%, NA provided assurance that each division are focussed on addressing this.

- National respiratory audit programme is being reviewed by CEOG chair and team to review disparity in what has been externally reported through to NHS centrally, the Medicine division are working on this and engaged in regular meetings with the Associate Director of Nursing & Governance to ensure progress is being made.

Resolved: SQAC received and **NOTED** the Clinical Effectiveness and Outcomes Group Chairs Annual Report and Highlight report

25/26/15 Patient Safety Group Terms of Reference and workplan

NA Presented the Patient Safety Group Terms of Reference and workplan.

NA advised that the Patient Safety Group had been working effectively and had successfully signed off the Patient Safety Incident Response Framework (PSIRF) by the Board. The Patient Safety Board had also completed the data collection and associated workplan, which would cover various aspects throughout the year.

NA advised that the workplan is designed to ensure that all patient safety initiatives are systematically addressed and monitored and that the group would continue to focus on key areas of patient safety, including the implementation of the PSIRF and other related activities. NA stated that the workplan would be reviewed and updated regularly to reflect any new priorities or changes in the patient safety landscape

Resolved: SQAC received and **NOTED** the Patient Safety Group Terms of Reference and workplan

25/26/16 Trust Wide priority Clinical Audit Plan 2025/26

NA presented the Trust Wide priority Clinical Audit Plan for 2025/26 and advised that there had been extensive engagement with relevant stakeholders, particularly with KB, to ensure that the audit plan is comprehensive and is aligned with the Trust priorities. Divisions had been fully engaged in the consultation ensuring that it reflects the needs and priorities of different areas within the Trust.

SQAC noted the extensive engagement with the Trust Wide Priority Clinical Audit Plan and noted that the Audit Plan is due to be monitored and approved by Audit & Risk Committee in June 2025.

Resolved: The Committee received, **NOTED** and approved the Trust Wide priority Clinical Audit Plan 2025/26

25/26/17 Confidential Enquiries/national guidance assurance report

- The trust participated in five audits and successfully submitted data as planned
- There was one instance where an Embrace submission was not made within the two-day turnaround in Quarter 4 due to a delay in notification, this is being followed up with an audit to monitor Embrace submissions following the introduction of a new cascade system
- NCEPOD Projects: Stabilization of the Critically ill Child Project is set to start in 2025
- Transition from Child to Adult Health Services: Recommendations from this project were published in 2023-2024 and are being overseen by the Transition Steering Group, which is making good progress despite the ongoing challenges with data collection and visibility of patients fitting into this cohort.
- LD Deaths Review: Learning Disability (LD) deaths continue to be reviewed by the Child Death Overview Panel process, which has replaced the requirement for the LeDeR (Learning Disabilities Mortality Review) reviews

Resolved: SQAC received and **NOTED** the progress and oversight of the Trust participation and compliance with the National Confidential Enquiry submissions for 2024/25

25/26/18 Liverpool Neonatal Partnership Monthly update

SON presented the Liverpool Neonatal Partnership monthly update and highlighted the following key points:-

Highlights:

- There was a significant drop in staff turnover and a slight reduction in sickness rates for March
- Mandatory training compliance remained above target.
- The percentage of Qualified in Specialty (QIS) nurses working on the neonatal unit at Alder Hey reached above 70% for the first time in approximately 12 months, with 77% of nurses on shift being QIS qualified.
- Retinopathy of Prematurity (ROP) screening achieved 100% compliance on both sites.
- 100% parental consultation within 24 hours was achieved on both sites.
- Two risks were identified for closure in April: - Out of hours cover for medical staff on 1C which was resolved with 24/7 medical staffing achieved by the Advanced Neonatal Nurse Practitioner

(ANMP) team and risk regarding Hearing screening at Liverpool Women's was closed due to NHS England oversight and is now closed
- SON advised that there was an error on page 13 and should read March rather than January
- Occupancy remained high at 97.5% on the 1C site at Alder Hey, while Liverpool Women's saw a reduction in occupancy leading to a decrease in bank spend
- Two moderate harm incidents were reported on the Liverpool Women's site involving thrombus in two infants. This issue has been escalated to the network for further investigation and monitoring, particularly focusing on heparinization of fluids
- There had been an increase in unplanned extubating incidents on the Liverpool Women's site and as a result LWH are updating the moving and handling guideline with targeted work involving Allied Health Professionals (AHPs)
- One Patient Safety Incident Investigation (PSII) was completed involving a ventilator issue with un humidified gases. Feedback was provided to the family, and the incident was closed. The same patient has had an investigation for a brachial plexus injury discovered upon transfer to 1C Alder Hey, the family are awaiting the outcome of this investigation.
- Data provision continues to be manually extracted from both sites, with ongoing efforts to integrate data into Power BI
- Governance, incidents, and risk management are being reviewed and reported as separate trust entities due to different reporting systems, with joint education, learning from excellence, and learning from incidents and deaths meetings

GM sought clarity regarding NICE guidance and status/implications, particularly for neonatal infection. SON advised that a new neonatal consultant had been allocated to review this guidance, as the task required significant time and resources. The challenge had been ensuring that there was time in job plans for consultants to undertake this work.GM supported the need for time to be allocated for this important task and acknowledged that this issued had been raised and was being addressed.

FB advised that SQAC are aware of the double reporting burden and that hopefully some progress would be made on this through 2025/2026

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

25/26/19 Gender Development Service Report

LC presented the Quarter 4 Gender Development Service Report

Highlights

- The Gender Development Service celebrated its first anniversary on April 2, 2025
- In Quarter 4 the service received 75 referrals from the national waiting list managed by NHSE
- The service has sufficient capacity to receive 25 referrals per month until the end of March 2026
- The average waiting time from initial assessment is around 8 weeks, with no delays in seeing children and young people
- The service has continued to increase both face-to-face and virtual activities. Despite the increase in activity, the DNA (Did Not Attend) rate has reduced to just under 7%, although it still fluctuates.
- 4 incidents were reported by the service, including 1 relating to an incorrect address and others related to sending appointment details, a deep dive had been requested to review the scheduling process and identify any patterns or themes
- Compliance with Level 3 safeguarding training had reduced, primarily due to capacity issues within the safeguarding team, however a dedicated safeguarding practitioner has been assigned to the service since December
- Safeguarding supervision had commenced, and 3 referrals to children's social care were made during the reporting period
- The service has a dedicated safeguarding practitioner working full-time, supported by the main safeguarding team
- The service celebrated its first face-to-face meeting with the Gender Services Forum in February, where children and young people designed artwork for the building.
- Positive feedback from children and young people highlighted their feelings of being valued, listened to, and heard in the service
- No complaints were received, and one Freedom of Information (FOI) request was noted.

FB acknowledged the good progress made and welcomed the positive feedback from C&YP forum.
FB referred to the recent Supreme Court ruling and its potential implications for the service.
LC advised that following the ruling the Trust is due to receive guidance regarding healthcare settings and advised on an internal group which is chaired by the Chief Nursing Officer. LC confirmed that

significant work had progressed across the Trust. The internal group would review the guidance once available to determine the necessary actions to ensure compliance and support for children, young people and staff. LC stated that she does not believe that the children within the system had raised any concerns in this regard.
NA advised that the Trust would await NHSE guidance, and act in line with other organisations. NA stated that he has had initial discussions with the Chief People Officer regarding patient perspective and both agree there is minimal impact, with caveat that clinical need would prioritise any of the requirements regarding single room/single accommodation. The impact for the Trust would be the provision for staff and the policies required to make the reasonable adjustments.
Resolved: SQAC received and **NOTED** the Gender Development Service Report

25/26/20 External Visits/Accreditation Report

JP presented the External Visits/Accreditation Report and advised that there are still some gaps within the report despite frequent reminders to divisions to submit inspection reports and outcomes. JP made a plea to divisions to submit relevant information relating to external visits/accreditation report.
ES advised on the need to revisit this policy, to focus on a more formal and comprehensive policy, capturing all external assurances and regulatory obligations. ES proposed changing the title of the report to reflect its formal nature and focus on regulatory and accrediting bodies such as CQC, HTA and UCAS. ES advised that the report should also include external bodies, including visits from bodies with powers to enforce e.g. the Information Commissioners Office (ICO).

FB acknowledged the importance of the External Visits/Accreditation report and emphasised the need for completeness and accuracy in the report. FB advised that she is supportive of the proposal to change the title of the report to reflect its formal nature and focus on regulatory and accrediting bodies, such as CQC, HTA, and UCAS. FB highlighted the necessity of capturing all external assurances and regulatory obligations comprehensively. FB stressed the importance of ensuring buy-in from the divisions to ensure a complete report at the end of the year and noted that it is not just the divisions but also corporate teams that need to supply the necessary information.

FB referred to reporting on non-captured activities and suggested that divisions should expand on any external visits or peer reviews that are not captured in the report but are significant and emphasised the importance of learning from these visits and ensuring that actions are implemented and embedded.

Resolved: SQAC were supportive of the proposed changes and the need for a clear process to manage and report on external visits and accreditations

LR highlighted the importance of including innovation and external funders and aligning these within the External Visits/Accreditation report.
LR advised that the CRD quarterly and annual report had not been included on the SQAC workplan and would follow this up offline with Governance Manager.
LC advised that she is happy to be involved in discussions and that C&MH Division have a clear process in place regarding external inspections and have Standard Operating Procedure in place within the Division.

Resolved: SQAC received and **NOTED** the External Visits/Accreditation Report, noting the current gaps and the plan to vary the report and improve the completion of the report through the relevant process in addition to changing the title of the report.

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

25/26/21 Board Assurance Framework

ES presented the BAF and provided an overview of the current status of Risks 1.1 Financial Impact on Patient Safety, Risk 1.2 Access to Services, Risk 1.4 EPR and Digital Issues and advised the committee on what actions had been taken to mitigate these risks.
ES advised that the committee is actively working to address these risks, with a focus on understanding and mitigating the impact of financial constraints on patient safety and access to services. Regular updates and reviews would ensure that these risks are managed effectively with a clear understanding of the actions needed to mitigate them.

Resolved: SQAC received and **NOTED t**he Board Assurance Framework

25/26/22 Ward Accreditation Annual Plan 25/26

NA presented the Ward Accreditation Annual Plan 25/36 and advised that all wards would be accredited by 18th June 2025.

FB stated that it is important to ensure that every ward has a recent accreditation at all times and associated actions plans are being implemented.

Resolved: SQAC received and **NOTED** the Ward Accreditation Annual Plan 25/26.

25/26/23 C15 – Infection Prevention & Control Policy

SQAC received, **NOTED** and **Ratified** C15 – Infection Prevention & Control Policy subject to the names on the policy being updated.

25/26/24 C19 – Infection Prevention & Control management of Outbreaks/Incidental Exposures

SQAC received, **NOTED** and **Ratified** C19 – Infection Prevention & Control management of Outbreaks/Incidental Exposures Policy

25/26/25 C32 – Aspergillus Policy

SQAC received, **NOTED** and **Ratified** C32 – Aspergillus Policy

25/26/26 C48 – Surveillance & Data Protection Policy

SQAC received, **NOTED** and Ratified C48 – Surveillance & Data Protection Policy subject to required updates being included relating to surgical site infection.

25/26/27 Staff Exclusion Agenda

SQAC received, **NOTED** and **Ratified** the Staff Exclusion Agenda

25/26/28 Managing Infusions and drug administration through Vascular Access Devices and Intravenous Administration set change guidelines

SQAC received, **NOTED** and **Ratified** Managing Infusions and drug administration through Vascular Access Devices and Intravenous Administration set change guidelines

25/26/29 C11 – Aseptic Non-Touch Technique (ANTT) Policy

SQAC received, **NOTED** and Ratified C11 – Aseptic Non-touch Technique (ANTT) Policy

25/26/30 Guidelines for Care & Maintenance of Intravenous Access Devices in Paediatric Patients

SQAC received, **NOTED** and **Ratified** the Guidelines for Care & Maintenance of Intravenous Access Devices in Paediatric Patients

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

25/26/31 No further business was raised.

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

25/26/32 The key assurances and highlights report was presented to the Board meeting held on 2025.

Date and Time of Next Meeting: 21st May 2025 at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 5th June 2025

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

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

Does this relate to a risk? Yes ☑ No

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

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

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

1. Executive Summary

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

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

2. Priority actions:

One Alder Hey & Thriving

Inclusion & belonging:

- We are making strong and measurable progress in delivering the NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan. All Trust Board members now have EDI objectives embedded into their annual appraisals, and our Board Assurance Framework is actively tracking progress. Inclusive recruitment practices are being implemented, with targeted training and leadership development programmes underway to address under-representation. We have launched new wellbeing initiatives, and continue to promote flexible working policies, all of which are contributing to a more inclusive and supportive workplace culture. Our commitment to transparency is reflected in ongoing pay gap analyses and the development of a robust equality data dashboard. These actions and continuous efforts demonstrate our collective accountability and sustained momentum toward creating a fairer, more equitable workforce.
- In 2023, we were proud to receive the Navajo Charter in recognition of our commitment to supporting LGBTQIA+ staff and fostering a culture of belonging. This year, we will be re-assessed for the Navajo Charter Mark, providing evidence of our continued progress. The re-assessment will follow the same format as before, with two Navajo assessors conducting short interviews with a range of staff over two days. These interviews are scheduled for the 26th and 27th of June. We've made significant strides in advancing our Navajo action plan and, while there is still more to do, we're excited to share some of our major successes. A preparation workshop will be held for all participating staff ahead of the interviews to ensure everyone feels confident and informed.

Staff Networks Updates:

- **ACE Network**: Our network members have been hard at work preparing for the launch of the 'People of the Posters' campaign. This initiative will feature staff members sharing their name, job role, and disability, helping to promote an inclusive

culture and encouraging others to feel confident in declaring their disabilities. We're also proud to announce the addition of a Stoma-friendly toilet. The network is planning a launch to raise awareness of this important facility among both staff and the children and young people we support.

- **REACH Network**: The network has been actively involved in developing a new leadership programme tailored for our internationally recruited staff. This initiative is grounded in evidence from national reports such as the Workforce Race Equality Standard (WRES), the 'Too Hot to Handle' report, and the McGregor-Smith Review, as well as insights from our local staff survey. These sources consistently highlight persistent challenges around racism and unequal access to career opportunities within the NHS. We've also received powerful qualitative feedback from our internationally recruited colleagues, many of whom have shared their frustration with barriers to career progression. In response, we partnered with the staff network to host a focus group, giving these staff members a platform to voice their needs and aspirations. Using this valuable input, we've begun designing the leadership programme in collaboration with our Organisational Development team. We're excited to launch the programme later this year and are committed to creating a more equitable and supportive environment for all.
- **Armed Forces Network**: The network proudly celebrated VE Day with a vibrant stall in the Atrium, highlighting the significance of the day and showcasing the fantastic work the network has been doing. The event was a great success, drawing interest and engagement from staff and visitors alike. As part of the celebrations, Treetops Restaurant offered a special wartime-themed menu, and our children and young people enjoyed a range of activities linked to VE Day, helping them learn about its historical importance in a fun and interactive way. Looking ahead, the network is actively planning events for Armed Forces Day in June and Remembrance Day in November. These events will be delivered in collaboration with local community groups and our Armed Forces colleagues, continuing our commitment to honouring service and fostering community connections.
- **LGBTQIA+ Network:** We're delighted to welcome Sam Reyne as the new Chair of our network. Sam brings a wealth of experience and insight that will be invaluable in driving our mission forward. Supporting Sam is Gwen Cowley, who joins as Deputy Chair. Together, they've already begun making a positive impact in promoting the network's work and values. One of their first initiatives is the introduction of monthly staff drop-in sessions, offering a safe and supportive space for colleagues to share ideas, raise challenges, and connect with others. Sam and Gwen are also leading preparations for Liverpool PRIDE this July. Promotion is already underway across the Trust, and we're encouraging everyone to get involved, show their support, and celebrate inclusivity together.

Values:

- A refreshed set of values were presented to and endorsed by the Board in April 2025. These are: Compassion, Courage, Commitment and Community.

- A bi-weekly values working group has been established comprising colleagues from: SALS, OD, HR, FTSU, Brilliant Basics, Staffside, Communications, L&D, EDI, Transformation. Working to a launch date of September, the group are focussed on two main areas of work: the development of a behavioural framework; and a communications plan.
- The group have agreed high level working definitions for each of the values to form the basis of an organisation wide consultation with staff to develop the more detailed behavioural framework.

Thriving Leaders framework:

- The core programme in the framework, Strong Foundations, will be reviewed over the summer to respond to feedback gathered during the year and to incorporate the new Trust values.
- The Thriving Leaders working group continues to develop and review the 8 core workstreams whilst awaiting the outcome of NHS England's development of a new Management and Leadership Framework, starting with a set of Standards and Competencies which are due to be finalised by Summer 2025.
- The group will be focussing on progressing the Clinical leadership review started earlier in the year and establishing the planned Leadership Faculty.

Thriving Teams:

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

Thriving Staff Index:

- The Thriving Staff Index, a tool developed to encourage staff to take a few moments to reflect on how they are feeling on a regular basis and encourage them to seek support if needed is in its final development stages and is now ready to be rolled out and evaluated as per the two-layered evaluation process described in an update paper presented to the People Committee in March 2025. The tool will also provide the Trust with a regular sense of how staff are feeling utilising the same categories of Thriving, Struggling and Suffering seen in the Thriving Teams Index.

Professional Development / The Development Hub

- Following the launch of a refreshed approach to Performance and Development Review (PDR) in April 2025 there is now an enhanced focus within one-to-one discussions on performance, wellbeing, development and career aspirations. Feedback from colleagues utilising the new paperwork and approach has been positive. Divisions are aware of the requirement for B7+ PDR's to be completed by 31st July 2025 and have been encouraged to introduce plans to facilitate this.

- The Development Hub philosophy was established through Vision 2030 workstream activity and a collaborative approach to the design of this was adopted, involving feedback and suggestions from a panel of internal stakeholders. 5 thematic areas were identified by colleagues as being key to suporting their development:-
    - Careers Advice and Guidance
    - Learning and Development Opportunities
    - Skill Scan
    - Career Pathways
    - Talent Pipeline

The Hub sections focusing on Careers Advice and Guidance, and Learning and Development Opportunities are now available for colleagues to access via the intranet; these will remain live with information being added and / or refreshed as required. The Skill Scan and Career Pathway themed activities are under development and the Talent Pipeline activity will follow, linked to Workforce Planning activity.

Future Workforce

- **People Practices**

The Partnership Agreement was agreed at the Joint Consultation and Negotiation Committee (JCNC) in May 2025. This Partnership Agreement and Framework describes the principles of partnership working in the Trust. Focusing on how we improve people practices in addition to adopting a just and restorative culture.

Sessions are being coordinated with the Staff Side Chair and the Deputy Chief People officer and Associate Director of Organisational Development in respect of the People Plan, partnership working and avoidable employee harm, to fully support the creation of a just and restorative culture through people practices.

A staff side representative is now a member of the Values working group.

Workforce Planning

Development of Workforce Planning templates are being finalised, which will support the clinical collaboratives as they develop the workforce needs for the future, though their transformational programmes. Long terms workforce planning will be captured in all transformation programmes, with the organisational design collaborative providing the organisational blueprint.

BOARD OF DIRECTORS

Thursday, 5th June 2025

Paper Title:	**Chair's Report from The People Committee meeting held on 22nd May 2025**
Report of:	**Jo Revill Committee Chair**
Paper Prepared by:	Jo Revill

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

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

1. Introduction

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

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

- Internal Communications provided good discussion around financial sustainability
- Monitoring Progress Against the People Plan
- Organisational Design Collaborative Update
- Trust/Divisional Metrics Update
- Staff Thriving Index Update
- Staff Survey Results
- Workforce Efficiencies Update
- Thriving Teams Index App due to launch beginning of June
- Workforce Efficiencies Update
- Mutually Agreed Resignation Scheme (MARS)
- Occupational Health Update
- Workforce Planning Audit
- Health & Safety Dashboard
- Equality, Diversity & Inclusion Annual Report
- Board Assurance Framework – Monitoring of Strategic Workforce Risks
- Sign-Off Annual Report to the Trust Board
- Board Assurance Report
- Policies for Ratification:

- Safe & Respectful behaviour Policy and Toolkit - ***APPROVED***
- Manual Handling of Loads & People Policy - ***APPROVED***
- Recruitment & Selection Policy – ***APPROVED***
- Relationships at Work ***Policy - APPROVED***

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

- There are continuing discussions around the impact of the current NHS climate and the financial position of the Trust on staff morale, and the Committee discussed the need for enhanced communications tailored at specific queries or some 'myth-busting'.

4. Positive highlights of note

- The Thriving Teams Index app is launching in June, so the ability to obtain real time feedback and sentiment will be vital in order for us to respond to what our people are telling us it is feeling like working at the Trust.

5. Issues for other committees

- n/a this month

6. Recommendations

The Board is asked to note the Chair's Highlight report for the People Committee meeting that took place on 22nd May 2025.

Alder Hey Children's NHS Foundation Trust

People Committee
Minutes of the meeting held on 12th March 2025
Team

Present:

Jo Revill	Non-Executive Director **(Chair)**	(JR)
Adam Bateman	Chief Operating Officer/Deputy Chief Executive	(AB)
Fiona Beveridge	Non-Executive Director	(FB)
Sian Calderwood	Associate Chief Operating Officer - Medicine	(SC)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
Chloe Lee	Associate Chief Operating Officer – Surgery	(CL)
Sarah Leo	Associate Chief Operating Officer – Research	(SL)
Sharon Owen	Deputy Chief People Officer	(SO)
Erica Saunders	Chief Corporate Affairs Officer	(ES)
Melissa Swindell	Chief People Officer	(MS

In attendance:

Angela Ditchfield	Head of EDI & Inclusion	(AD)
Joe Fitzpatrick	Internal Communications Manager	(JF)
Veronica Greenwood	Director of Allied Health Professionals	(VG)
Jill Preece	Governance Manager	(JP)
Gill Foden	Head of Learning & Development	(GF)
Darren Shaw	Head of Organisational Development	(DS)
Neil Thomas	Acting Health & Safety Manager	(NT)
Kerry Turner	FTSU Guardian	(KT)
Julie Worthington	Staff Side Chair	(JW)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Apologies:

Nathan Askew	Chief Nursing, AHP and Experience Officer	(NA)
Alfie Bass	Chief Medical Officer	(AB)
Katherine Birch	Director of Alder Hey Academy	(KB)
Pauline Brown	Director of Nursing	(PB)
Lisa Cooper	Director of Community & Mental Health Services	(LC)
Carolyn Cowperthwaite	Acting Associate Chief Nurse – Surgery	(CC)
Urmi Das	Director, Division of Medicine	(UD)
Garth Dallas	Non-Executive Director	(GD)
Jo Potier	Associate Director of Organisational Development	(JP)
Kate Warriner	Chief Transformation and Digital Officer	(KW)

24/25/102 **Declarations of Interest**

No declarations were declared.

24/25/103 **Minutes of the previous meeting held on 12th March 2025**

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

24/25/104 **Matters Arising and Action Log**

Action log was updated accordingly.

24/25/105 **Internal Communications Update**

The Committee received the Internal Communications update report.

JF informed the committee on progress of the new intranet pilot which has identified

changes are needed.

Next steps include creating space for a shared forum and ensuring there is alignment for user's needs. This will continue to be reviewed as part of Q1 data for 2025 and we will report back to the committee on this in due course.

JR commented that this project remains an important tool for the organisation, and it is good for the committee membership to see the progression stages showing it is improving. JR asked in terms of priority settings what steps will being taken to support colleagues as part of greater user experience. JF advised that the team is continuing to actively work with the People Service Team to gain more knowledge and understanding to improve the experience.

Resolved: The Committee received the Internal Communications Report.

24/25/106 **Monitor Progress against the People Plan**

The Committee received an update on progress Against the People Plan detailing the next steps and current progress in line with our Vision 2030.

MS highlighted that the current priorities and top 3 areas of focus were:

- PDR
- Whole time equivalent
- Sickness

The Committee noted the progress within the content of the people plan report

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

24/25/107 **Trust Wide Metrics**

The Committee received the Trust Wide metrics report (February 2025 data). MS highlighted the following to the committee:

The Committee noted the contents of the Trust Wide Metrics.

Resolved: The Committee received Trust Wide Metrics Report.

Medicine

The Committee received the Medicine Division metrics report (February 2025) data and noted progress to date.

- Sickness absence shows a rise relating to long-term sickness. Senior Leaders continue to work with HRBPs to manage all return to work appropriately. There remains a 6-month action plan to reduce all risks relating to sickness absence
- PDR Compliance band 7 + reported 89% compliance. Senior Leaders continue to work with the L&D Team to manage and maintain completion figures.
- Mandatory Training compliance showed an increase in compliance. The

Division of Medicine has actions in place to secure and ensure all training is completed at appropriate timelines.

- The Divisional People Committee held good discussions on strategic and operational pressures and challenges.

The Division continues to forward plan all operational targets.

JR referred to the organisational change noting there seems to be a good platform of learning feedback for sharing with our colleagues. SC added this remains part of the divisions proactive communication and engagement which is to learn as much as possible and provide good conversations with colleagues.

GF highlighted that the Learning and Development Team continue to offer Stress Risk Assessment Training for stress and anxiety, and this is offered to all managers.

Resolved: The Committee received the metrics for the Medicine Division.

Clinical Research Division

The Committee received the Clinical Research Division metrics report (February 2025) data and noted progress to date. SL highlighted the following:

- Turnover reported at 7.4% to date for the month of February 2025.
- The Divisional Away-day is scheduled to take place on 1st April 2025.
- Wellbeing Week remains in production planning for 2025/26 financial year.
- PDR compliance reported at 100% to date.

SL added that the Clinical Research Division continues to make positive improvements throughout and remains prioritised supported by HRBP colleagues.

Resolved: The Committee received the metrics for the Clinical Research Division.

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (February 2025) data and noted progress to date. RG highlighted the following:

- Sickness Absence for the division remains at trust target.
- Return-to-Work compliance remains a priority focus and is monitored by Senior Leadership to improve activity across services.
- PDR compliance reported 80% overall. Band 7 + reported 93% to date.

The Community and Mental Health Division held a development session in February 2025 with the Senior Leadership team with a focus on t annual planning. The division conducted a joint session with Human Resources around Recruitment and Selection to improve processes and how to bring future change to Alder Hey.

RG updated on the development session held with Outpatient Department colleagues supported by John Grinnell, Chief Executive.

FB referred to the lessons learnt session relating to improved recruitment processes and asked what the initial focus and challenges are on this. RG added the division is reviewing the overall processes including updating all paperwork ensuring we improve diversity within our workforce and in making the necessary reasonable adjustments.

Resolved: The Committee received the metrics for the Community and Mental Health Division.

Surgery Division

The Committee received the Surgery Division metrics report (February 2025) data. CL highlighted the following to the committee:

- Sickness Absence reported below trust target for the third consecutive month. Long-term sickness cases are showing a slight increase overall. All cases are being managed with action plans in place to stabilise service provisions.
- Mandatory Training shows a slight increase and remains steady. Senior Leaders continue to proactively manage all compliance across services.
- PDR compliance overall reported 82% to date. Band 7 + reported at 85% to date. All Managers continue to plan for 2026 completion deadline.
- Time to Hire remains an area of focus and continues to be managed effectively and appropriately.
- The Surgery Division reported one organisational change which remains under management review.

Next Steps
The Division of Surgery plans to implement a financial sustainability group meeting into the divisional workforce plans for 2025/26.

JR referred to the time to hire data and asked if the division receives enough guidance on visa processes. CL assured the visa process is managed to the best to our ability, acknowledge and guidance.

SO informed the committee there is a regional and national requirement for Alder Hey to provide our workforce return data which comes into effect in early 2025. In addition, Alder Hey's job planning compliance data is also required to be submitted. All data has set targets in place, recorded accurately and is monitored accordingly.

Resolved: The Committee received the metrics report for the Surgery Division.

Corporate

The Committee received the Corporate metrics report (February 2025) data and noted progress to date. ES drew the committee's attention to the following:

- Sickness Absence relating to long-term cases remains stable across the service.
- PDR compliance remains a focus supported by the L&D Team.

- Return to Work compliance remains an area of challenge with plans to undergo a deep dive to improve the quality and frequency of conversations taking place.

The Corporate Service Collaborative group met in February 2025 and there were some good discussions on annual planning. Initial focus remains on our workforce metrics with mitigations in place to continue monitoring individual cases for long term sickness.

Action: SO will conduct a further deep dive on Return-to-work data will be shared with the committee in due course:

The Chair thanked all divisions for their detailed metric reports.

Resolved: Committee received the Corporate Services Metrics Update.

24/25/108 **Staff Survey Results**

The Committee received and noted the content of the Staff Survey Results. DS provided the committee with the Staff Survey report and highlighted the following:

- Staff Survey achieved a 62% response rate for 2024/25.
- Alder Hey ranks first in terms of our people promises.
- Increased Engagement and Morale noted among colleagues across services.
- Plans in place to enhance communication efforts going forward.
- Staff Survey data will be published on the NHS Staff Survey website.

DS informed the committee the NHS Staff Survey live system remains embargoed and will be fully available and accessible on 13/03/2025 and all data will be released. Once available the data will be published on the NHS staff survey external website.

Areas for Improvement

- Appraisals
- Experience Variation

FB asked what process will be put in place to ensure feedback will be communicated to all departmental areas. DS commented that there is a workstream and the data and conversations packs will be shared. DS added I that we are developing a tool around thriving teams index to pull together and identify teams who are struggling. In addition, teams continue to track activity and plan around better ways to utilise data.

JR referenced that Alder Hey are seeing an increase in the number of cases reported relating to discrimination on ethnicity. AD advised the committee this links in following the Southport incident and the fact that more people are speaking up and feeling safe is positive. The Reach Network Team have plans in place supported by Finance. The Northwest Anti-Racism Framework will help support this development and continues to push data to improve change.

Resolved: The Committee received the Staff Survey Results Update

24/25/109 **Raising Concerns/Freedom to Speak Up (FTSU)**

The Committee received the Raising Concerns/Freedom To Speak Up update and noted the contents. KT drew the committee's attention to the following:

- 25 cases reported in Q4.
- 19 cases reported in Q3.
- FTSU training is currently running at 98% compliance to date across the organisation.

The freedom to speak up visibility walkabout programme continues to conduct around 6-8 visits across departments per month, which is now supported by our Executives and Non-Executive colleagues. This showcases our commitment by the organisation assigned to the FTSU principles.

The FTSU App development is currently out for testing supported by FTSU champions. The aim to do a soft launch in the next couple of months remains on course. KT will continue to work with the Innovation Team to identify visibility linked to FTSU standards and expectations.

KT is attending London's National Guardian Office Conference this month focusing on organisational culture and will feedback to the committee.

Resolved: The Committee received the Freedom To Speak Up Report.

24/25/110 **Thriving Teams Index Update**

The Committee received the Thriving Teams Index Update and noted the contents. DS drew the committee's attention to the following:

DS referred to the recent pilot that was brought to the committee's attention in 2024. The aim is to launch the pilot in April 2025 and have the first set of data ready for the People Committee meeting in May 2025.

Action: DS will provide the committee with an update on progress of the pilot launch in May's 2025 Meeting.

The Chair was pleased to see good progress on this project and hopes to see the reassurances around the work on making this anonymous. .

Resolved: The Committee received the Thriving Teams Index Update.

24/25/111 **Workforce Efficiencies Update**

The committee received the Workforce Efficiencies Update Report. SO provided a reflection on Alder Hey's Workforce Efficiencies activity for assurance and oversight.

SO shared the most recent forecast position with the committee and confirmed this is shared with the ICB monthly. There remain challenges to maintain Alder Hey's position and SO assured the committee there are actions in place to stabilise service provisions across the organisation.

The Workforce Efficiencies Programme Group Meeting continues to be held on a bi-weekly basis, chaired by SO. There are expectations to further expand this programme in terms of the scope. In addition, this work will report into the financial improvement programme

JR thanked SO for the detailed overview on the workforce efficiency update.

Resolved: The Committee received the Workforce Efficiencies Update.

24/25/112 **Fit for the Future**

The Committee received and noted the contents of the 'Fit for the Future' Update.

The Fit for The Future collaborative encompasses organisational development and organisational design and is designed to support and enable our 3 big clinical transformations.

ES added that the corporate service collaboration group fits into this because it's proved to be quite an effective group. It has established a safe space for corporate departmental heads to raise issues and work in a mutually supportive way and the intention is that this will report into 'fit for the future'.

JR referred to learning and development and asked whether we have really brought out continuous learning for our colleagues as every workplace is going through big transformational changes and staff are having to learn more about digital. MS noted that the Digital, Date and AI Collaborative will be picking this up.

Resolved: The Committee noted the Fit for the Future.

24/25/113 **PDR Update**

The Committee received a proposal to renew and refresh the PDR process for all colleagues on Agenda for Change contracts.

Data presented shows that, to date, PDR compliance for band 7 and above is 92%, for all other staff it is 81%.

The new process aims to increase compliance and importantly the quality of the PDR conversation. The paperwork has been streamlined to make it easier, and we will roll out a full training programme alongside this to support staff and managers.

FB added this is a good paper and will be a positive step forward for individuals and managers.

Resolved: The Committee received and approved the PDR proposal.

24/25/114 **Long Term Sickness Deep Dive**

The Committee received and noted the Long-Term Sickness Deep Dive report. SO highlighted the following for the committee's attention:

- Alder Hey's organisational position for 2024/25 was 5%. Alder Hey is now reporting above trust target in similarity to other Trusts in Cheshire & Merseyside.
- Next steps include an initial review of our early intervention process we currently have in place with occupational health to make sure this process is effective.
- Human Resources will re-launch a training package on sickness absence.
- SALs colleagues will support in the triangulation of the data we have around sickness absence ensure our interventions are as effective as they should be.

JR thanked SO for the thorough paper.

Action: SO will feedback to the committee in July on our latest position.

Resolved: The Committee noted the Long-Term Sickness Deep Dive.

24/25/114 **EDS22 Summary Report**

The committee received and noted the contents of the EDS22 Summary Report. AD drew the committee's attention to the following:

The EDS22 report was submitted to the committee for approval prior to publication. The Senior Nurse Leadership Team had input prior to approval, with discussions at SQAC.

AD noted the report has made significant progress in terms of improvement.

JR suggested to showcase what excellence looks like in order to feedback that back to the organisation.

MS formally thanked AD for the EDS22 report update.

Resolved: The Committee received and approved the EDS22 Summary Report.

24/25/115 **Gender Pay Gap**

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

The Gender Pay Gap Report is being brought to the People Committee for ratification prior to publication.

The mean gender pay gap report shows a positive decrease reporting at 25% compared to a previous figure of 27%.

In terms of actions, Alder Hey will be focusing on the promotion of flexible working, supporting the ongoing aim of developing an inclusive culture, and working with the staff networks to promote this.

JR referred to the Clinical Excellence Awards and asked if this year we were taking the was the same approach. AD confirmed that Clinical Excellence Awards ceased on 1st April 2024.

FB commented this is a great report showcasing real improvement compared to reports in the previous years. FB added it would be interesting to see a breakdown of the AFC staff and the dental and medical group to identify what those gaps are.

ES referred to the remuneration report section required in the trust annual report each year which has got statutory provisions within it and certain ratios must be expressed on highest/lowest pay grades.

Action: ES suggested AD and JP could do some work on how we expand upon that section to include some additional context and narrative on this, this year.

Resolved: The committee noted the Gender Pay Gap.

24/25/116 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

The Committee received and acknowledged the February 2025 Board Assurance Framework.

ES advised we are working to refresh the workforce policies for 25/26.

Resolved: The Committee noted the Board Assurance Framework.

24/25/117 **Policies for ratification**:

- **Slips, Trips & Falls Policy**

The Committee received the Slips, Trips & Falls Policy and noted the detailed overview of recent updates.

- **Transport Policy**

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

- **Fire Policy**

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

Resolved: The Committee APPROVED all policies set out as above.

24/25/118 **LNC Minutes**

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

24/25/119 **Equality, Diversity & Inclusion Steering Group (EDISG) Minutes**

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

24/25/120 **Any Other Business**

Noting to report.

24/25/121 **Review of Meeting – Chair's Report to Board**

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

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

Divisional Metrics:
Divisional metrics continue to be managed and maintained.
PDRs remains an area of focus across
Sickness long term cases continue to be managed.

Trust Wide Metrics:
The Trust Metrics remain stable and continue to be monitored.

Policies for Ratification: APPROVED
- The Slips, Trips & Falls Policy
- Transport Policy
- The Fire Policy

Date and Time of Next meeting.
Thursday 22nd May 2025 at 2pm – Tony Bell Boardroom, Institute Building

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Monday 28 April 2025 at 1:00pm**
VEC Meeting Room, Innovation Hub

Present:	Mr J. Kelly	Non-Executive Director (Chair)	(JK)
	Dame. J. Williams	Non-Executive Director	(JW)
	Mr. J. Grinnell	Managing Director/Chief Finance Officer	(JG)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Mrs. R. Lea	Interim CFO	(RL)
In Attendance:	Mr. N. Askew	Chief Nursing Officer	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mr. A. McColl	Associate Director of Finance	(AMc)
	Ms. E. Kirkpatrick	Associate Director of Finance	(EK)
	Ms. N. Palin	Director of Transformation	(NP)
	Mr. G. Wadeson	Associate Director of Finance, Income	(GW)
	Mrs. E Rees	Executive Assistant (minutes)	(ER)
25/26/017-19	Ms. R. Greer	Associate COO – Community/MHLD	(RG)
25/26/017-19	Ms. C. Lee	Associate COO – Surgery	(CL)
25/26/017-19	Mrs. S. Calderwood	Associate COO – Medicine	(SC)
25/26/017-19	Ms. N Pickard		(NP)
25/26/017-19	Ms. E. Evans	Business Accountant – Community/MHLD	(EE)
25/26/017-19	Ms. L. Simon	Business Accountant – Medicine	(LS)
25/26/020	Ms. J. Halloran	Deputy Development Director	(JH)
25/26/020	Mr. J. Glenn	Senior Project Manager	(JGl)
Apologies:	Mrs. S. Arora	Non-Executive Director	(SA)

25/26/007	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
25/26/008	**Minutes of the Previous Meeting** The minutes from the meetings held on the 25 March 2025 were agreed as an accurate record of the meeting.
25/26/009	**Matters Arising and Action Log** The action log was updated.
25/26/010	**Declarations of Interest** There were none to declare.
25/26/011	**<u>Top 5 Risks</u>**

	Immediate Financial Performance including System Position RL reported that the month 12 position was £1.5m surplus to plan in month and a £3.3m surplus to plan for the year. Despite the trust having signalled to the ICB at M11 significant risks to the delivery of the £3.3m target (c.£1m), a number of mitigations materialised in M12 which supported the achievement of the £3.3m plan. The mitigations were specifically around elective income, procurement rebate, review of SPV deductions due, and a further review of non recurrent items. **Capital Programme** The capital programme for the year-end was managed effectively, with the final position aligning closely with the forecast despite some delays in spending. The 25/26 capital programme was detailed, with a range of scenarios presented including a worst case scenario which highlights a number of risks with the current allocations. There is a risk associated with capital allocations not being locked in from the ICB, which could impact the ability to invest in core and critical areas. The system's financial position and the need for balanced planning were emphasised, with discussions on how to manage the capital programme effectively while addressing emerging risks and ensuring quality and safety. **Efficiency Programme** RL advised that the recurrent CIP of £13.9m was achieved for this year and remains significantly higher than previous year achievements. We need to address the reality of working within our current limitations while aiming to achieve continuous improvement in the coming years. Next year, we plan to drive further efficiency and build upon our current position across the divisions.. **Benefits Realisation** This was discussed under the annual plan agenda item. **The Campus and Park Developments** This was discussed later on the agenda. **Action** **It was agreed to update the top 5 risks proposal and bring back to the next meeting - EK** **Resolved:** The Committee received and noted the Top 5 Risks.
25/26/012	**Finance Report** **Month 12 Financial Position**: EK advised that the organisation achieved a surplus of £3.3m for the year, with positive financial performance in Month 12. Income levels across commissioners was achieved in a different mix than forecast however negotiations with specialist and ICB Commissioners helped resolve income challenges, ensuring the organisation met its financial targets. Divisions held their positions well, with significant reductions in non-clinical bank, agency spend, and overtime contributing to the positive financial outcome. The final numbers for the system position indicated that the overall target of £195m was met, ensuring the system's financial stability. The organisation reported £4.1 million in litigation and other adjustments in Month 12, which helped achieve the

	year-end surplus. The pension costs were accounted for, impacting the income and pay figures for Month 12. **Resolved:** The Committee noted the M12 Finance Report.
25/26/013	**<u>M12 Integrated Performance Report</u>** The IPR update highlighted improvements in immediate performance and diagnostics, while also identifying areas requiring further attention, such as long waiting times in surgery and overdue follow-ups. Highlights were: • Activity against plans showed a provisional 5% increase, with stronger performance in medicine and surgery. • Immediate performance improved, reaching 87% for the month, which was considered a positive outcome. • Diagnostics within six weeks were at 94%, indicating slight improvement but still below the target. • There were additional patients waiting over 52 weeks in surgery, which required further attention. • Overdue follow-ups remained a challenge, particularly in surgery, with efforts needed to address this issue. **Resolved:** The Committee noted the M12 Integrated Performance Report.
25/26/014	**<u>Annual Plan Update</u>** RL advised that the Trust had submitted its annual plan targeting a £3.4m surplus, which was initially accepted by the system. The system faced a significant deficit of £84m and urgent action was required to address the deficit, with a mandate to submit a plan by the end of April to meet the gap. In view of this the ICB had allocated an additional £3.7m stretch target, increasing its surplus target to £7m. She added that the methodology for distributing the deficit was based on turnover, with the organisation contributing its fair share. The committee expressed concerns about the feasibility of achieving the additional stretch target and the implications for children's health and well-being. Overall, the annual plan discussion focused on addressing the system's significant deficit, managing emerging controls, and ensuring the organisation's ability to meet its financial targets while prioritising children's health and well-being. Overall, the annual plan discussion focused on addressing the system's significant deficit, managing emerging controls, and ensuring the organization's ability to meet its financial targets while prioritizing children's health and well-being. **Action** **It was agreed that an update would be provided at the next meeting on the latest position with the ICB and any response received. RL**

	Resolved: The Committee noted the Annual Plan update.
25/26/015	**FIP Update** The FIP discussion focused on bridging the £10m gap in the CIP target through transformation efforts, stretch targets, and run rate reductions, with a strong emphasis on tracking and transparency. Highlights were: • The organisation targeted a £25m CIP for the year, with a gap of just over £10m identified. • Transformation efforts focused on three clinical collaboratives: Acute, Urgent Care & Diagnostics, Neighbourhood and Prevention, and Reimagined Elective care with identified savings of just under £3 million. • Additional stretch targets were set, including £1m from further transformation efforts across clinical divisions and £700k from data and digital initiatives. • Research and innovation proposed up to £350k in savings through external income streams. • Corporate areas were tasked with achieving non-pay savings of 5% in divisions, plus some additional stretch targets in areas with high contractual spend. • Weekly tracking and QIA sign-offs were emphasized to ensure progress and transparency. **Resolved:** The Committee noted the FIP update.
25/26/016	**IPR Update April 2025** The IPR has been reviewed and updated to reflect the challenges and goals for the 2025/26 financial year and will be going to Trust Board for approval. **Resolved** The Committee noted the IPR Update.
25/26/017	**Medicine Division** The Medicine Division attended for the annual plan discussion only. **Resolved:** The Committee noted the update on the Medicine Division.
25/26/018	**Surgery Division** The Surgery Division attended for the annual plan discussion only. **Resolved:** The Committee noted the update on the Surgery Division.
25/26/019	**Community Division** The Community Division attended for the annual plan discussion only. **Resolved:**

	The Committee noted the update on the Community Division.
25/26/020	**Campus Update** JH advised that the park project is nearing completion with all Harris fencing being removed except around the Swale, reducing trip hazards. The planning committee will meet in June, aiming to complete phase three by December. The elective hub is within budget but under pressure. A workshop to address cost concerns has been rescheduled to May 9th. New items include post-occupancy evaluations to enhance governance, budgeting, and risk management. Updates on the progress of two net-zero sustainable bids and future pipelines will be provided. **NICU/SDEC** JGl provided an update that the project is progressing well, with walls going up and first fix services being installed. There are significant cost pressures that need to be managed carefully to ensure the project remains within budget. The main points of concern include provisional sums, VAT liability, design changes, and prolongation cost. **Action** **JH to liaise with Alder Hey Charity regarding opportunities to further support campus projects.** **Resolved:** The Committee noted the campus update.
25/26/21	**Board Assurance Framework** The Committee received the Board Assurance Framework Report (BAF) for March 2025. ES advised that this would be updated following the risks noted in the meeting. **Resolved:** The Committee noted the Board Assurance Framework Report.
25/26/022	**FTPC Annual Report** It was noted that the report referred to RABD and it was agreed to keep in the same format and use FTPC. The risk section would be updated to reflect the conversation in the meeting today. **Action** **It was agreed to update the risk section. ES** **Resolved** The Committee noted the FRPC Annual Report.
25/26/023	**Any Other Business** MS provided an update on the Mars approvals, noting the impact of the emerging controls on the approved posts. The team discussed the need to review the approved posts in light of the vacancy freeze and encourage internal movement.

25/26/024	**Review of the Meeting** The Chair noted that the meeting provided comprehensive updates on the Trust's operational and financial performance.
	Date and Time of Next Meeting: Monday 21 May at 2pm via Teams

BOARD OF DIRECTORS

Thursday, 5th June 2025

Paper Title:	**Board Assurance Framework Report (April 2025) and Year-end 2024/25 Report**
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 ☑
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 April 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 2025/26

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 have timely and safe access to elective, urgent and follow up care	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Finance, Transformation and Performance Committee
1.4	Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People Committee
3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	Finance, Transformation and Performance Committee
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	Finance, Transformation and Performance Committee
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	Finance, Transformation and Performance Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People	Futures Committee
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	Finance, Transformation and Performance Committee

3. Summary of the BAF at 13th May 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 have timely and safe access to elective, urgent and follow up care	FTPC / SQAC	**5x3**	3x3
1.3 RL	Building and infrastructure defects that could affect quality and provision of services	FTPC	4x3	2x3
1.4 LC	Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.	FTPC / SQAC	**3x5**	3x3
1.5 LC	Lack of visibility at Board level across the Gender Service	Trust Board	4x1	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	FTPC	4x2	3x2
3.2 KW	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	FTPC	**4x4**	4x2
3.4 RL	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments	FTPC	**4x5**	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	FTPC	**4x4**	2x4

4. Summary of April 2025 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  Risk 1.1 has been reviewed in light of the challenging NHS climate and been updated to reflect the changes. Some controls continue and the current financial challenges across the NHS and system have been included as a potential to our ability to deliver safe and effective care. The Financial risk is more fully articulated in the relevant section of the BAF but the impact on Quality and Safety will be monitored through SQAC.

- ***Lack of visibility at Board level across the Gender Service (LC).***
  BAF risk reviewed. Propose risk score is adjusted to target score - consequences remain major but likelihood rare. The Trust board is effectively sighted on CYPGS through the existing governance structure, which includes quarterly SQAC, divisional director presentations to board, and yearly QAR. The service's first QAR took place on 30 April 2025 and Board colleagues were happy with the report. Please see uploaded documents for audit trail.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  Initial review of BAF risk undertaken and availability of medication is improving slowly. Discussion with Divisional Chief Nurse and agreement for score to remain same for further month and will be reviewed in May with a view to amending.

- ***Children and young people have timely and safe access to elective, urgent and follow up care (AB).***
  Standard controls and monitoring has continued with a revised focus against 2025/26 acute and elective targets.

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***
  Meetings with Project Co partners and execs over corroded pipework have taken place to discuss the future repair/replacement of the affected areas. The trust has received further correspondence on the matter and are taking advice on next steps. Exec representatives are aware of the issue and involved in discussions with Project Co Directors. A further update on this is due by early June.

  Out-of-range water temperatures continue to be monitored, and local mitigations are in place such as filters on water outlets. Awaiting update from Mite review.

  Water safety group meetings held alongside operational groups to monitor progress.

  Internal AH staff pipework meetings have also taken place

  Notification on tap filters has been issued to Project Co.

  Green roofs are also being monitored.

- ***Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services. (LC).***
  BAF risk reviewed and actions updated.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***
  Risk reviewed - actions on track and aligned to priorities set out in the people plan 2030. Workforce numbers continue to undergo robust scrutiny through both Workforce efficiencies group and strategic command. Workforce metrics for 2025/26 adjusted accordingly.

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

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  Risks reviewed actions on track.

- ***Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus (RL).***
  Risk Reviewed. No change to score. Phase 3 remains on target for completion Dec 2025.

- ***Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (KW).***
  The 90-day plans have now commenced and are actively being tracked. Financial allocations for the Collaborative 3 programmes have been updated to reflect the costed plans. We remain focused on ensuring alignment with the long-term strategic position.

  However, the increased financial targets present a heightened risk to achieving the 2030 Vision, as the quantified financial benefits have not yet been fully validated. Until there is greater clarity and confidence around deliverability, this remains a key risk.

  To support delivery, five Collaborative 3 programmes have been established, each with an SRO drawn from the Divisional Directors. As of March/April, each collaborative has been tasked with producing updated financial forecasts to assess the potential benefits and delivery risk. In parallel, a Transformation Programme Board is being established to provide oversight and governance, ensuring alignment with both strategic priorities and financial objectives.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***
  Risk reviewed and all actions and gaps updated tor reflect new financial year. Score increased to 20 given the level of risk and uncertainty in the new financial plan for the year ahead. Continued dialogue with ICB and NHSE re the deliverability of the plan and the actions required across the system to deliver financial balance for the ICS.

- ***System working to deliver 2030 Strategy (DJ).***
  Significant changes in external environment e.g. NHSE abolition and 50% running cost reductions in ICB - creating uncertain environment externally. The risk rating remains a red 16 - no change in month - and all BAF's under review during May/June.

- ***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).***
  3 outstanding actions remain which include recruitment of the Futures comms post (interviews on 9th May), the development of a Futures comms strategy (delayed by not having someone in post) and sign off of the IZ funding agreement which is still pending. Overall review of risk underway in line with updated targets for new financial year. Score remains 9.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***
  Risk reviewed as part of annual process, score remains the same and some additional actions added. Risk around workforce restrictions, lack of funding for key infrastructure and hardware currently being reviewed and mitigation/risk plans being produced. AI strategy now approved at Board and moved to next phase of developing investment profile and mobilisation plan.

5. Corporate risks (15+) linked to BAF Risks (as at 1 May 2025)

There are currently 24 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
2450	There will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres, Major Trauma, specialist surgery, burns and ECMO. Inability to provide 24/7 haematology laboratory service.	5x5	Medicine	2.1	Jul 2021	Mar 2024
2635	Risk to business continuity of radiography services trust wide due to staffing availability and skill mix resulting in interruption to elective services and delay to non-elective services	4x4	Medicine	2.1	May 2022	Oct 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.4	Dec 2019	*Apr 2023
2100	Risk of inability to provide safe staffing levels due to absence.	4x4	Corporate Services	2.1	Jan 2020	*Apr 2023
2487	Disruption in patient's supply of medication and / or treatment	4x4	Community		Apr 2023	July 2024
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program	4x4	Surgery	3.4	Aug 2022	Feb 2024
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post.	4x4	Medicine	2.1	Feb 2023	Oct 2024
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x4	Medicine	2.1	Apr 2023	June 2024
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	4x4	Community	2.2	Feb 2023	*Apr 2023
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	4x4	Community	1.6	Jun 2024	Jun 2024
027	Fragility of Inherited Metabolic Disease Service (IMD)	3x5	Medicine	2.1	Jun 2023	Dec 2024
140	Anaesthetic cover out of hours - ward based issues	5x3	Corporate Services	1.2, 2.1 & 2.2	Feb 2024	Feb 2024
173	Business Continuity Incidents disrupting the Trust’s ability to maintain statutory duties	3x5	Corporate Services		Mar 2024	Mar 2024
298	ED Reception Support	4x4	Medicine		Dec 2024	Feb 2025
271	Safeguarding Nursing Team Capacity	5x3	Community	2.1	Nov 2024	Nov 2024
288	CAMHS Planned Safeguarding Supervision	3x5	Community	2.1	Nov 2024	Nov 2024
341	Named Doctor for Children in Care	4x4	Community		Apr 2025	Apr 2025

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
335	Radiology Report Addendums are not visible on Meditech	3x5	Medicine	4.2	Mar 2025	Mar 2025
297	Transcription delay and increase of turnaround times ***(NEW)***	4x4	Corporate Services	2.1	Dec 2024	Apr 2025
289	Delay in Building Works within the Rainbow Centre required for SARC Accreditation ***(NEW)***	4x4	Community		Nov 2024	Feb 2025
1.2 Children and young people have timely and safe access to elective, urgent and follow up care (5x3=15)						
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.4	Jul 2021	*Apr 2023
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)						
	None					
1.4 Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services. (3x5=15)						
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	4x4	Community	1.1	Dec 2019	*Apr 2023
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.2	Jul 2021	*Apr 2023
1.5 Lack of visibility at Board level across the Gender Service (4x2=8)						
	None					
1.6 Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (4x4=16)						
236	Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	4x4	Community	1.2	Jun 2024	Jun 2024
STRATEGIC OBJECTIVE: Support our people						
2.1 Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (3x4=12)						
2450	There will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres, Major Trauma, specialist surgery, burns and ECMO. Inability to provide 24/7 haematology laboratory service.	5x5	Medicine	1.1	Jul 2021	Mar 2024
297	Transcription delay and increase of turnaround times ***(NEW)***	4x4	Corporate Services	1.1	Dec 2024	Apr 2025

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
140	Anaesthetic cover out of hours - ward based issues	5x3	Corporate Services		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	Corporate Services	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)	3x5	Medicine	1.2	Jun 2023	Dec 2024
2.2 Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (3x3=9)						
140	Anaesthetic cover out of hours - ward based issues	5x3	Corporate Services		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					

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Collaborate for children and young people						
3.1 Failure to fully realise the Trust's vision for the Park and Alder Hey campus (4x2=8)						
	None					
3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (4x4=16)						
	None					
3.4 Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments. (4x4=16)						
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Programme	4x4	Surgery		Aug 2022	Feb 2024
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	PIMP end-of-life server which is no longer supported by the supplier	4x4	Corporate Services		Jul 2024	Sep 2024
292	Inappropriate sharing of demographics	5x3	Corporate Services		Dec 2024	Dec 2024
335	Radiology Report Addendums are not visible on Meditech	3x5	Medicine	1.1	Mar 2025	Mar 2025

* risk movement data not available pre-move to InPhase

6. Month-on-month overview of risk scores during 2024/25 (April 2024 to March 2025)

BAF Risk		2024									2025		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
STRATEGIC PILLAR: Outstanding Care and experience													
1.1	Inability to deliver safe and high-quality services	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5
1.3	Building and infrastructure defects that could affect quality and provision of services.	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3
1.4	Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5	3x5
1.5	Lack of visibility at Board level across the Gender Service	-	-	4x2	4x2	4x2	4x2	4x2	4x2	4x2	4x2	4x2	4x2
1.6	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	-	-	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4
STRATEGIC PILLAR: 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	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4	3x4
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	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
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	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
2.3	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3
STRATEGIC PILLAR: Collaborate for children and young people													

BAF Risk		2024									2025		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
3.1	Failure to fully realise the Trust's Vision for the Park and Campus	3x4	3x4	3x4	3x4	3x4	3x4	4x2	4x2	4x2	4x2	4x2	4x2
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	4x3	4x3	5x3	5x3	5x3	4x3	4x3	4x3	4x3	4x4	4x4	4x4
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4
3.5	System Working to deliver 2030 Strategy	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4
STRATEGIC PILLAR: Pioneering breakthroughs													
4.1	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.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
STRATEGIC PILLAR: 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	3x4	3x4	3x4	3x4	3x4	3x4	4x4	4x4	4x4	4x4	4x4

7. Analysis of the risk ratings

It can be difficult to effectively score and update the ratings of BAF risks, because of their very nature they are often a composite of a number of lower-level risks: the risk rating score is therefore largely indicative at any point in time and any consideration of progress at the end of a year represents a direction of travel rather than an absolute score. However, the following observations can be made:

- Of the 15 risks on the BAF during the course of the year twelve didn't change their risk rating
- Two risks increased in score during the year (3.2 & 4.2).
- One risk decreased in score during the year (3.1)

- The following risks evolved to better reflect risk to delivery of our 2030 Strategy and challenging financial environment:
    - ‘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’ to ‘Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services’.
    - ‘Financial Environment’ to ‘Failure to meet financial targets, changing NHS regime and inability to meet the Trust’s ongoing capital commitments’.

8. Recommendation

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

Erica Saunders
Chief Corporate Affairs Officer

Inability to deliver safe and high quality services.	
Risk Number	Strategic Objectives
1.1	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

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

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

May 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. Reported to board bi-annually including update against NHS Impact Self-Assessment.
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 and reporting into SQAC as directed by the Chair. Clinical Cabinet in place to review all EQIAs
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, ward and departmental accreditation 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. Triangulation of data through Aggregated Analysis Reports to 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 derived from the Patient Experience Strategy 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. Chairs report to SQAC.
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
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. Emerging CQC 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. Increased oversight relating to the financial pressures resulting in inability to deliver 2030 Strategy.

Action	Description	May 2025	
		Due Date	Action Update
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	1. Continue to monitor KPI's at SQAC and within divisional governance structures (no further controls required, monitoring controls are in place)	31/03/2026	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.
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)	31/03/2026	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.	31/03/2026	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
4. Patient Experience	Experience Strategy Group established to evaluate resource required. SQAC will have oversight of ambition and achievements of the Group.	31/03/2026	
5. Delivery of 2030 Strategy	5. Revise EQIA process, establish a Clinical Cabinet. Oversight through SQAC, FTPC and Trust Board	31/03/2026	Clinical summits have been held which will prioritise the changes that will have the biggest impact.

Children and young people have timely and safe access to elective, urgent and follow up care.	
Risk Number	Strategic Objectives
1.2	Outstanding care and experience

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Responsive		Adam Bateman

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

Description

With a growth in demand for elective, urgent and follow-up care maintaining timely access to high quality care and meeting national access standard sis challenging. This is compounded by a tight financial environment and our NHS contract has limited scope for growth in income to fund additional capacity; productivity improvements are insufficient to meet demand and lower waiting times.. Our approach is centred on providing enhanced support to departments with significant demand or service issues, helping them to create centre of excellence; innovating; seizing productivity opportunities; and collaborating with providers and system partners to modernise and optimise our patient pathways and service models.

May 2025	
Control Description	Control Assurance Internal
Controls for waiting time in the Emergency Department (ED) includes: - Acute response Team and Patient Flow - Emergency Department staffing rotas, establishment and skill mix reviews support staffing levels to meet minimum safe standards and align to demand	Daily reports to NHS England - Daily situational reports and patient flow meetings Staffing reports reviewed ant staffing huddle meetings
- Safety huddles and patient handover huddles - A new Paediatric Assessment Unit and Urgent Care Centre - Winter Plan with flow and escalation procedures - Two transformation collaboratives driving service improvement: - i) Neighbourhood Care supporting prevention and more care in the community - i) Acute, Diagnostics and Urgent Care	-Daily Performance summary -monthly Performance report to Operational delivery group -Performance reports to FTP Board Sub-@Committee
Controls for delivering an improvement in referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Monthly access to care with General Managers from the divisions - Activity plans for 25/26 adjusted to achieve national access targets - Real time reporting of RTT waiting list and tracking tool which highlights patients that could breach monthly / quarterly targets - Transformation programme to re-imagine elective care services to create centres of excellence	- Weekly Performance Report to Executive Directors - The NHSE weekly waiting time submission is reviewed and signed off by the Head of Performance - RTT performance is included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board
- Controls for improving access to follow-up care: - Real time report on the follow-up waiting list, waiting times and risk categories - Patient Initiated Follow Up (PIFU) pathway and system initiated - Patient portal for ISLA Care supports waiting list validation and PIFU - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	Weekly Executive Summary - Follow up metrics included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board - Safe Waiting List Management Group Chaired by Patient Safety Lead

Gaps in Controls / Assurance

1. There is inadequate capacity in ENT and Paediatric Dentistry to have less than 1% of children and young people on the waiting list waiting over 52 weeks for treatment
2. In urgent care there are opportunities to further improve timeliness of care and experience through a Same Day Emergency Care Centre, expanded Paediatric Assessment Unit and virtual urgent care service.
3. To achieve a sustainable position in follow-up care, as measured by having no patients waiting 6 months beyond their target date, a more radical shift in follow- care pathways is required.

Action	Description	May 2025	
		Due Date	Action Update
Improve access to elective care	Our access target for 2025-26 is to achieve an RTT standard of 63% and to reduce the number of patients waiting less than 52 weeks to less than 1% of the total waiting list. Our high impact changes 1) Specialty level productivity improvement plans 2) A systematic approach to waiting list validation. Using an online portal we will make contact with patients on our non-admitted waiting list to confirm they still require treatment. 3) Benchmarking through GIRFT and CHA to deliver an increase in the number of cases per list 4) Targeted use of in-sourcing and waiting list initiatives to specialties with inadequate capacity to meet national waiting time standards 5) Improve clinic utilisation through better management and scheduling processes to enable clinics to have a planned utilisation of at least 100%>	31/03/2026	
Improve the timeliness and experience of urgent care	Our operational and transformational plan for urgent care includes the following high-impact changes: 1. Expanded Paediatrics Assessment Unit 2. Open Same Day Emergency Care Centre 3. Deploy Ambient Artificial Intelligence to improve productivity 4. Move to a self check in model for some patients, using a digital solution 5. Establish performance reports on the number of patients seen per clinician	31/03/2026	

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

CQC Domains	Linked Risks	Owner
Safe		Rachel Lea

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

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

May 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	May 2025	
		Due Date	Action Update
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	30/11/2024	Reports continue to be received from Project Co on the current status. These reports will continue until a permanent solution is agreed. I have extended the date range for completion. A board to board meeting was held on the 5th June where option where discussed with Exec reps.

Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.

Risk Number	Strategic Objectives
1.4	Outstanding care and experience

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

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

Description

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 18w. In addition, Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.

May 2025	
Control Description	Control Assurance Internal
Existing BI Dashboard developed to support management of open caseload	Open caseload dashboard routinely reviewed by clinical leads and assistant clinical leads with practitioners
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; 2) Challenges with visibility of clinical risk and safeguarding information via the electronic patient record (EPR) to enable services to safely manage clinical risk and need without workarounds;

Action	Description	May 2025	
		Due Date	Action Update
Administration training	Training needs analysis to be completed following issues identified w/c 24 Feb 2025 within admin teams issues with booking and scheduling of appointments, validation and closure of activity training needs analysis and training plan to be arranged in conjunction with clinical systems training team and validation team	31/05/2025	
Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	30/09/2025	
Meditech Expanse - Task and Finish Group	Task and finish group commenced to review EPR changes required following CQC inspection	31/05/2025	
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/05/2025	
Review of RTT performance trajectories and improvement plans for Liverpool and Sefton CAMHS	Performance trajectories and improvement plans to be produced and shared at Access to Care on a regular basis to track progress. Latest date for performance (Sefton) to be met end of September 2025. Liverpool's trajectory in progress - capacity and demand underway to be reviewed monthly as part of BAF Risk Review	30/09/2025	
ROMS collection and reporting	improve recording and reporting of routine outcome measures	30/06/2025	

Lack of visibility at Board level across the Gender Service	
Risk Number	Strategic Objectives
1.5	Outstanding care and experience

CQC Domains	Linked Risks	Owner
		Lisa Cooper

Risk Rating		
Actual	Target	Assurance Committee
4	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.

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

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

CQC Domains	Linked Risks	Owner
		Lisa Cooper

Risk Rating		
Actual	Target	Assurance Committee
16	4	

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.

May 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	May 2025	
		Due Date	Action Update
Risk 236 - Action 1	Engagement with suppliers to increase knowledge and seek support.	30/06/2025	Work with suppliers and feedback from local pharmacies and parents/carers appears to suggest that supplies are starting to come through more consistently in the past couple of weeks. This remains patchy but is showing signs of some improvement.
Risk 236 - Action 8 (carried over from Risk #70)	Daily reviews to take place to monitor progress against actions and monitor supply of relevant medications.	09/09/2025	medication shortage continues still reviewing this weekly(not on a daily basis) this is because all other stocks of ADHD medications are now at sufficient supplies within our area . 12 hour medications prep still unable to obtain supplies, Alder Hey ADHD CYP being moved over to different medications . Currently no end date
Risk 236 - Action 9 (carried over from Risk #70)	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative if necessary	08/07/2025	ongoing

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

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

Risk Rating		
Actual	Target	Assurance Committee
12	6	People Committee

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

May 2025	
Control Description	Control Assurance Internal
Monthly Ops Board monitoring	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
People Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Apprenticeship Strategy implemented	Annual update to PC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
PDR and appraisal process in place	Monthly reporting to Board and PC
Nursing Workforce Report	Reports to PC, SQAC and Board
Nurse Retention Lead	Bi-monthly reports to PC
Recruitment Strategy currently in development	progress to be reported PC
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files
Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030	

Gaps in Controls / Assurance
1. Not meeting compliance target in relation to some mandatory training topics 2. Sickness absence levels higher than target 3. Lack of workforce planning across the organisation 4. Lack of robust talent and succession planning 5. Lack of a robust Trust wide Recruitment Strategy 6. Lack of inclusive practices to increase diversity across the organisation

Action	Description	May 2025	
		Due Date	Action Update
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 and succession planning	The next stages of the People Plan and key deliverables for 24/25 were presented to Trust board on 6th June 2024 and the plan approved. The plan requires key strategic areas of focus, one of those three areas is the development plans for Future workforce. Succession and Talent management is a workstream that sits beneath this strategic initiative. HR, OD and Academy will work together to review skill mix, talent and succession planning, prioritising those areas were there is the most need over the next 12 months.	11/06/2024	
5. Lack of a robust Trust wide Recruitment Strategy	The next stage of the people Plan 24/25 there is a key work stream related to the Future Workforce, which addresses accessible and diversified recruitment and the Trust recruitment strategy. This action is addressed through the 24/25 People Plan.	31/03/2025	Action linked to Trust's People Plan and delivery will be dependent on resource within HR team being increased. A Business Case has been shared with Exec Team - outcome awaited.
6. Lack of inclusive practises to increase diversity across the organisation	A comprehensive EDI plan is in place, which is aligned to the NHS England high impact changes.	31/03/2025	

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	
Risk Number	Strategic Objectives
2.2	Support our People

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

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.

May 2025	
Control Description	Control Assurance Internal
The People Plan Implementation	Monthly Board reports Bi-monthyl reporting to PAWC
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on Trust Intranet and accessible for staff
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2023 Staff Survey Report - main report, divisional reports and team level reports
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Thriving Leadership Programme	Strategy implementation as part of the People Plan
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at People and Wellbeing Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC bi-monthly
Regular Schwartz Rounds in place	Steering Group established
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to PAWC
Alignment of staff safety and patient safety work via developing safety culture training and developing Restorative Just & Learning culture strategy	Patient Safety Board minutes
Monthly Thriving Teams MDT established comprising all corporate support functions who work with teams. Chaired by Associate Director of Organisational Development and enables shared thinking about teams in need of support and joint working where indicated.	

Gaps in Controls / Assurance
- lack of embedded safety culture across the organisation - lack of understanding about a just and restorative culture approach - lack of consistent compassionate leadership - Inconsistent application of Trust values and behavioural framework - insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas - insufficient OD resource available to fully address all culture tensions and challenges when they arise

Action	Description	May 2025	
		Due Date	Action Update
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards. Thriving Staff Index and Thriving Teams Index to be developed.	30/09/2025	Thriving Teams Index progressing with relevant team based metrics scoped with HR to complement data derived from Staff Survey. Next steps are to review the draft tool and determine next steps to include consultation with Divisional senior teams re usefulness and usability of the tool
OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/03/2025	Action parked in view of current financial situation. To be reinstated at a later date
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	15/09/2025	Second AEH workshop held with HR business partnering teams to agree working definition of AEH, work through case examples and agree next steps. Agreed process for debriefing following complex/distressing HR cases to be worked up into clear pathway. Next steps are to meet again to review actions and convene a third workshop to include staffside and FTSU. February AEH workshop cancelled and rearranged for April 30th 2025 Second AEH workshop to be help on 12th February with HR team with a view to a 3rd workshop to be held with HR and staffside to be coordinated by the Deputy CPO
Safety culture programme	Safety culture programme of work to be agreed and developed with the Patient Safety leads and Chief People Officer to reflect need for an integrated safety culture including both patient safety as staff safety as key to an adaptive safety culture. Safety culture training to be developed and implemented with teams as part of this wider programme to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors.	21/07/2025	Meeting with Patient Safety Lead to agree draft Safety Culture decision document and to review safety culture data from staff survey. Agreed he will arrange a meeting to discuss and agree with CMO/CNO/CPO. Safety Culture training proposal being recosted to be resubmitted for approval as a key part of the wider programme of work No further progress with this action. Proposal still with execs and resource to be agreed for the delivery of the training. Meeting held to look at integration of safety culture training and STAT programme running in theatres. Further meeting to be arranged by Patient Safety lead to be confirmed
Thriving Leaders framework	Thriving Leaders programme to include: Strong Foundations review and update to reflect wider culture work (including safety culture) and Vision 2030 & Clinical Leadership focussed review and development and Operational Leaders programme.NHSE Board level leadership competencies published with full appraisal process to follow in autumn 2024. All leader competencies to be developed based on same principles with reference to NHSE line manager competencies and other published leadership competencies.	30/09/2025	Clinical Leads work to be progressed in conjunction with Directors of People and Transformation to align next steps with overall transformation programme and workforce efficiencies. Initial meeting planned for 9th April to agree next steps and align work to broader leadership and management review.
Values and behavioural framework review, update and implementation	New values and behavioural framework to be developed and embedded across the organisation.	08/09/2025	First meeting of Values working group met on 29th April to agree membership for the group, scope of work, timescales and task and finish groups. Agreed to work towards launch of the new values in September 2025 with plans for immediate and medium term actions relating to values definition and behaviour framework and comms plan. New values (Compassion, Courage, Commitment, Community) agreed at Trust Board on 3rd April. Full implementation plan to be developed and Values working group to be established to progress this.

Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	
Risk Number	Strategic Objectives
2.3	Support our People

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

Risk Rating		
Actual	Target	Assurance Committee
12	4	People Committee

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

May 2025	
Control Description	Control Assurance Internal
Establishment of 4 x Staff Networks	All networks have appointed chairs, supported by Head of EDI. members of EDI Steering Group and report bi-monthly
Education and Training in EDI	Mandaotry EDI Training for all staff. current compl;iance above Trust target of 90%.
Head of EDI (0.6wte) in post. joint post with Clatterbridge Cancer Centre.	
Actions taken in response to Gender Pay Gap	
PAWC Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	bi-@monthly reporting to Board via PAWC on diversity and inclusion issues -@monthly Corporate report (including Workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PAWC
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	monitored through PAWC
People Policies	People Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	monthly recruitment reports provided by HR to divisions. -@Workforce Race Equality Standards. -@ bi-@monthly report to PAWC.
NHS England Improvement Plan supported by Trust Board, and associated actions into action plan	NHSE EDI Improvement Plan reported to Board
Actions taken in response to WDES	monthly recruitment reports provided by HR to divisions. -@ Workforce Disability Equality Standards. -@ bi-@monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 3 of delivery, continues to include a focus on inclusive leadership
EDI Steering Group established - Chaired by NED	Minutes reported into PAWC
actions taken in response to the Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to EDS22	Reported to People and Wellbeing Committee

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

Action	Description	May 2025	
		Due Date	Action Update
1. Multi-factoral issues spanning training and education	Education and training programme launched. Conversations underway to implement EDI training as mandatory. Training needs continue to be assessed and identify learning needs. New training has been developed to provide recruiting managers with training this will be launched in May	31/03/2025	
2. Sufficient EDI resources to support the EDI agenda	Business case for additional resource to be developed. Head of EDI to commence her role full time in the Trust from 1st May 2025	31/03/2025	
3. Cultural awareness and understanding	- Introduction of Staff Networks - develop and implement education and awareness programmes	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

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.

May 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	May 2025	
		Due Date	Action Update
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	30/11/2025	Meetings will continue with LCC until full legal agreement of transfer of Park to the Council.
Adoption of the SWALE by United Utilities	Engaged with planning consultants to assist with planning requirements.	09/05/2024	
Funding availability and potential market inflation	Continual monitoring of market inflation	30/04/2025	Regular updates continue to be provided to RABD and Trust Board as appropriate
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	30/04/2025	
Successful realisation of the moves plan	Establish timelines and plans for each project and associated moves: 1) Vacate 3SM & move staff to former police station and other (Summer 2024) 2) Vacate Histopathology and mover staff to alternative accommodation (Winter 2025)	28/02/2025	Initial plan created, now in delay. Re-work required, Date Entered : 11/04/2023 13:11 Entered By : David Powell
Weather conditions causing potential delays	Dry season now upon us – all works now in accordance with revised programme and on target.	30/11/2024	

Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment					
Risk Number			Strategic Objectives		
3.2			Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
Well-Led		Kate Warriner	16	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.

May 2025	
Control Description	Control Assurance Internal
Portfolio Board	Benefits tracker
Executive sponsor roles within the programme	
Transformational collaboratives with Divisional SROs	Programme assurance framework
Operational Plan incorporates Vision 2030 deliverables (2025/26)	Operational Plan
Executive Portfolios all incorporate elements of Vision 2030 delivery	
Reports to Board and FTPC	
Assurance and support mechanism framework for transformational collaboratives	

Gaps in Controls / Assurance
1. Shift of focus to meet demands 2. Failure to develop capacity for delivery 3. Failure to build capacity and skills within our workforce to deliver the 2030 Strategy 4. Failure to deprioritise to enable requisite focus on areas of need and transformational change 5. Risk of 'mission creep' associated to the Strategy

Action	Description	May 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
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Rachel Lea

Risk Rating		
Actual	Target	Assurance Committee
20	12	Finance, Transformation & Performance Committee

Description

Failure to deliver financial targets in particular the level of efficiency and cost reduction required.
Inability to invest in the capital programme due to constrained capital and cash allocation.
Detrimental impact due to system performance.

May 2025

Control Description	Control Assurance Internal
Organisation-wide financial annual plan.	- Specific Reports submitted monthly and annually as part of business plan process.(i.e annual plan reviewed by FT&P) - Monitored through IPR and the monthly financial report that is shared with FT&P and Trust Board.
Active engagement within ICB and NHSE.	- Attendance at system forums - Cascade of system and national information on a regular basis
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. -@ interactive financial dashboard
Capital Management 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. Oversight by FTPC through monthly updates at top 5 key risk
Divisional performance discussed at FT&P with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting through Operational Board and FT&P with divisional leads ('3 at the Top')
Financial Improvement Programme (FIP) in place to drive financial decision making whilst ensuring quality and safety impact is minimised subject to programme assessment and sub-committee performance management	FIP now in place with weekly strategic command meetings to approve financial decisions and drive cost reduction. Executive leadership through COO and CFO. Reported weekly through Exec Meeting and monthly through FTPC. All decisions will have a EIA/QIA approved before implementation
Financial performance escalation framework in place	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. Quarterly divisional performance at Ops Board and FTPC along with deep dive into any high-risk areas. Divisional Directors report on performance at Trust Board.
Transformation Programme & benefits realisation	Weekly meetings are in pace for the transformation collaboratives which includes benefits realisation and cost reduction and savings. Reported to FTPC as a top 5 key risk.

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations including a cap on growth and overall financial position of Trust.
2. Inequity of CYP in prioritisation in national funding .
3. Devolved specialised commissioning and uncertainty impact to specialist trusts
4. Current system spending is above fair share funding allocation
5. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
6. Funding models not aligned to 2030 creating a shortfall.
7. Deliverability of high risk recurrent CIP programme
8. Increasing inflationary pressures outside of AH control
9. Divisional budget positions are not achieved due to emerging cost pressures.
10. Challenged system financial position and additional controls to be followed by providers

Action	Description	May 2025	
		Due Date	Action Update
Changing financial regime	1. Close monitoring of financial directions from NHS England to ensure the Trust delivers its Plan 2. Working closely with the ICB	31/03/2026	
Delivery of 5 year capital programme	Risks around Capital Plan to be monitored closely. Capital management group established and regular reporting from capital leads. Reporitng into FTPC and Board. Capital remains a key risk on FTPC	31/03/2026	Capital plan submitted as part of 23/24 draft plan with some indicative allocations on areas whilst awaiting final plans. Re-profiling of spend in 23/24 has reduced the gap in year but further work required on 24/25 plans. D 23/24 Capital plan submitted in final plan. Due to changes in CDEL limits for the future years, further work is ongoing on the next 3 years including a review with each capital lead. This work will be complete and presented to executive team early June and reported back through FTP and TB once full risk is known.
Devolved specialist commissioning	Regular reporting to strategic execs and assurance to FTP and Trust Board Financial Analysis required to understand risk Financial analysis to be undertaken on impact of revision to allocations Regular exec to exec meetings with specialized commisisoning	31/03/2026	
High risk recurrent Efficiency programme	Transformation programme in place with weekly check ins on collaboratives reporting into the portfolio board and weekly execs. New reporting dashboards to be put in place reporting weekly to execs and into FTPC showing the latest CIP position with focus on recurrent schemes.	31/03/2026	
Inflationary pressures	7. Monitor closely impact of inflation increases working with HPL to obtain data on supplier increases and inflation avoidance through negotiations.	31/03/2025	
Shortfall against Long Term Financial Plan	LTFM produced to e shared with FTPC and Board and submitted to ICB. 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	30/09/2026	This work is now included as part of the optimisation work underway and originally expected Dec but due to issues outside of our control, now expected February. Annual planning and budget setting is due to be complete end of January and this will include a full bridge and detail of WTE/Activity and £ to inform the overall trust plan. Date Entered : 11/01/2023 10:49 Entered By : Rachel Lea Annual planning process complete and bridge completed by division. However further delays to the completion of the LTFM and the productivity work has resulted in this not being completed in the time-frame initially set. This will form part of the 2030 financial strategy to be completed in Q2.

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

CQC Domains	Linked Risks	Owner
Well-Led		Danielle Jones

Risk Rating		
Actual	Target	Assurance Committee
16	9	Trust Strategy Board

Description
Risk of inability to control execution of 2030 Vision due to system complexities, constantly evolving statutory and political and system environment. Impact of membership of a system that is in national financial recovery. Risk of failure to keep CYP prioritised in the wider NHS context and competing priorities, and therefore risk to delivery of Vision. Risk of constantly changing relationships and key personnel due to destabilisation of the commissioning environment.

May 2025	
Control Description	Control Assurance Internal
Membership of CMPC Provider Collaboratives - to ensure CYP voice high on agenda	Membership of CMPC provider collaboratives.
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	Beyond Programme recurrently funded by ICS - update funding confirmed for 25/26 March 25 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 and Strategy Board
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings. Feb 25 - System-wide CYP Neighbourhood engagement event with LCR and all key partners
Maintain effective relationships and continually build new ones with system 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
Continual reflection of the impact of delegation of specialist services into ICBs. Routine reflection of the risks / opportunities for CYP.	Children's Hospital Alliance proposals (under development). On current CHA agenda in March 25
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. Impact of delegation of Specialist Commissioned services into ICBs – increased challenges getting things done for specialised services
3. Executing the comprehensive Stakeholder Engagement Plan
4. National mandates, system finance and productivity challenges forcing us to prioritise unexpected programmes of work

Action	Description	May 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	31/03/2026	Ongoing influencing of Commissioning Plans - CYP strategic commissioning plan in development via CYP Committe with ICB - March 25
2. Future delegation of Specialist Commissioned services into ICSs	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2026	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	31/03/2026	Horizon and policy scanning ongoing- presentation at Dec 24 Trust Board, and within monthly Board 'CYP System' item Jan/Feb/Mar 25
3. 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+	31/03/2026	Holistic stakeholder management plan in development. Connection strategic partnerships and opportunities agenda.

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

CQC Domains	Linked Risks	Owner
Well-Led		John Chester

Risk Rating		
Actual	Target	Assurance Committee
9	6	Futures Committee

Description
Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships – which would delay new discoveries. Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities. Risk of exposure to ethical challenges and national and international reputational risks.

May 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	May 2025	
		Due Date	Action Update
3a. Financial Model	Case for internal and multi-sector inward investment. Plans underway through £10m club to secure external funds for internal investment to grow through Futures. Futures bid coordinator started in post in July.	30/06/2024	IZ award supported by Futures Committee and Trust Board - awaiting final sign off of agreement with LCR Combined Authority
4. Capacity and capability	Greater engagement with and education of R&I communities Futures people pillar established, Futures programme Board to commenced in May 2024. New infrastructure being established followjbg approval of business case in August	31/03/2025	Comms post interviews delayed until end of April due to large number of applications
5. Comms Strategy for Futures	Engagement and support of Exec colleagues for evolving Strategy. New post agreed (CRD funded) to support marketing and comms for Futures - est start date Sept 24	31/03/2025	Interviews delayed until late April due to large number of applications

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

May 2025	
Control Description	Control Assurance Internal
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
Regular update to Trust Board on digital developments, Monthly update to FTP	Board agendas, reports and minutes
Digital Centre of Excellence in place & fully resourced - Chaired by Trust CCIO	Digital Centre of Excellence 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 refresh underway to reflect changing environment. Digital Data and Insights key components of Vision 2030 and associated governance and plans	Digital Centre of Excellence. Relationship with Futures. Digital and Data Collaborative established.
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.
Digital Data and AI Collaborative Established as part of transformation programme	Multidisciplinary leadership roles identified. Delivery programme in place.
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
6. Capital investment anticipated lower than required
7. Optimizing user experience of digital systems review

Action	Description	May 2025	
		Due Date	Action Update
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	29/08/2025	
Cyber Assurance Framework & Strategic review of Cyber Security	This has replaced the action around Cyber Essentials +.	31/07/2025	
Digital systems review		31/03/2026	
Experienced Resources	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce	30/06/2025	
Investment plan for programme and business as ususal resource		31/03/2026	

BOARD OF DIRECTORS

Thursday, 5th June 2025

Paper Title:	**Board of Directors – Annual Fit and Proper Persons Checks**
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	NHS England FPPT Framework
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:	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
BAF 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
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Alder Hey Children's NHS Foundation Trust

Fit and Proper Persons Test – Assurance Report

1. Executive Summary

The purpose of this report is to provide assurance that an annual check has been undertaken for the Board of Directors to confirm their continuing compliance with the 'Fit and Proper Persons' requirements.

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test' (FPPT).

2. Current State

The new NHS England FPPT Framework was published in 2023/24 and this has been adopted fully in the Trust's FPPT Policy, with enhanced DBS checks being completed for all Board of Directors every 3 years, as part of this process. The Trust's Fit and Proper Persons Policy specifies the scope of the staff who are included as:

"All Board Directors – Executive and Non-Executive; (voting and non-voting) attendees of the Board and Governors. It applies to all permanent, acting and interim Board level positions".

The results of these checks are shown in the attached table and the Board of Directors can be assured that no areas of concern have been identified.

In February 2025, the Board of Directors completed the Fit and Proper Persons Test Self Declaration Form and confirmed their compliance with each of the following statements:

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
    - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
    - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
    - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

In addition, and in accordance with the new Guidance, organisations are required to undertake the following additional checks annually for each Board Member:

- Social Media Check
- Disqualified Directors & Removed Trustees Check
- Individual Insolvency Register
- UK Civil Litigation
- Professional Registration

The Trust engaged the services of Gatenby Sanderson and Neotas - specialists in undertaking these checks to provide external assurance to the Board. The Trust received the outcome of these checks on 4th March 2025 confirming no adverse findings and professional registrations all up to date where applicable. Individual Directors' records have been updated on ESR.

The new Guidance also looks at preventing unsuitable staff from being redeployed or re-employed in NHS, ICBs, and independent healthcare and adult social care sectors. Board Member references therefore need to be completed when a Board Member leaves the organisation irrespective of whether a reference has been requested by a future employer. These have been completed as required and kept locally on file.

3. Conclusion

The Chair reviewed the signed declarations (SID for the Chair) and determined that all Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test. The required information was submitted to NHS England on 14th May 2025 in accordance with the updated guidance.

Board Member		**Date FPP Self-Declaration Signed**	**Chair sign-off**
Jo Williams	Chair	19/02	20/02 (SID)
John Grinnell	Chief Executive	19/02	11/03
Adam Bateman	Chief Operating Officer/Deputy Chief Executive	28/02	11/03
Alfie Bass	Chief Medical Officer	20/02	11/03
Benedetta Pettorini	Director of Surgery	26/02	11/03
Dani Jones	Chief Strategy & Partnerships Officer	26/02	11/03
Erica Saunders	Chief Corporate Affairs Officer	20/02	11/03
Fiona Beveridge	Non-Executive Director	19/02	11/03
Garth Dallas	Non-Executive Director	26/02	11/03
Gerald Meehan	Non-Executive Director	25/02	11/03
Jo Revill	Non-Executive Director	25/02	11/03
John Chester	Chief Scientific Officer	27/02	11/03

John Kelly	Non-Executive Director	19/02	11/03
Kate Warriner	Chief & Digital Information Officer	20/02	11/03
Kerry Byrne	Non-Executive Director	20/02	11/03
Lisa Cooper	Director of Community & Mental Health Division	19/02	11/03
Melissa Swindell	Chief People Officer	27/02	11/03
Nathan Askew	Chief Nursing Officer	20/02	11/03
Rachel Lea	Interim CFO	24/02	11/03
Shalni Arora	Non-Executive Director	20/02	11/03
Urmi Das	Director of Medicine	25/02	11/03

4. Recommendation

The Board is asked to note the content of this paper and record that the Fit and Proper Persons Test has been conducted for the period 2024/25 and all Board members satisfy the requirements.

Board Members are also asked to acknowledge their ongoing duty to inform the Chair should circumstances change, and you can no longer comply with the Fit and Proper Person Test, as described above.

Erica Saunders
Chief Corporate Affairs Officer