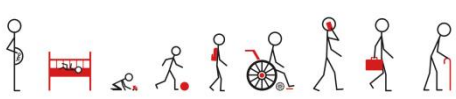
NW CHD ODN Board Meeting
Summary Notes
11th August 2025

Chair: Carolyn Cowperthwaite



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Item 1 – Welcome, Introductions & Apologies

Present:

Abby Prendergast (AP)	Associate Director of Strategy and Partnerships	Alder Hey Children's Hospital NHS Foundation Trust
Attilio Lotto (AL) ***(Attending for Ram Dhannapuneni)***	Consultant Congenital Cardiac Surgeon	Alder Hey Children's Hospital
Caroline Jones (CJ)	Clinical Lead & Consultant Fetal & Paediatric Cardiologist / Joint Clinical Director NW CHD ODN	Alder Hey Children's Hospital NHS FT
Carolyn Cowperthwaite (CC)	Chair – NW CHD Board	NW CHD Network
Chrissy Pope (CP) ***(Attending for Chloe Lee)***	Interim General Manager – Division of Surgery	Alder Hey Children's Hospital NHS FT
Christopher Dewhurst (CH)	Consultant Neonatologist and Deputy Medical Director	Liverpool Women's NHS FT
Damien Cullington (DC)	Consultant Adult Congenital Cardiologist / ACHD Clinical Lead / Joint Clinical Director NW CHD ODN	Liverpool Heart & Chest Hospital NHS FT
Gemma Ingham (GI) ***Guest***	Programme Manager, Division of Surgery	Alder Hey Children's Hospital
Helen Chadwick (HC)	Service Specialist (Specialised Commissioning Team	NHS England & NHS Improvement
Janet Rathburn (JR)	PPV Representative	NW CHD Network
Jill Moran (JM)	Network Support Officer	NW CHD Network
Joe Downie (JD)	Director of Operations	Liverpool Women's Hospital
John Brennan (JB)	Deputy Chief Medical Officer	Liverpool University Hospitals NHS FT
Jonathan Mathews (JMa)	Chief Operating Officer	Liverpool Heart & Chest Hospitals NHS FT
Josh Bainbridge (JBa) ***(Attending for Rachael Barber)***	Divisional Director, Division of Medicine	Manchester University NHS FT - Royal Manchester Children's Hospital
Kyrstie Crompton (KC)	PPV Representative	NW CHD Network
Linda Griffiths (LG)	Lead Nurse	NW CHD Network
Manoj Kuduvalli (MK)	Divisional Medical Director for Surgery/Consultant Cardiac & Aortic Surgeon	Liverpool Heart & Chest Hospital NHS FT
Nicola Marpole (NM)	Network Manager	NW CHD Network
Paulo Santos Eden (PSE)	Paediatric Cardiologist Consultant & Clinical Lead	Manchester University NHS FT
Susan Kedward (SW) ***(Attending for Emma King & Amy Lewis)***	Commissioning Manager, Cardiac Team	NHS Wales – Joint Commissioning Committee (JCC)

Apologies:

Alfie Bass (AB)	Medical Director	Alder Hey Children's Hospital NHS FT
Amy Lewis (AMe)	Senior Planning Manager - Paediatrics	NHS Wales – Joint Commissioning Committee (JCC)
Andrea Myerscough (AM)	Director of Operations	Manchester University NHS FT
Beth Weston (BW)	Chief Operating Officer	Liverpool University Hospitals NHS FT
Chloe Lee (CL)	Associate Chief Operating Officer	Alder Hey Children's Hospital NHS FT
Cordelia Lieb-Corkish (CL-C)	Operational Manager	Alder Hey Children's Hospital
Emma King (EK)	Senior Planning Manager - Adults	NHS Wales – Joint Commissioning Committee (JCC)
Harriet Riggs (HR)	Co-Chair PECs Group & Consultant Paediatric Consultant	Northern Care Alliance - Oldham
Michelle McLaren (MMc)	Lead Nurse	NW CHD Network
Rachael Barber (RB)	Consultant Paediatric Intensivist/Deputy Medical Director/RMCH Paediatric Clinical Lead	Manchester University NHS FT
Ram Dhannapuneni (RD)	Consultant Cardiac Surgeon	Alder Hey Children's Hospital NHS FT
Sameer Misra (SM)	PECS Joint Chair & Director of Medical Education Consultant Paediatrician and Lead for Cardiology	Bolton NHS FT
Yahya Najjar (YN)	Consultant Cardiologist & Clinical Head of Cardiac Services	Manchester University NHS FT

Declarations of Interest: None

Welcome & Introductions

Carolyn opened the meeting and welcomed everyone, including guests attending on behalf of board members.

Action Tracker

- **Current pathway for paediatric and adult CHD patients Aberystwyth is not clear.**

  Update: Sue Kedward, attending on behalf of Emma King and Amy Lewis, will pick up this action as a matter of urgency.

- **National network funding**

  Update: NM to invite Marion Eaves, title, NHSE to the November board meeting to update this on topic and a national update.

- **Database sharing agreement**
  Update: will be discussed at item 3 of the agenda.

Item 2 – Patient Story

Janet Rathburn, Chair of the Patient & Public Voice (PPV) Group

JR shared a positive account on behalf of Jan Tate, a CHD patient and member of the PPV group. The patient's observations and suggestions regarding their experience and potential opportunities to improve the service will be shared with providers and considered appropriately.

Damien Cullington (DC) commented the team already provides patient contact details, including a helpline number and PAS email, on all correspondence. However, GPs are increasingly contacting individual clinicians directly for advice, which improves communication but increases administrative workload to redirect enquiries. While this aspect of patient management is well covered, Liverpool lacks a system similar to the Manchester's HIVE system, which allows direct messaging with patients via a mobile app and would be highly useful.

Liverpool is unlikely to adopt a new patient communication system soon. While reminders and easier booking systems would be beneficial, current NHS capacity and funding limits make this unrealistic. The upcoming database should help with tracking patients and reducing lost to follow-up, but overall, maintaining patient contact remains a challenge.

Linda Griffiths (LG) commented the helpline is excellent but mainly known to patients under the congenital heart team. Some congenital heart patients who do not see a specialist are unaware it exists or how to access it, highlighting a need for better network-wide communication about its availability.

ACTION: Network to develop a plan to raise awareness of the helpline.

Item 3 – Network Update/Finance

Nicola Marpole, Network Manager, NW CHD Network

Proposed Improvements to Back-log and Waiting List Data

The network is revising how regional backlog data is presented to make reports clearer and more actionable. Proposed changes include:

- A **summary dashboard** for each trust with key metrics (e.g., referrals, wait times, DNAs, backlogs) tailored to that provider.
- A **colour-coded RAG rating system** (green - stability, red – significant change and amber – starting to see shift or developing trend) with agreed thresholds for significant changes.
- A **bullet-point summary** of notable quarterly or yearly changes, highlighting growth, improvements, or pressures.
- Retention of the **full dataset** for deeper analysis when needed.
- Refinement of inpatient data and expansion of metrics once the new database is live will allow near-live monthly updates.

The aim is to make reporting more focused, responsive, and useful, with the new format planned for the November board meeting and feedback to follow.

Financial and Operational Pressures

- The network has not yet received confirmation of its 2025–26 budget allocation, creating planning difficulties.
- Early indications suggest a possible shortfall. Work is underway with Alder Hey to calculate the required budget, factoring in inflation, pay uplifts, and increments. If a gap is confirmed, a paper will be submitted to NHS England outlining the deficit, its impact on core costs (e.g., salaries, training, website maintenance), and potential risks to delivering the work plan. The board will be kept updated and may be asked to support further action.

PPV Update

- PPV representatives contacted local MPs to raise concerns about possible regional variation in CHD services and requested supporting data from NHS England. Following correspondence with Southport MP Patrick Hurley, a response from NHS England and the Department of Health and Social Care was received and shared with the group, who are reviewing it before deciding next steps. NHS England has asked to be informed of any future related correspondence, a request the PPV group largely supports for transparency and constructive relationships. The matter will be discussed at the September PPV meeting, with the network offering ongoing support and keeping leadership informed to ensure the patient voice remains central.

On-going Work

Transition Pathway Mapping (2025–26 Work Plan)

- Scoping will soon begin with Level 1 and 2 centres to map current paediatric-to-adult CHD transition models and identify any areas for improvement.

Level 3 Service Review

- First meeting held to define the scope and structure of a regional review of Level 3 paediatric cardiology services.
- An initial survey will capture a consistent picture of current provision, assess equity of access, and identify opportunities to strengthen local care. Further updates at the November board

Health Inequalities & Quality Improvement

- NHS England will peer review Level 1 centres starting in October 2025; details for Level 2 centres are still unclear.
- Fetal cardiology self-assessment reports for Liverpool Women's are finalised; St Mary's is being finalised. Findings and actions from both will be presented at the November meeting.
- Level 3 centres will be identified for self-assessment alongside the broader Level 3 review.

Single Paediatric Service

- Joint response from RMCH, Alder Hey, and the network has been sent to NHS England; a paper is being prepared for the regional leadership team.

CHD National Networks Annual Meeting

- The North West Network will host the meeting in Liverpool, likely in February 2026.
- The event will start national work to review and update CHD standards (first published in 2016) to reflect modern clinical practice and patient needs.

Regional CHD Database Project

- User testing is progressing; the database will support service planning, improve patient care, and could become a commercially viable product for other networks or specialties.
- Liverpool Heart and Chest Hospital has completed development work and data integration is underway — a major milestone.
- Delays at Alder Hey and MFT are limiting full system testing; NHS England requires demonstrable progress by October.
- **Risk:** If sufficient progress is not shown, NHS England could withdraw support.
  Request to board: for Alder Hey and MFT representatives to confirm organisational support, escalate local barriers, confirm internal project status, and provide timelines for data submission to maintain momentum.

Caroline Jones (CJ) confirmed support for the database project from Alder Hey and agreed to discuss it with Chloe Lee and their IT department to ensure it is prioritised, given the tight deadlines for completion and sustainability. CJ will take the matter back to her team to secure it on their priority list, with NM requesting an official response from the trust by a set deadline to keep progress moving.

Josh Bainbridge confirmed MFT's continued support for the database project, noting the delay is due to information governance capacity rather than lack of willingness. JB will follow up with the relevant colleagues while the clinical group medical director is on leave and committed to providing at least a holding response within a week to help move the process forward.

ACTION: CJ to prioritise discussions with IT department and colleagues to support the database requests from Alder Hey. JB will follow up with relevant colleagues at Manchester.

Item 4 – Network Education & Study Days

Linda Griffiths, Lead Nurse, NW CHD Network on behalf of Michelle McLaren, Lead Nurse, Education, NW CHD Network

Document Development

- Michelle McLaren has been leading the development of the network's training and education strategy, which is expected to be approved at the board meeting alongside the training plan for the 2025–26 financial year which has also been circulated for review.

Events hosted since May board meeting

- **May:** Webinar on the Little Hearts at Home app, focusing on keeping single-ventricle patients safe at home.
- **June:** Regional study day on learning disabilities, co-produced with Mencap, the Learning Disability Forum, and others, incorporating drama-based learning.
- **July:** Tetrology of Fallot study day for nurses and allied health professionals, with excellent feedback and attendance.
- Ongoing rolling training programme for sonographers in partnership with Tiny Tickers and the fetal cardiac team, most recently held on June 14.

Future plans

- Planning underway for joint event with the NW Neonatal Network in March 2026 to focus on neonatal cardiac issues – antenatal diagnosis, perinatal management, PDA, Neonatal echo and rhythm issues. This will be a chargeable event and target audience will include PECs, neonatologists, cardiologists, ANPs, cardiac physiologists and registrars.
- Webinars for paediatric cardiac and ACHD emergencies to target Primary Care and EDs.
- The network remains very active in delivering and supporting a wide range of training events, from weekly sessions to annual ACHD Masters modules.

Discussion centred on the concern that the budget constraints could significantly reduce the delivery of training, potentially cutting half of the current programme. Without sufficient funds, external in-person talks may not be possible, limiting engagement and discussion compared to face-to-face events. The leadership team has considered seeking soft funding or sponsorship, but obtaining such support is increasingly difficult.

Education is a core function of the network and securing funding is essential to maintain these commitments.

Item 5 - Patient Representatives

Janet Rathburn, Chair, and Kyrstie Crompton, member, PPV Group

PPV Promotional Video

- The group has been busy promoting a video launched during British Heart Week, which has received positive attention locally and nationally, including interviews and social media engagement. The video has been widely viewed by professionals and is being used as a resource for parents of newly diagnosed babies. Efforts are underway to extend its use in schools, with assemblies already incorporating the video.

MP Letters

- The group has also engaged with MPs to raise concerns about funding and perceived inequalities in CHD services. Following the response from NHSE the PPV group plans to consider next steps collectively while keeping the board informed.

Face-to-Face Meeting

- The annual face-to-face meeting on September 6 will focus on reviewing and developing the group's work plan, with an emphasis on sustainability, development, and attracting new representatives. Caroline Jones and Damien Cullington will participate in a Q&A session at the meeting. Planning has also begun for a Patient Information Day later in the year.

Informal Zoom sessions

- Sessions continue to provide valuable opportunities for engagement, though the group aims to increase family participation.

"Stroll in the park" event

- Scheduled for Saturday August 31- this will allow PPV representatives and their families to meet members of the Learning Disability Forum for informal support. PPV group member, Heather Lawson has been actively supporting the needs of patients with CHD and learning difficulties.

St Bart's PPV Group

- The NW PPV group has also assisted the lead nurse at St Barts in establishing a local PPV group. Three new representatives are expected to join at the October meeting, further enhancing family representation.

Recent meetings

- Presentations to the group have included updates on health professional training from Michelle McLaren, as well as insights into paediatric dental care challenges from Helen Walker and Dr. Lauren Crowder. The presentations highlighted difficulties in accessing dental care for children requiring procedures and the issue of limited clinic space. The group acknowledged the contribution of professionals giving their time and expertise.

The PPV group continues to contribute to the network newsletter, including sharing patient stories. Despite a break from meetings in August, the group remains active behind the scenes and looks forward to further engagement and collaboration at upcoming events. JR concluded by thanking Linda Griffiths and Nicola Marpole for their essential ongoing support.

DC requested for JR to share Mr Hurley's government response with SLT. JR agreed to get permission from the PPV group members to share it. DC also highlighted the need for government support to improve dental services for both children and adults, noting that previous strategies have stalled.

NM commented that the Welsh Government has recently launched an initiative to reform dental services and issued a public consultation, to which the Network has responded.

Item 6 – Alder Hey Cardiac Transformation Programme

Gemma Ingham, Programme Manager, Division of Surgery, Alder Hey

Overview of First Year and Plans for Year 2 in Cardiology Centre of Excellence Strategy

Focus and Prioritisation

- Cardiology has been identified as the first priority area for the Centre of Excellence strategy.
- The aim is to align resources with key strategic areas, increasing visibility and support across the trust.
- Efforts focus on identifying quick wins and setting achievable targets for Year 1, while planning for Year 2 and 3.

Governance and Engagement (Q1)

- Establishment of a formal steering group.
- Clinical and stakeholder workshops conducted to map current services, identify gaps, and assess pressure points.
- Success: Increased engagement and alignment with the wider trust strategy.

Quick Wins and Operational Improvements

- Secured a dedicated handover room to improve daily operations.
- Pilots for flexible use of clinic rooms introduced to improve autonomy and efficiency.
- Launch of Team Information Bulletin to share updates, successes, and avoid duplication across services.

Service Enhancements and Initiatives

- Review of the “consultant of the week” model to optimise capacity and clinic schedules.
- Exploring a router solution to improve service efficiency.
- Transition pathway for patients moving from paediatric to adult services is being scoped.
- Partnership with the Youth Forum to gain patient feedback and co-develop solutions.

Data and Resources

- Mapping of equipment, digital systems, and process gaps.
- Planning bids to the British Heart Foundation and internal funding for equipment and innovative solutions (including AI).

Year 1 Priorities

- Refine transition processes and reduce inappropriate 17+ patient caseloads.
- Implement room usage and booking agreements for team flexibility.
- Optimize consultant time through new pathways (e.g., GP referrals for ECGs).
- Prepare for British Heart Foundation innovation funding opportunities.

Year 2 and 3 Goals

- Expand remote monitoring and community-based care for patients.
- Develop mutual aid arrangements with regional partners.
- Share successful initiatives across the trust.
- Address workforce gaps and plan for sustainable service growth.

Overall Summary

The first year focused on establishing governance, engaging stakeholders, identifying quick wins, and scoping improvements for cardiology services. The plan for the next two years emphasises scaling innovations, optimising workforce, enhancing patient pathways, and leveraging funding opportunities to strengthen the Centre of Excellence.

LG praised the plans and highlighted the importance of transition as part of quality improvement. The network already has an established cardiac transition pathway (recently updated in 2024) and suggested that local improvements should be co-ordinated with the network to ensure alignment and consistency. GI agreed to link their work with the wider network.

CC agreed it would be beneficial for the board to receive an update on the project next year.

Item 7 - Regional Updates including Data

Caroline Jones, Clinical Lead & Consultant Fetal & Paediatric Cardiologist Paediatrics - Alder Hey Children's Hospital

Waiting Lists – Surgery & Intervention

- Overall, the lists for surgery and interventions are in a healthy state, though the surgical waiting list is slightly longer than preferred. Compared to other level 1 centres nationally, their position is relatively strong.
- Intervention wait list has improved significantly, largely due to the addition of a third interventionist who is now handling more complex cases, demonstrating a positive impact on reducing waiting times.
- The electrophysiology (EP) waiting list remains a challenge. Currently, there is only one consultant handling EP cases, which has caused the list to grow. Need to consider additional resources, potentially through a business case for extra lab time, to manage and reduce the EP waiting list effectively.

Surgical Wait Times & Cancellations

- The initial transformation work has successfully reduced new patient waiting times to four weeks, largely due to ANP-led clinics.
- Upcoming plans include adjusting clinic templates to convert some new patient slots into follow-up appointments to tackle the persistent follow-up backlog.
- A key strategy is shifting lower-risk, lower-intensity cases to allied health professional–led clinics, with follow-up backlog management being a major focus over the next year.

Overall DNA rate (%) & New Patients per month

- DNA rates remain stable, and referrals are steady at around 300 per month with no significant changes.

New Patient Backlog

- The initial transformation work has reduced new patient waiting times to four weeks, thanks to ANP-led clinics.
- Clinic templates will soon be adjusted to convert some new patient slots into follow-up appointments to address the persistent follow-up backlog.
- A key strategy is moving lower-risk, lower-intensity cases to allied health professional–led clinics, with follow-up backlog management being a major focus over the next year.

Transition Services

- The team is reviewing transition services for patients over 17, but data issues in the NHS have made it difficult to identify the actual patients needing care.
- Many listed patients may not require CHD services, sometimes needing direct referral to adult cardiology instead.
- Clinics are running smoothly, and while the current system provides excellent care, there's recognition it could be more streamlined and tailored.
- The goal is to offer a consistent transition service across Level 1, 2, and 3 centres, with ongoing engagement from all stakeholders.

Paulo Eden Santos, Paediatric Cardiologist Consultant & Clinical Lead, Royal Manchester Children's Hospital, Manchester University NHS FT

New Patients/Follow-Up Backlogs

- Patient backlog has fluctuated, peaking in June 2023, dropping sharply by September, and rising again to around 613 in June this year.
- Follow-up appointment backlog peaked at 1,322 in April last year, fell to 822 by January, and has since risen to 917 in June.
- Overall, backlogs are more stable, but seasonal peaks continue to create periods of higher demand and system pressure.

DNAs

- DNA (Did Not Attend) rates have improved from 16% in September last year to 6% in January, though they remain variable and more consistent improvement is still needed. When families are not contacted before booking, rates tend to stay between 8–11% with no clear downward trend.
- New referral volumes remain steady at around 200–250 per month, with peaks of 275 in April and 267 in June, indicating sustained demand. This means backlog reduction must rely on process efficiencies rather than fewer new cases. Positively, no patients are waiting over 52 weeks, though many still wait over three months, which needs continued focus.

Transition

- Transition pathway data shows considerable month-to-month variation, with around 11–12 patients moving each month.
- While the patient backlog has improved from its peak, it has started to rise again this year.
- Follow-up backlog reductions have plateaued, and DNA rates remain a challenge.
- Efforts to stabilize the transition pathway will align with network guidelines to reduce large fluctuations.

Summary:
The board discussed the backlog and DNA rates from a risk perspective, focusing on patient safety and service sustainability. Key points:

- There is a persistent capacity versus demand gap in paediatric cardiology in Manchester, with around 250 new referrals per month.
- Current consultant numbers (7 permanent, 3–4 temporary) are insufficient, leaving the service short by at least two consultants. Recruitment is slow due to limited availability of qualified staff.
- Backlog reductions have been achieved temporarily through additional work by existing staff, but these are not sustainable long-term. Follow-up backlogs have stabilised.
- Risk is formally recognised at high levels: paediatric cardiology is one of the highest-scoring risks in the clinical group and is reported to the hospital and MFT executives.
- Mitigation strategies include incremental workforce growth, improving junior doctor capacity, middle-grade staff seeing patients independently, and better stratification of waiting lists based on patient risk.
- Ongoing improvement programs are in place to validate backlogs, optimise follow-ups, and provide oversight, giving the board assurance about risk management while acknowledging ongoing challenges.

This emphasises both the pressures on the service and the structured approach to managing risk and improving capacity.

Damien Cullington, Consultant Adult Congenital Cardiologist / ACHD Clinical Lead / Joint Clinical Director NW CHD ODN, Liverpool Heart & Chest Hospital NHS FT

Intervention & EP Surgery

- The EP list shows no backlog issues, but surgical and interventional patient backlogs are evolving. Efforts are underway to address these, including discussions about creating a new aortic surgeon role with a training component to support simpler ACHD procedures over the next few years.
- Surgical capacity is limited not by the number of surgeons (4 in total) or operating days (2 per week), but by the current service agreement, which provides only 42 weeks of activity compared to a potential 52-week model. Extra operating lists are being added to increase throughput.
- For interventional patients, efficiency and organisational improvements are being implemented, and while the waiting list has stabilised at a higher level than desired, upcoming changes aim to achieve a more consistent reduction.

Interventional and Surgical Waits

- For new patients, very few are overdue for appointments, and none are overdue by more than 12 months.
- For follow-ups, 767 patients are overdue, mostly in the 3–6 month and 6+ month categories.
- These numbers have remained fairly static since September last year.
- Incremental improvements are expected over time with the introduction of weekly nurse led clinics at LHCH, but significant changes will only become evident over several years.

DNA Rates

- DNA rates remain fairly static and are close to the national average.
- New patient referrals fluctuate between 100 and 150 per month.

Blackpool Teaching Hospitals NHS FT

New Patients/Follow-Up Patients

- Blackpool continues to face backlog challenges for new patients and follow-ups, which are flagged on the risk register.
- Only 12 full-day clinics are delivered per year, and additional capacity is limited due to space and staffing constraints.
- Some patients are being redirected to nurse led clinics to help free up consultant time.
- Long waits are not always due to appointment availability—some result from patients not engaging with the service despite repeated efforts.
- A significant portion of follow-up patients are overdue by more than 12 months, partly for the same reason.

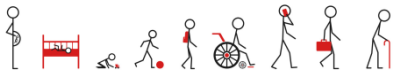
DNA/New Patient Referrals

- DNA rates in Blackpool have improved significantly, driven by patient messaging and proactive administrative follow-up. While progress has been made, further improvements are expected gradually over the next 6 to 12 months.

Manchester Royal Infirmary

New Patients/Follow-Up Patients

- Manchester Royal has seen significant improvements in new patient wait times due to increased consultant presence, changes in clinic delivery, and the introduction of nurse-led clinics for simple congenital heart lesions.
- Despite this, about 500 patients remain on the backlog, which has stayed static. Nurse led clinics are expected to help reduce this.
- Current data does not fully capture patient complexity, making it important to identify those with complex conditions who are over 12 months overdue, as they require more urgent attention.



Item 8 – Paediatric Cardiology Single Service

Caroline Jones, Clinical Lead & Consultant Fetal & Paediatric Cardiologist Paediatrics - Alder Hey Children's Hospital

CJ had nothing to report and asked if HC could provide any update from NHSE perspective.

Item 9 – Commissioner Update

Helen Chadwick, Service Specialist for Internal Medicine Programme of Care (Specialised Commissioning), NHS England – Northwest

HC responded to the Paediatric Cardiology Single Service update:

- From a commissioner perspective, feedback will be provided to the three Integrated Care Boards. The team is integrating data linked with the CHD database and risk engagement for a single-service view. The database progress report submitted in April was well-received, with benefits such as helping track patient follow-ups and overdue appointments being recognised. Workforce challenges and service struggles, especially in Manchester, are now clearer. Ongoing updates for the database are expected in October, alongside network self-assessments and assurance reports, to support planning and oversight.

Other NHSE Update

- The CHD environment is busy, with multiple internal and national developments ongoing.
- NHS England is being dissolved, and responsibilities are moving to Integrated Care Boards, but timelines have shifted, now expected around April 2027.
- Despite this, the network remains operational with its budget unchanged.
- Discussions about future regional structures and the "shift left" agenda are ongoing, but the situation is fluid.
- The focus currently is on producing a paper to support recent data and inform planning amid financial pressures and scrutiny on spending.

Abby Prendergast (AP) expressed thanks for the ongoing support of the CHD ODN and acknowledged the challenging circumstances in the commissioning environment. AP thanked Helen personally, highlighting her support and sought clarification on the paediatric single case, specifically regarding the recommendations going to the SLT and whether they are in support of the case or are more for discussion?

HC responded commissioners are reviewing the CHD service against its original vision, investment, and current priorities. Key points include:

- Workforce is a major focus, with Liverpool showing growth and productivity despite pressures, while Manchester is slightly behind.
- Data limitations make full analysis difficult, but inequities between regions are evident.
- Outputs are commendable given workforce challenges, but sustainability and deficits are concerns.
- The analysis will feed into broader reviews by public health, finance, and quality teams to guide decisions on next steps and potential investments.
- The aim is to assess pressures, validate the initial business case, and inform discussions across leadership and specialised commissioning groups.

Overall, the situation highlights operational pressures, regional inequities, and the need for careful, evidence-based planning before making final recommendations.

The discussion focuses on improving efficiency in handling a complex case before it goes to the Senior Leadership Team (SLT). Key points:

- Responses from providers and commissioners currently take 3–4 months due to the case's complexity.
- AP and JB offered to have medical directors or chief executives present at SLT meetings to address questions directly, preventing delays from back-and-forth communications.
- Helen agreed this approach is helpful and emphasized the need to clarify the decision-making route (e.g., Northwest Committee vs SLT) to plan timing and attendance.
- The process so far has been a thorough analytical exercise, considering business cases, network data, risk assessment, quality, and activity.
- Collaborative involvement is encouraged to streamline communication and decision-making.

In essence, the focus is on collaboration and proactive engagement to reduce delays and improve clarity in decision-making.

Item 10 – Provider Risk Register Update

Linda Griffiths, Lead Nurse, NW CHD Network

LG's presentation outlined the current challenges and proposed changes to risk reporting within the network:

Background

- Since 2019, risks were reported by the network itself, but from 2024, providers were tasked with reporting their own risks quarterly, focusing on scores of 12 and above.

Current Issues

- Engagement from providers has declined; written reports are inconsistent or missing.
- Verbal updates do not allow full updates to the central risk tracker.
- Risks are fragmented across different internal registers within providers, making oversight difficult.
- The network has limited visibility of regional risks, making it difficult to identify those affecting multiple providers, services, and patient groups that could be addressed through a coordinated network approach.
- Lack of full oversight limits the network's ability to assure NHS England that risks are mitigated and managed.

Proposal

- Possible shift to exemption reporting: providers only report if they have risks scored 12 or above; if none, they send a "no returns" email.
- Aim to reduce reporting burden, improve compliance, and allow the board to focus on significant risks.
- Trial period of 6–12 months starting November, with review of compliance and assurance afterward.

In short, the proposal is to simplify reporting to improve compliance, oversight, and focus on high-risk areas.

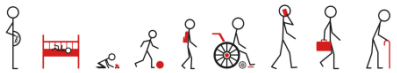
Summary
The discussion focuses on ensuring effective risk oversight at the board level:

Board Responsibility

- The board must provide assurance to NHS England that providers are managing risks appropriately, especially risks scored 12 and above. Ownership of risks by providers is crucial.

Key Points from CC (Chair):

- Need a clear lead/contact for risk reporting.



- Reporting of significant risks must be mandatory; the board should track submissions and follow up on missing reports.
- The goal is safety for patients and staff, not punitive action.
- Oversight should be at each board meeting until a reliable process is established.

Provider Perspective:

- MK raised that network-wide risk lists are missing; assurance documents from providers were not submitted, creating gaps.
- NM confirmed the issue: despite providing templates, no responses were received this cycle.

Proposal

- Move to **formal exception reporting** to simplify the process: providers only report significant risks or submit “no risks” updates.
- The board will maintain high-level oversight without interfering in providers’ internal risk management.
- Quarterly meetings will continue to support process improvement.

In essence, the board wants mandatory, high-level assurance on significant risks, using a simplified reporting method to improve compliance and oversight.

Item 11 – Any Other Business

Congratulations!

- NM announced that LG, network lead nurse, has been nominated and shortlisted for an Alder Hey Stars Award in the Patient Experience category. The recognition highlights her dedication to the PPV group, Learning Disability Forum, and Patient Experience Forum. The award final is on 19th September, and colleagues are encouraged to wish her luck.

Closing Remarks from the Chair

Summary

Key updates and actions from the board meeting:

- **Helpline Awareness Plan** is needed.
- **Dashboard** expected by November.
- **Transition Pathway Mapping** remains ongoing and important.
- **Peer review for Level 1 centres** scheduled from October.
- **Single service paediatric service** work continues, with HC coordinating support.
- **CHD Standards Review** will be hosted in Liverpool in February 2026.
- **PPV Group** praised for outstanding engagement, video work, MP collaboration, and increasing reps.
- **Training and Education Strategy** progressing, though funding remains a risk.
- **Engagement with Primary Care** emphasised as a priority.
- **Risk Register Tracker**: full submission required for November to provide assurance to NHS England.

The meeting concluded positively, with appreciation for everyone’s efforts and an invitation to reach out for support before the next meeting in November.

Date of Next Meetings

Monday 17th November 10.00am-12.00noon via MS Teams