BOARD OF DIRECTORS PUBLIC MEETING
Thursday 4th September 2025, commencing at 10:30am
Lecture Theatre 1, 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.	**25/26/133**	**10:30 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**25/26/134**	**10:31 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**25/26/135**	**10:32 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meetings held on: **26th June and 3rd July 2025.**	**D**	Read enclosure
4.	**25/26/136**	**10:34 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**25/26/137**	**10:35 (10 mins)**	**Chair's/Chief Executive's Update.**	Chair/ J. Grinnell	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**25/26/138**	**10:45 (10 mins)**	**NHS 10-Year Plan: Latest regulatory updates.**	M. Ashe/ E. Saunders	To receive an update on the current position.	**N**	Presentation
7.	**25/26/139**	**10:55 (30 mins)**	**Future Shape of Alder Hey:** • **Closing the Gap In-Year Programme.** • **Medium term plan.**	K. Warriner N. Palin/ R. Lea/ A Bateman/ M. Ashe	To receive a report on the approach to progressing Alder Hey's in year and medium-term plans between August and December 2025.	**N**	Read reports/ Presentation
8.	**25/26/140**	**11:25 (15 mins)**	**System Wide Update, including:**	D. Jones/ R. Lea	To receive an update on the current position.	**N**	Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			• **C&M Financial Position update.**				
Performance Against Annual Plan							
9.	**25/26/141**	**11:40 (10 mins)**	**Integrated Operational Plan Progress Update.**	A. Bateman	To receive an update on progress.	**A**	Read report
10.	**25/26/142**	**11:50 (10 mins)**	**Winter Plan and Board Assurance Statement.**	A. Bateman	To receive the winter plan and Board assurance statement.	**A**	Read report
11.	**25/26/143**	**12:00 (35 mins)**	**Evidence of Our Performance:** • **Flash Report, M5**. • **Integrated Performance Report for M4, 2025/26:** - **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
12.	**25/26/144**	**12:35 (10 mins)**	**2025/26 Capital Plan Update.**	R. Lea	To receive an update and approve the latest Capital Plan.	**A**	Presentation
Lunch (12:45pm-1:15pm)							
Unrivalled Experience							
13.	**25/26/145**	**13:15 (10 mins)**	**CQC Inspection: Alder Hey Community Mental Health, ASD and ADHD Services.**	L. Cooper	To receive a report on the outcome of the CQC inspection of Community Mental Health, ASD and ADHD Services.	**N**	Read report
14.	**25/26/146**	**13:25 (5 mins)**	**Brilliant Basics Update.**	N. Askew	To receive an update.	**A**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
15.	**25/26/147**	**13:30 (5 mins)**	**Compliments, Complaints and PALS Report, Q1.**	N. Askew	To receive an update on the Q1 position.	A	Read report
16.	**25/26/148**	**13:35 (5 mins)**	**Digital, Data and Information Technology Update.**	K. Warriner	To receive an update on the current position.	**A**	Read report
17.	**25/26/149**	**13:40 (5 mins)**	**Learning from Patient Safety Incidents, Q1.**	N. Askew	To receive an update on the Q1 position.	**A**	Read report
18.	**25/26/150**	**13:45 (5 mins)**	**Infection, Prevention and Control Report, Q1.**	B. Pettorini	To receive an update on the Q1 position.	**A**	Read report
19.	**25/26/151**	**13:50 (5 mins)**	**Framework of Quality Assurance and Improvement.**	B. Pettorini	To receive an update on the current position.	**A**	Read report
20.	**25/26/152**	**13:55 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 23.7.25.** - **Approved minutes from the meeting held on the 25.6.25.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 25.6.25.	**A**	Read enclosures
Collaborating in Communities							
21.	**25/26/153**	**14:00 (10 mins)**	**Liverpool Neonatal Partnership Board:** - **Chair's Highlight Report from the meeting held on the 18.8.25.**	K. Byrne	To receive an update on the LNP Board meeting that took place on the 18.8.25.	**A**	Read enclosure
Supporting our People							
22.	**25/26/154**	**14:10 (10 mins)**	**Wellbeing Guardian Dashboard.**	J. Revill	To receive an update on the current position.	**A**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
23.	**25/26/155**	**14:20 (10 mins)**	**Thriving Culture Programme: Overview & Progress Report.**	J. Potier	To receive an update on the current position.	**N**	Read report
24.	**25/26/156**	**14:30 (5 mins)**	**People Plan Strategic Update.**	M. Swindell	To receive an update on the current position.	**A**	Read report
25.	**25/26/157**	**14:35 (5 mins)**	**EDI Action Plan Update.**	M. Swindell	To receive an update on the current position.	**A**	Read enclosure
26.	**25/26/158**	**14:40 (5 mins)**	**People Committee:** - **Chair's Highlight Report from the meeting held on the 24.7.25.** - **Approved minutes from the meeting held on the 22.5.25.**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 22.5.25.	**A**	Read enclosure
Strong Foundations (Board Assurance)							
27.	**25/26/159**	**14:45 (5 mins)**	**C&M Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common.**	E. Saunders	To approve the revised CMPC Joint Working Agreement and Committee in Common.	**D**	Read report
28.	**25/26/160**	**14:50 (5 mins)**	**Assessing Provider Capability: Guidance for NHS Trust Boards.**	E. Saunders	To note.	**N**	Read enclosure
29.	**25/26/161**	**14:55 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 17.7.25.** - **Approved minutes from the meeting held on the 19.6.25.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 19.6.25.	**A**	Read enclosures
30.	**25/26/162**	**15:00 (10 mins)**	**Finance, Transformation and Performance Committee:**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 30.6.25.	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- **Chair's verbal update from the meeting held on the 22.7.25.** - **Approved minutes from the meeting held on the 30.6.25.** - **2025/26 Top Key Risks,** **(M4).**				
31.	**25/26/163**	**15:10 (10 mins)**	**Board Assurance Framework Report; including:** • **Corporate Risk Register.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
32.	**25/26/164**	**15:20 (5 mins)**	**Governor Election Results.**	E. Saunders	To receive an update.	**N**	Read enclosure
33.	**25/26/165**	**15:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
34.	**25/26/166**	**15:29 (1 min)**	**Review of Meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday, 2nd October 2025, LT1, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in July and August 2025: • **426:** Lease for Construction Compound at Alder Lodge. • **427:** Deed of Variation to transfer Laidrah Ltd. • **428:** Grant Funding Agreement – POIZ-LCR. • **429:** Eaton Road Garage alternations – 2016 minor works building contract JCT.

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M4, 2025/26	R. Lea

Alder Hey Children's NHS Foundation Trust

EXTRAORDINARY MEETING OF THE BOARD OF DIRECTORS
Confirmed Minutes of the meeting held on **Thursday 26th June 2025 at 16:00**
via Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	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	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 25/26/90	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
Apologies:	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)

25/26/88 Welcome and Apologies

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

25/26/89 Declarations of Interest

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

25/26/90 Draft Annual Report and Accounts for 2024/25:

The Chief Corporate Affairs Officer, Erica Saunders presented the draft Annual Report for 2024/25 to the Board for approval purposes. It was confirmed that the report has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual. The Board was provided with an overview of the report which was considered to be consistent

with the information reported throughout the year and reflects the organisation's challenges and achievements, with all auditable sections tested and found compliant by Ernst and Young (E&Y).

The Chief Executive, John Grinnell, offered thanks to ES and JP for compiling an excellent report. It was felt that the document effectively captures the complexity of the work that takes place at Alder Hey and clearly presents the organisation's performance throughout the year in a balanced manner. It emphasises the Trust's involvement with children and young people, in addition to its initiatives focused on innovation and organisational transformation throughout this period. Despite numerous challenges, Alder Hey has delivered a surplus while maintaining high performance standards. JG commended the Annual Report to the Board.

Annual Accounts, 2024/25

The Interim Chief Financial Officer, Rachel Lea, presented the draft Annual Accounts for 2024/25, noting that the Trust delivered a £1.9m surplus for the year. Attention was drawn to a key adjustment to the accounts relating to the lease car scheme which reduced the Trust's reported performance by £1.8m against a control total of £3.4m. The adjustment was reviewed and agreed upon by the Audit and Risk Committee, approved by the External Auditors, and accepted by NHS England; the ICB was also informed.

It was reported that capital expenditure totaled £21.4m in line with the set limit for the plan, and the year-end cash balance was £53.7m. No further material adjustments were required following the audit.

The Chair of the Audit and Risk Committee, Kerry Byrne, advised that the 2024/25 audit process had proceeded smoothly. Minimal actions were required compared to previous years, reflecting the significant efforts of the Finance team on the Capital Plan, which has positioned the Trust well. The £2m adjustment, which was noted last year, could not be included in the 2023/24 accounts as the Elective Hub had not been fully completed; however, it has been effectively managed in 2024/25.

External Audit Year-end Report, 2024/25 – 'ISA260'.

HR confirmed that an unqualified audit opinion would be issued, with no significant weaknesses identified in the Trust's arrangements for value for money (VFM). The Board was informed that a limited number of control recommendations were issued, and that Management has provided an appropriate response. These recommendations will be followed up during the 2025/26 audit.

The Chair noted that, despite challenging circumstances, the Trust achieved a positive outcome in 2024/25. The Chair extended congratulations to RL, the Finance Team, and all those whose efforts contributed to this success.

Letter of Representations

HR stated that an unqualified opinion will be provided once the signed accounts and Letter of Representations (LoR) have been received. The Board authorised the signing of the LoR.

On behalf of E&Y, HR offered thanks to everyone involved in the audit for their co-operation and efforts.

Resolved:
The Board:

- Approved the Trust's Annual Report and Accounts for 2024/25.
- Received and noted the External Audit Year-end report, 2024/25 'ISA260'.
- Agreed for the Letter of Representations to be signed.

25/26/91 Committee Annual Reports 2024/25

The Board received the following Committee Annual Reports for 2024/25, noting that each Committee had fulfilled its Terms of Reference and managed its governance processes during the year:

- Audit and Risk Committee (ARC).
- Safety and Quality Assurance Committee (SQAC).
- Finance, Transformation and Performance Committee (FTPC).
- People Committee.
- Futures Committee.

ARC reported progress on risk tolerance implementation; the FTPC highlighted the increased operational pressures that have been experienced during the year; SQAC was commended for its robust reporting and expertise in the face of demand; the People Committee emphasised the increased focus on workforce changes, thriving, and adapting to cultural shifts; and the Futures Committee noted ongoing improvements and strategic discussions.

The Chair thanked each of the Assurance Committee Chairs for their leadership during the year and acknowledged the significant teamwork that has contributed to the Trust's achievements in 2024/25.

Resolved:
The Board received and approved the 2024/25 Annual Reports for each of the Assurance Committees.

25/26/92 Board Self-Certification of Compliance with the Provider Licence

The Board received the 2024/25 Board annual self-assessment and self-certification of compliance with the NHS provider licence. It was confirmed that the Trust remains fully compliant with all statutory and constitutional obligations as a Foundation Trust, and that all necessary documentation has been completed and is available for inspection if required. No areas of non-compliance were reported.

Resolved:
The Board approved the proposed confirmation of compliance with condition CoS7: Availability of Resources in the Provider Licence

25/26/93 Any Other Business

There were none to discuss

25/26/94 Review of the Meeting

It was felt that the meeting was very succinct.

Date and Time of Next Meeting: Thursday 3rd July 2025, LT4, Institute in the Park.

PUBLIC MEETING OF THE BOARD OF DIRECTORS
Confirmed Minutes of the meeting held on **Thursday 3rd July at 10:00am**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(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	Chief Scientific Officer	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Ms. C. Lee	ACOO for Division of Surgery	(CL)
	Mrs. K. McKeown	Board Administrator (minutes)	(KMC)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 24/25/109	Mrs. N. Palin	Director of Transformation	(NP)
Apologies:	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)

Patient Story

The Chair welcomed Lindsay Neil (*Clinical Lead for CYP's Gender Service*) and Jordan Mitchell (T*rainee clinical psychologist*) who were invited to July's Board to share Ethan's story on his behalf.

Lindsay provided an overview of the service, emphasising that its focus extends beyond gender as it is also about helping patients improve their quality of life. Jordan shared the story that sits behind Ethan's emotional support shark which has been adopted as a mascot for the male transgender community.

Ethan is 17 and has been on the national waiting list for several years. He faced mixed support at school, with staff using his name but not the correct pronouns. After becoming overwhelmed by his performing arts course, Ethan switched subjects but now feels lost, wanting to go to college but fearing he'll be overwhelmed again. Referrals for neurodivergence were declined, and colleges are asking for a clear understanding of Ethan's needs in order to offer support, but the local pathway won't accept a referral without educational input. Talented in drawing and gaming, Ethan hopes to pursue his passions but has lost confidence due to prejudice. As part of the pathway, the service

helped Ethan understand his needs and offered support to help manage them. Ethan experiences general anxiety and relies heavily on his mum, who is struggling to find time for herself. The family are really pleased with the support that the service has provided and are eager to engage with the service and give back by participating in a patient group that has been established. Ethan loves people and animals especially his three cats who have got four names each but needs help building confidence and understanding in terms of how his gender identity fits in, which the service will continue to do.

The Chair queried the transition processes for patients upon discharge. It was reported that once a patient is 18 years and 3 months discharge procedures are initiated. The service adheres to a transfer protocol with English Identity Clinics, which includes completing a transfer form and providing assessment documentation. Subsequently, patients are placed on a priority list. Transition experiences vary, particularly given the significant pressures on adult waiting lists; consequently, the service takes great care to ensure patients are not disadvantaged. Most individuals are seen within a year of referral. Despite constraints on both services, this system is functioning effectively. Ultimately, it is the young person's choice whether to move to adult services. If a young person is not ready for transfer at the end of their time with the service, they will be discharged back to their GP. It was pointed out that the service is in its early stages.

The Chair offered thanks to the team for their commitment in delivering this valuable service throughout the past year. Positive feedback from service users indicates that the service provides something new and fresh in a challenging environment.

25/26/103 Welcome and Apologies

The Chair welcomed everyone, noted apologies, and acknowledged that July's Board is Shalni Arora's last meeting in her role as Non-Executive Director for Alder Hey.

25/26/104 Declarations of Interest

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

25/26/105 Minutes of the previous meeting held on 5th June 2025.
Resolved:
The minutes from the meeting held on the 5.6.25 were agreed as an accurate record of the meeting.

25/26/106 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

25/26/107 Chair's and CEO's Update

The 3rd of July marks the launch of the NHS 10-year plan following an event on the 2.7.25 which was hosted by the Secretary of State for Health and Social Care, Wes Streeting, and the Chief Executive of NHSE, Jim Mackey. It was reported that the Trust will analyse the plan further and work is taking place to document the

primary themes and think about the strategic considerations that are required. There is an emphasis on neighbourhoods, which aligns with the Trust's ongoing work, and notable changes are being implemented which includes the dissolution of 201 regulatory organisations. Technology is highlighted in the plan and the Trust is monitoring the developments related to a £10b investment across capital and revenue streams. In addition to this, the plan places importance on prevention, obesity, and prioritising UK-trained doctors. It was confirmed that a briefing will be circulated to the Board in due course.

It was reported that a new performance framework for the NHS, which operates similarly to that put in place by Monitor, is being implemented alongside the 10-year plan. Provisional ratings were released on the 2.7.25 and Alder Hey was assigned a rating of 1, which indicates lowest risk, with 5 being highest risk. Key focus areas include mental health, access, and quality standards.

The Board was advised that PWC's report will be available by September 2025 and it will focus on resilience and delivery plans in respect to financial performance. Further clarification will be provided in terms of the operating model and how the system is expected to develop.

The Trust has managed a measles outbreak in recent days, maintaining business continuity whilst addressing the incident effectively. Collaboration with Public Health colleagues is ongoing to identify further actions, including to address falling levels of vaccination among children which has been a contributing factor.

Work will take place over the summer period on the organisation's internal communications plan and the launch of the Trust's new values is scheduled for September 2025.

The Chair advised that the anniversary of the tragic incident in Southport falls on the 29th of July 2025. It was confirmed that the Trust is collaborating with relevant agencies to ensure appropriate communications are made that are respectful to the victims and their families. Flags are to be flown at half-mast, in accordance with the wishes of the bereaved families for a low-key observance.

Resolved:
The Board noted the updates provided by the Chair and the CEO.

25/26/108 C&M System Update

Financial Position

It was reported that the Cheshire and Merseyside (C&M) position is yet to be shared therefore an update will be provided once Board reconvenes in September. For M2, C&M is reporting a £16 million deficit, which represents 38% of the overall plan that C&M are aiming to meet by the year-end. Addressing the CIP target remains challenging and has thus far been achieved through non-recurrent measures. Cash flow continues to be an issue in C&M, with efforts focused on ensuring providers maintain sufficient cash reserves. Two-weekly performance meetings are ongoing to provide updates on workstreams. The Trust has participated in this process and has received positive feedback.

Resolved:
The Board noted the update on the C&M financial position.

25/26/109 Improvement Programme Update

Integrated Portfolio Board, Q1

The Board was provided with a summary of the first quarter of activity for the newly established Integrated Portfolio Board (IPB). It was reported that the IPB was created to bring greater alignment, oversight, and strategic coordination across the organisation's major strands of Financial Improvement, Transformation, and Growth and Opportunities. A number of slides were shared that provided the following information:

- Current success;
  - Financial improvement performance.
  - Collaboratives.
  - Portfolio overview.
  - Stronger experience led ambitions.
- Strategic learnings;
  - Strategic versus short-term tension.
  - Milestone and benefit maturity varies.
  - Focus on activity instead of outcomes.
  - Ambition versus delivery gap.
- Improvement: Sharpening focus;
  - PID assurance.
  - Enhances Executive oversight.
  - Strategic filter and stop.
  - Decision impact tracking.
- Realising Vision 2030;
  - Clinically led vision.
  - Repositioning transformation.
  - Organisational design Exec Away Day in September to review the proposed organisational structure, corporate support model, and leadership/governance.
  - Strategy Board in October to discuss the operating model and collaborative framework, define a clear work plan for Vision 2030, including Growth and Opportunities.
- Vision 2030 outcomes and measures.

A discussion took place about the importance of the organisation's objectives being more ambitious yet focussed on specific priorities. A contingency plan is required, introducing new types of measures, capacity, and having the ability to twin track in terms of a financial approach whilst maintaining a focus on Vision 2030.

The Board was advised that some services at Alder Hey end for some cohorts of young people at the age of 16 years and 3 days when they transition to adult care which can be problematic and present challenges for them. It was felt that consideration should be given to service cut-off points (0-19, 0-18, and 0-25), when focussing on strategic filter and stop.

Financial Improvement Programme

The Board was provided with an update on the Financial Improvement Programme which included an overview of the schemes reviewed/decisions approved to date, the current CIP position and a forward look, as detailed in the report.

A question was asked about the end date of the Financial Improvement Programme. It was confirmed that it will continue until the financial gap is closed, after which it will transition.

C&M recommendations for the management of Bank Staff pay rates

The Board received a report from the C&M Chief Nursing Officers outlining the jointly agreed recommendations for the management of Bank Staff pay rates. The paper outlines the case for change regarding the current Agenda for Change (AfC) bank pay rates for temporary registered nurse staffing across all C&M NHS Acute, Mental Health, Community and Specialist Trusts. Specifically, it proposes a set of agreed principles and recommendations based on the combined knowledge and experience of the Chief Nurses. The aim is to balance cost reduction with the need to ensure adequate staffing levels at peak periods of demand, while mitigating the risks associated with poor fill rates. This proposal considers the bank rates of all C&M trusts and the specific risks associated with each organisation, in order to, where reasonably practicable, ensure a system wide approach. In addition, consideration has been given to the terms agreed within the Greater Manchester system to aim for a harmonised approach across the North West.

It was reported that those on the lowest AfC banding will remain at the top-point whilst all Band 5 staff will be paid at mid-point of the grade of shift required. While this carries risks such as staff declining shifts, a regional move has been made to standardise pay aims.

It was queried as to whether the Chief Nursing Officers have considered situations where an individual is offered a higher payment. It was reported that Manchester adopted a strategy of incentivising certain areas by moving a shift from the mid-point to the top of the pay band. While Alder Hey is not currently able to implement this approach, it may be possible in the winter. It was confirmed that a set of criteria has been established outlining when this can be applied.

Reference was made to the process concerning hours owed and owing, with acknowledgment of the substantial total involved. The Board was informed that the team has maintained a consistent focus on this matter over an extended period, and it was confirmed that service requirements are prioritised before any negotiation regarding time repayment. It was further reported that time accrued is expected to be taken within the same month, and confirmation was given that the Trust will soon begin transitioning to this approach.

For noting
The Board approved recommendations made by C&M for the management of Bank pay rates, as detailed in the report.

Transformation Programme update

This item was addressed during the IPB update.

Resolved:
The Board acknowledged the updates presented in the Improvement Programme update.

25/26/110 Evidence of Our Performance

The Board was provided with an update on the recent outbreak of measles at the Trust. It was reported that there have been seven cases since the 6.6.25 which Alder Hey has managed via a moderate Business Continuity Plan but this could change due to the tracing that has been undertaken of those who were exposed which is approximately 200 people.

The Trust has reached out to the Director of Public Health for Liverpool City Council (LCC), Matt Ashton, who has written to all schools to raise awareness about the importance of children being vaccinated. The Trust is also looking to strengthen its message regarding vaccination and collaborate with partners to address this matter publicly.

A discussion took place, and a number of suggestions were put forward about collaborating with the LCC to support the work that they are undertaking with schools to raise awareness, working with communities via the Local Authority where vaccination uptake is low, downloading posters to reach out to groups who attend Alder Hey, and linking in with networks that can help.

Flash Report, M3

The Board received the Flash Report for June 2025.

A concern was raised around a possible emerging risk relating to an increase in the number of children and young people (CYP) waiting over 52 weeks for referral to treatment (RTT). It was reported that this is being monitored carefully. In terms of patients waiting within 18 weeks the Trust's performance is currently 57.6% against a target of 63%. While this reflects ongoing improvement, it was noted that certain specialties may require additional support to maintain progress.

Integrated Performance Report

Outstanding Care and Experience – Safe and Caring

- 67% of complaints received a response within 25 working days. Although this represents a decrease from the previous month, each delayed response was accompanied by a justified reason for its lateness.

Revolutionising Care

- There has been a sustained improvement in all areas of ED performance measures, with May's performance at 84.8%.
- Diagnostic performance has remained strong with 95% of tests completed in under 6 weeks.
- The RTT waiting list within 18 weeks continues to reduce and has done so for the last 12 months from 24.5k to 20k.
- There has been an increase in the number of patients waiting over 52 weeks for referral to treatment, rising from 250 in April to 395 in June. This was confirmed as a significant risk for the Trust.
- It was reported that there is a risk that elective weekend work may not be undertaken due to current pay rates. The team has proposed a contingency plan to address this issue, which includes reallocating some of the savings from other areas to support the underlying plan.

Pioneering

- The metrics in the IPR are progressing.
- A Round Table discussion is to be held to bring together academic researchers.
- *Director Role (Liverpool Institute of Child Health and Wellbeing)* – Recruitment is underway with five possible candidates identified. Discussions are set for the week of the 7th of July 2025, and interviews will follow in September.
- The Trust is still awaiting the sign off of the Grant Funding Agreement with the Combined Authority for Paediatric Open Innovation Zone (POIZ).

Support our People

- Staff turnover figures have increased recently due to the end of a group of fixed term contracts, transfer of the iDigital team, and the leaving dates for colleagues who left as part of the Mutually Agreed Resignation Scheme (MARS). Following a request it was agreed to include a graph in the IPR to reflect staff turnover figures.

25/26/110.1 Action: MS

- Sickness absence in May 2025 was 5.47%, above the 5% target but down from 5.71% in April. Short-term sickness accounted for 1.57% and long-term for 3.90%. This marks the twelfth consecutive month above the target, which is now set at 4.5% for 2025/26. The Trust is considering plans to adopt a 90-day sprint process, based on another trust's approach, to address sickness rates.

Financial Sustainability: Well Led

- Due to challenges related to pay rates and rising drug expenditures in June, the Trust has reported an income shortfall of £300k, with £200k being attributable to adverse performance within that single month.
- The current position reflects a variance of over £0.5 million from the planned figures. Contract management within PFIs has enabled certain offsets due to applicable deductions, which have been recorded as a one-off recurring item.
- There is an emerging risk relating to the Q2 profile with some divisions moving into escalation. A meeting with the Division of Surgery has been scheduled to clarify activity challenges, and ongoing discussions are taking place with commissioners re allocations. In order to remain aligned with the organisation's trajectory a rapid response is underway to address these unforeseen developments resulting from unintended consequences. Divisions who are off plan will be attending July's Finance, Transformation and Performance Committee (FTPC) to share and discuss their action plans for mitigation. A deep dive into the increased drug spend will also be conducted to understand the reason for this.

Community and Mental Health Division

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

Reference was made to the increase in CYP waiting 52+ weeks for a partnership appointment. It was reported that there has been a delayed impact in terms of CYP waiting for an appointment as a result of staff leaving and joining the Gender Service. An Improvement Plan has been implemented to address this issue, with meetings taking place on a weekly basis. It was confirmed that there will be zero CYP waiting by the end of September 2025 due to undertaking a review of systems

and processes as part of the Improvement Plan and having recruited to all posts with the exception of one.

Division of Medicine

- *Metabolic Service:* The service is currently experiencing operational difficulties due to the recent retirement of a consultant. The Trust has reached out to Manchester for assistance and is awaiting their response. The Board was advised that a formal letter will be sent by the Trust to arrange a meeting. Plans to strengthen the service include recruiting a paediatrician and offering training and support to the dieticians involved in the service.

Division of Surgery

- *Coding:* The Division is currently facing challenges related to coding; however, a number of mitigations are in place for M3.
- *Was Not Brought (WNB):* WNB rates increased in month at 10%. Key areas now have plans, and conversations will take place with families to discuss the measures that the Trust has implemented to help reduce WNB.

The Chair expressed interest in understanding the reasons behind WNB in the Division of Surgery and emphasised the importance of reviewing this issue with the aim of reducing these occurrences.

A number of questions were raised and responded to in respect to the systems in place to remind patients about their appointments, and understanding capacity issues and gaps in terms of unintended consequences

Resolved:
The Board:

- Noted the Flash Report for M3.
- Noted the content of the IPR for Month 2.

25/26/111 Capital Plan, 2025/26

The Board received a summary of the proposed capital plan for 2025/26 following an Executive capital prioritisation session and approval at FTPC. A number of slides were shared that provided the following information:

- Key headlines;
  - Anticipated CDEL for 2025/26 of £29.1m *(£23.8m confirmed, £5.3m pending).*
  - Total initial capital requests £36.9m, including committed schemes of £25.1m.
  - Available funding of £4m against an £11.8m capital request leaves a gap of £7.8m.
- Prioritised requests have been classified as:
  - *Rank 1:* Immediate allocation required for the completion of existing builds and statutory/planning obligations of £3m.
  - *Rank 2:* Other prioritised requests of £4.9m to be agreed in principle, pending final confirmation of funding.
  - *Rank 3:* £3.1m not prioritised for 2025/26 unless additional funding becomes available.
- The proposal recommends advancing with Rank 1 and 2 schemes at a total cost of £7.9m, resulting in a potential funding shortfall of £3.9 million.

However, measures and mitigation strategies will be implemented throughout July to address and reduce this gap.
- Business cases will be presented to FTPC for each scheme ahead of final approval.
- An additional update will be presented to FTPC at the end of July, with a subsequent report to the Trust Board in September.

The Board was advised that discussions are underway with providers across C&M regarding the redistribution of capital between years. While efforts are being made to address the current situation, there may be additional challenges in the following year.

The Chair noted the risks and opportunities as depicted in the presentation and drew attention to the importance of looking beyond 2025/26.

Resolved:
The Board noted the update on the 2025/26 Capital Plan.

25/26/112 Sunflower House Update

A report was submitted to the Board to provide an overview of Sunflower House (Tier 4 Inpatient Unit), highlighting current challenges and actions being taken to support CYP and staff. Attention was drawn to the sections in the report relating to referral data, workforce, 2025 NHS Staff Survey, recruitment, complaints, incidents, and key achievements.

The Chair pointed out that the team is engaged in highly challenging work and that absenteeism within the service is currently at 9%. It was queried as to whether it is necessary for the Trust to review its recruitment processes, explore rotation opportunities within the unit, and consider benchmarking against practices in other specialised units. It was acknowledged that there has been a rise in sickness rates resulting from injuries sustained by staff while caring for a specific child with very challenging behaviours. It was confirmed that all staff will be fully trained in PAMOVA conflict management training by the 31.7.25 (*compliance is currently at 66%*).

It was reported that the Trust provides staff based in the unit with opportunities for internal rotation, though further assessment of this approach could be considered. Additionally, teams meet quarterly as part of a "1 in 6" initiative. The Board was advised that all staff members received training during the Covid period, but it is essential for staff to remain well-informed and have the flexibility to rotate when needed. Efforts are also underway to recruit additional experienced staff.

The Chair stated that it is important for the organisation to be aware of the challenges that staff are experiencing and emphasised the need for staff within Alder Hey to feel included and valued.

Resolved:
The Board noted the contents of the report and the current challenges and actions being taken to support CYP and staff within Sunflower House.

25/26/113 CYP Gender Service NW Programme Update

The Board received an update on the CYP Gender Service (CYPGS) Northwest programme. As the programme is established and fully operational, the Board was

asked to approve the closure of the CYPGS programme structure and utilise existing governance and engagement channels, including the National Provider Network, North West Paediatric Partnership Board, and divisional clinical and operational governance to maintain oversight and assurance of the CYPGS Northwest. Following discussion, the Board confirmed its approval.

Resolved:
The Board approved the closure of the CYPGS programme structure and agreed that the Trust should utilise existing governance and engagement channels to maintain oversight and assurance of the CYPGS Northwest.

25/26/114 Mortality Report, Q4

The Board received the Mortality Report for Q4. The following points were highlighted:

- The percentage of cases reviewed by the Hospital Mortality Review Group (HMRG) within the four-month target is now at 90% compliance, an increase compared to the previous report. It was noted that all deaths at the Trust undergo review by the HMRG.
- The Trust is collaborating with the national team to explore more comprehensive and meaningful ways to represent neonatal mortality. The Board was advised that the Neonatal Mortality Report is developing.

Resolved:
The Board received the Mortality Report for Q4.

25/26/115 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 21.5.25 were submitted to the Board for information and assurance purposes.

During the meeting in June the Committee discussed the limited assurance that was received in respect to Mitie's performance, and cleanliness issues within the Trust. The Committee received an update from Mitie on the ongoing plans to enhance their performance and responsiveness. In terms of the report on cleanliness, the Committee received an overview of the current position and the challenges being experienced within the service. Both matters are subject to ongoing review and appropriate monitoring.

Resolved:
The Board noted the approved minutes from the meeting held on the 21.5.25.

25/26/116 Liverpool Neonatal Partnership Board

The Board was provided with a summary of the key activities undertaken by the Liverpool Neonatal Partnership (LNP) in preparation of the opening of the new surgical Neonatal Intensive Care Unit (NICU) in January 2026. The following points were highlighted:

- A new leadership structure has been approved, and recruitment for a single lead is underway.
- A meeting was held with the Chief Pharmacist on the 2.7.25, resulting in some progress in terms of the alignment of the Chief Pharmacist role which is critical to the safe opening of the new unit.

- Active engagement in clinical haematology has increased.
- Surgical teams are in the process of agreeing clinical pathways to ensure the pathways are clear when the NICU opens.
- The work taking place around culture has been launched.

Letter from NHSE re maternity and neonatal care

The Board acknowledged the letter from NHSE regarding maternity and neonatal care. It was reported that the Trust is liaising with the Liverpool Women's Hospital in respect to the five key areas detailed in the letter.

Resolved:
The Board noted the LNP Board update for May 2025 and acknowledged the letter from NHSE regarding maternity and neonatal care.

25/26/117 Futures Committee

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

During June's meeting the Committee received an update on the four pillars, and concerns were raised about job planning for clinicians and the capacity to conduct research. It was reported that the Trust is awaiting the POIZ contract and that a Product Strategy is to be developed to enable the Trust to deliver its performance metrics for POIZ. A number of discissions took place regarding the governance for POIZ, financial performance, and improvement initiatives. The Board was advised that the Futures Committee will transition into the Growth and Opportunities Committee, with its inaugural meeting to be scheduled for September 2025.

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

25/26/118 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:

- The Trust has been preparing for the Navajo Chartermark reassessment, with continued support from stakeholders across the organisation who will participate in the reassessment process. It was confirmed that the reassessment is scheduled for the 3rd and 4th of July. The Trust is confident that Navajo will recognise the work that has taken place to support the implementation of the action plan and attention was drawn to the importance of the Trust's ongoing commitment in terms of supporting LGBTQIA+ staff and building an inclusive culture.
- The Board was advised that the Liverpool Pride event has been reinstated and will take place on the 26.7.25 with a new route and a focus on community led celebrations.
- It was reported that a new app has been launched to collect real-time feedback from staff about their working experiences and opinions. The app is designed to build a picture of staff views and provide timely data to inform organisational actions.

The Chair emphasised that achieving the Trust's targets is dependent on the collective efforts of everyone who works at Alder Hey and highlighted the importance of effective communication and robust support for employees to help maximise workforce performance. The Chair drew attention to the value of sharing these points with Staff Side and recognised that the workforce is a key asset to the Trust. Thanks were offered to the Chief People Officer and her team for their ongoing work.

A request was made for the continued attendance of Executive Directors at JCNC meetings, particularly in light of the return of a number of Union representatives who are providing valuable new insights and supporting the development of constructive relationships. There was also a suggestion to invite the Chair of the FTPC to discuss how Trust finances relate to the workforce.

Resolved:
The Board noted the People Plan strategic update.

25/26/119 Audit and Risk Committee

Resolved:
The Board noted the Chair's Highlight Report from the meeting held on the 19.6.25 and the approved minutes from the 17.4.25.

25/26/120 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 21.5.25 were submitted to the Board for information and assurance purposes.

During June's meeting the Committee focussed on the long-term and short-term considerations of the FIP. It was reported that a number of unintended consequences have been observed, which suggests that the current approach may be influencing the overall tone of discussions. While the FIP is shaping the conversation, it was felt that it is important to also acknowledge its positive aspects. In terms of moving forward, it was suggested that the Trust should strive to reset and balance the tone to reflect both challenges and opportunities.

Following the comments received, the Board was informed that upcoming communications will place greater emphasis on forward-looking perspectives.

2024/25 Top Key Risks (M2)

The Board was advised of the latest position of the 2024/25 FTPC's key risks for M2.

Resolved:
The Board noted the approved minutes from the meeting held on the 21.5.25 and the update on the Committee's top key risks in M2.

25/26/121 Acute Care Floor Revenue Business Case

The Board received the Acute Care Floor Revenue Business Case, which outlined the development of a new model incorporating a same-day emergency care facility and an expanded Paediatric Assessment Unit within the new hospital facilities. The preferred option involves establishing a 20-bed assessment area, with an estimated additional annual staffing cost of £400k, designed to be cost-neutral

through operational efficiencies such as reduced use of spill beds. The Board noted that while the physical infrastructure allows for future flexibility, the primary constraint is staffing resources. There is also an ambition to expand inpatient cardiac services, contingent on securing appropriate commissioning support.

Whilst the preferred option of the Clinical team is Option 1, there is recognition that Option 2 is more feasible at this stage in the current financial climate and as such this is put forward as the recommended option. The Board was presented with a number of options and agreed to proceed with the initial phase via the use of Option 2. Additionally, it was requested that the full business case/change programme be presented in October 2025 to provide a comprehensive overview of the strategic vision and options.

25/26/121.1 Action: AB

Resolved:
The Board approved Option 2 as outlined in the Acute Care Floor Revenue Business Case:

Option 2: 16 PAU Beds and 4 SDEC Spaces

- Relocate the UTC to collocate with ED.
- Expanded the PAU assessment space to 16 beds with a robust senior led clinical model covering seven days per week, 12 hours per day.
- Establish an SDEC unit to the 50% of the estate available working with speciality services to devise appropriate transformative pathways to change the way we deliver care however capacity may become limited quickly resulting in a further ask for expansion of staffing to cover the remaining estate.

25/26/122 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:

- It was reported that visibility of the Gender Service is at target, prompting a review and consideration for closure of this BAF risk. It was reported that the service is reporting to SQAC at an operational level.
- A review of the People risks is in the process of being undertaken.
- A report on risk appetite is to be submitted to the People Committee in July.
- It was acknowledged that the BAF should incorporate risks associated with the new NHS 10-year Plan. It was proposed that the Board review this matter to ensure the Trust has the appropriate level of oversight.

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

25/26/123 Any Other Business

On behalf of the Board, the Chair formally expressed appreciation to SA for her exemplary leadership and dedication during her tenure as Non-Executive Director

at Alder Hey. The Board conveyed its best wishes to SA for continued success in her future roles. In response, SA extended her gratitude to all colleagues and stated that it had been a privilege to contribute to such an outstanding organisation dedicated to supporting children and young people.

It was reported that Alder Hey was acknowledged during the launch of the NHS 10 Year Plan for its outstanding staff who deliver exceptional care to CYP.

The Board was informed of the visit that the Trust received to the Rainbow Centre from the Police and Crime Commissioner. It was noted that further discussions are ongoing regarding the potential location of the Barn House One Stop Shop on the Alder Hey site.

25/26/124 Review of the Meeting

At the request of the Chair, Non-Executive Director, Mark Jennings (MJ) provided a review of the meeting. MJ suggested that future evaluations should look at whether the Board meetings have the right balance across a number of dimensions such as breadth versus depth of topics, time spent discussing patients versus politics and finance, the relative contribution of Executives and NEDs, the support versus challenge balance from NEDs, and the output of the session being decisions and actions versus noting.

MJ thanked the Executives for the quality of the reports and noted that the session had effectively covered the operational reports on a by-exception basis, meaning that there was adequate discussion of a number of important topics: nursing bank rate stabilisation, the business case for the new acute care floor, Sunflower House, the Gender Service, mortality, and the LNP. The Board left the meeting clear on the financial position (*the need to invoke contingency measures to close the gap to plan*) and the people risks around low morale. There had been good challenge on transformation and the Executives had been open about the need for a rethink in that space.

The area MJ suggested for improvement was in the number of decisions being brought to the Board (*currently very low*) and the level of actions versus noting. MJ suggested the Board be used more for evaluation of options and coming to collective decisions, not least to take explicit shared accountability with the Executive team for some of the difficult financial decisions that are necessary. The Executives should consider more asks of the Board to make full use of the available expertise.

Date and Time of Next Meeting: Thursday 4.9.25 at 10:30am in LT1, Institute in the Park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2025- March 2026)

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
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	
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	Sep-25	**1.7.25** - Guidance is yet to be published. **ACTION TO REMAIN OPEN**
Actions for October 2025							
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	Oct-25	
3.7.25	25/26/110.1	Evidence of Our Performance	*IPR* - Include a graph in the IPR to reflect staff turnover figures.	M. Swindell	Oct-25	On track Oct-25	
3.7.25	25/26/121.1	Acute Care Floor Revenue Business Case	Submit the full Acute Care Revenue Business Case/Change Programme during October's Board to provide a comprehensive overview fo the strategic visions and options.	A. Bateman	Oct-25	On track Oct-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	
Actions for January 2026							
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	Jan-26	**31.1.25** - The family advised that February is too soon for them to attend Board to share their story. Contact will be made with the family again in six month's time. **ACTION TO REMAIN OPEN**
Status							
Overdue							
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
6.6.24	24/25/83.1	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	Closed	**1.7.25** - This will be included in the report submitted to the Board in September. **29.8.25** - This action has been addressed. **ACTION CLOSED**
5.6.25	25/26/68.1	Chair's and CEO's Update	Invite Rachel Isba to a future Board meeting to provide an update on the that has been undertaken.	K. McKeown		Closed	**1.7.25** - Dr. Isba has been invited to Board to present a young person's story in Ocotber. The focus will be on the work that is being undertaken regarding Ketamine clinics. **ACTION CLOSED**
5.6.25	25/26/73.1	Compliments, Complaints and PALS Report, Q	Present the Compliments, Complaints and PALS report to the Trust's governors at the next Council of Governors meeting in September.	N. Askew	Sep-25	Closed	29.8.25 - This item has been included on September's CoG agenda. **ACTION CLOSED**
5.6.25	25/26/79.1	Use of Restrictive Physical Interventions Annual	Further detail to be included in the 2025/26 annual report relating to themes and trends relating to reporting including clinical holding. This will also	L. Cooper	Sep-25	Closed	**29.8.25** - This action has been addressed and information will be included in the 2025/26 Annual Report. **ACTION CLOSED**

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 4th September 2025

Paper Title:	**Creating the Future Shape of Alder Hey – Outline Plan, Aug – Dec 2025**
Report of:	**Kate Warriner – Chief Transformation and Digital Officer**
Paper Prepared by:	**Kate Warriner – Chief Transformation and Digital Officer**

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

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

Risk Number	Risk Description	Score
3.2	BAF Risk 3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	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	Y	**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

Creating the Future Shape of Alder Hey – In Year and Medium Term Plans

1. Purpose of Report

This report sets out the approach to progressing Alder Hey's in year and medium term plans between August and December 2025.

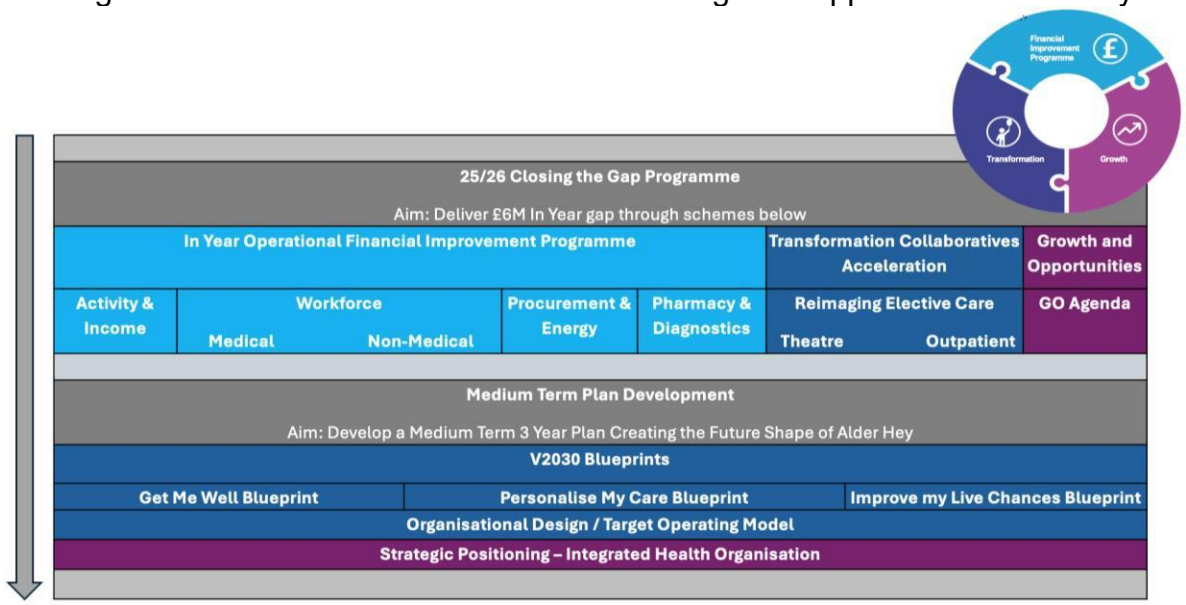
2. In Year and Medium Plan Development

The in year plan is underway, with the launch of the Closing the Gap Programme in August 2025 to address the £6M financial gap for 2025/26.

In parallel, work on the medium term plan commenced in August 2025 with the development of the Vision 2030 blueprints and the organisation's Target Operating Model. This plan will be aligned with emerging NHS England (NHSE) Planning Guidance, which requires Board approval by December 2025.

Strategic exploration of an Integrated Health Organisation (IHO) for Children and Young People (CYP) has also commenced.

The diagram below demonstrates a view of the integrated approach in its entirety.



To support delivery, a high level milestone plan has been developed for the August - December period. This includes additional Board time in November and dedicated discussion at the October Strategy Board.

Key Board Milestones:

- Board of Directors: 4th September
- Strategy Board: 2nd October
- Extended Board Time Out: 6th November
- Board of Directors: 5th December

3. Closing the In Year Gap Programme

The £6M gap for 2025/26 is being addressed through a single programme of work, tracked weekly through a strategic command approach using the established Financial Improvement Programme methodology. This approach has been initiated and established at pace with an initial deep dive held at Finance, Transformation and Performance Committee in August 2025.

The scope of the programme includes:

- Operational Improvements: Activity & Income, Workforce, Procurement & Energy, Pharmacy, Diagnostics
- Transformation Collaboratives: Theatres, Outpatients
- Growth and Opportunities

Reporting Arrangements:

- August – FTPC deep dive completed
- Weekly Executive Led grip and control in place from August
- Monthly updates scheduled to Board of Directors

Additionally, there have been discussions with Integrated Care Board (ICB) with regards to a CYP blueprint for CYP and the 3.8M stretch target. As part of this, work has commenced across Cheshire and Merseyside with the C&M Turnaround Director. The AH blueprints (referenced below) will form the foundation of an aligned Cheshire & Merseyside Blueprint for CYP.

With regards to the 3.8M stretch, this work includes both a short term focus on some high impact changes for CYP. Accountability on this must sit with ICB, with Alder Hey as a CYP lead voice to support with expertise, new models and a longer term focus on developing Alder Hey's role further in C&M.

4. Medium Term Plan Components

The Alder Hey medium term plan will be shaped around three core components:

- Vision 2030 blueprints**,** which will set out a three year transformation programme
- Development of a Target Operating Model (TOM) to define the future form and ways of working for Alder Hey
- Opportunities for a Children and Young People Integrated Health Organisation (IHO) within the wider system

Together, these components will bring forward an integrated plan that covers clinical, workforce and financial strategies, alongside quality improvement, digital, infrastructure and capital development.

4.1 Vision 2030 Three Year Blueprints

The Vision 2030 Blueprints aim is to clearly outline a future clinical shape of Alder Hey. The blueprints will:

- Focus on three areas of need: Get Me Well, Personalise My Care, Improve My Life Chances
- Articulate service models, pathways, transformation programme (2026–2029), and financial/benefits plans

Many of the new models of care are dependent on new ways of working in partnership with the system - joining up care for CYP across pathways and organisations, and transforming at scale. The blueprints identify C&M pathways as well as clinical areas internal to AH.

The first draft of the Blueprints are due at the end of August, with clinical input planned over September and October. The blueprints are being developed from a number of existing sources with an aim to provide a clear clinical shape and programme of work.

Board Timetable:

- September: Board update
- October: Strategy Board discussion
- November: Extended Board Time Out (deep dive)
- December Formal approval

4.2 Target Operating Model (TOM)

The Target Operating Model (TOM) aim is to develop and clearly outline the future form of Alder Hey. The TOM will set out:

- How we organise ourselves to make Vision 2030 real
- The way people, processes, digital, finance and culture fit together
- A clear framework for improvement and sustainability
- A way to test and learn now, while preparing for Alder Hey's role as a CYP IHO

Phase 1 (in-year) is underway, with a wider TOM in development aligned to the milestones set out in this report.

Board Timetable:

- September: Board update
- October: Strategy Board discussion
- November: Extended Board Time Out (deep dive)
- December Formal approval

4.3 CYP Integrated Health Organisation (IHO)

Following the publication of the NHS 10 Year Plan, the aim is to shape and develop a strategic proposal for the exploration and potential development of a IHO for CYP in Cheshire and Merseyside. There are multiple aspects to this, in terms of external influence nationally and locally, the development of a proposition and a dependency on NHS England performance framework and pioneer selection.

Our Growth and Opportunities (GO) stream are leading this work, GO establishment and key stakeholder engagement are underway.

Indicative Timeline:

- 2025/26 – Engagement and case development
- Apr 2026 – Potential selection as pioneer IHO
- Apr 2027 – IHO implementation

Board Timetable:

- September: Initial discussion
- October: Strategy Board deep dive
- November: Extended Board Time Out (update)
- December: Progress update

5. Priorities and Deliverables

The table below summarises the priority areas, proposed deadlines by month with what should go where in terms of committees and Board.

Priority Area	August	September	October	November	December
1. Closing the In Year Gap Exec Lead AB/RL	• FTPC plan agreed • Programme in place, monitored through weekly strategic command	• Weekly updates via FIP • Update to FTPC and Board of Directors • Progress of plans	• Weekly updates via FIP • Update to FTPC and Board of Directors • Progress of plans	• Weekly updates via FIP • Update to FTPC and Board of Directors • Progress of plans	• Weekly updates via FIP • Update to FTPC and Board of Directors • Progress of plans
2. Vision 2030 Blueprints Exec Lead KW	• Blueprints first draft for review via weekly group	• Blueprints further draft for review end September • Clinical and Executive input throughout September through collaboratives • Update to September Board	• Blueprint Shape and Progress presented to October strategy Board • Further iteration throughout October • Final version of Blueprints completed and signed off by Executives end October	• Deep dive with Board at Extended Board Time Out linked to TOM	• Board approval of Medium Term Plan including Blueprints, 3 year transformation programme and benefits plans and TOM

Priority Area	August	September	October	November	December
3. Target Operating Model Exec Lead MS	• Scope of work agreed	• First draft of Target Operating Model developed by end September • Weekly updates at Execs • 11th Sept Corporate TOM	• Shape of TOM update to Strategy Board • 15th October Executive Time Out to further develop and refine TOM • Next draft of TOM complete by end October • Weekly updates at Execs	• Deep dive with Board at Extended Board Time Out • Final draft of TOM end November	
4. Strategic Positioning – CYP IHO Exec Lead DJ	• Shape of potential IHO drafted • Partner and Executive Discussion/Development	• September Private Board discussion on opportunities • Inaugural Growth and Opportunities Committee	• October Strategy Board discussion including external 'state of the nation' • October Strategy Board IHO architecture proposal	• Update Board Extended Time Out Discussion	• Board Update

6. Summary and Next Steps

Between August and December 2025, Alder Hey has commenced implementation of an in year plan to close the financial gap and a medium term plan aligned to NHS England's emerging planning guidance.

Next Steps include:

- Executives to continue progressing operational and strategic workstreams for each priority, with weekly tracking and updates to FTPC and the Board.
- Finance, Transformation and Performance Committee (FTPC) to oversee delivery of the in year financial recovery plan and receive regular progress reports
- Board and Strategy Board to provide input to Blueprints, Target Operating Model and emerging IHO work
- Board of Directors (Dec) to formally approve the medium term plan

Board of Directors are asked to note the contents of this report and support the proposed approach.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	Vision 2030 Transformation and Closing the Gap. Programme Update
Report of:	Natalie Palin: Director of Transformation and Change Kate Warriner: Chief Transformation and Digital Officer Rachel Lea: Interim Chief Finance 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	R	Partially Assured Controls are still maturing – evidence shows that further action is required to	☐	Not Assured Evidence indicates poor effectiveness of controls

		applied and effective in practice		improve their effectiveness		

1. Executive Summary

At the July Board, members considered the Vision 2030 Transformation Update. That discussion set an important tone: our ambitions are high, but we must sharpen focus, strengthen benefit discipline, and embed clear governance if we are to deliver.
This paper provides the next step. It sets out how the organisation is leading the *Closing the Gap* priority through a **single integrated programme**, designed both to deliver the £6M in-year financial requirement for 2025/26 and to lay the groundwork for the next phase of transformation.

The programme is deliberately designed to combine **transactional actions** (such as procurement savings, pharmacy optimisation, diagnostics and income validation) with a set of **accelerated collaborative actions** linked directly to Vision 2030:

- **Organisational Design – Workforce**
- **Reimagined Elective Care – Activity, Theatres and Outpatients**

These collaborative actions are more than short-term measures. They are the **foundational building blocks** of the multi-year transformation programme, delivering immediate improvement while also shaping the Target Operating Model and future blueprints. In this way, *Closing the Gap* is not separate from transformation – it is its first discipline: the discipline of focus, delivery, and assurance.

2. Assessment of Current Position

The programme was formally launched in August, using the methodology that underpinned the Financial Improvement Programme. This provides a consistent framework of weekly tracking, milestone management, and executive oversight.

So far, progress is **mixed but tangible**. Transactional actions such as procurement, diagnostics and pharmacy have begun to release early savings, though benefit validation is uneven. The collaborative actions are showing greater promise. Workforce redesign and theatres productivity are gaining traction, while outpatients requires tighter scope and leadership focus. These are high-impact areas that not only support this year's £6M target but also begin to re-shape our operating model for the longer term.

The latest financial position is shown below. While significant progress has been made, overall delivery confidence remains variable hence why routine and habits linked to the governance structures have been implemented.

Table 1: Closing the Gap – Financial Position (August)

Ref	Programme Area	SRO	Financial Target (IYE)	Latest Forecast (IYE)	Financial Target (FYE)	Latest Forecast (FYE)	Confidence Rating
CTG1	Activity, Coding & Income	AB/KW	£0.5m	£1m improvement to income plan plus £0.5m coding	£0	£0	
CTG2	Workforce – Medical	A.Bass	£0.5m	£0.15m	£2m	£0.4m	
CTG3	Workforce – Non-Medical	MS	£3m	£1.7m	£3m	£1.7m	
CTG4	Procurement & Energy	NA/RL	£0.6m	£0.2m	£1m	£0.4m	
CTG5	Pharmacy & Diagnostics	RL	£0.5m	£0.3m	£1.5m	£1.1m	
CTG6	Elective Care – Theatre	CL	£1m	£0.4m	£2m	£0.4m	
CTG7	Elective Care – Outpatient	AB	£0.8m	£0.8m based on 50% income	£2m	£1.9m	
CTG8	R & I (GO Agenda)	JC	£0.4m	£0.2m	£1m	£0.2m	
	Total		**£7.3m**	**£5.25m**	**£12.5m**	**£6.1m**	

The collaborative areas in particular provide the "double dividend" – contributing to this year's gap while also creating the foundation for the three-year CYP blueprints.

3. Governance

Closing the Gap is being delivered as a single, formal programme, not as a collection of isolated savings. The governance is deliberately simple but strong:

- **Finance Improvement Programme (Tactical):** focused on operational and financial delivery, ensuring grip at pace.
- **Transformation Board (monthly):** the key forum for milestones, risks, integration across collaboratives, and resource support. This ensures transactional actions and collaborative accelerators are managed together.
- **Portfolio Board (monthly):** oversees strategic alignment, applies the Strategic Filter, and connects in-year delivery to Vision 2030.
- **FTPC**: provides first-line assurance through deep dives and reporting.
- **Trust Board**: receives monthly updates and assurance on overall programme delivery.

This governance ensures the Board has a single line of sight from weekly operational grip through to long-term strategy.

4. Programme Governance Review and Assurance Maturity

While the governance structure is clear, assurance reviews show that **programme governance maturity is still variable across the collaborative workstreams**.
The Programme Assurance matrix (Appendix 1) highlights several consistent themes:

- Benefits have been defined but are not consistently tracked – NB not all programmes are managed through the corporate team.
- Risk reviews are in place but not yet embedded at the frequency needed.
- Equality and Quality Impact Assessments remain incomplete in some areas.
- Scope and approach are still emerging in parts of the Organisational Design collaborative.

Figure 1: Programme Assurance (August 2025) *(heatmap as included in Appendix)*

These findings are not unexpected given the pace of mobilisation. What matters is that they are visible, acknowledged, and being actively managed. The Transformation Board has taken ownership of addressing these assurance gaps. Its immediate priorities are to:

- Embed monthly risk reviews across all collaboratives.
- Ensure recurrent benefit tracking is in place for every programme.
- Complete EIA/QIA as standard practice.
- Provide targeted support to amber and red rated workstreams.

By doing so, we strengthen the programme's credibility and ensure that delivery discipline is embedded.

5. Risks and Concerns

The programme is ambitious, and delivery is not without risk. The most significant risks include dilution of focus, lack of recurrent benefits, quality compromise, fragmentation between transactional and transformational, and resourcing stretch.

Each is being actively mitigated through governance, with escalation to the Transformation Board and Finance Improvement Programme.

Risk	Impact	Mitigation
Plans lack focus	Benefits diluted	Stop/start discipline; executive challenge
Benefits not recurrent	Gap closed only in 25/26	Sharper benefit logic; recurrent tracking
Operational savings compromise quality	Impact on patient safety/experience	Clinical Cabinet oversight; EIA/QIA; SPC monitoring
Fragmentation between transactional vs collaborative	Loss of alignment with Vision 2030	Transformation Board integrates both as one programme
Resource stretch	Delivery slowed or spread too thin	Monthly review and reprioritisation at Transformation Board

6. Next Steps (Aug–Dec 2025)

The next period is about **delivery with discipline**:

- FTPC has received the first Deep Dive and will continue to track progress.
- Transformation Board will continue to oversee milestones monthly and escalate risks.
- September–October will focus on delivering the scope of workforce and outpatient collaborative actions.
- In November, the Board will receive a Time-Out Deep Dive on overall programme progress.
- In December, the Board will be asked to approve the integrated trajectory into 2026.

7. Conclusion

This paper bridges the ambition of Vision 2030 with the immediate necessity of financial delivery. Closing the Gap is not a distraction from transformation; it is the first step. It is a **single integrated programme** that deliberately combines:

- **Transactional actions** that provide immediate grip.
- **Collaborative actions** – Organisational Design – Workforce, and Reimagined Elective Care – Activity, Theatres, Outpatients – that provide the **foundational building blocks of the multi-year transformation**.

In doing so, the programme is anchored across three horizons: securing grip in 25/26, embedding collaboratives into the next three-year blueprints and Target Operating Model, and positioning Alder Hey in the context of the wider system.

This ensures that every action taken today is aligned to tomorrow's system design, and that we remain grounded in our consistent principles of being **clinically led, empowering teams, and working with fewer silos**.

The Board is asked to:

1. **Note** progress and assurance on delivery.
2. **Endorse** the integrated programme management structure and governance review.
3. **Support** the continued focus on fewer, high-value priorities that both close the in-year gap and form the foundations of Vision 2030.

Appendix 1: August Programme Governance

Collaboratives	Programmes	Project status	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY RATING	Targets / benefits defined/on track	Milestone plan is defined/on track	OVERALL FINANCIAL DELIVERY	Comments / Escalations
Re-imagining Elective Care	Centres of Excellence	In delivery												1. Majority of milestones are on track or complete. 2. Benefits are defined but not yet tracked. 3. Regular risk reviews required. 4. EIA/QIA not complete.
	Sustainable Outpatients	In delivery												
	Clinical Productivity	In delivery												
Acute, Urgent Care and Diagnostics	Acute Care Ground Floor Mobilisation	In delivery												1. Benefits are defined but not yet tracked for Acute Care Ground Floor 2. Regular risk reviews required for Acute Care Ground Floor. 3 EIA/QIA not complete for Acute Care Ground Floor. 4. Gen Paeds @ it's best and Diagnostic are profiled to start later in the year and so red ratings in some areas can be expected.
	Gen Paeds @	Emerging - in scope												
	Diagnostics	Emerging - in scope												
Organisational Design	Culture and Values	In delivery												1. Scope and approach for Leaders & Managers to be defined. 2. Benefits for Leaders & Managers to be baselined and tracking begin. 3. Overaching EA QIA drafted pending sign off 26 Aug 4. Stakeholder engagement to increase for AHP workstream 5. Regular risk reviews required for Patient Admin & Support 6. Unable to rate Governance workstreams at this time. 7. Skills for the future project documentation to be worked up - as to be expected - functions as supporting workstreams to others.
	Leaders and Managers	Emerging - in scope												
	L&M - AHP	In Delivery												
	L&M - Patient Administration & Support	Emerging - in scope												
	Governance	In Delivery												
	Skills for the Future	Emerging - in scope												
Neighbourhoods and Prevention	Neighbourhoods and Prevention	Emerging - in scope												1. EIA / QIA not yet complete but this is to be expected.
Digital	Digital	In Delivery												1. EIA/QIA for each workstream not yet completed. 2. Benefits defined and targets identified but no benefits tracking available.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Integrated Operational Plan: Progress to date**
Report of:	**Adam Bateman, Deputy Chief Executive & Chief Operating Officer**
Paper Prepared by:	**Matthew Upton, Acting Head of Performance**

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

Executive Summary

This report provides an update on the progress of the Integrated Operational Plan for 2025/26, detailing performance against four key priority areas and national operational priorities. The Trust has shown exceptional performance in a challenging environment, evidenced by its Segment 1 placement in the National Oversight Framework and a "CQC Outstanding" rating in Mental Health and Neurodiverse services.

Significant progress has been made in several areas. Patient safety has been enhanced through the implementation of the NPEWS system and the successful deployment of Martha's Rule. The Trust is also transforming key clinical services, with developments in the Neighbourhood model and the Same Day Emergency Care (SDEC) centre. The new AI Strategy is being rolled out, with digital solutions like Lyrebird and Copilot already in use to improve staff experience.

Financial sustainability remains a key challenge. While the Financial Improvement Programme is in place, the CIP programme is currently behind its target, with a forecasted in-year gap of £6m. A new "Closing the Gap" programme has been established to address this and develop a sustainable financial model. Additionally, there are ongoing challenges with meeting the 52-week waiting time target for certain specialties, primarily due to changes in local pay agreements that have impacted weekend activity.

From a workforce perspective, there has been a significant reduction in bank and agency WTE; however, there remains a gap of approximately 100 WTE to the planned end of March 2026 target.

The Trust continues to grow its partnerships, with the launch of the POIZ funding and new collaborations with organisations like Edge Hill University. The new Growth and Opportunities Committee will focus on campus and sustainability initiatives. Looking ahead, the Trust is preparing for winter challenges with a strong plan focused on productivity and collaborative efforts with partners. A new medium-term strategy is being developed to provide a clearer narrative for service transformation whilst meeting the needs of children and young people.

1. Introduction

Guided by our 2030 Vision and the needs of children, young people and their families the Integrated Operational Plan outlined the four priority areas for delivery in 2025/26. Additionally, the national operating priorities for 2025/26 were included, which aim to improve access to care, increase productivity and drive reform. The report provides an update on progress made this year against the priority areas, national operating priorities and workforce plan.

2. Priority areas for delivery

The following section provides an update on the progress made so far this year against the four priority areas for delivery.

i. **Patient safety**: reduce preventable harm, support safe care and act on learning through a just and restorative culture.

We continue to focus on reducing pressure ulcers, particularly grade 2 ulcers and those related to medical devices. We have implemented the NPEWS system, which enables observations to be directly entered into the patient record system and provides automated alerts. Martha's Rule has been deployed across all inpatient areas, with the target of responding to activation within 10 minutes being consistently met.

Additionally, a deteriorating patient working group has been established, using data-driven approaches. Feedback from learning reviews indicates an improved response in line with a just and restorative culture.

ii. **Transforming key clinical services and support services:** we will offer, with our partners, new services in neighbourhoods; open the first paediatric same day emergency care centre (SDEC) in England; and improve access to elective care through more efficient service models. We will modernise our support services, harnessing data and AI solutions to reduce burden and improve staff experience.

Progress continues across the transformation programme, with significant developments in key clinical and support services. The Neighbourhood model is developing successfully, as we have completed the first multidisciplinary team workshop and are currently working on data packs for three neighbourhoods. Additionally, the SDEC is progressing, with pilot pathways being scoped and bed modelling options set to be presented to the Clinical Cabinet in August.

The AI Strategy has been launched to positive feedback both internally and externally, receiving recognition from the trade press. We are currently deploying digital AI solutions such as Lyrebird and Copilot, with over 268 users successfully onboarded and additional training planned. A regional opportunity to explore ambient voice technology is scheduled for late August, supporting the Trust's goal of modernising support services and enhancing the staff experience.

iii. **Securing financial sustainability: through a new financial improvement programme.**

The Financial Improvement Programme has become an integral part of the trust's governance structure for 2025/26. Weekly FIP decision meetings and Corporate Collaboratives are actively promoting transformational change.

The CIP programme for this year continues to face challenges. To date, 68% (£15.5m) of the £22.7m target has been implemented or fully developed, leaving £4m in amber and £3.2m in red. In response to the level of amber and red CIP remaining, to ensure financial sustainability for the

year and beyond, the Closing the Gap programme has been established for the remainder of the year. This programme aims to identify additional in-year savings and develop a sustainable financial model for the future.

iv. **Grow the future: our local, national and global partnerships will grow our reach, positively impacting the health and wellbeing of more CYPF. Our commercial and academic collaborations will accelerate discoveries in research, innovation, digital and education. Through our Green Plan we will reduce carbon emissions and improve public health.**

The POIZ funding has been launched, and we are making progress on both internal and external appointments to expedite the implementation. Interviews for the Director of Liverpool Institute of Health and Wellbeing are scheduled for September. Additionally, a research community event is planned for the fourth quarter of 2025.

We are committed to developing an integrated future system for CYP and collaborating across C&M to advance this initiative. Our partnership with the Liverpool Tripartite has started with a focus on lung health.

A new framework for observerships has been launched, including a website that is now accepting applications. There have been advancements in observerships with China, and we are continuously pursuing opportunities with Peru.

Final draft of a new strategic partnership agreement with Edge Hill University for a national PGCE programme to be delivered this academic year.

The new Growth and Opportunities Committee is set to launch this September, aiming to enhance our focus on campus and sustainable initiatives. In addition a framework for providing healthcare to private patients has been established.

Challenges persist in several areas within Grow the future, including:

1. Meeting the income generation target for robotic process automation.

2. Achieving the research income target for the third MRI scanner.

3. Ongoing financial pressures within the C&M system are constraining the potential for large-scale transformation, particularly in the absence of an official mandate

4. Capacity for clinical engagement and timely implementation to deliver on programmes aligned to strategic priorities.

5. There is a gap in general and commercial management skills, which may require external recruitment to address.

3. Supporting our People: The Workforce plan

The delivery of the workforce plan has been supported by the Workforce Efficiencies Programme, the Organisational Design Collaborative, and the Workforce Establishment & Vacancy Panel

meeting. Whilst a significant reduction in bank and agency WTE has been achieved (- -48.88 WTE from M12 24/25), there remains a gap (circa 100 WTE) to the planned end of March 2026 WTE.

	M12 24/25	M01 25/26	M02 25/26	M03 25/26	M04 25/26	M12 25/26
Substantive	4,136.71	4,079.84	4053.46	4051.37	4054.61	
Trainees	178.2	172.86	165.21	169.41	163.97	
Bank	140.71	101.17	98.54	91.03	94.18	
Agency	8.11	6.49	4.64	5.69	5.76	
Total Workforce	**4,463.73**	**4,360.36**	**4,321.85**	**4,317.50**	**4318.52**	
Plan	4,273.40	4,481.85	4,490.85	4486.16	4454.36	4,213.30
Difference from previous month		-103.37	-38.51	-4.35	1.02	
Difference to M12 plan		-147.06	-108.55	-104.20	-105.22	-105.22

As part of the Closing the Gap programme additional workforce measures have been identified to support further reduction. This includes specific actions on sickness absence improvement, supported through the delivery of the 90-Day Sickness Improvement project which commenced in July. While short term sickness has been consistently under the 2% target this year, long term sickness has been increasing to 4% in July 2025, with additional targeted action.

4. National Operational Priorities:

The image below illustrates the performance of M1 and M4 against national operational priorities. In response to the year-to-date performance, the 'assessment to deliver' metric has been revised.

Priority	Measure	M1	M4	25/26 National Target	Assessment to deliver	25/26 Internal target
Reduce the time people wait for elective care	% of patients waiting no longer than 18 weeks for treatment	54%	60%	63%		63%
	% of patients waiting no longer than 18 weeks for a first appointment	58%	61%	67%		67%
	Reduce the proportion of patients waiting over 52 weeks	2.0%	2.0%	1%		1%
	Improve performance against the 28-day cancer faster diagnosis standard	96%	96%	80%		98%
Improve ED waiting times	Improve A&E waiting times to treat patients within 4 hours	85%	85%	78%		83%
Live within the budget, reducing waste & improving productivity	Deliver a balanced financial position for 2025/26	(£1.2m)	(£1.5m)	£7.2m		£7.2m
	Reduce agency expenditure, with a minimum 30% reduction across the system	62k	£0.2m	£0.9m		£0.5m
Improve mental health and learning disability care	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP compared to 2019	0	17,783	N/A		43,340

The next two sections will provide additional details on metrics where our delivery assessment is rated as amber or red.

4.1 Proportion of patients waiting over 52 weeks

The changes to the AHP local pay agreement have temporarily halted weekend outpatient and theatre activities. As a result, there has been an increase in the number of patients waiting over 52 weeks, particularly in ENT and Dentistry. Outpatient clinics resumed in late August, and the division is working to reinstate theatres starting in October. While there is a plan to achieve the necessary activity levels, it depends on successfully resuming weekend theatre lists, the recruitment of hard-to-fill positions, and ongoing support from insourcing.

4.2 Deliver a balanced financial position

Year to date (to month 4) performance was a £1.5m deficit which was adverse to plan by £0.3m, having been on plan in month 1 and 2, with small deficits in month 3 and 4, primarily driven by

industrial action in month 4. However, the year-to-date position has been supported by several non-recurrent items that have benefited the position in the year, with the underlying position to date being c. £4.6m.

The trust is forecasting to externally achieve £3.4m in line with ICB requirements (pre-stretch); which assumes that the £6m closing the gap programme delivers. The stretch target of £3.8m is a system risk share and discussions are ongoing with the ICB on how Alder Hey can support achievement of this target.

4.3 National Oversight Framework

The NHS Oversight Framework 2025/26 is due to be formally published in September 2025 and describes a consistent and transparent approach to assessing ICBs and NHS trusts and foundation trusts. Its primary objectives are to ensure public accountability for performance and to provide a robust foundation for how NHS England collaborates with systems and providers to support improvement.

This new framework replaces the previous judgement-based approach with a data driven segmentation model across six key domains. The framework explicitly states that segmentation is based on a focused set of metrics that target the priorities set out in the 2025/26 NHS priorities and operational planning guidance. These metrics are scored individually (1 to 4, with 1 being the highest rating) and then consolidated, averaged, and quartiled to give an overall segment.

Alder Hey is currently in Segment 1, signifying consistently high performance across all domains and delivery against plans. Maintaining this status requires monitoring of all specified metrics, particularly financial performance, as any deficit or receipt of deficit support would automatically limit our segment to a maximum of 3, regardless of operational delivery.

5. The months ahead

As we enter the second half of the year, we are not without our challenges. The financial environment is extremely challenging. We have forecasted a gap of £6m that we need to close, which requires us to reduce our expenses by £1m each month. While we have a plan to achieve this, we recognise that it is becoming increasingly difficult and the associated impact is felt across the whole organisation.

A key strategy of the Board has been to focus on our people and to support their well-being. We recognise the significant impact that the current financial environment is having on everyone, and we remain very concerned about morale. We will be launching our new values and implementing a leadership connection programme designed to strengthen our unity and facilitate learning from one another. This approach will help us make informed decisions together.

As we enter winter, we will face challenges in meeting our access targets. However, we have developed a strong winter plan and are focusing on improving our productivity to maintain access to services. This is particularly challenging given the current financial environment, which limits

our capacity to deliver additional shifts. We will seek to collaborate more with partners to accelerate access, such as through elective hubs and the paediatric 111 system.

6. Conclusion

This report highlights exceptional performance in a very challenging environment. We are placed in segment 1 of the National Oversight Framework, maintain our safety standards, and have achieved a CQC Outstanding rating in Mental Health and Neurodiverse services. We are also making significant progress in managing deteriorating patients.

This performance is a testament to the hard work and dedication of our staff, and we are committed to providing them with the support they need to continue transforming services . We are making progress on our workforce plan, having reduced bank and agency WTE by 48.88% from the previous year. However, we continue to work on closing the remaining gap of around 100 WTE to reach our target.

While access to services remains a challenge, we have plans in place to increase productivity, and we are being asked to provide mutual aid within the C&M areas, the region, and Ireland. Additionally, we are prioritising the development of our digital offerings, focusing on how artificial intelligence can assist our colleagues and enable us to treat more children effectively.

Our wider goal to address issues affecting children and young people is both ambitious and shows signs of real progress. We are launching POIZ and aiming to highlight child health through our Institute of Child Health & Wellbeing. Our foundational academic partnerships are strong, and we aim to further strengthen them. We are not resting on our accomplishments; instead, we are looking to fundamentally transform how services are delivered. Examples of this include our SDEC programme and our soon-to-be-opened new Neonatal Intensive Care Unit.

Despite the turbulent system environment, we are increasingly recognised as a valuable partner throughout the entire pathway for Children and Young People which includes neighbourhoods, community and mental health services, as well as acute care, diagnostics, and our tertiary role. This recognition is evident in the development of stronger relationships across the health sector, particularly with our partners in the triumvirate (Mersey Care and LUG), local authorities, primary care, academia, and industry. We hope that the second half of the year will provide additional partnership opportunities that will enhance our impact on Children and Young People.

We recognise that our current approach to managing our financial resources is not sustainable. Therefore, we have presented a plan to the Board to develop a medium-term strategy. This strategy will provide a clearer narrative for the organisation on how we will transform our services, expand our reach, and positively impact the lives of more Children and Young People.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	Winter Plan 2025/26
Report of:	Adam Bateman, Chief Operating Officer
Paper Prepared by:	Nikita Pickard, Interim Associate Chief Operating Officer

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This is the plan for managing in Winter 2025-2026. This has been pulled together in collaboration with key stakeholders across the organisation and with clinical oversight. This plan will be implemented through a fortnightly working group made up of cross divisional and cross discipline representation.
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:	Any additional resource requirements are currently subject to separate business case proposals.

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

Alder Hey Autumn & Winter Emergency Response Plan

August 2025

Version 1.1

Contents

1. Introduction

1.1 Purpose of the Plan

The primary objective of this Winter Planning Document is to provide a clear framework for preparedness, response, and resilience, ensuring that the Trust can effectively navigate the increased demand and maintain the delivery of high-quality care throughout the winter period.

1.2 Scope

This document encompasses all critical aspects of service delivery at Alder Hey which would be impacted by seasonal winter pressures including, urgent and emergency care, critical care and elective care. It outlines the coordination of resources, staffing requirements, patient flow management, and infrastructure considerations. The scope extends to both immediate response mechanisms and longer-term strategic initiatives designed to enhance overall operational resilience.

This plan therefore sets out the modelling, escalation framework and capacity interventions that underpin this year's winter plan. This plan is focused on delivering outstanding safe care to C&YP through, and keeping our staff safe, through this period of higher demand.

2. Approach to Alder Hey's Winter Plan 2025-26

2.1 Overarching Aim

To ensure the Trust is prepared to manage anticipated seasonal pressures, maintaining a focus on providing safe, effective and efficient care for children and young people, while also supporting our staff to remain safe and well at work.

2.2 Key Principles

The overarching aim of the Winter Plan will be delivered through three key areas:

1. Capacity & Flow
2. Alternative Services
3. Vaccination

These will all be underpinned by robust datasets and information sharing.

2.3 Reflections on 2024-25's Winter Plan

Before progressing ahead to develop the Winter Plan for 2023-24 colleagues across the Trust reflected on last years winter plan identifying areas which worked well and areas which may require further focus and prioritisation this year.

What Worked Well	Areas to Improve
Achieved 78.9% ED performance across Winter months (October 24-March 25)	Peaks of occupancy > 95% were reached
Overall midnight bed occupancy of 81.8% for October 24-March 25 with an overall midday bed occupancy of 85.2%.	Elements of elective planning could have been managed more effectively.
Zero days where nurse staffing fell below a RAG of Amber.	Clarity regarding escalation spaces was required; they were challenging to open and manage
Managed a higher incidence of positive respiratory cases when compared to the same timer period in 2023/24	Vaccination rates were below the national target.
Operated within a different estate successfully	
Increase in staff flu vaccines from 34% to 40% when compared to previous year	
Transitioned to a new provider for the Primary Care Stream element of the UTC with minimal disruption to service.	

3. Demand Modelling

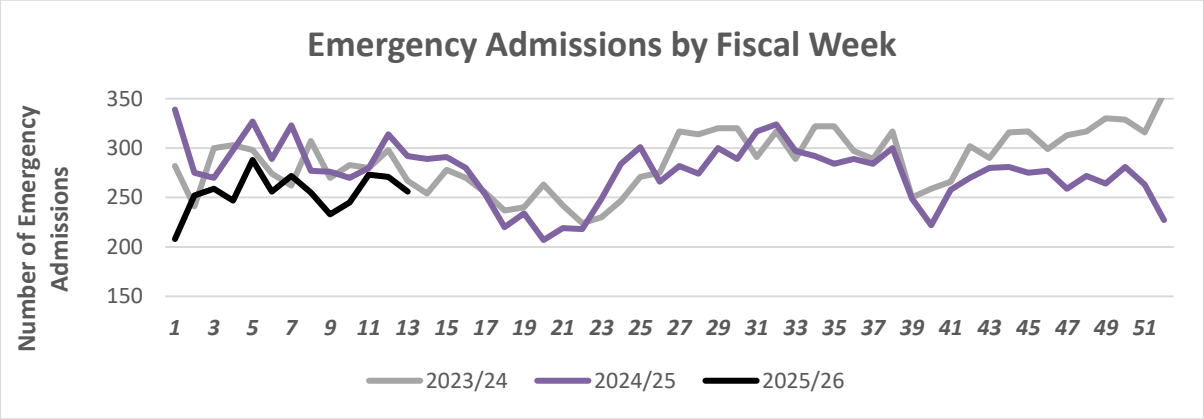
3.1 Emergency Attendances

	2022/23			2023/24			2024/25			2025/26		
	Attendances	Breaches	%	Attendances	Breaches	%	Attendances	Breaches	%	Attendances	Breaches	%
April	5385	1481	72.5%	5063	800	84.2%	5628	704	87.5%	5665	794	86.0%
May	6025	1582	73.7%	5775	873	84.9%	6132	816	86.7%	5927	901	84.8%
June	5692	1261	77.8%	5671	815	85.6%	5734	934	83.7%	5799	886	84.7%
July	5546	1337	75.9%	5051	461	90.9%	5493	667	87.9%			
August	4201	406	90.3%	4479	344	92.3%	4093	301	92.6%			
September	4985	815	83.7%	5438	1205	77.8%	5337	825	84.5%			
October	6013	1480	75.4%	6512	1956	70.0%	6255	1144	81.7%			
November	6610	2331	64.7%	6040	1298	78.5%	6642	1755	73.6%			
December	7419	2843	61.7%	6328	944	85.1%	6151	1163	81.1%			
January	5167	1212	76.5%	6324	1149	81.8%	5814	1262	78.3%			
February	4956	1097	77.9%	6189	1334	78.4%	5553	1161	79.1%			
March	5911	1328	77.5%	6895	1073	84.4%	6460	1304	79.8%			

Average attendances in 2024/25 were in line with 2023/24 at 5,750 per month; however, it is noted that this is a seasonal position with an average of 6,140 per month October-March.

3.2 Emergency Admissions

The below chart shows the emergency admissions since 1st April 2023 up to 20th July 2025 including Emergency Decisions Unit and Paediatric Assessment Unit admissions. This shows an increase in admissions from October -March compared to other months of the year. Of note, admissions from October 2024-March 2025 were 3.7% below the same period in 2023/2024.



3.3 Elective Demand

The elective schedule will run as per the same schedule a last winter. There has been no change to speciality allocation in theatres and minimal variation in case mix that would result in an increased number of elective bed days. However there is a programme of work ongoing in surgery which may

have a positive impact in reducing elective bed days focusing on converting overnight stays to day case.

Unfortunately data is not available to model the impact of this on bed occupancy going forward.

3.4 Australian Influenza 2025

IMMUNISATION COALITION

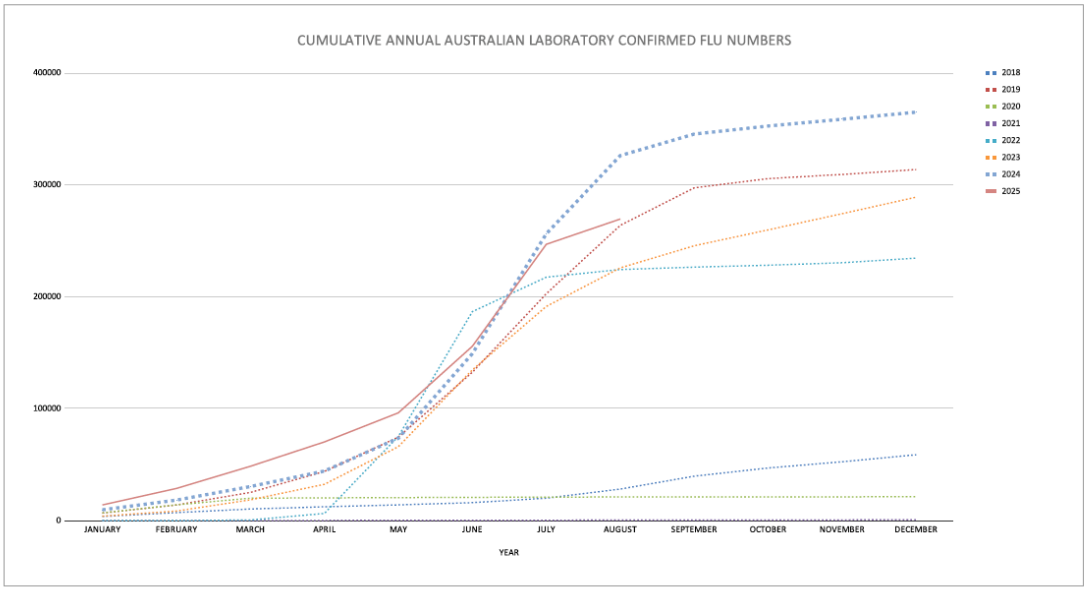
The Immunisation Coalition is the leading voice in whole-of-life immunisation in Australia, protecting all Australians against communicable diseases.

For more information, please visit our website: https://www.immunisationcoalition.org.au/news-data/influenza-statistics/

CUMULATIVE ANNUAL AUSTRALIAN INFLUENZA STATISTICS

YEAR	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
2018	3,751	7,218	10,407	12,383	14,095	16,090	20,057	28,215	39,738	47,062	52,604	58,877
2019	6,808	13,993	25,227	43,972	74,622	132,573	202,673	263,763	297,294	305,551	309,293	313,615
2020	6,963	14,143	20,056	20,360	20,597	20,825	21,018	21,143	21,202	21,238	21,291	21,355
2021	56	104	160	224	296	367	427	480	536	587	655	753
2022	40	79	619	6,447	75,267	186,671	217,486	224,352	226,480	228,162	230,396	234,581
2023	4,053	8,592	18,583	32,480	66,073	134,660	191,359	225,782	245,561	259,741	274,208	288,956
2024	9,706	18,345	30,489	44,312	73,620	149,158	256,224	326,102	345,335	352,527	358,576	364,894
2025	**14,056**	**28,776**	**48,592**	**70,332**	**96,329**	**155,752**	**246,865**	**269,433**				

Data valid as at: **11 August 2025**



Reference: These statistics are taken from the Aust Government Department of Health, National Notifiable Diseases Surveillance System

In 2025 Australia has experienced a record high 70,332 flu cases in the first quarter of the year - an increase of nearly 50% on cases reported in 2024. By May, this figure rose to 96,329; a steep increase from the previous month and figures reported from the previous year, and indeed every year since 2018. It is important to note that cases were reported much earlier than in previous years, with several occurring before winter had even officially begun.

Influenza vaccination uptake was lower in all groups compared with the previous year, with less than one third of Australian children taking the vaccine. Reasons given for low uptake include vaccine fatigue, misinformation and complacency. In 2025 the Immunisation Coalition reports that only 24.7% of eligible 6m0-5yrs and 14.3% of 5-<15yrs eligible patients had the flu vaccine. These figures were equally low in previous years which could potentially have an impact on the record number of reported cases in 2025.

It is important to note that the Australian flu season has not yet concluded- as such available data reflects only the early part of the season, and any conclusions drawn should be tempered with this

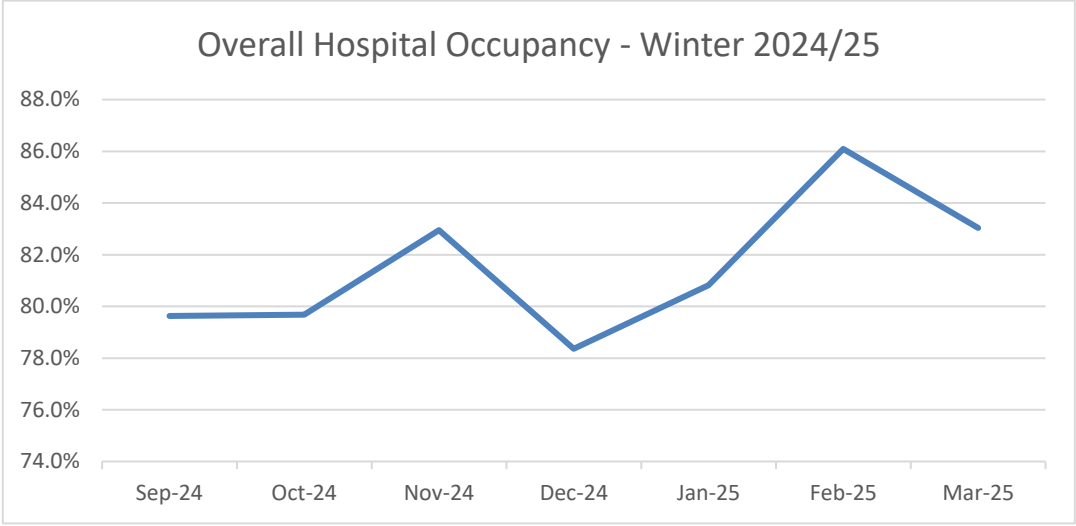
understanding. However, if transmission patterns are similar, Australia's early surge could suggest that the UK could also face a challenging flu season which may start earlier than expected. An emphasis should be placed on vaccination promotion and surge capacity planning so that we may be prepared for flu season in the UK.

References:

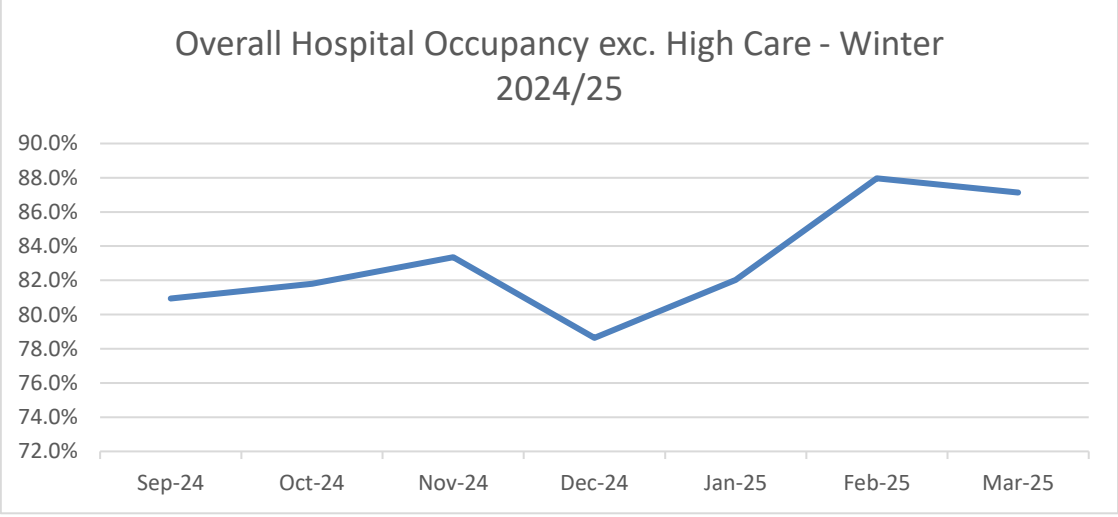
- https://ausvaxsafety.org.au/2025-australian-flu-season-who-should-get-flu-shot-which-vaccines-are-available-and-what-expect
- https://nindss.health.gov.au/pbi-dashboard/
- https://www.immunisationcoalition.org.au/news-data/influenza-statistics/

3.5 Hospital Occupancy 2024-2025

The below shows the overall hospital midnight occupancy for winter 2024/25 including high care beds and excluding assessment beds.



The below shows overall hospital midnight occupancy for winter 2024/25 excluding high care and assessment beds.



4. National Guidance

The **National Urgent and Emergency Care (UEC) Plan for Winter 2025/26** outlines **seven key priorities** aimed at delivering the biggest impact on urgent and emergency care services during the winter months. These priorities are:

1. **Faster Ambulance Response for Category 2 Patients**
   Ensure that Category 2 patients (e.g., those with strokes, heart attacks, or sepsis) receive an ambulance within **30 minutes**, down from the previous average of 35 minutes
2. **Ambulance Handover Time Standard**
   Meet the **maximum 45-minute ambulance handover time**, helping to reduce delays and get ambulances back on the road more quickly
3. **Improved A&E Performance**
   Ensure that **78% of patients** attending A&E are admitted, transferred, or discharged within **4 hours**, improving from the current 75%
4. **Reduce Long Emergency Department Waits**
   Cut the number of patients waiting over **12 hours** for admission or discharge to **less than 10%** of cases, and eliminate **24-hour waits** for mental health admissions
5. **Tackle Delayed Discharges**
   Focus on reducing the nearly **30,000 patients** annually who stay **21 days beyond** their discharge-ready date, freeing up to **500,000 bed days**
6. **Expand Urgent Care Outside Hospitals**
   Increase the number of patients receiving urgent care in **primary, community, and mental health settings**, including through **Urgent Community Response teams** and **virtual wards**
7. **Boost Vaccination and Digital Infrastructure**
   Improve **vaccination rates** among frontline staff and invest in **digital tools** to streamline care, including a £20 million investment in **Connected Care Records** and expansion of the **Federated Data Platform**

Central themes underpinning the delivery of these priorities are leadership accountability, integrated winter planning, and performance transparency, with clear roles and responsibilities assigned to NHS England, trusts, integrated care boards, and local authorities to ensure timely, safe, and effective care delivery. These have been considered in the context for Children and Young People when designing the initiatives for this year for Alder Hey.

5. Alder Hey's Winter Initiatives for 2025-26

The table below provides an overview of the high impact initiatives in place and under development to ensure the delivery of the Winter Plan's aim.

	Description	Initiatives	Goals
Capacity & Flow	Clear escalation plans with defined roles and responsibilities	• Daily Sit Rep for Front Facing Teams • New ED Escalation plan aligned with SHREWD • Hierarchy of escalation spaces and defined criteria • Elective forward look dashboards • Review of key roles within hospital flow • Clinically Ready to Proceed[1] • Reduce admissions through increase in RSV uptake	• Clear decision-making framework • Visible leadership • Ability to de-escalate in a timely manner • Collective ownership of the challenge • Consistent message • Proactive management
Alternative Services	Establishment and expansion of services that provide an alternative to ED	• Expansion of CCNT pathways available via the Virtual Ward • Expansion of direct access to Virtual Ward from Community Partners • Establishing a Paediatric CAS pilot • Exploring the option to utilise telemedicine to support the use of alternative providers e.g. WICs.	• Reduce unnecessary attendances to ED • Reduce admissions • Reduce length of stay
Staff Health & Wellbeing	Ensure staff are supported in being protected from illness within the work environment	• Staff vaccination programme • Expansion of fit testing programme • Improvement in recording of interventions through ESR	• Minimum 50% staff vaccination rate • Minimum 80% fit testing compliance across high-risk groups

[1] Clinically Ready to Proceed refers to the point at which a healthcare professional determines that a patient no longer requires active treatment or monitoring in ED and is ready to move on to the next stage of care

5.1 Capacity & Flow

Escalation Plans – The ratification of a new ED escalation plan aligned with SHREWD metrics with clear actions to address. This will be established alongside a hierarchy of clinical escalation spaces in extremis (Appendix 1).

Medical Model – The medical model of care within escalation from both a clinical and leadership perspective is under review to ensure we are maximising the opportunity to manage capacity challenges utilising this workforce.

Clinically Ready to Proceed – The roll out and publication of Clinically Ready to Proceed (CRtP) within ED and owned at speciality level across the organisation with actions to address non-timely responses. This will support management of the four-hour target and improvements that we are looking to make.

Elective Management – Proactive data driven elective management and escalation at ward and speciality to maximise delivery of the elective programme.

Leadership – Clear expectations of key roles across the organisation including Nursing Leads, Hospital Manager of the Week, Senior Manager On Call and Executive On Call include visibility throughout the week.

Weekly LOS Meetings – The Medical Division has a well-established weekly LOS meeting chaired by Head of Nursing and attended by ward leads and the Complex Discharge teams. The Paediatrics Matron/Ward manager undertake daily huddles on 4C to review inpatients with an out of area (OoA) post code with a view to repatriation; bed managers actively manage repatriations to local DGHs once identified.

PAU Model – An enhanced model of PAU cover is in the process of being recruited to following successful approval of a business case. This will support senior decision making at the front door 7 days per week.

Weekly Performance Reports – Weekly performance reports will be issued to clinical teams demonstrating overall performance against length of stay and discharge metrics to support clinical ownership. Close monitoring of the ED target will also occur utilising this information with Trust wide ownership as we strive towards achieving 95% seen and discharged or transferred within 4 hours.

5.2 Alternative Services

ED Streaming – Maximising streaming from the front door to the onsite UTC with double capacity in the primary care stream from October-March.

Paediatric Assessment Unit – Increasing effectiveness and reducing length of stay on the Paediatric Assessment Unit through the implementation of the new model of care and establishing new operational oversight.

Virtual Ward – Expansion of virtual ward pathways to increase admission avoidance and reduce overall length of stay. Furthermore, expanding the number of GP practices onboard with direct access referrals into the virtual ward in order to avoid attendances where appropriate.

Complex Care Team – Working within community to keep patients at home rather than attending ED.

Paediatric CAS – The implementation of a dedicated Paediatric 111 Clinical Advisory Service (PCAS) for Cheshire & Merseyside (C&M), aimed at delivering urgent, paediatric-specific clinical advice to families with children aged 0–5. This initiative will enhance the existing NHS 111 pathway, improving clinical outcomes, reducing unnecessary Emergency Department (ED) visits, and generating substantial financial and operational efficiencies.

Bluebell House – Bluebell House has opened this year as a day unit for children and young people with eating disorders. This facilitate will support reducing admissions to acute wards for patients who do not require medical intervention.

5.3 Staff Health and Wellbeing

Improved Vaccination Rates: flu vaccination roll out aiming for minimum of 50%. The trust is offering online bookable appointment and drop-in sessions in addition to targeted vaccination in high volume areas. There is also a refreshed communication campaign to support the launch of this service.

SALS Support: ongoing staff support is available via the SALS team with any specific season channels identified feeding into the winter planning meetings.

Proactive sickness management: Review of highest sickness reasons within departments and proactively trying to mitigate.

FIT Testing: Ensuring improved FIT testing compliance with a minimum of 80% in high risk areas and then the subsequent access to appropriate PPE to protect staff through the course of their work.

6. Capacity and Escalation Plan

This section will focus on the Trust's available capacity this winter and escalation options.

6.1 General & Acute Capacity

Table one – G&A Bed Capacity

G&A Bed Capacity	
2024-25	201
2025-26	201
Variance	0

Last winter owing to a number of estate development works, the Trust operated with -7 G&A beds compared to previous winter, inclusive of escalation beds. This will be the same occupancy for this year.

Table two- Detailed distribution of beds and change between 2024-25 and 2025-26

	2024-25		2024-25	
Ward	Baseline Capacity	Escalation Beds	Baseline Capacity	Escalation Beds
1c Cardiac Ward	23	0	23	0
1c Neonatal Ward	9	0	9	0
3a (General Surgery)	32	0	32	0
4a (Neurology/Orthopaedic)	32	0	32	0
3c (Specialist Medicine)	31	0	31	0
4c (General Medicine)	22	0	22	0
3b (Cancer Services)	13	0	13	TBC
4b (Complex Medicine)	24	0	24	0
Burns Ward	5	0	5	0
EDU & PAU	10	2 chairs	10	2 chairs
4 Medical beds on HDU	0	4	0	4
Total Bed Capacity	**201**	**6**	**201**	**6**

Table Three- Summary of Core & Escalation Bed Capacity

	Weekday	Weekend
Core Capacity	191	187
Assessment Capacity	10	10
Escalation capacity	6	10
Total Winter Capacity	207	207

Consideration has been given to the wider estate that could be utilised for escalation in extremis. A table of this capacity is provided in appendix 1.

6.2 Critical Care

A key priority of the winter plan is to maintain access to critical care services to children requiring emergency or urgent access. Therefore, our plans are centred on resilient staffing and service arrangements to provide care for paediatric patients. If the situation changes to a worst-case scenario either nationally or regionally, we will work with colleagues in the network and support as needed based on the balance of clinical need across all age ranges.

Table five- critical care bed capacity

Critical Care	2024-25	2025-26	
	Capacity	Capacity	Variance
PICU	21	21	0
HDU	15	15	0

Critical care will be operational with the same volume of beds this winter.

The occupancy over winter 2024/25 ranged between 73%-86% for PICU and 47%-91% for HDU.

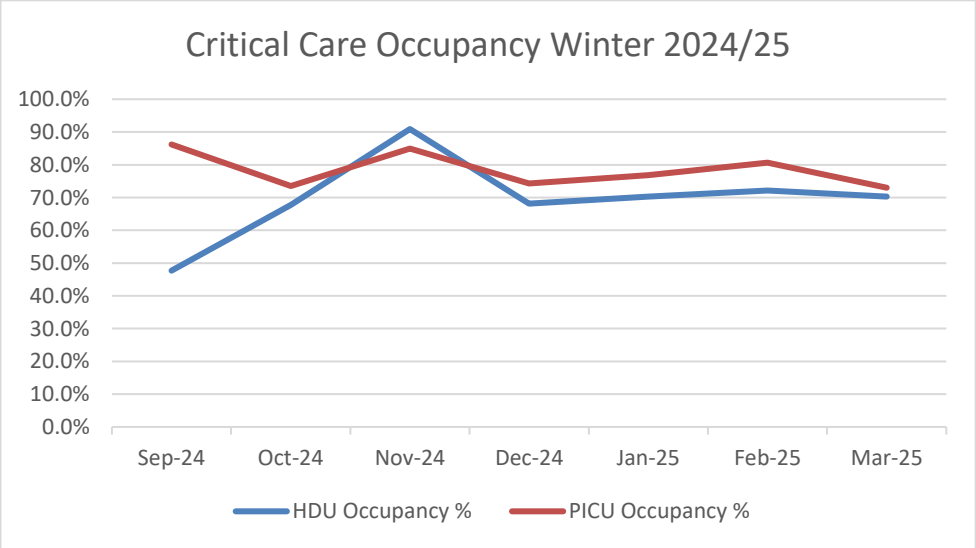


Table six- Critical Care surge capacity

	Level 3 beds	Level 2 beds	Total
A. Baseline (commissioned)	21	15	36
B. Severe pressure surge	23	18	41
C. Extreme pressure surge	28	20	48

There is physical space in critical care for 43 beds. Therefore, in level 3 'severe pressures' scenario it is possible to flex capacity up to 41 bed spaces (23 ventilated ICU + 18 HDU). This would be dependent on staffing levels with additional support to ensure safe nurse to patient ratios.

In extreme pressure the additional surge beds in reserve would be opened on the Burns Unit and a business continuity plan for Burns would be enacted re-providing the service in a Surgical Ward.

The staffing for the extreme surge beds would need to be supported from other departments across the trust; therefore, there would need to be a reduction in elective activity to facilitate this.

6.3 ED Capacity

Despite securing increased capacity to See and Treat low acuity patients through the Urgent Treatment Centre, the Emergency department at peak times may experience capacity challenges within the department. This would be within the waiting care, assessment cubicles or within resus capacity. The response in increase demand and necessary steps are included within the ED escalation document. The ED triggers for escalation can be found in appendix 2.

6.4 Staffing Capacity

Where low staffing availability or high patient acuity affects staffing levels and ratios and capacity requires review, the following process will be followed to request the closure of bed capacity: Opening and Closing of Wards Policy .

6.5 Staffing Escalation

Daily Safer Staffing meetings take place to review nurse staffing levels and arrangements. Where possible the trust will work to maintaining the nationally recognised levels of nursing care. There may be times when the ideal nursing levels will fall short and then the Safer Staffing chair or out of hours is the Clinical Site Practitioner will make decisions to balance the risk across all areas of the organisation.

At times this may lead to working to alternative ratios. The ward mangers and senior nursing team have agreed the minimum staffing requirements which are articulated through a red, amber or green staffing model and describe the skill mix required for each ward. Where an alternative staffing model is in use the nurse in charge of the relevant area will need to make alterations to how staff work to facilitate safe care for all children and young people. This may involve, for example, the use of task allocation nursing. Core key standards relating to staffing will be maintained as referenced in the Respiratory syncytial virus 2021 preparedness Children's safer nurse staffing framework for inpatient care in acute hospitals (2021) which is supported by relevant professional bodies and trade unions.

If the Trust is escalating through capacity levels staff may be required to change their working commitments to support The Emergency Department or Wards. All options will be considered via the Safer Staffing group; however, considerations would include:

- Staff in educational or training roles returning to patient facing roles
- A suspension of non-urgent meetings for clinical managers
- Requesting support from nurse specialities who are not usually base on the wards

All escalation protocols are included in the Trust Escalation Plan Trust Escalation Plan (policy currently under review for updating).

7. Enabling Factors

7.1 Patient Flow

A detailed Patient Flow Policy is in place. This policy is currently under review and will be updated by the end of October 2025.

The arrangements and routines for the management of patient flow (including transfers from critical care, emergency and elective admissions are managed as follows) are summarised below:

Daily Bed Meetings and Trust Status Report: Bed meetings run at 08:30 hrs, 12:00 hrs and 15:30 hrs. The aim of the daily bed meetings is to establish the predicted admission rates from an emergency and elective perspective and ensure patient flow is maintained by ensuring timely discharges and inter hospital transfers.

The bed meetings are chaired by the Bed Management Team and supported by the Hospital Manager of the Week.

Safer Staffing Huddle: This meeting runs prior to all the bed meetings to review nurse staffing across and agree the staffing models to be deployed. The meeting is chaired by a member of the trust's senior nursing team and attended by a matron from each clinical division. This staffing model confirms the staffing on each ward and advises it is safe to proceed with the established bed numbers for each ward.

Daily Forward Look/ Bed Meeting: At the 15:30 Bed Meeting, the next day's staffing, elective demand, and capacity is reviewed. This may mean that actions are required to expedite discharges, prioritise TCI's, and in extreme circumstances reduce elective admissions. These actions and decisions are taken by the Hospital Manager of the Week.

Emergency Department Safety Huddle: This daily meeting is held at 17:15 and is attended by the Senior Clinical Site Coordinator, Bed Management Team, Emergency Department Nurse in Charge, the Emergency Department Consultant in Charge, and the Senior Manager On Call when required.

Weekend Planning: Every Friday by midday a detailed weekend plan will be issued by the Bed Management Team.

Tactical Command: In periods of heightened and sustained levels of escalation the establishment of an operational Tactical Command Room will be deployed. This will run by a Tactical Commander appointed by the Chief Operating Officer.

7.2 Escalation Plans

Departmental escalation plans (including for Paediatric Intensive Care Unit and the Emergency Department) are contained in the Trust Escalation Plan.

7.3 Finance

Within this plan there is no planned additional financial expenditure for winter however there may be additional ad hoc expenditure relating to surges in pressures dependent upon activity seen. For example, a significant surge in infection or disease outbreak may result in increased domestic and IPC staffing requirements. Any additional costs that may require to be incurred will be authorised through the existing financial control forums with full rationale for approval.

8. Monitoring

This section of the Trust's winter plan outlines the strategies and systems in place to ensure that the plan is effectively implemented, and that patient care and hospital operations are sustained during the winter months. Monitoring of the plan against demand and performance is crucial to ensure escalation protocols are triggered and maintain focus on ensuring the delivery of safe patient care.

8.1 Performance Metrics and Key Indicators

- **Capacity Utilisation**: Monitoring bed occupancy rates, ICU capacity, and overall hospital space to ensure there is enough capacity to handle increased demand.
- **Emergency Department (ED) Performance**: Regular review of waiting times, particularly the four-hour ED target, and patient flow through urgent care services.
- **Discharge Rates and Delayed Transfers of Care**: Monitoring how quickly patients are being discharged and identifying any blockages in the discharge process to free up hospital beds.
- **Length of Stay**: Tracking the length of patient stays to identify any delays or inefficiencies that could impact capacity.
- **Ambulance Handover Delays**: Monitoring ambulance handover times to ensure patients are transferred to hospital care quickly and that ambulances are available for the next call.

8.2 Data Collection and Reporting

- **Real-Time Data Monitoring**: Acute trusts are required to have systems in place to monitor key performance indicators in real time, using dashboards and reporting mechanisms.
- **Daily and Weekly Reporting**: The trust management must provide daily and weekly reports to NHS England or regional teams. This helps in assessing pressures across the system and identifying where intervention may be required.
- **Bed-State Reporting**: Hospitals report on bed availability to ensure accurate assessments of current capacity and resource allocation.

8.3 Escalation Protocols

- **Triggers for Escalation**: Monitoring must identify when predefined capacity thresholds or performance triggers are breached (e.g., high bed occupancy, long waits in A&E, or ambulance delays). These breaches would prompt the activation of contingency measures, such as opening additional wards or redirecting resources.
- **Integrated Care Systems (ICS) Coordination**: Close coordination with the wider Integrated Care System (ICS) and local authorities to ensure that social care and

community services are prepared to take patients and support hospital discharges when needed.

8.4 Workforce Monitoring

- **Staffing Levels**: Real-time monitoring of staffing levels, particularly for critical areas such as emergency departments and intensive care. This includes tracking staff sickness rates, which tend to increase during the winter, and ensuring there are sufficient staffing contingencies in place.
- **Agency and Bank Staff Usage**: Monitoring the use of temporary staff to meet demand and ensure they are integrated effectively into teams without compromising the quality of care.

8.5 Patient Safety Monitoring

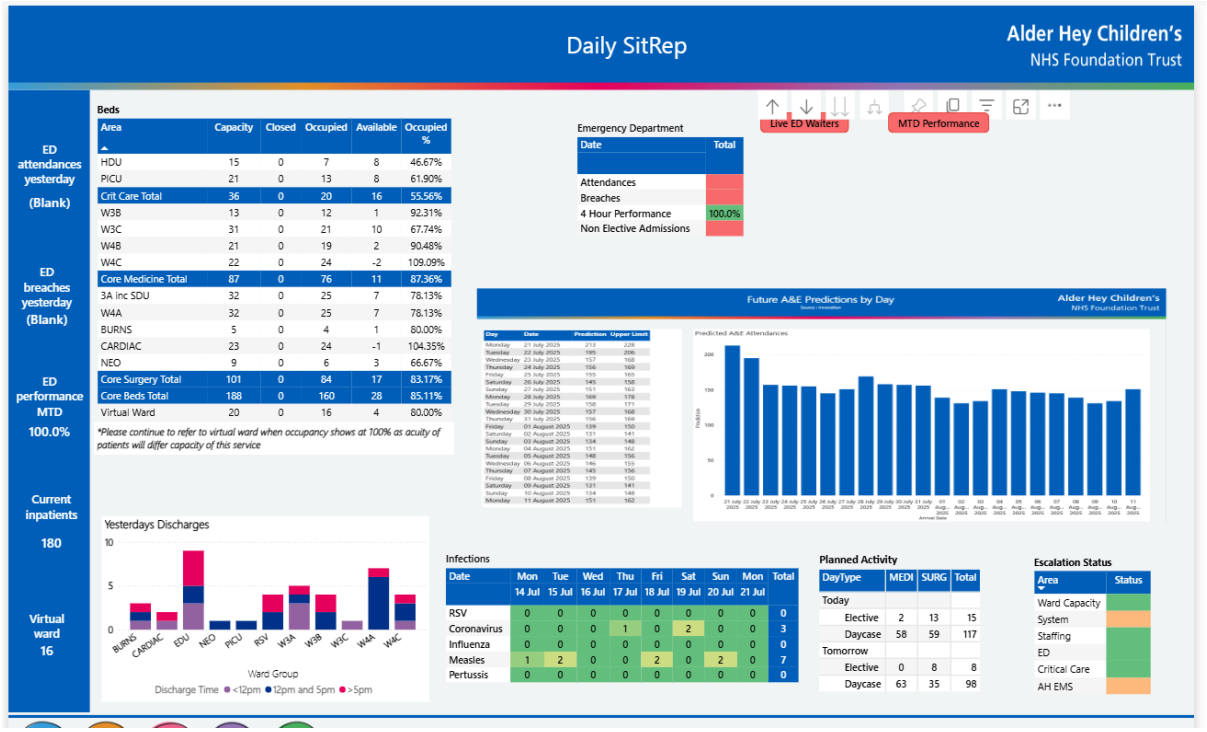
- **Incident Reporting**: Tracking incidents such as extended waits, infections, and medication errors, which might rise due to pressure on services. This ensures that even in high-demand periods, patient safety is maintained. Relevant incidents reported will feed into the weekly winter preparedness meetings.
- **Infection Control**: Monitoring the incidence of flu, COVID-19, and other infectious diseases, alongside compliance with infection control protocols.
- **Flu and COVID-19 Vaccination Uptake**: Monitoring vaccination uptake among staff and eligible patients to ensure compliance with national targets for flu and COVID-19 vaccination.

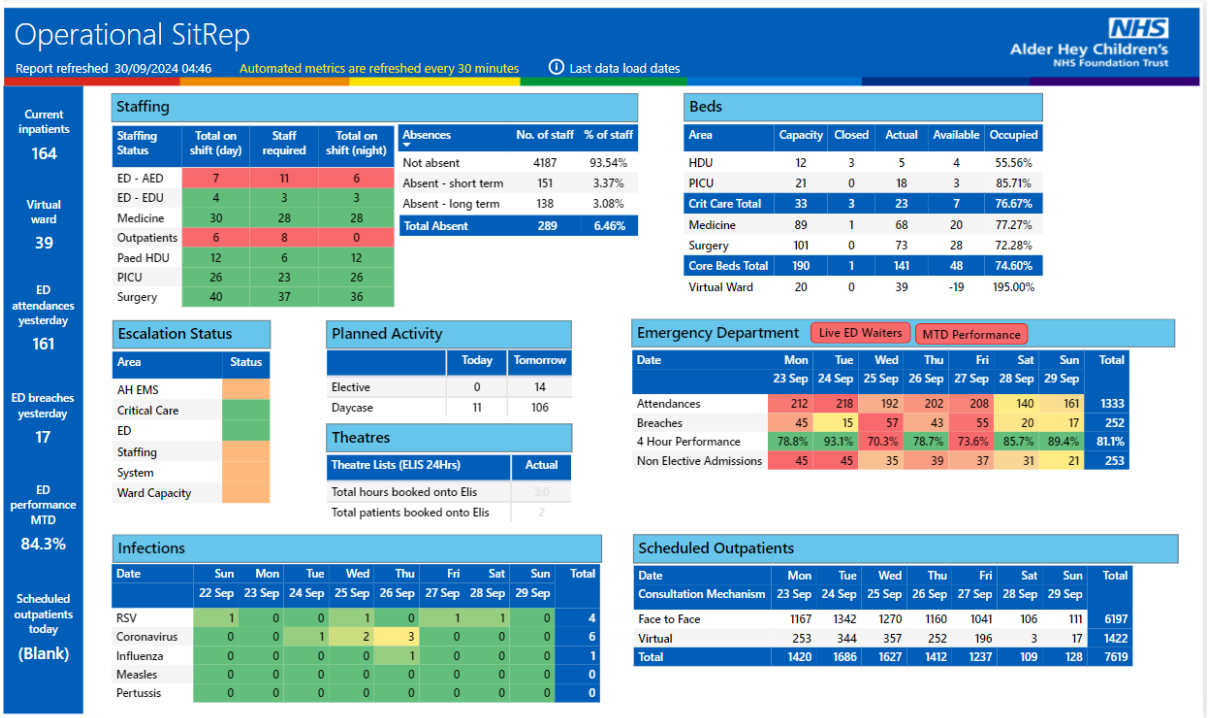
8.6 Collaboration with Other Stakeholders

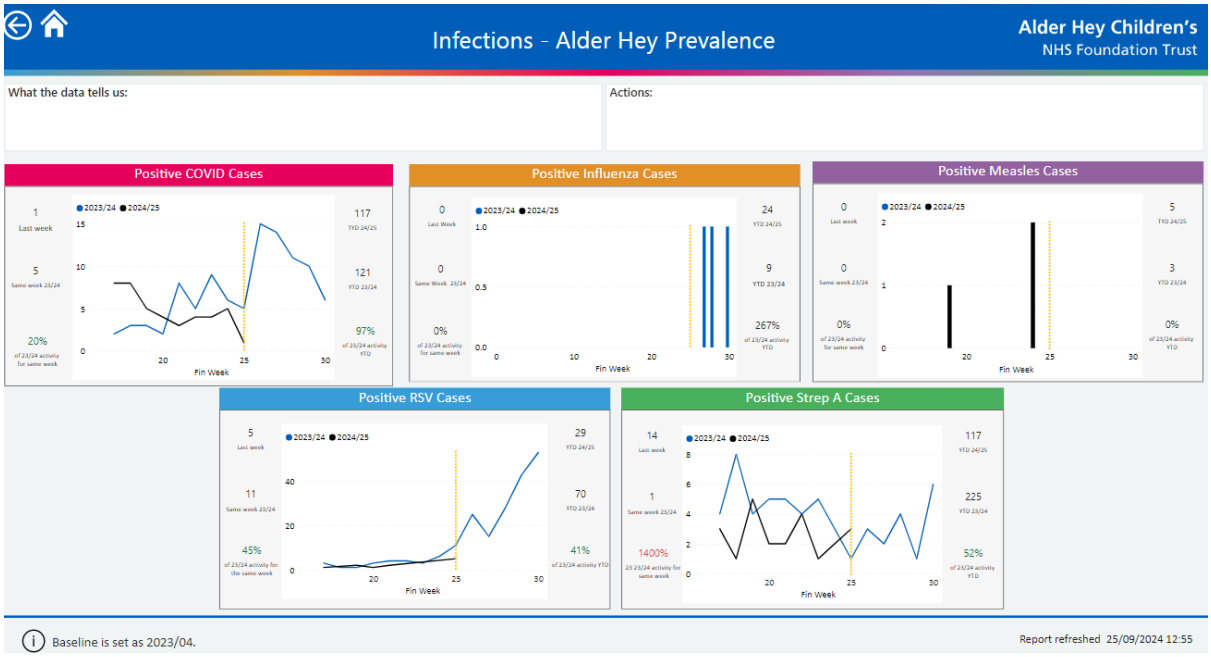
- **Regional and National Reporting**: Acute trusts must collaborate with NHS regional and national teams to provide a comprehensive view of system pressures.
- **Partnership with Primary Care and Community Services**: Close monitoring of referrals from primary care and effective coordination with community services to prevent unnecessary admissions and to manage discharges.

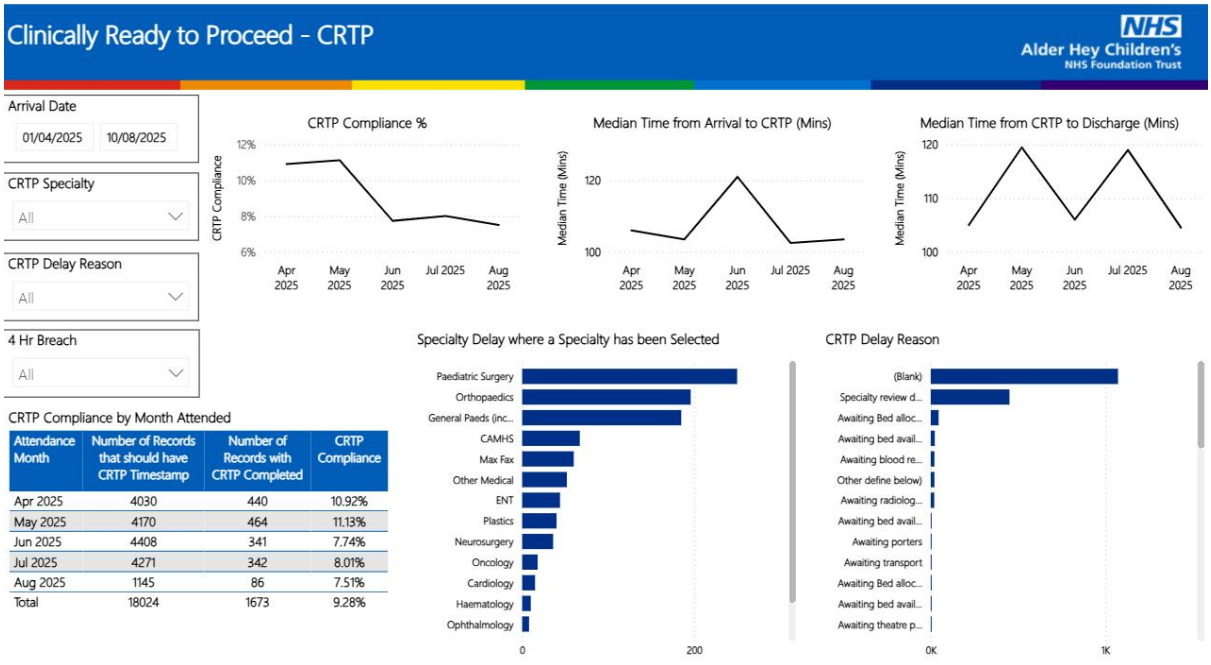
Below are examples of the monitoring reports created via Power BI app including:

- Daily SitRep for clinical and ward based teams
- The Trust's Operational daily SITREP for management and Executive Oversight
- Dedicated winter plan report
- Clinically Ready to Proceed Data
- NWAS Turnaround Dashboard


Daily SitRep
Alder Hey Children's
NHS Foundation Trust
ED attendances yesterday
(Blank)
ED breaches yesterday
(Blank)
ED performance MTD
100.0%
Current inpatients
180
Virtual ward
16
Beds
Area | Capacity | Closed | Occupied | Available | Occupied %
HDU | 15 | 0 | 7 | 8 | 46.67%
PICU | 21 | 0 | 13 | 8 | 61.90%
Crit Care Total | 36 | 0 | 20 | 16 | 55.56%
W3B | 13 | 0 | 12 | 1 | 92.31%
W3C | 31 | 0 | 21 | 10 | 67.74%
W4B | 21 | 0 | 19 | 2 | 90.48%
W4C | 22 | 0 | 24 | -2 | 109.09%
Core Medicine Total | 87 | 0 | 76 | 11 | 87.36%
3A inc SDU | 32 | 0 | 25 | 7 | 78.13%
W4A | 32 | 0 | 25 | 7 | 78.13%
BURNS | 5 | 0 | 4 | 1 | 80.00%
CARDIAC | 23 | 0 | 24 | -1 | 104.35%
NEO | 9 | 0 | 6 | 3 | 66.67%
Core Surgery Total | 101 | 0 | 84 | 17 | 83.17%
Core Beds Total | 188 | 0 | 160 | 28 | 85.11%
Virtual Ward | 20 | 0 | 16 | 4 | 80.00%
*Please continue to refer to virtual ward when occupancy shows at 100% as acuity of patients will differ capacity of this service
Emergency Department
Live ED Waiters
MTD Performance
Date | Total
Attendances
Breaches
4 Hour Performance | 100.0%
Non Elective Admissions
Future A&E Predictions by Day
Alder Hey Children's
NHS Foundation Trust
Predicted A&E Attendances
Yesterdays Discharges
BURNS CARDIAC EDU NEO PICU RSV W3A W3B W3C W4A W4C
Ward Group
Discharge Time <12pm 12pm and 5pm >5pm
Infections
Date | Mon 14 Jul | Tue 15 Jul | Wed 16 Jul | Thu 17 Jul | Fri 18 Jul | Sat 19 Jul | Sun 20 Jul | Mon 21 Jul | Total
RSV | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0
Coronavirus | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 3
Influenza | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0
Measles | 1 | 2 | 0 | 0 | 2 | 0 | 2 | 0 | 7
Pertussis | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0
Planned Activity
DayType | MEDI | SURG | Total
Today
Elective | 2 | 13 | 15
Daycase | 58 | 59 | 117
Tomorrow
Elective | 0 | 8 | 8
Daycase | 63 | 35 | 98
Escalation Status
Area | Status
Ward Capacity
System
Staffing
ED
Critical Care
AH EMS

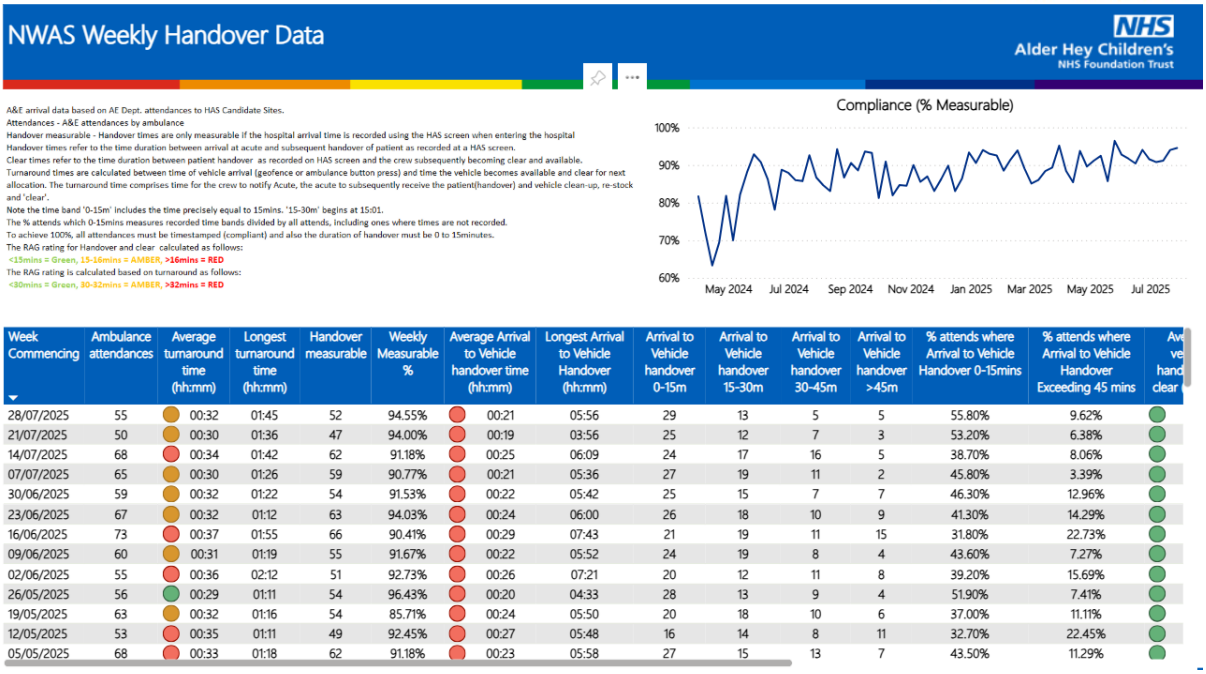

Operational SitRep
Report refreshed 30/09/2024 04:46
Automated metrics are refreshed every 30 minutes
Last data load dates
NHS
Alder Hey Children's
NHS Foundation Trust
Current inpatients
164
Virtual ward
39
ED attendances yesterday
161
ED breaches yesterday
17
ED performance MTD
84.3%
Scheduled outpatients today
(Blank)
Staffing
Staffing Status | Total on shift (day) | Staff required | Total on shift (night)
ED - AED | 7 | 11 | 6
ED - EDU | 4 | 3 | 3
Medicine | 30 | 28 | 28
Outpatients | 6 | 8 | 0
Paed HDU | 12 | 6 | 12
PICU | 26 | 23 | 26
Surgery | 40 | 37 | 36
Absences | No. of staff | % of staff
Not absent | 4187 | 93.54%
Absent - short term | 151 | 3.37%
Absent - long term | 138 | 3.08%
Total Absent | 289 | 6.46%
Beds
Area | Capacity | Closed | Actual | Available | Occupied
HDU | 12 | 3 | 5 | 4 | 55.56%
PICU | 21 | 0 | 18 | 3 | 85.71%
Crit Care Total | 33 | 3 | 23 | 7 | 76.67%
Medicine | 89 | 1 | 68 | 20 | 77.27%
Surgery | 101 | 0 | 73 | 28 | 72.28%
Core Beds Total | 190 | 1 | 141 | 48 | 74.60%
Virtual Ward | 20 | 0 | 39 | -19 | 195.00%
Escalation Status
Area | Status
AH EMS
Critical Care
ED
Staffing
System
Ward Capacity
Planned Activity
Today | Tomorrow
Elective | 0 | 14
Daycase | 11 | 106
Theatres
Theatre Lists (ELIS 24Hrs) | Actual
Total hours booked onto Elis
Total patients booked onto Elis | 2
Emergency Department
Live ED Waiters
MTD Performance
Date | Mon 23 Sep | Tue 24 Sep | Wed 25 Sep | Thu 26 Sep | Fri 27 Sep | Sat 28 Sep | Sun 29 Sep | Total
Attendances | 212 | 218 | 192 | 202 | 208 | 140 | 161 | 1333
Breaches | 45 | 15 | 57 | 43 | 55 | 20 | 17 | 252
4 Hour Performance | 78.8% | 93.1% | 70.3% | 78.7% | 73.6% | 85.7% | 89.4% | 81.1%
Non Elective Admissions | 45 | 45 | 35 | 39 | 37 | 31 | 21 | 253
Infections
Date | Sun 22 Sep | Mon 23 Sep | Tue 24 Sep | Wed 25 Sep | Thu 26 Sep | Fri 27 Sep | Sat 28 Sep | Sun 29 Sep | Total
RSV | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 4
Coronavirus | 0 | 0 | 1 | 2 | 3 | 0 | 0 | 0 | 6
Influenza | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1
Measles | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0
Pertussis | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0
Scheduled Outpatients
Date | Consultation Mechanism | Mon 23 Sep | Tue 24 Sep | Wed 25 Sep | Thu 26 Sep | Fri 27 Sep | Sat 28 Sep | Sun 29 Sep | Total
Face to Face | 1167 | 1342 | 1270 | 1160 | 1041 | 106 | 111 | 6197
Virtual | 253 | 344 | 357 | 252 | 196 | 3 | 17 | 1422
Total | 1420 | 1686 | 1627 | 1412 | 1237 | 109 | 128 | 7619





CRTP Compliance by Month Attended

Attendance Month	Number of Records that should have CRTP Timestamp	Number of Records with CRTP Completed	CRTP Compliance
Apr 2025	4030	440	10.92%
May 2025	4170	464	11.13%
Jun 2025	4408	341	7.74%
Jul 2025	4271	342	8.01%
Aug 2025	1145	86	7.51%
Total	18024	1673	9.28%



NWAS Weekly Handover Data

NHS Alder Hey Children's NHS Foundation Trust

A&E arrival data based on AE Dept. attendances to HAS Candidate Sites.
Attendances - A&E attendances by ambulance
Handover measurable - Handover times are only measurable if the hospital arrival time is recorded using the HAS screen when entering the hospital
Handover times refer to the time duration between arrival at acute and subsequent handover of patient as recorded at a HAS screen.
Clear times refer to the time duration between patient handover as recorded on HAS screen and the crew subsequently becoming clear and available.
Turnaround times are calculated between time of vehicle arrival (geofence or ambulance button press) and time the vehicle becomes available and clear for next allocation. The turnaround time comprises time for the crew to notify Acute, the acute to subsequently receive the patient(handover) and vehicle clean-up, re-stock and 'clear'.
Note the time band '0-15m' includes the time precisely equal to 15mins. '15-30m' begins at 15:01.
The % attends which 0-15mins measures recorded time bands divided by all attends, including ones where times are not recorded.
To achieve 100%, all attendances must be timestamped (compliant) and also the duration of handover must be 0 to 15minutes.
The RAG rating for Handover and clear calculated as follows:
<15mins = Green, 15-16mins = AMBER, >16mins = RED
The RAG rating is calculated based on turnaround as follows:
<30mins = Green, 30-32mins = AMBER, >32mins = RED

Compliance (% Measurable)

100%
90%
80%
70%
60%
May 2024 Jul 2024 Sep 2024 Nov 2024 Jan 2025 Mar 2025 May 2025 Jul 2025

Week Commencing	Ambulance attendances	Average turnaround time (hh:mm)	Longest turnaround time (hh:mm)	Handover measurable	Weekly Measurable %	Average Arrival to Vehicle handover time (hh:mm)	Longest Arrival to Vehicle Handover (hh:mm)	Arrival to Vehicle handover 0-15m	Arrival to Vehicle handover 15-30m	Arrival to Vehicle handover 30-45m	Arrival to Vehicle handover >45m	% attends where Arrival to Vehicle Handover 0-15mins	% attends where Arrival to Vehicle Handover Exceeding 45 mins	Av ve hand clear
28/07/2025	55	00:32	01:45	52	94.55%	00:21	05:56	29	13	5	5	55.80%	9.62%	
21/07/2025	50	00:30	01:36	47	94.00%	00:19	03:56	25	12	7	3	53.20%	6.38%	
14/07/2025	68	00:34	01:42	62	91.18%	00:25	06:09	24	17	16	5	38.70%	8.06%	
07/07/2025	65	00:30	01:26	59	90.77%	00:21	05:36	27	19	11	2	45.80%	3.39%	
30/06/2025	59	00:32	01:22	54	91.53%	00:22	05:42	25	15	7	7	46.30%	12.96%	
23/06/2025	67	00:32	01:12	63	94.03%	00:24	06:00	26	18	10	9	41.30%	14.29%	
16/06/2025	73	00:37	01:55	66	90.41%	00:29	07:43	21	19	11	15	31.80%	22.73%	
09/06/2025	60	00:31	01:19	55	91.67%	00:22	05:52	24	19	8	4	43.60%	7.27%	
02/06/2025	55	00:36	02:12	51	92.73%	00:26	07:21	20	12	11	8	39.20%	15.69%	
26/05/2025	56	00:29	01:11	54	96.43%	00:20	04:33	28	13	9	4	51.90%	7.41%	
19/05/2025	63	00:32	01:16	54	85.71%	00:24	05:50	20	18	10	6	37.00%	11.11%	
12/05/2025	53	00:35	01:11	49	92.45%	00:27	05:48	16	14	8	11	32.70%	22.45%	
05/05/2025	68	00:33	01:18	62	91.18%	00:23	05:58	27	15	13	7	43.50%	11.29%	

The monitoring section of the plan plays a critical role in ensuring that NHS acute trusts are resilient and prepared to handle the increased demands of winter. It focuses on real-time data, rapid escalation of issues, and coordination across the healthcare system to deliver safe and efficient care.

9. Conclusion

In conclusion the Winter Plan outlines a comprehensive strategy to ensure the Trust is fully prepared to manage the increased demand during the winter period. By focusing on optimising capacity, improving patient flow, ensuring robust staffing, and enhancing collaboration with community partners, the Trust aims to provide safe, efficient, and high-quality care to all patients, even during peak pressure times.

Appendix 1: Escalation Areas

Winter Beds

For winter the following area will be opened to support flow:

Location	Space Available	Staffing Model	Proposed Clinical Criteria	Points to Note
Ward 4B	3 ward beds	1RN or Amber staffing	As per ward admissions	
Ward 3A	4 Beds (Weekend Only)	1RN or Amber staffing	As per ward admissions	

Escalation Red

Location	Space Available	Staffing Model	Proposed Clinical Criteria	Points to Note
3B Oncology Bay	3 Beds	Amber staffing model	Oncology only	Escalation policy as per:  Escalation policy 120924.docx
HDU	4 Beds	2RN	As per last year	Escalation policy as per:  1B medical escalation SOP 2.do

Escalation in Extremis

The following areas are clinical areas on the Alder Hey site that do not currently house acute inpatients but could potentially be repurposed should it be required in extremis. Extremis would be defined as:

- Capacity sustainably on black with no plan to de-escalate
- ED is at risk of providing corridor care

To utilise any of these spaces would require the agreement of COO and CNO in hours and Executive On Call Out of Hours. Consideration should also be given to the level of business continuity the organisation is operating at:

Location	Space Available	Staffing Model	Proposed Clinical Criteria	Points to Note
Clinical Research Unit	2 Beds	2RN – Monday-Friday RN potential available from CRF 8am-6pm	Lowest acuity patients as agreed by HoN's (research senior medical/ nursing leadership to be involved in agreeing acceptance of patients).	Pause in routine research activity and any release of research nurses would be reported to funders as CRF is NIHR funded facility. This will result in financial and reputational harm. Urgent reviews of patients on clinical trials (ie adverse events after experimental medicine are required to continue). Patient safety incidents through delayed treatments for those that have commenced within the trial will be monitored.
Medical Day Case Unit	2 Beds	2RN	Lowest acuity patients as agreed by HoN's	Would result in day case cancellations
Surgical Day Case	26 beds (however shared air handling with theatre recovery)	Theatre and day case staff during the day.	One big open space – consideration would need to be given around isolation.	Would stop day case throughput (5 theatres) which would have a negative impact on the experience of patients and families as well as financial position.

		No facilities for overnight.	Daytime escalation valve whilst additional overnight capacity could be established or discharges facilitated. EDU type patients or those stable and transferring to the ward bed within 8 hours	No facilities for showering, kitchen for parents, limited toilet facilities.

Appendix 2: ED Escalation Levels

Emergency Department Escalation Level	Trigger
GREEN **SHREWD Level 1** ***Business as usual – low risk to patient safety and experience***	• No triggers
AMBER **SHREWD Level 2** ***Low to moderate risk to patient safety and experience***	**TWO** of the following*: ❖ <3 EDU/PAU Beds Available ❖ Ambulance Handover delays (15-30 minutes for standard handover) ❖ 30-49 in Dept ❖ >20 pts in ED waiting area ❖ 10-15 pts attend per hours for 2 consecutive hours (non-streamed patients) ❖ Resuscitation capacity (to include HD cubicles) less than 2 spaces ❖ 1 RN gap not covered ❖ Less than 6 on medical rota at one time (weekdays 8:00-22:00 weekends 12:00-22:00) or less than 4 on weekends 08:00-12:00). Less than 3 on night. ❖ Delay in triage > 15 mins ❖ > 5 patients with a delay of 60-90mins for 1st clinician assessment ❖ Delay of 60-90 mins for speciality referral review ❖ Longest length of stay in department > 8 hours ❖ ED 4 Hour Performance between 70%-78% ❖ >30 min waits for allocation of inpatient bed and transfer after DTA ❖ 50% reduction of UTC stream capacity *Can be one trigger by professional judgement with joint decision of CIC and NIC
RED **SHREWD Level 3** ***Moderate to high risk to patient safety and experience***	**TWO** of the following*: ❖ No EDU/PAU capacity

	❖ Ambulance Handover delays (31-60 minutes for standard handover) ❖ 50-70 pts in ED (in any area) ❖ >30 pts in waiting room ❖ 15-20 pts attend for 2 consecutive hours (non-streamed) ❖ Resuscitation capacity (to include HD cubicles) only 1 space available ❖ 2 clinician gaps not covered ❖ 2 RN gap not covered ❖ Less than 5 on medical rota at one time (weekdays 8:00-22:00 weekends 12:00-22:00) or less than 3 on weekends 08:00-12:00). Less than 3 on night. ❖ Delay in triage >30 mins ❖ 5 patients with a delay of 90-120mins for 1st clinician assessment ❖ Delay of 90-120 mins for speciality assessment ❖ Longest length of stay in the department >10 hours ❖ ED 4 Hour Performance between 60-69% ❖ >60 min waits for allocation of inpatient bed and transfer ❖ No UTC capacity
BLACK **SHREWD Level 4** ***High to severe risk to patient safety and experience***	**TWO** of the following: ❖ Ambulance Handover delays (more than 60 minutes for standard handover) ❖ 20+ pts attend for 2 consecutive hours (non-streamed) ❖ 70+ in Dept ❖ 40+ pts waiting in waiting area ❖ Resuscitation capacity (including HD cubicles) full, with no immediate ability to create space for unexpected arrival ❖ Staff shortage – more than 50% of establishment of any clinical staff group ❖ Delay triage > 60 mins ❖ 5 patients with a delay of 240+ mins for 1st clinician assessment ❖ Delay of 240+ mins for speciality clinician assessment ❖ Longest length of stay in the department > 12 hours ❖ ED performance <60%

[redacted]	❖ >90 min wait for allocation of inpatient bed and transfer ❖ No UTC capacity

Flash Report August 2025

Performance is subject to change

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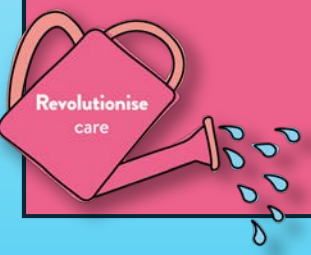
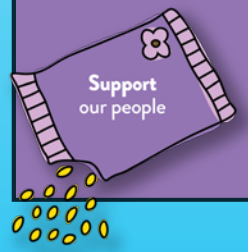
1	0	94.6%	3	10
Severe/Fatal Incidents/Never Events	Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections	Patients deteriorating from an inpatient bed



89.8%	409	59.8%	1.64	94.8%
ED: %Treated within 4 Hours	Number of RTT Patients waiting >52weeks	% Patients waiting within 18 weeks (RTT)	Elective activiy per clinical WTE	Diagnostic Performance



-107	10.8%	76.6%	6.3%
Estimated Workforce Plan	Staff Turnover	%PDRs Completed	% Sickness

Financial Sustainability	-£1m	TBC	-£2.9m
	I&E position	I&E year end forecast to plan (Variance)	CIP (Forecast vs full year target)

HIGHLIGHT

- Sustained performance for time to be seen and treated in ED - 6th consecutive month 80%+.
- High proportion of diagnostic tests completed in six weeks.
- 5th consecutive month of improvement for % patients waiting under 18 weeks for treatment
- Good patient experience scores.
- Sustained reduced volume of patients deteriorating from an inpatient bed.

CHALLENGES

- Increase in the number of CYP waiting >52 weeks.
- 3 healthcare associated infections; 2 C.Diff and 1 MSSA

VISION 2030

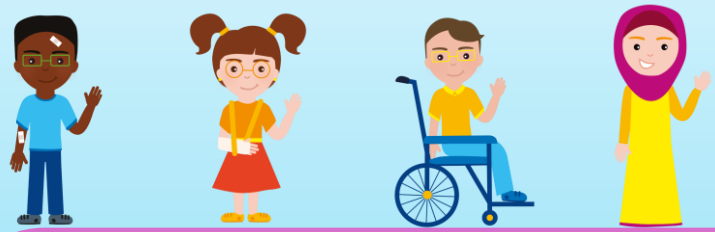
NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: August 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	13	n/a	↓
Number of Incidents per 1,000 bed days – No Harm	86	77.4	↑
Number of Incidents per 1,000 bed days – Low Harm and above	17	19.6	↓

Executive Summary

Timely responses were achieved, with 97% of PALS concerns answered within 5 working days and 96% of formal complaints within 25 days. Patient safety improved, with fewer unexpected PICU admissions from HDU over the past four months and no preventable harm linked to patient deterioration. Sepsis treatment compliance reached 91% in ED and 85% for inpatients. FFT response volumes peaked in July following the rollout of shorter questionnaires, though ED FFT scores remain below the 95% target, while reception areas perform strongly.

Support Our People

	Value	Target	Trend
Workforce Plan	4,319	4,454	↓
Staff Turnover	12.1%	10%	↑
Sickness Absence (Total)	6.1%	4.5%	↑

Executive Summary

Mandatory training compliance remains strong at over 90%, with time-to-hire outperforming target since April and short-term sickness staying below 2%. Workforce numbers are stable, though a significant CIP challenge remains, requiring a reduction of over 100 WTE by March 2026. Long-term sickness absence is a concern, with a 90-day improvement programme underway. PDR completion for Band 7+ staff has risen to 70% by July, though still behind target, with reminders issued to supervisors.

Revolutionise Care

	Value	Target	Trend
ED % Treated Within 4 Hours	84.7%	78%	↑
% RTT Patients Waiting >52 Weeks*	2.14%	1.6%	↑
RTT Waiting List Within 18 Weeks*	58.8%	58.3%	↑

Executive Summary

ED performance remains strong at 85% within 4 hours. RTT performance is gradually improving through waiting list validation and increased elective/outpatient activity, with theatre utilisation above 80% and activity levels exceeding plan. Long waits are reducing, with fewer patients waiting over two years for follow-ups, though the proportion waiting over 52 weeks remains above target. CAMHS 52-week waits have slightly increased following validation, but recovery plans are in place. Initiatives such as weekend clinics and a new opt-in process for ENT and Dentistry aim to reduce long waits and WNB. The new patient demographic system is improving data accuracy and expected to support better communication and lower WNB rates.

Financial Sustainability

	Value	Target	Trend
I&E Year End Forecast	£7.1m	£7.1m	↔
Recurrent Efficiency Plans Delivered	£2.1m	£6.1m	↓
ERF Income (YTD)	£33.4m	32.8m	↑

Executive Summary

The Trust delivered a £0.3m surplus in-month but remains £1.5m deficit YTD, largely due to industrial action. Forecast delivery of the £7.16m planned surplus is dependent on mitigating CIP and ICB risk share, with a risk-adjusted forecast of £3.4m. CIP is on plan YTD, with £11.9m transacted, though a significant proportion remains in progress or opportunity stage. Cash is below plan due to unpaid accruals, and capital is behind profile owing to budget phasing. Delivery of the £22.7m CIP programme remains a key risk, with divisional pressures—particularly in Medicine—prompting an August–March recovery plan. Mitigations include the Financial Improvement Programme, cost controls, divisional escalation, and biweekly CIP deep dives. Capital risks persist, though priority one items have been approved, with funding solutions for priority two items being progressed. Transformation and "Closing the Gap" actions are critical to securing year-end delivery and long-term sustainability.

*RTT Targets based on revised trajectory

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

• 97% of PALS concerns responded to within 5 working days and 96% of formal complaints responded to within 25 working days resulting in the majority of families receiving a timely response to their concerns • Decreasing number of patients unexpectedly admitted to PICU from HDU in the past 4 months • 91% of patients in ED received antibiotics for sepsis concern • Highest number of FFT responses in July compared to the last 12 months which correlates with the shorter questionnaires going live

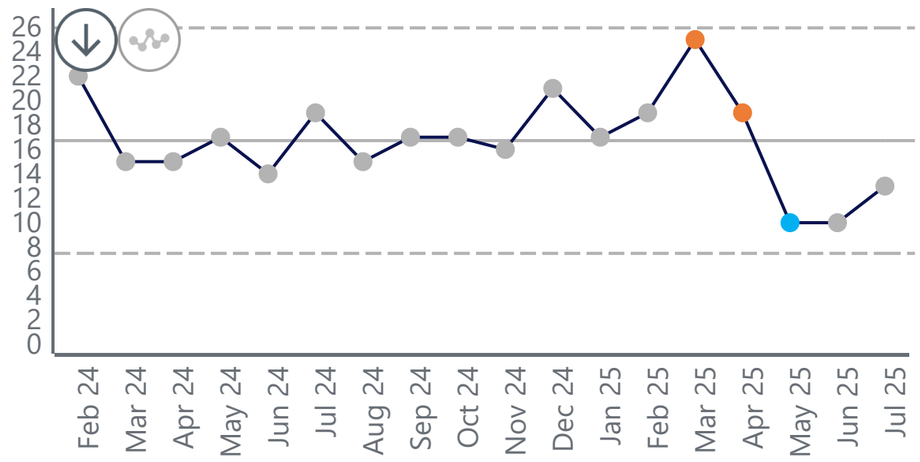
Areas of Concern:

• FFT related to ED continues to be below 95% however reception area continues to be • No harm associated with patients who have deteriorated and identified as preventable (4 since September 2024) • 85% of inpatients received antibiotics for sepsis concern

Forward Look (with actions)

• Continued roll out of shortened FFT

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



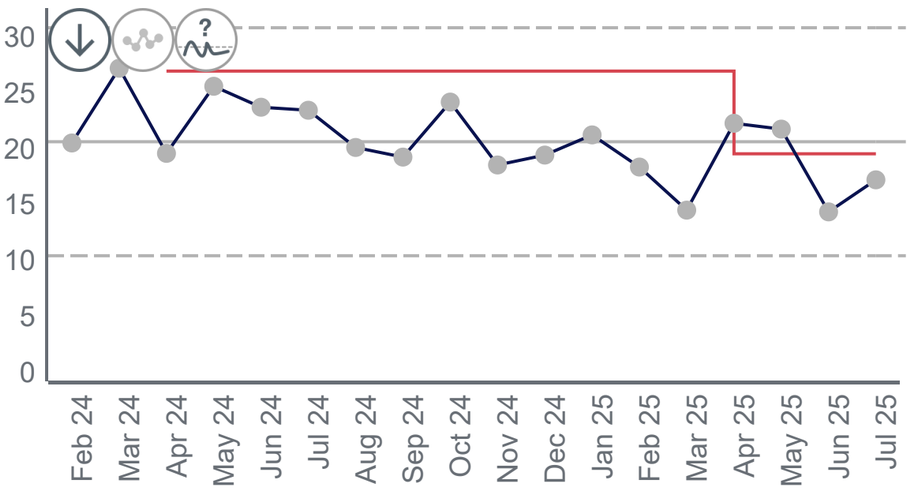
Technical Analysis:

Common cause variation with 13 patients deteriorating from an inpatient bed to PICU with an average of 17 a month during the last 18 months. Third consecutive month below the average.

Actions:

All cases are reviewed by Response Team

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



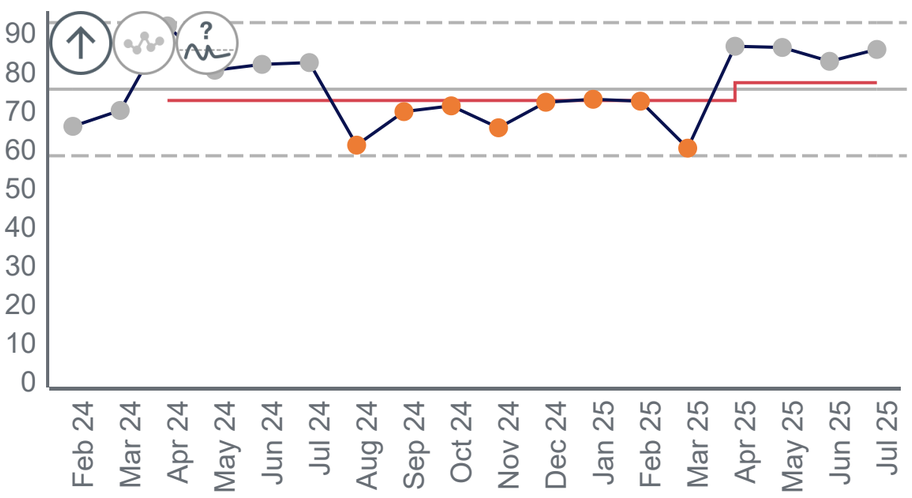
Technical Analysis:

Common cause variation with performance of 17 incidents of harm per 1,000 bed days, with a monthly average of 21 incidents during the period. 2nd consecutive month below target. Incidents are assessed on Physical and Psychological Harms. The target is set on a 5% reduction of 24/25, with a monthly target of 19.6

Actions:

Continued culture that encourages reporting of all incidents including near misses

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



Technical Analysis:

Common cause variation observed with 88 incidents of no harm per 1000 bed days, with a monthly average of 75. Incidents are assessed on both Physical and Psychological Harms. The target is set against a 5% improvement on 24/25 with monthly target 77.4. 4th consecutive month above target.

Actions:

Continued culture that encourages reporting of all incidents including near misses

Integrated Performance Report | August 2025

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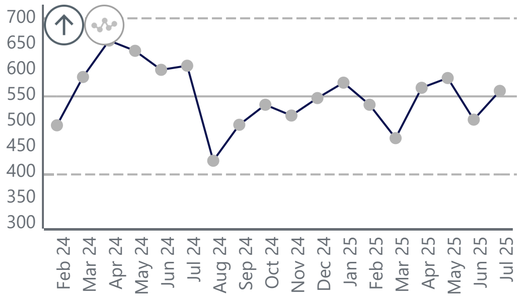
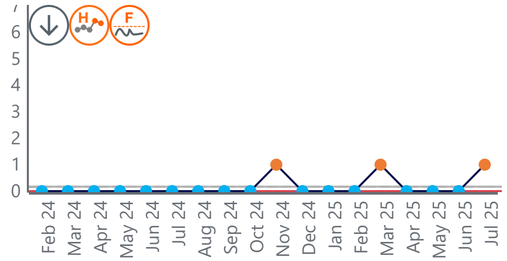
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



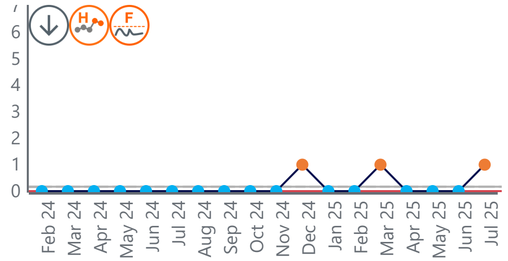
Severe or Fatal Incidents – Physical only

Target: Internal

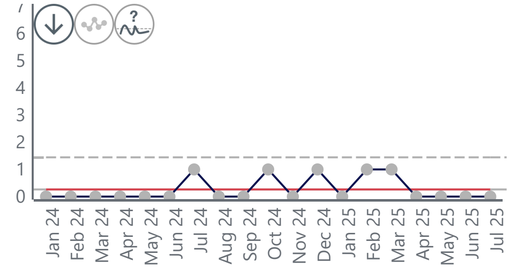


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

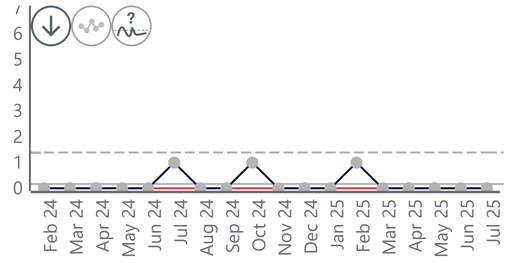


Number of PSIIs (Patient safety incident investigation) undertaken



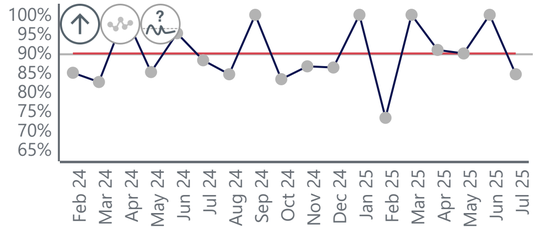
Number of Never Events

Target: Internal



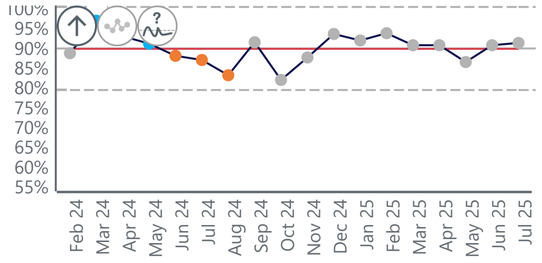
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

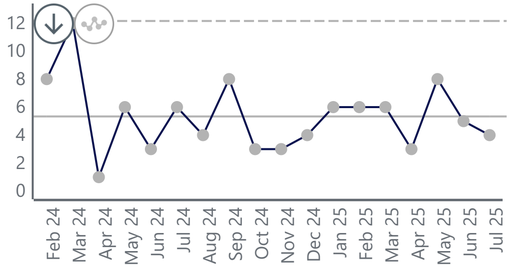


Sepsis % Patients receiving antibiotic within 60 mins for ED

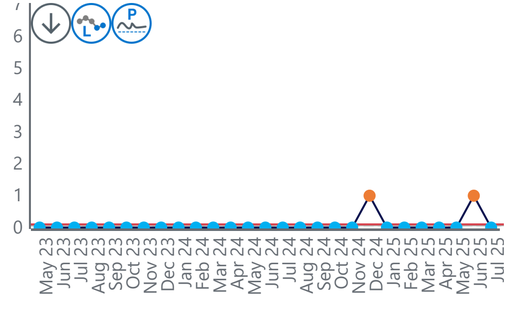
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

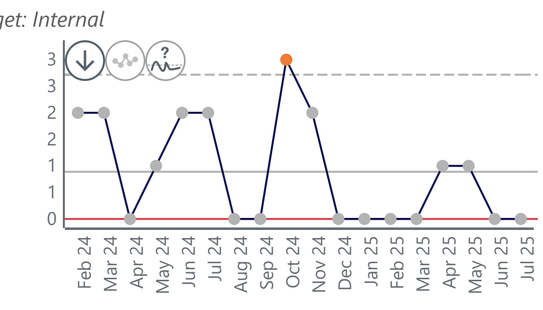


Pressure Ulcers Category 3 and 4

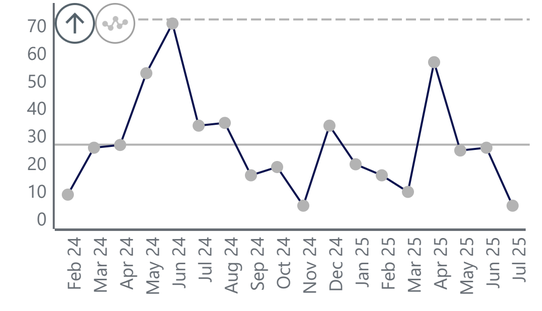


Pressure Ulcers Category 2

Target: Internal

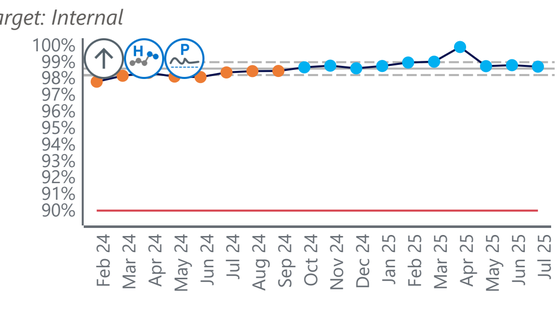


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



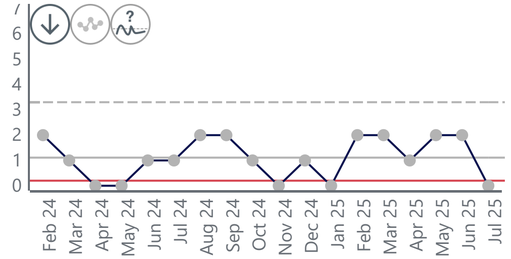
Integrated Performance Report | August 2025

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

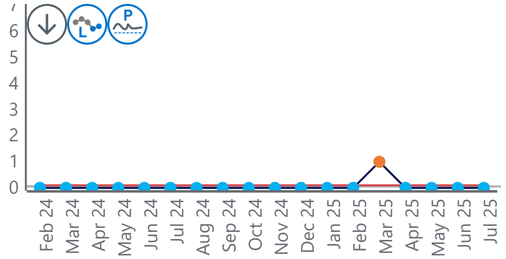
Hospital Acquired Organisms - MSSA

Target: Internal



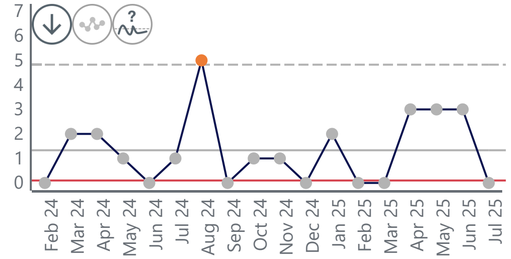
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



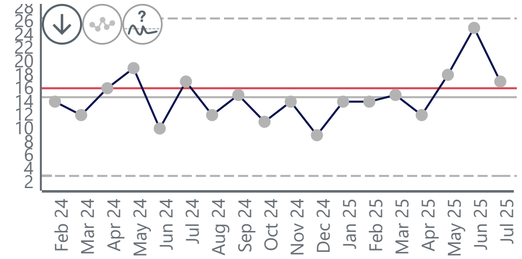
Hospital Acquired Organisms - (C.Difficile)

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

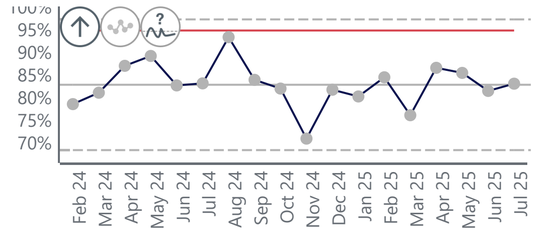
Target: Internal

Trust: % of very good/good ratings for 'Overall, how was your experience of our service

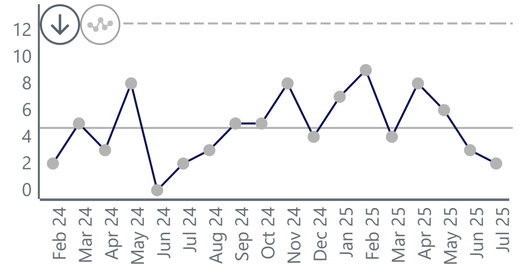
Target: Statutory

ED: % of very good/good ratings for 'Overall, how was your experience of our service

Target: Internal

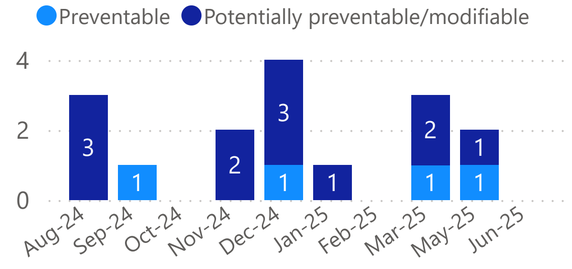


Number of patients deteriorating from HDU admitted to PICU

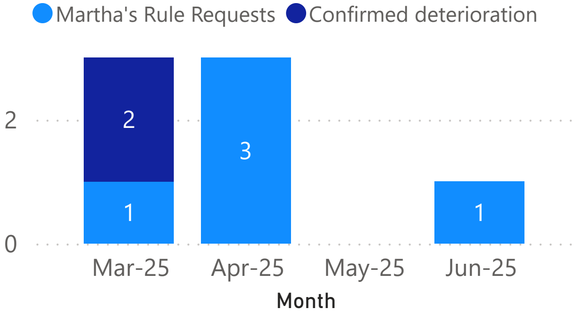


Predictable and preventable deteriorating patients

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:

• ED performance for patients waiting less than 4 hours remains strong at 85% • RTT performance continues to gradually improve due to ongoing validation of the waiting list and a focus on maximising outpatient and elective activity • Theatre touchtime utilisation consistently above 80% throughout the year • YTD performance (volume) for elective and outpatient activity remains above plan • Gradual reduction in the number of patients that would be waiting over two years for their follow up appointment • DMO1 performance remains above 95% target.

Areas of Concern:

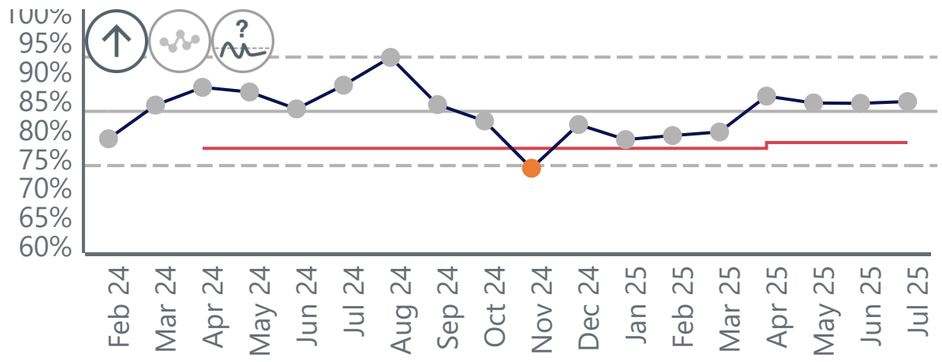
• The number of patients waiting over 52 weeks remains above the 1% target • The number of CAMHS young people waiting over 52 weeks has risen slightly due to an internal validation. A recovery plan is in place, and treatment plans are being prioritised • WNB remains above the trust target.

Forward Look (with actions)

• Weekend outpatient clinics for ENT and Dentistry are set to restart in August 25, allowing appointments for patients who have been waiting over 52 weeks • A new opt-in process for ENT and Dentistry began in August 25. The goal is to reduce WNB and the number of patients waiting over 52 weeks in the services with the highest volume • Patient demographic system is now live and has proven positive thus far, as there is a high volume of patients with incorrect contact details in Meditech. This is expected to improve communication with families and reduce WNB.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

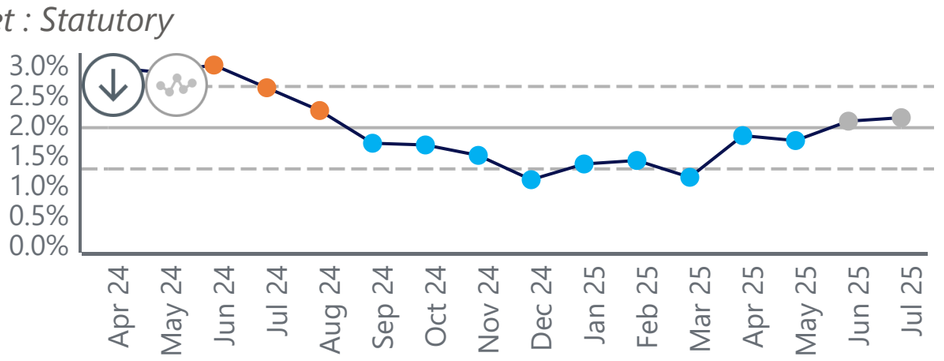
Achieved the national target in July-25. Common cause variation observed with performance of 85%, increase from June-25 (84.7%). July-25 performance is -2.9% compared to July-24 (87.9%). July-25 seen 103 less attendances compared to July-24. With July-25 seeing +0.2% Resus and Very Urgent patients in comparison

Actions:

Positive performance in July whilst managing measles. Double validation of all patients 4hours-4hours 30 to ensure robust data submission. Utilising August to focus on Handover 45 in advance of winter. Launching review and dissemination of Clinically Ready to Proceed with Trust wide ownership of this data.

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

Target : Statutory



Technical Analysis:

2.14% 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 by March 2026. This is a increase from June-25 position of 2.08% with the total volume at 401. 80% current waits >52 weeks within Dentistry & ENT

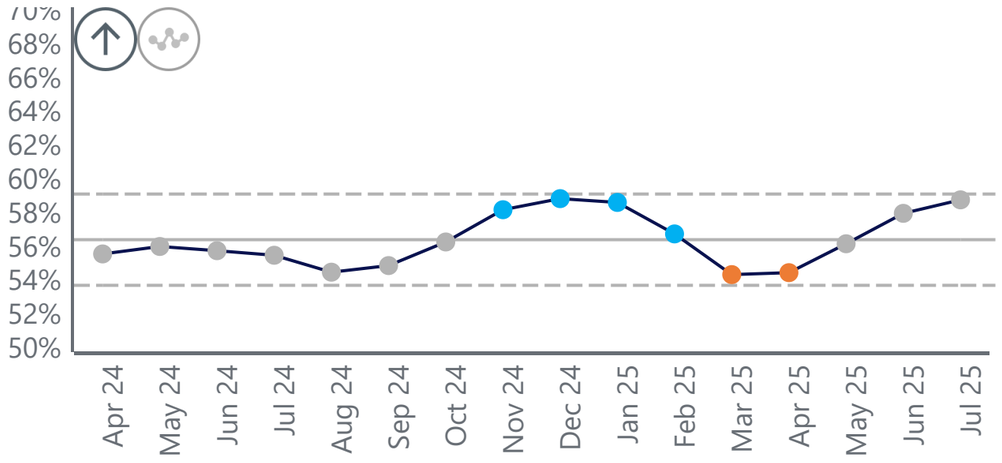
Actions:

Weekend outpatient clinics for ENT and Dentistry are set to restart in August 25, allowing appointments for patients who have been waiting over 52 weeks.

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

RTT waiting list within 18 weeks



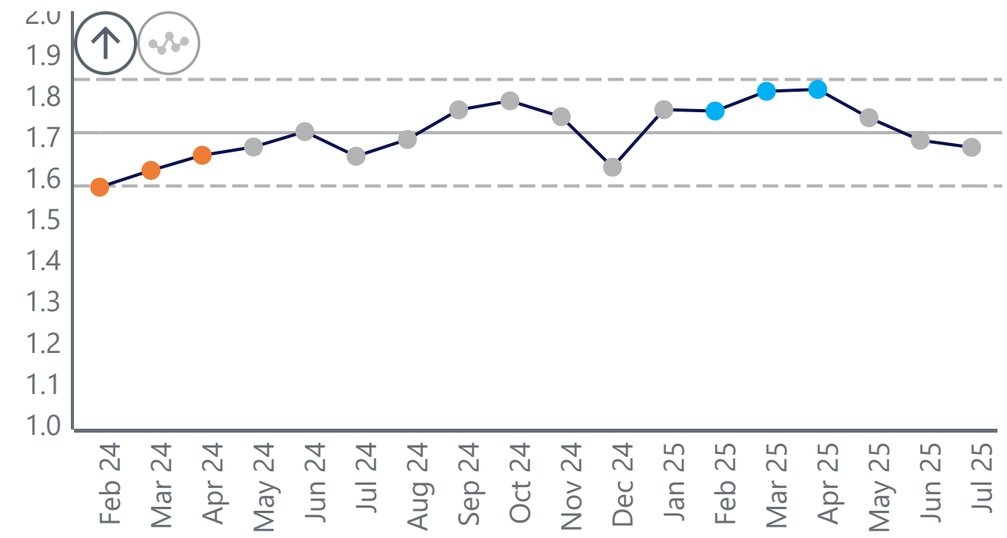
Technical Analysis:

Common cause variation with performance of 58.8% against a year end target of 63.1% by March 2026. This is improvment from June 2025 position of 58%. Oral Surgery and Dentistry lowest performing of services with >100 waiters.

Actions:

Further validation planned over the coming months. A new opt-in process for ENT and Dentistry began in August 25. If successful will roll out to other services to reduce WNB and improve RTT performance

Elective admissions (IP & DC) per clinical WTE



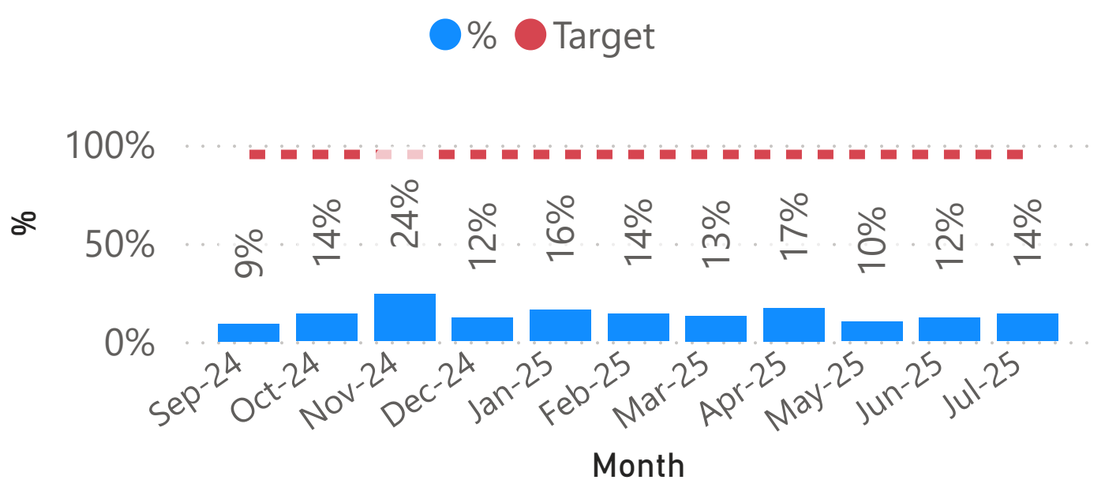
Technical Analysis:

Common cause variation has been observed with performance of 1.68 admissions per Clinical WTE (1607.55). Slight increase from July 2024 rate at 1.66, with July-25 experiencing +1.66 extra admissions per working day compared to July 2024.

Actions:

The project aimed at reducing same-day cancellations is progressing well. We are now ready to implement the 'no pre-op, no surgery' policy, which we anticipate will decrease the number of patients deemed unfit for surgery on the day of their operation.

% 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 July 2025 is 14% against a target of 95% which is an increase from performance of 12% in June 2025.

Actions:

Focus remains on longest waiting children and young people therefore % of young people receiving an outcome within 65 weeks of assessment remains low as expected. The new assessment pathway for ASD and ADHD is due to go live in September 2025 which will provide an improved and streamlined pathway. Demand continues to exceed capacity for these services which remains under review with commissioners.

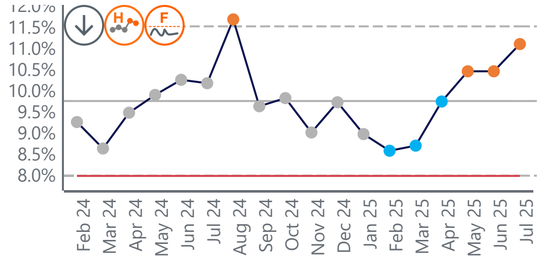
Integrated Performance Report | August 2025

NHS
Alder Hey Children's
NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

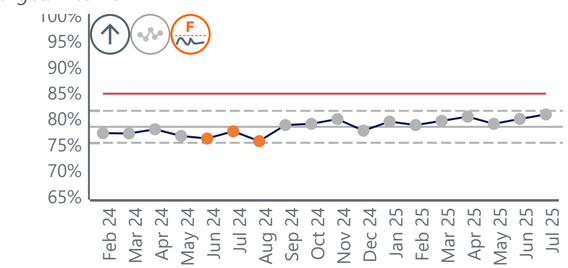
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

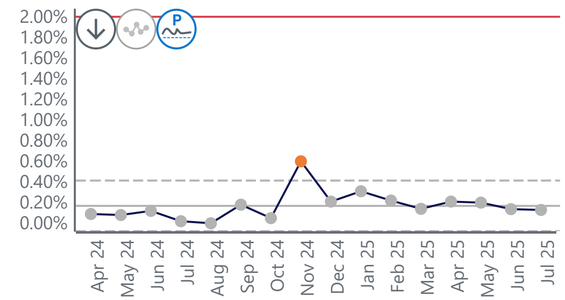


Theatre Utilisation (Capped Touch Time)

Target: Internal

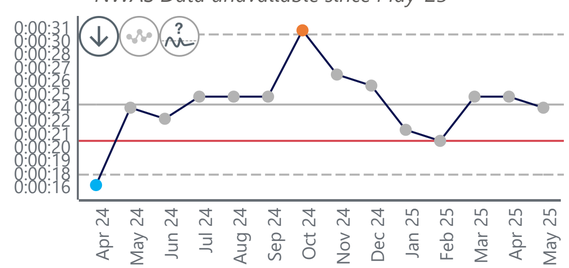


% of ED attends over 12 hours



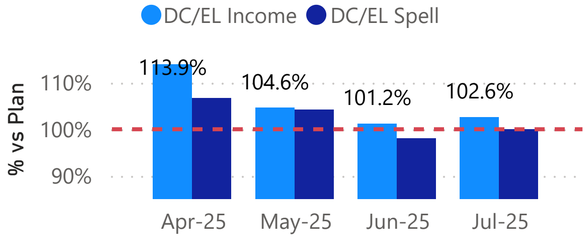
Average Ambulance Vehicle to Handover Time

NWAS Data unavailable since May-25



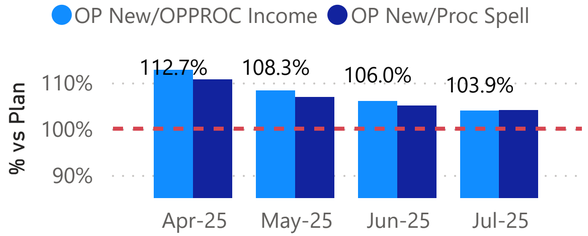
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance



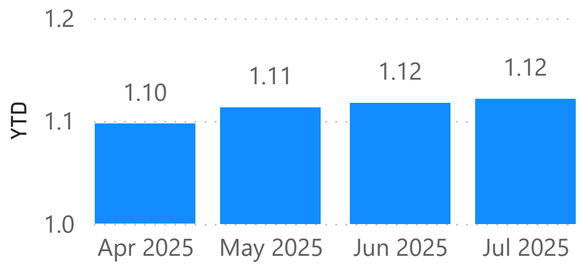
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

SLAM Performance

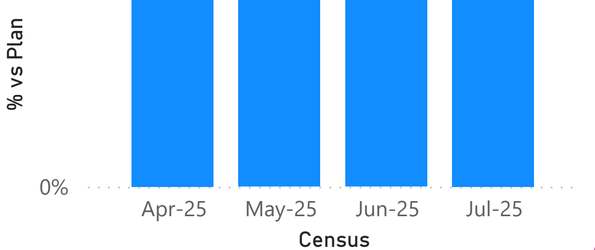


Activity per £1k Operating Expenditure

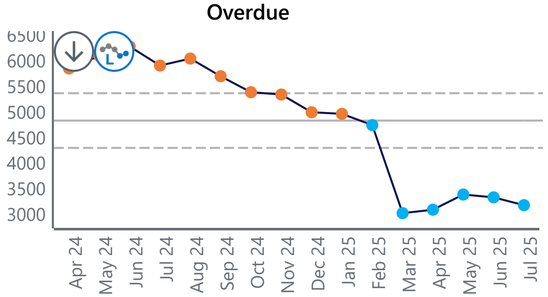
YTD Position



% follow up waiting list on PIFU

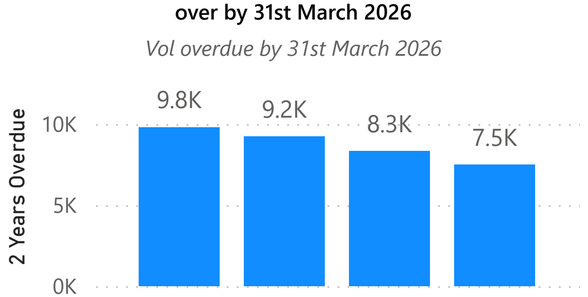


Volume of active outpatient follow up waits - 2 Years & Overdue

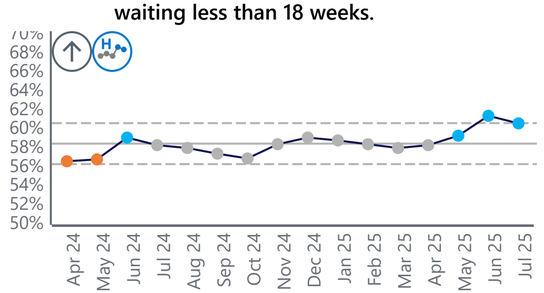


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

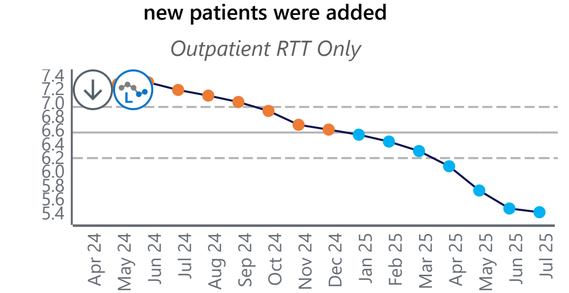


Time to first attendance, waiting for first event and of those waiting less than 18 weeks.



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

Outpatient RTT Only



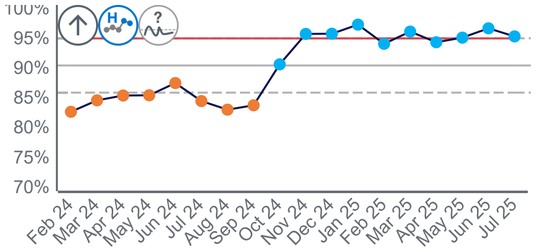
Integrated Performance Report | August 2025

Alder Hey Children's NHS Foundation Trust

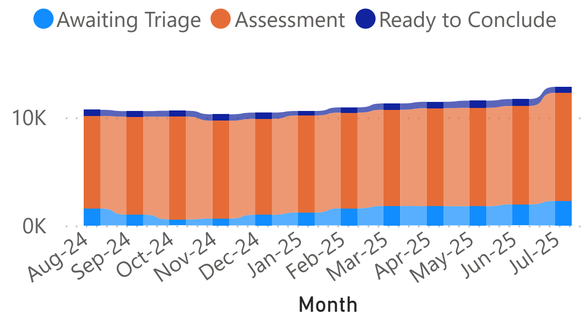
Revolutionise Care - Effective & Responsive - Watch Metrics

Diagnostics: % Completed Within 6 Weeks of referral

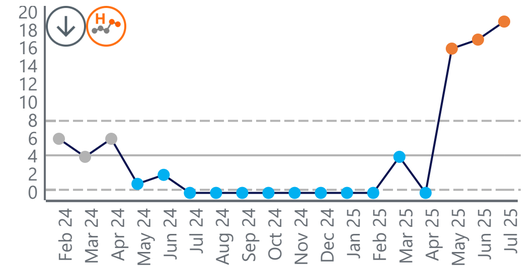
Target: Statutory



ADHD/ASD Diagnosis Status

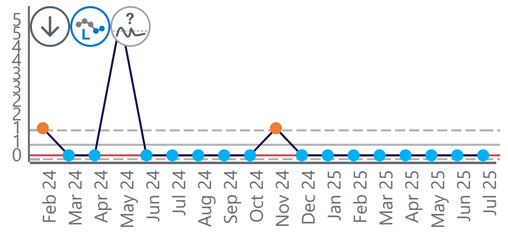


CAMHS: Number of children & young people waiting >52weeks



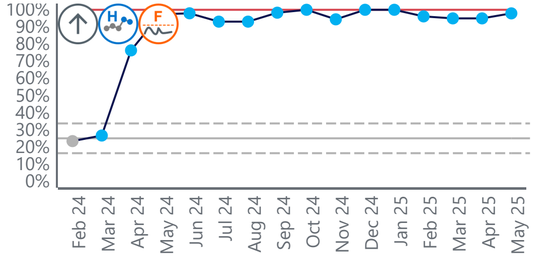
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



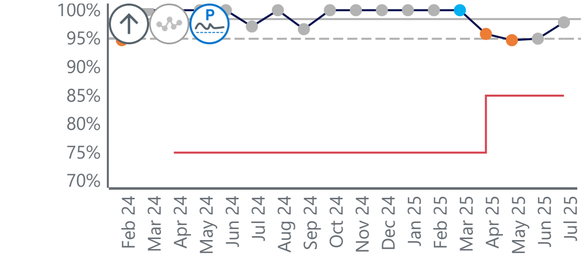
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



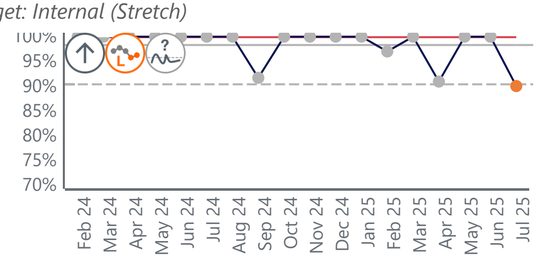
Cancer: Faster Diagnosis within 28 days

Target: Statutory



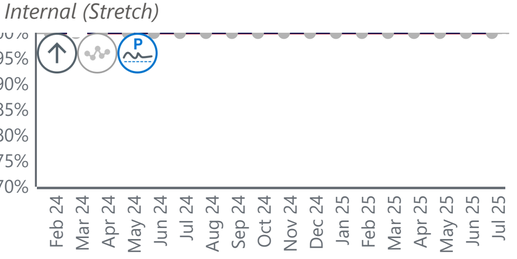
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)

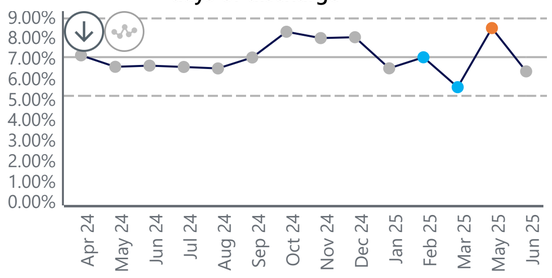


31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

Target: Internal (Stretch)



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



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

- Mandatory training completion remains over 90%
- Time to hire (TTH) has been out performing the target since April 25
- Short term sickness absence remains below the 2% target

Areas of Concern:

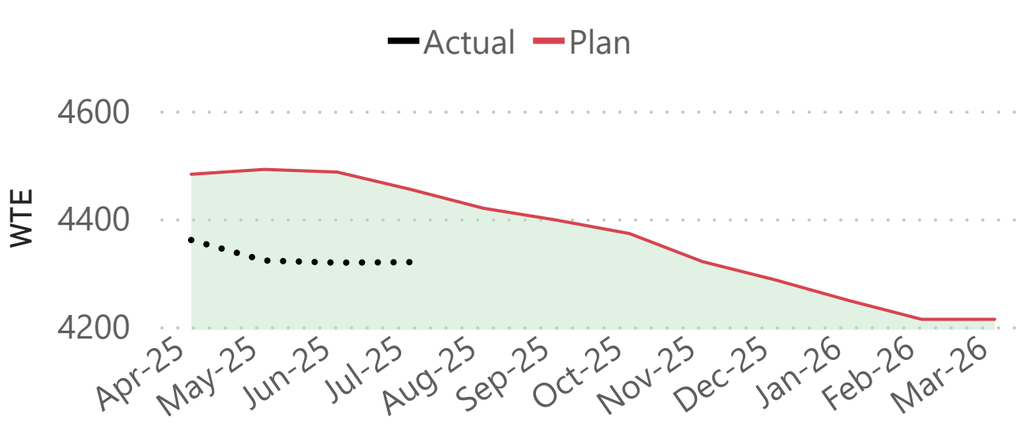
- Total Workforce (WTE): total workforce has remained largely static from June to July 2025. The CIP requirement across the year remains significant, with the March 2026 plan over 100 WTE lower than the current position. Additional measures have been agreed and overseen via the Workforce Establishment & Vacancy Panel meeting, and Organisation Design collaborative.

Forward Look (with actions)

- Long term sickness absence levels are challenging. The 90-day improvement programme presented to the July People Committee has now commenced • B7+ PDRs reset from 1st April 2025, due for completion by the end of July. Though behind the target, there has been a significant increase in completion to 70% at the end of July. L&D colleagues have contacted all supervisors with a reminder.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

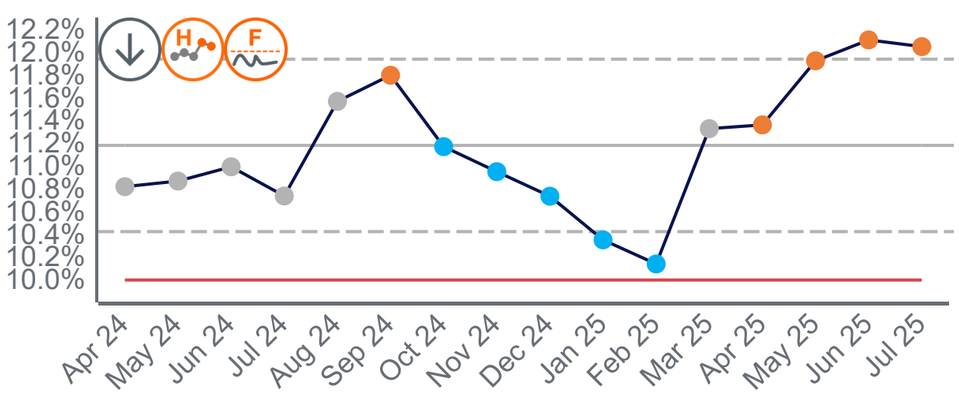
Total workforce for the end of July 2025 was 135 WTE below plan. Actual WTE was 4,319 against a plan of 4,454.

Actions:

WTE in July 2025:
Substantive colleagues (Inc. Trainees): 4218.58 (June: 4220.78)
Bank usage: 94.18 (June: 91.03)
Agency usage: 5.76 (June: 5.69).
In addition, overtime reduced from June (£100,438) to July (£85,427), though slightly higher than May (£82,799), which was the lowest across the previous 12 months.

Staff Turnover

Target: Internal



Technical Analysis:

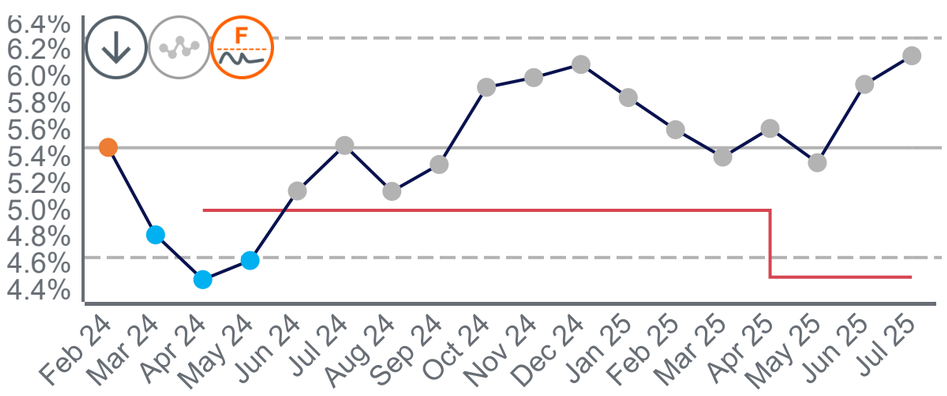
Special cause variation of concerning nature observed with performance of 12.1% in July 2025 against an internal target of 10%. 5th consecutive month against average performance for the 16 months after showing a downward trend Sept 24 to Feb 25.

Actions:

Having seen a steady decline, staff turnover has recently increased due to the end of a group of fixed term contracts, transfer of the digital team, and the leaving dates for colleagues who left as part of the MARS scheme.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Total sickness absence in July 2025 is 6.16% which is above the 5% target and an increase from June 2025 at 5.94%. July 2025 performance comprises STS at 1.60% which had reduced from June and LTS at 4.55% which has increased. Still demonstrating common cause variation, May 2024 is last period which would have achieved target which is now 4.5% in 2025/2026.

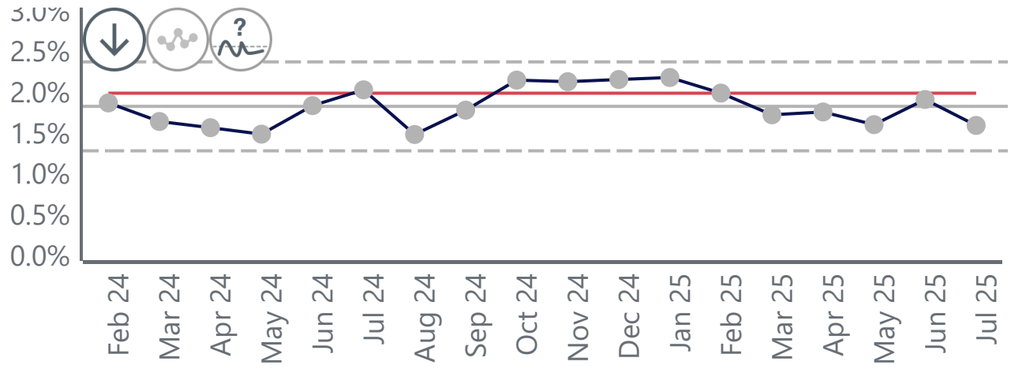
Actions:

Long term sickness absence levels are challenging, with a detailed paper presented at People Committee in July. This included a 90-day sickness improvement programme, informed by analysis of existing data and intelligence. Actions focus around training & resources, data and appreciative inquiry

Supporting Our People - Watch Metrics

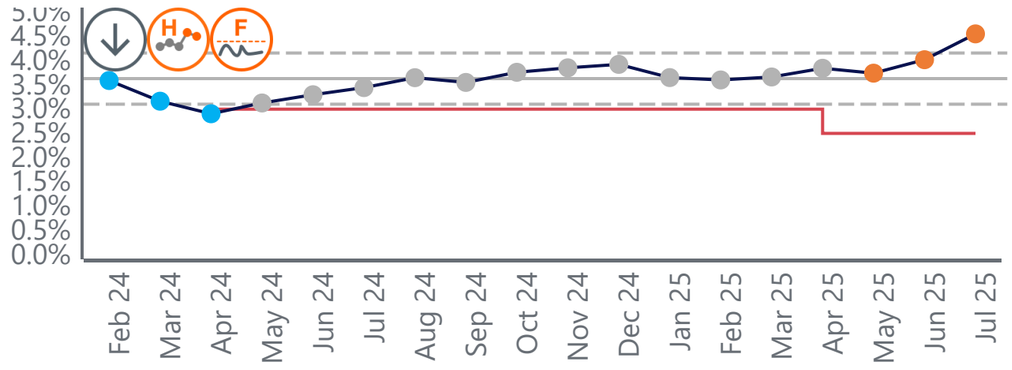
Short Term Sickness

Target: Internal



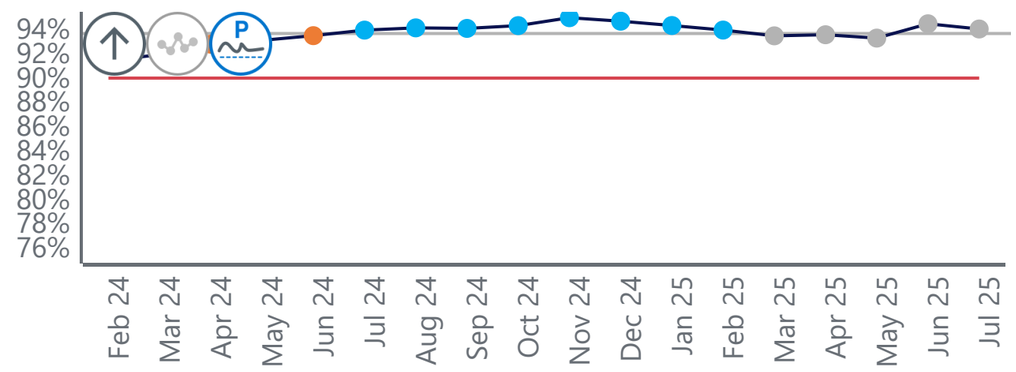
Long Term Sickness

Target: Internal

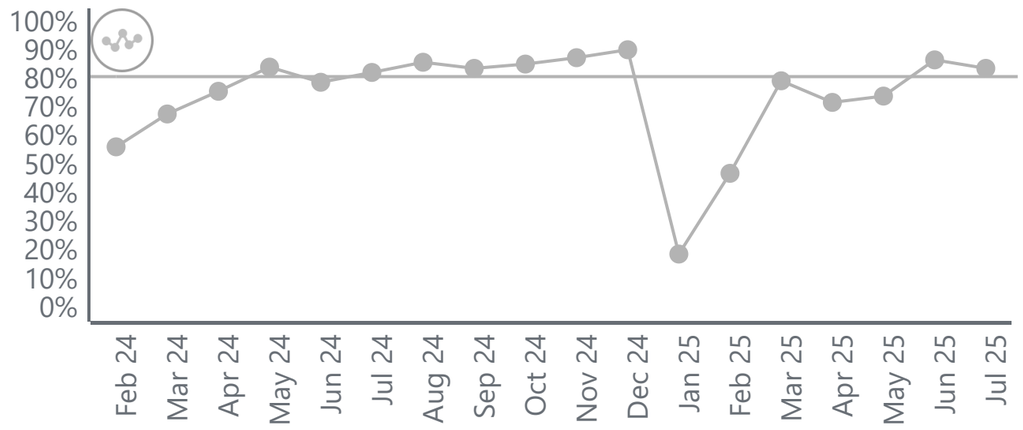


Mandatory Training

Target: Internal

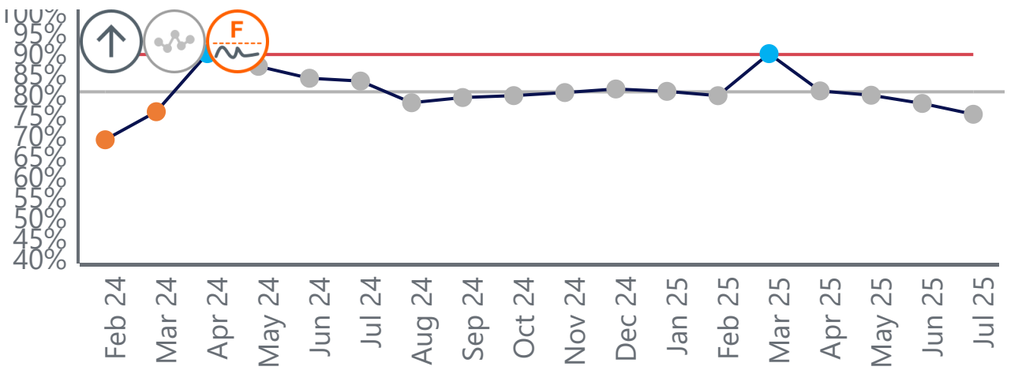


Medical Appraisal

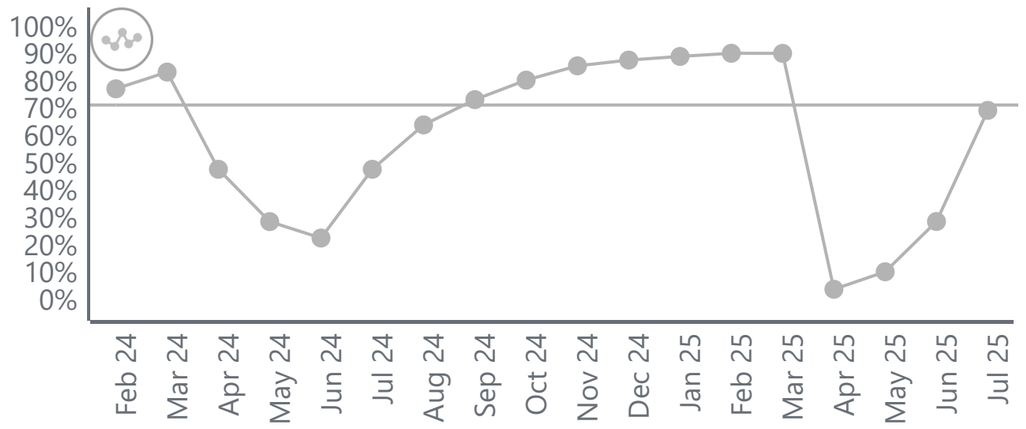


% PDRs Completed (Rolling 12 Months)

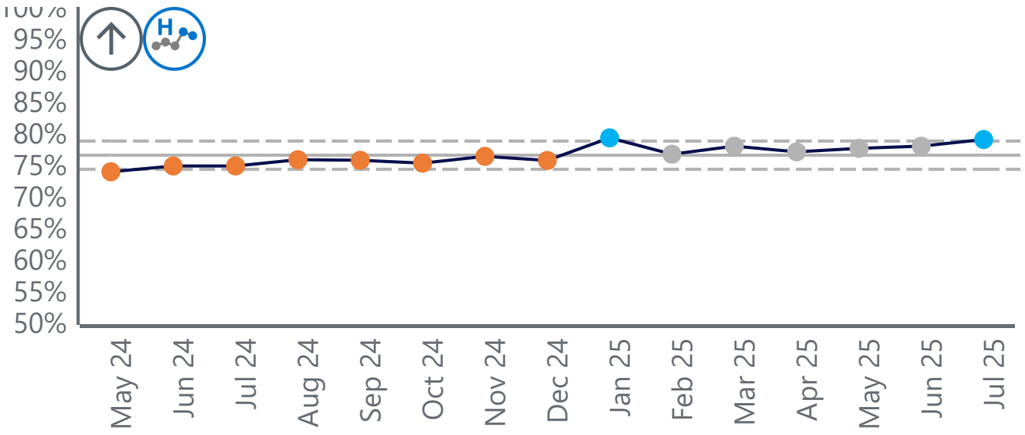
Target: Internal



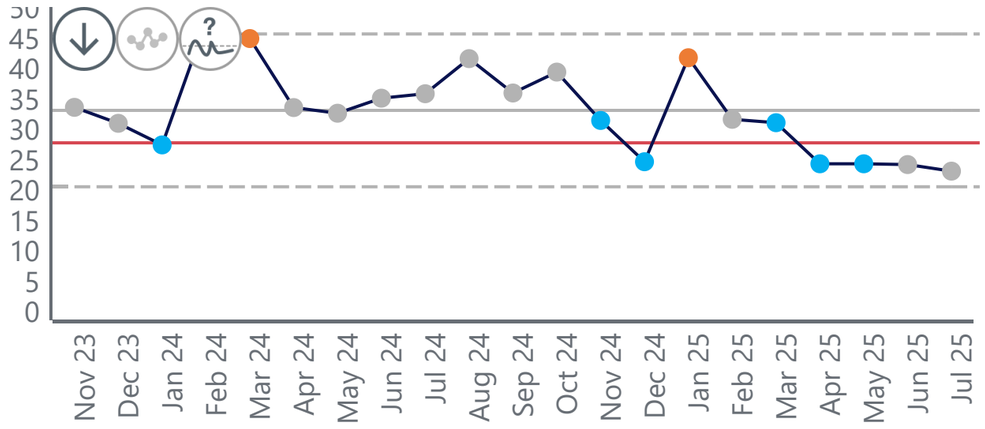
PDR B7+ Completed (Rolling 12 Months)



Workforce Stability



Average Time to Hire



Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

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

Highlights:

• Paediatric Open Innovation Zone (POIZ) funding agreement with LCR Combined Authority fully executed • Dan Hawcutt has led the way in updating the national curriculum by working with MHRA and >6000 young people to show CYP how to report suspected side effects, which will help make medicines safer (press release pending) • Collaborative development of innovation competition in primary and secondary schools to be launched in September with opportunity to create dedicated POIZ PPIE group • Collaborative Futures funding award (59,945) from AH Charity to develop a Trustwide approach to funding for travel/training/conferences including an integrated PDR app linked with the Training Needs Analysis data. • External funding successes include an i4i fast award (e-Arts-for-theBlues: A digital creative therapy for children referred to mental health services) awarded to Vicky Gray in collaboration with Edge Hill University • The Mobile Research Unit team have been out recruiting to the ELSA study across community centres facilitated by 8 Alder Hey Parent Champions plus MRU discussions about community vaccines following the measles response. • Invite to stage 2 of the NHS Charities Together funding call for 'Adapting the WNB Model to address inequalities in access to mental health services' for up to £150k

Areas of Concern:

• Underperformance in recruitment to time and target for sponsored (see research risk register) - deep dive report going to Sept Futures Management Board • Adverse financial position predominantly driven by underperformance against RPA and MRI business cases – reporting to FIP on 28th August • Continued concerns about clinical capacity to support research and innovation activities (particular risk around inability to deliver neurology studies currently under review)

Forward Look (with actions)

• Plans in place for Futures photography cohort with role profiles with photos taken by ACE students (end Oct- Dec) • NHSA subscription renewal under review to ensure value for money • Launch of the IDEA framework to support embedding research across the Trust planned for Sept
• Launch of next phase of seed corn funding to support continued external funding applications to be launch in August

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

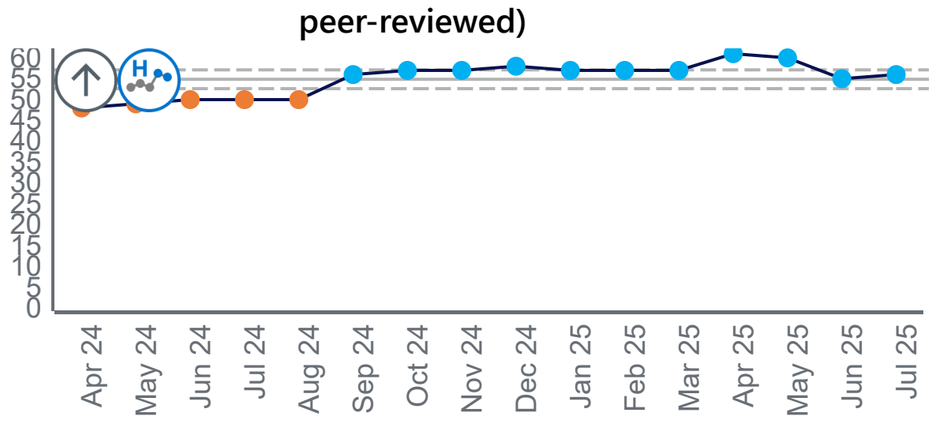
Technical Analysis:

Under Development

Actions:

Under Development

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



Technical Analysis:

Number of CIs leading NIHR portfolio studies per month

Actions:

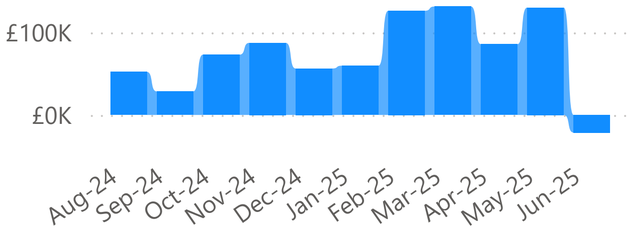
No specific action require. Continuing to invest internal capacity and capability funds into supporting existing and new CIs. New round to be launched in August.

Integrated Performance Report | August 2025

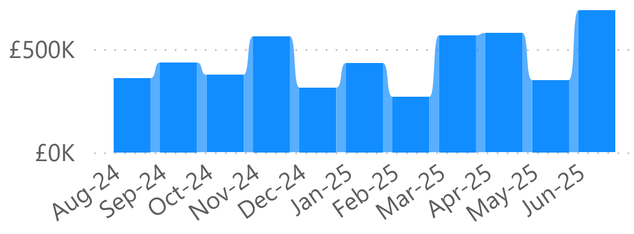
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

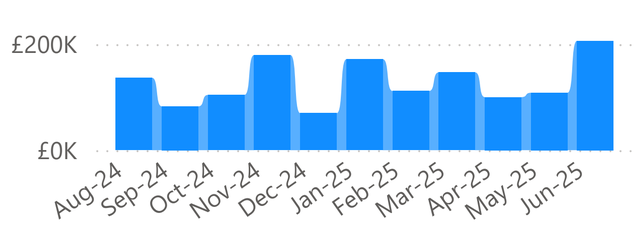
External innovation income received by month (commercial and non-commercial)



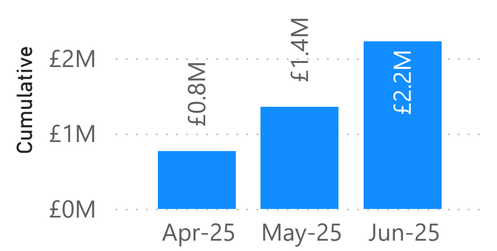
External research income received by month (commercial and non-commercial but excluding NIHR)



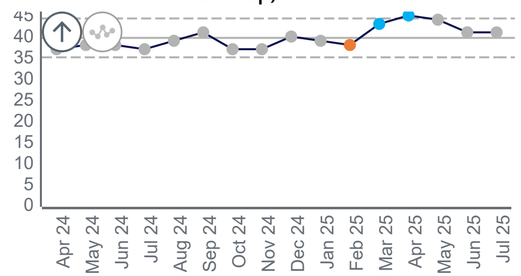
NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)



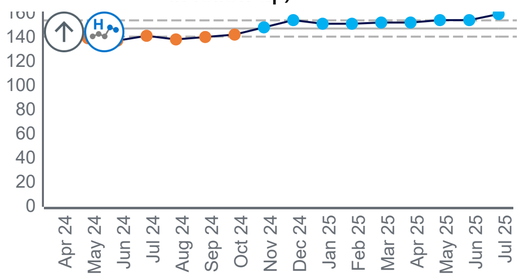
External income received by month across Research and Innovation (YTD Cumulative)



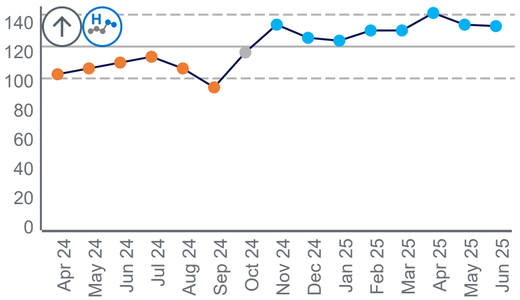
Number of open commercial studies (recruiting and in follow up)



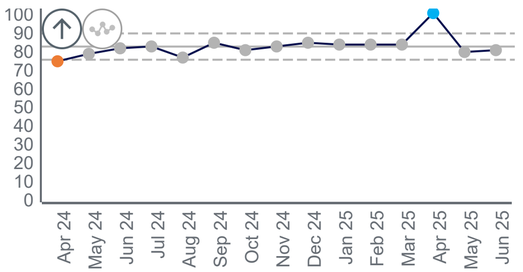
Number of open non-commercial studies (recruiting and in follow up)



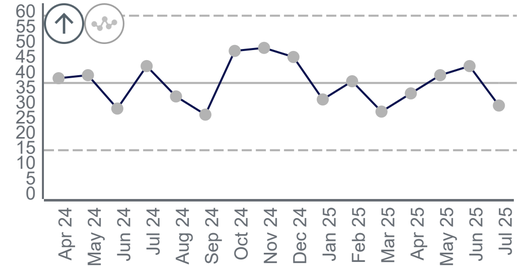
Number of participants recruited to all studies



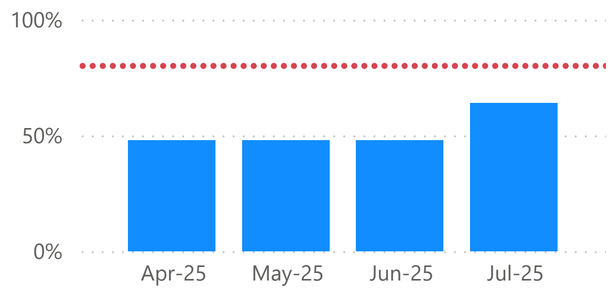
Number of participants recruited to all NIHR portfolio studies



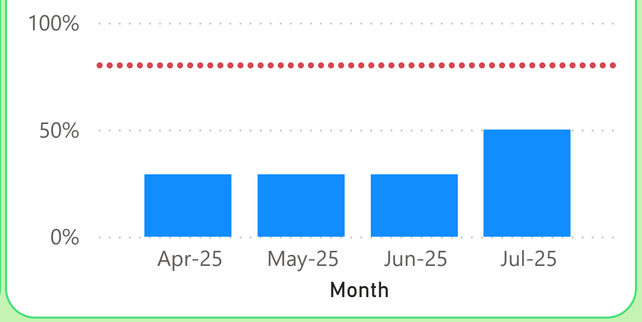
Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



Recruitment to time and target (RTT) for all open studies hosted by AH



Recruitment to time and target (RTT) open AH sponsored studies only



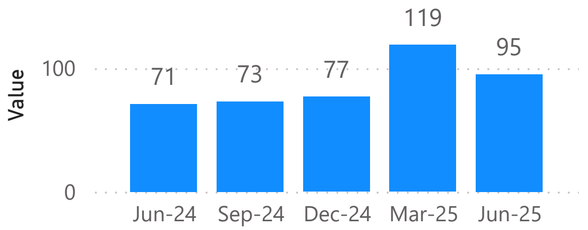
Integrated Performance Report | August 2025

Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

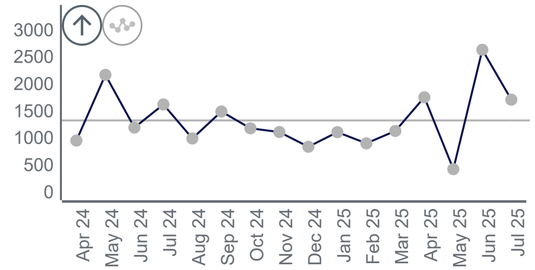
Number of publications with AH author by quarter including journal impact factor

Quarterly

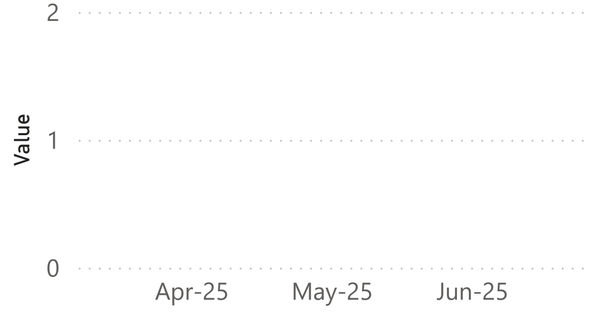


Number of businesses supported by POIZ

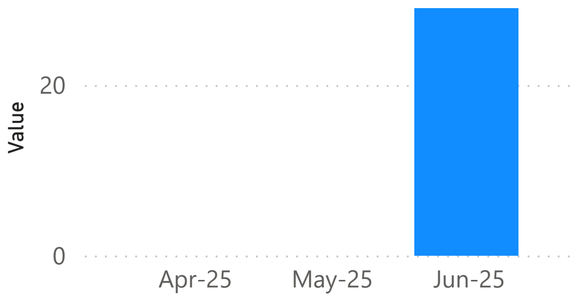
Manual hours released from automation/AI solutions - Monthly



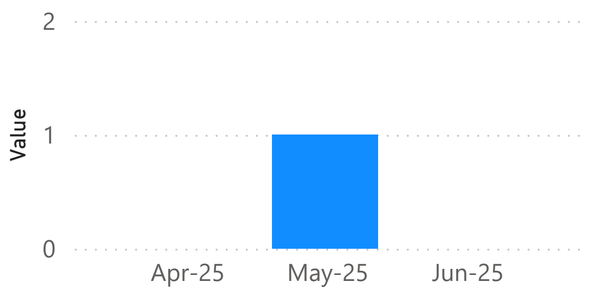
Number of staff trained in innovation methods



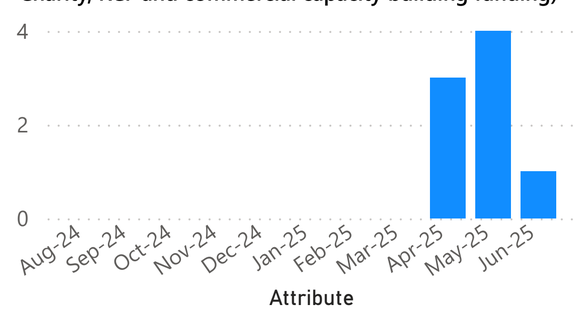
Number of staff trained in research methods



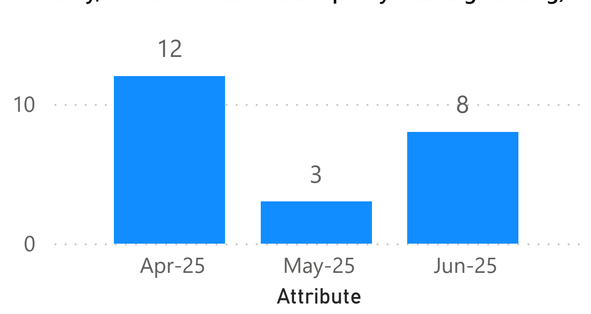
Number of AH-hosted jobs created through new external funding (POIZ metric)



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



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



Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

Trust reported £0.3m surplus in month, £1.5m deficit YTD - off plan by £0.3m due to the impact of industrial action. Pressures arising from measles outbreak have been absorbed. Forecasting to achieve £7.160m planned surplus subject to CIP and ICB risk share being mitigated. Risk adjusted forecast is £3.4m due to ICB risk share. CIP is on plan YTD. Overall, £11.9m CIP has been transacted in year with £2m fully developed and £8.8m in progress/opportunity stage. On track to deliver subject to amber and red schemes. Cash lower than plan due to income accruals not yet paid. Capital behind plan due to phasing of budget.

Areas of Concern:

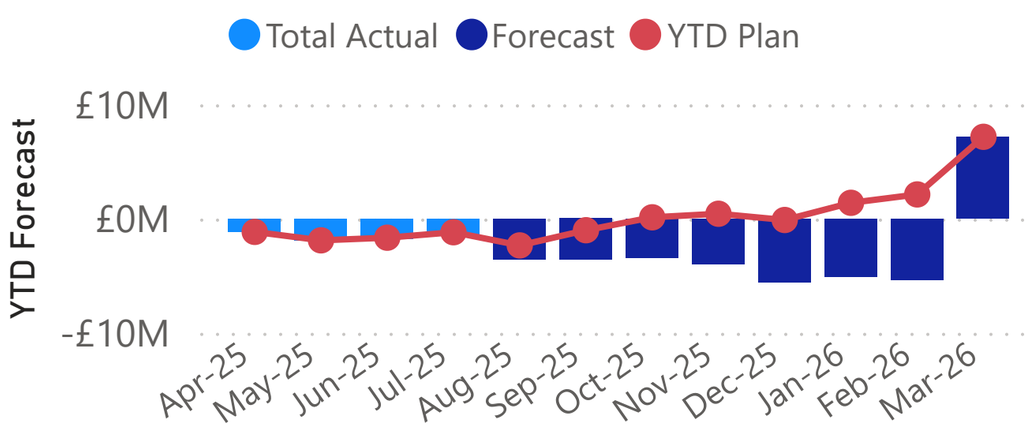
Delivery of CIP programme continues to present a risk. Mitigating actions are being progressed through the Financial Improvement Programme (FIP) and collaborative workstreams. Divisional forecasts at M4 have continued to highlight challenges particularly within Medicine division. In response, execs have agreed a plan from August to March aimed at closing the current forecast gap to ensure delivery of the £22.7m CIP plan. Capital programme remains a risk given funding allocation. Capital Prioritisation Workshop held in June with priority one items given the go ahead, and an action to resolve funding for priority two items by end of July.

Forward Look (with actions)

Continued cost control measures are being implemented through FIP to support achievement of year end position and focus on transformation to aid longer term financial sustainability. Additional 'Closing the Gap' Action Plan will need to be delivered to de-risk CIP programme delivery. Continued prioritisation of capital programme. Finance Escalation process for off-plan divisions and biweekly CIP deep dives now in place.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

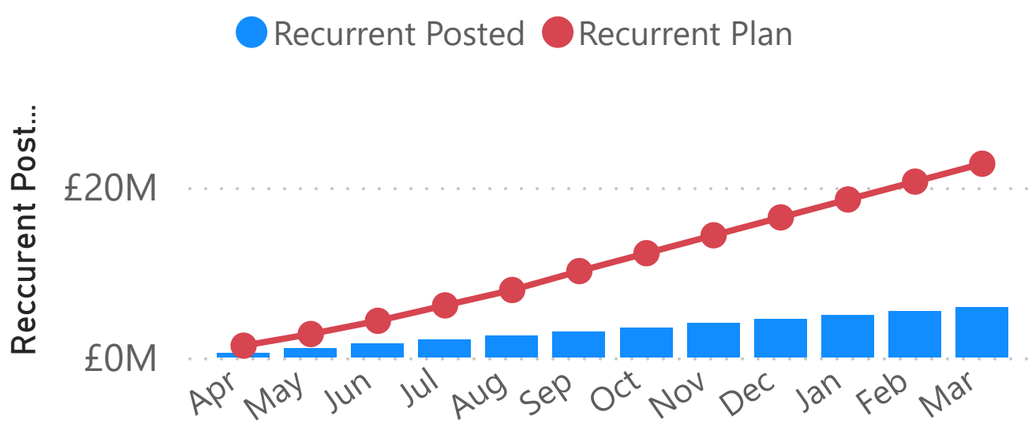
Current plan is £7.160m surplus which we aim to achieve. Risks to delivery of this is linked to achievement of CIP still in progress, identification of system wide schemes to deliver stretch target and management of in year pressures.

Actions:

Continue to monitor efficiency schemes in progress and cost control for arising pressures to be managed through FIP, SDG meeting, CIP deep dives and finance escalation meetings for those off plan.

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



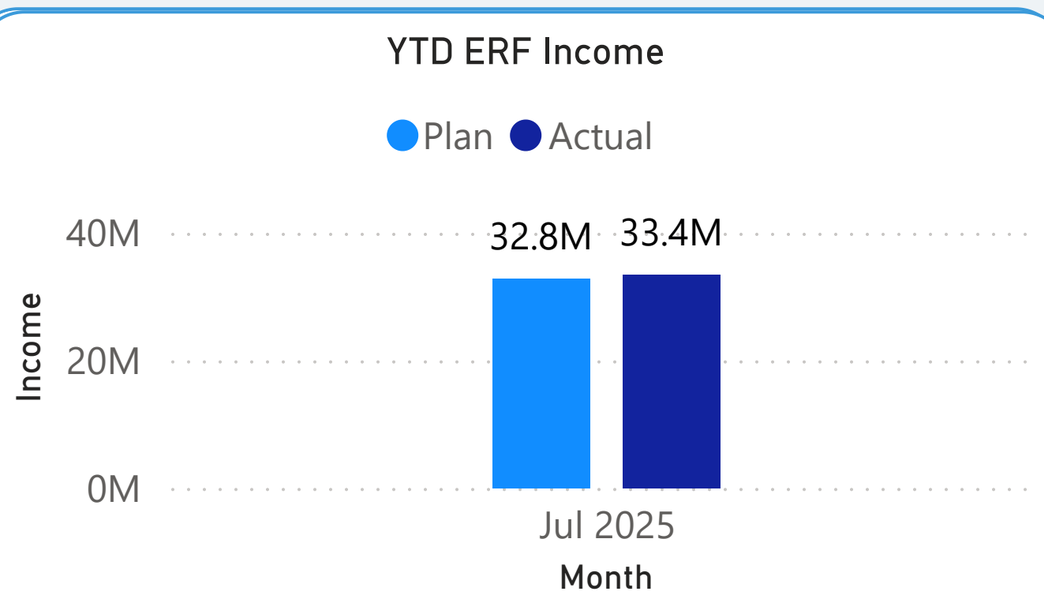
Technical Analysis:

Recurrent CIP identified and in progress is £11.9m.

Actions:

Significant work is ongoing to support the delivery of efficiency targets across the Trust through the FIP and 'Closing the Gap' schemes.

YTD ERF Income



Technical Analysis:

July performance estimated at 98%. Risk around reduced activity given less WLI due to rate change. Divisions identifying areas to mitigate.

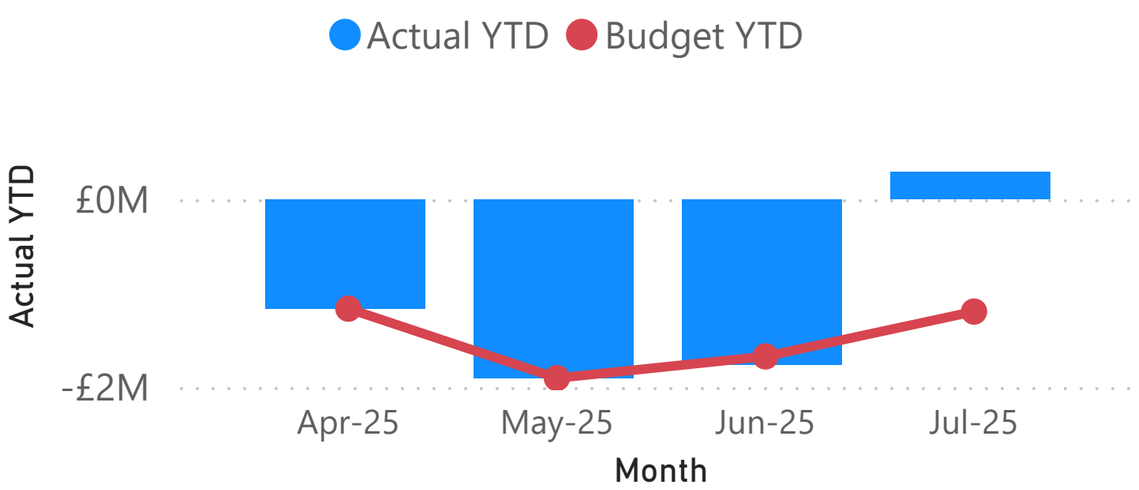
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

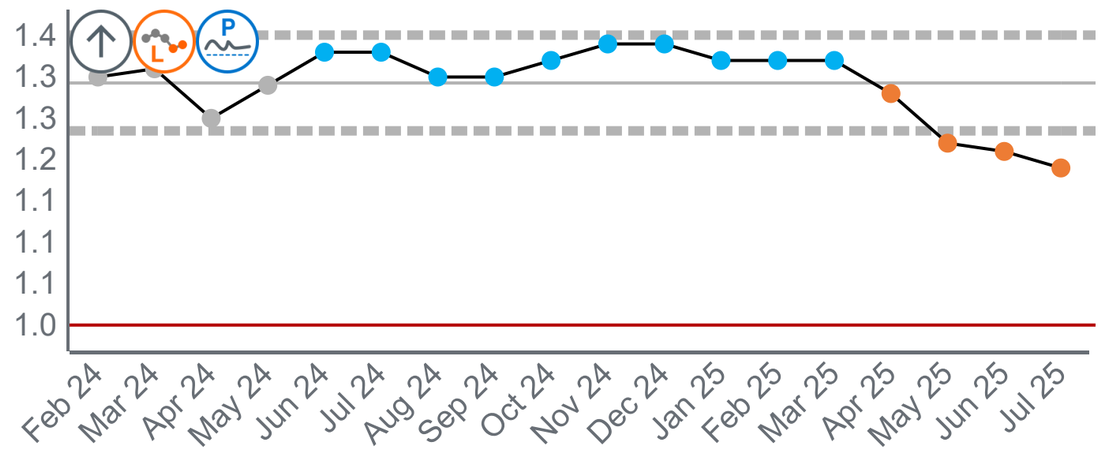
I&E distance from target (cumulative YTD)

Target: Internal

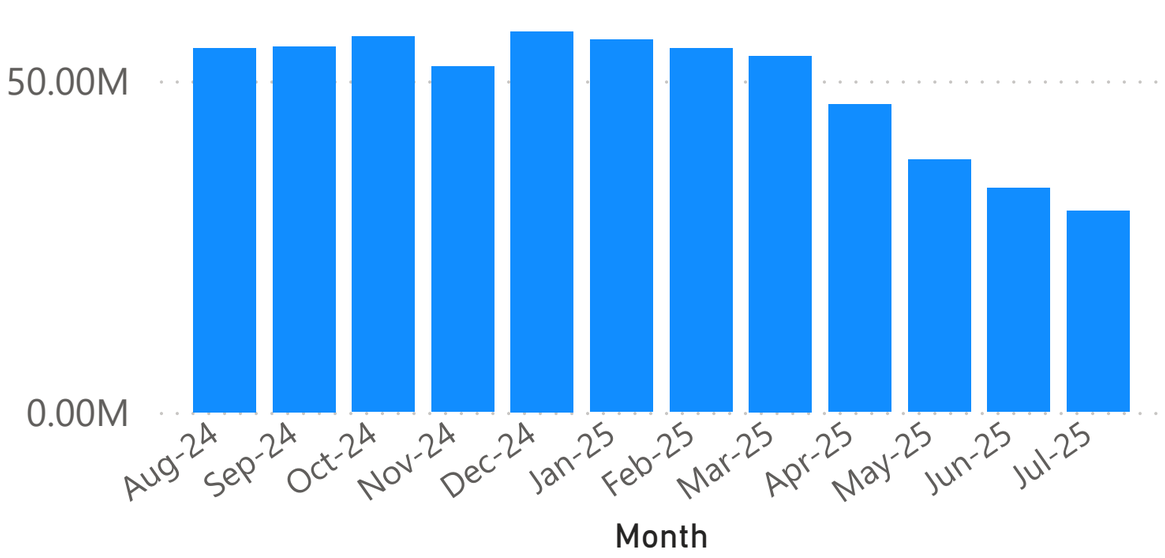


Liquidity

Target: Internal

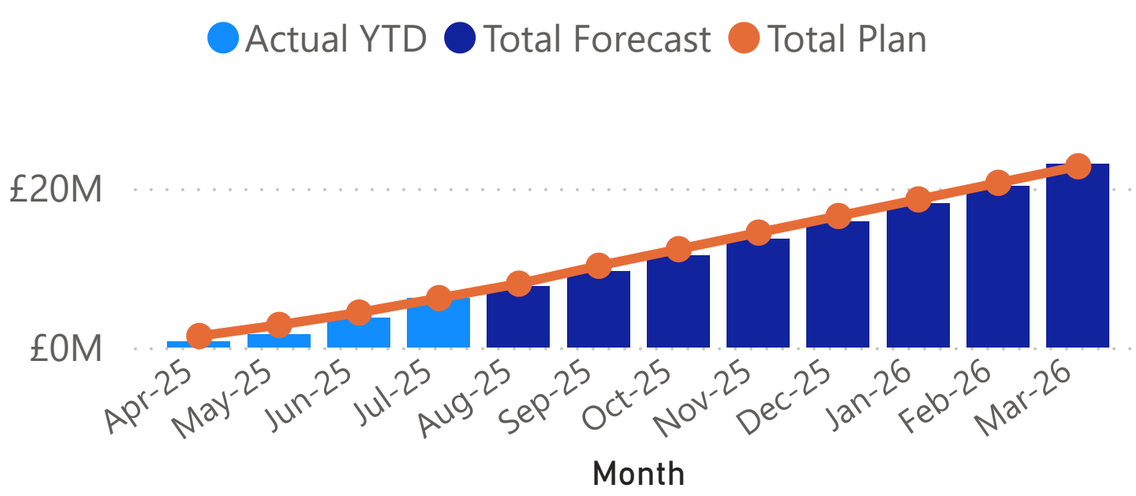


Cash In Bank



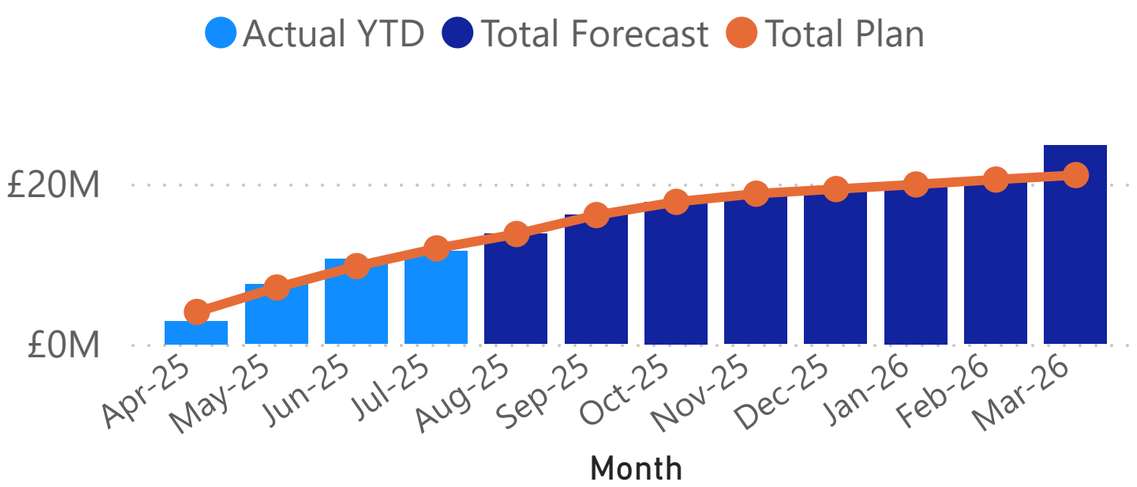
In Year CIP – forecast against plan

Target: Internal



Capital – YTD spend and forecast against plan

Target: Internal



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

100% of high risks within review date

Legacy risk information for Corporate Services -All risk details transcribed over into updated InPhase risk module

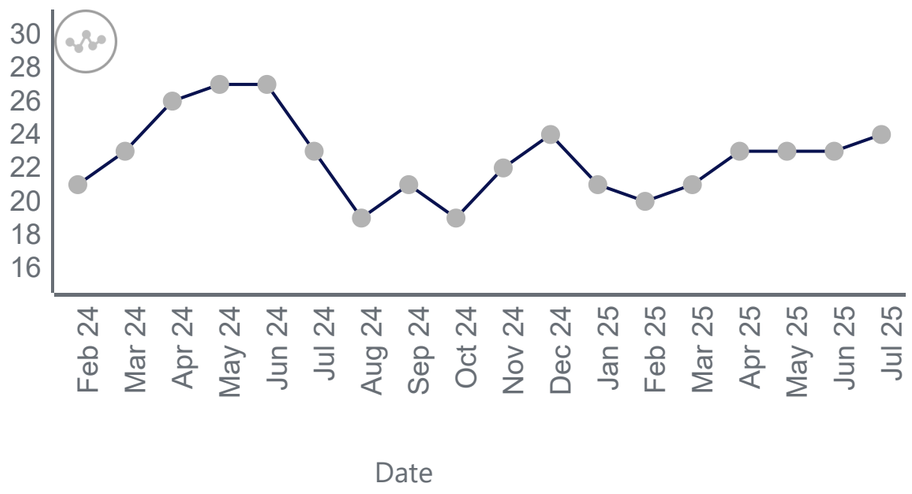
Areas of Concern:

Previous IPR risk watch metric reported incorrected. Escalated to BI team and now rectified

Forward Look (with actions)

Discussions with Medicine Division with view to rolling out Risk Appetite from October 25.

Number of High Risks (scored 15 and above)



Technical Analysis:

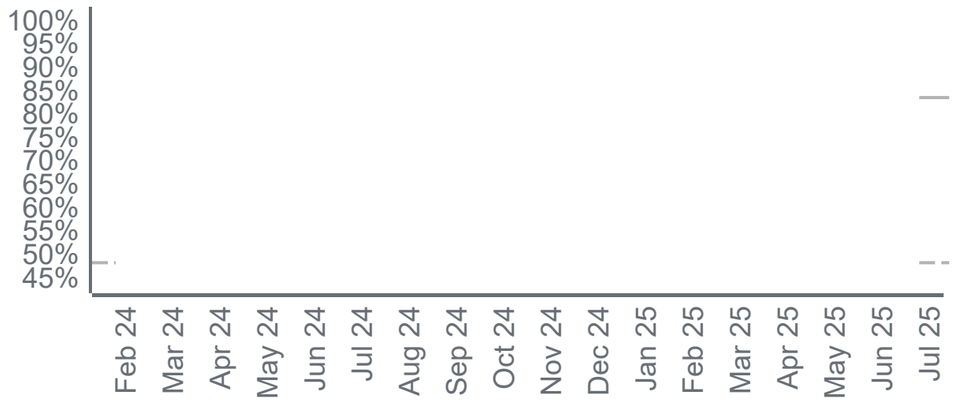
24 high risks on risk register as of the 31 July 2025.

Actions:

Reporting categories as outlined below:
Quality – Safety = 13 risks
Workforce – Sustainability = 4 risks
Compliance & Regulatory = 3 risks
Financial – Investment = 2 risks
Quality – Effectiveness = 1 risk
Reputation = 1 risk

% of High Risks within review date

Target: Internal



Technical Analysis:

Visual currently being updated

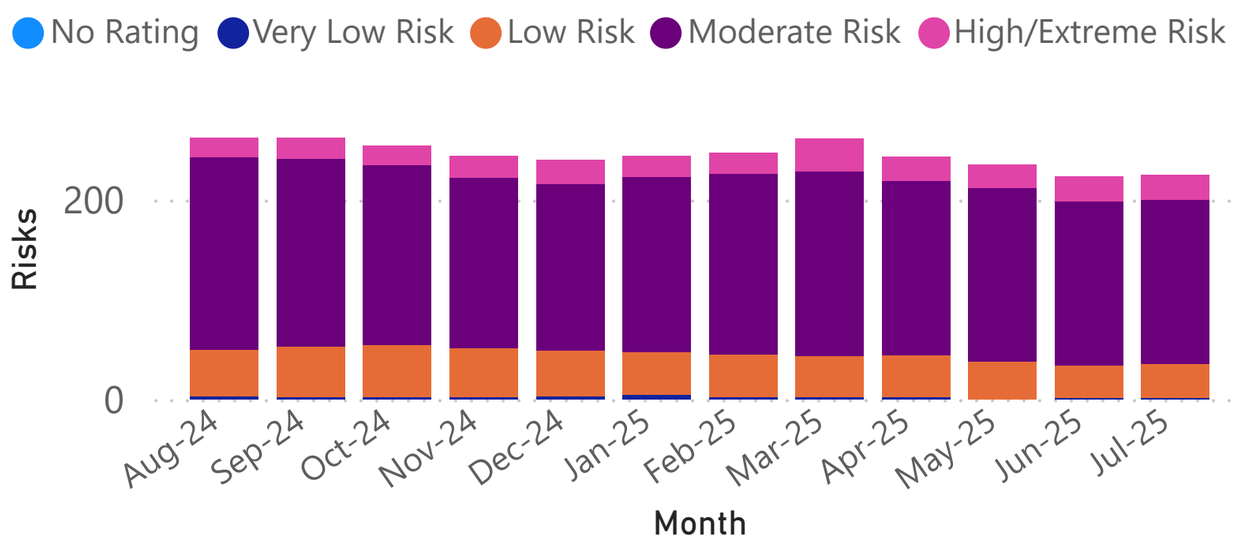
Actions:

100% of high risks within review date

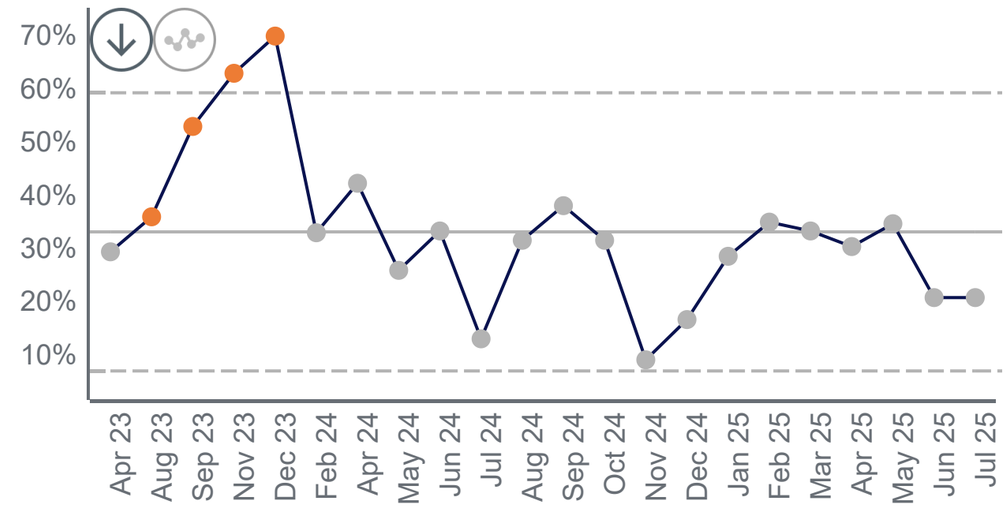
Risk watch metric - 5/24 (20.8%) of high risks with actions past expected date of completion-Risk owners informed

Well Led - Risk Management

Trust Risk Profile



% of high risks with actions past expected date of completion



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• CQC Inspection of Community Mental Health, ASD & ADHD Services rated outstanding

• Divisional nomination in all categories for the staff awards

• Continued improvement in number of complaints responded to within 25 working days (86%) and number of PALS resolved within 5 days (94%)

• Improvement in WNB rate (13%)

• Maintained staff turnover rate (10.8%)

• Continued reduction in number of CYP waiting over 65 weeks for ASD/ADHD diagnosis (3136)

• Continued improvement in Community Mental Health Services (Liverpool) urgent waiting times

Areas of Concern

• Increase in referral turnaround time (routine referrals)

• Increase in children & young people waiting over 52 weeks for treatment to start (19) in Community Mental Health Services (Liverpool) - improvement plan in place with 0 x 52+ weeks expected end of September.

• Number of clinical letters outstanding continues to increase (2300+), and reduction in the number of clinical letters completed within 10 days due to delays in transcription process

• Increase in sickness absence (6.4%)

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

Forward Look (with actions)

• Referral team improvement plan in place to meet KPI by 31 August 2025

• Clinic Utilisation review and WNB deep dive continues

• Liverpool CAMHS performance improvement plan in place using A3 brilliant basics methodology – Trajectory for improvement finalised, introduction of choice clinics on track for August 2025

• Continued work ongoing to improve Mental Health data reporting. Phase 1 completed with 2024/25 annual data re-submitted - awaiting publication (July 2025) expecting 0% data quality errors and significant increase in data flowing. Phase 2 (Crisis Care) work commenced.

• No child or young person waiting longer than 2 years for follow up. Work ongoing to address children waiting 1+ year. Increase in number of children waiting 1+ year due to impact of ADHD medication shortage from July 2024

• ASD / ADHD transformation programme continuing with good engagement from teams and external colleagues - on track to go live 1 September 2025.

• Work ongoing to provide psychological support to children impacted by the Southport critical incident.

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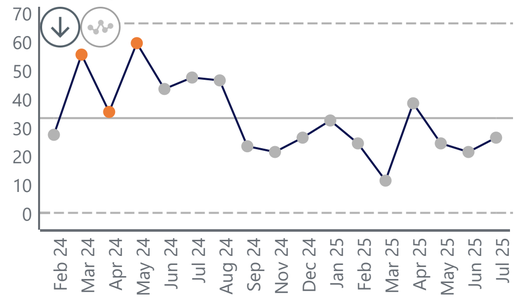
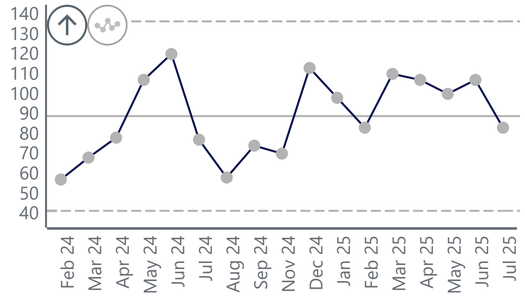
Divisional Performance Summary - Community & Mental Health

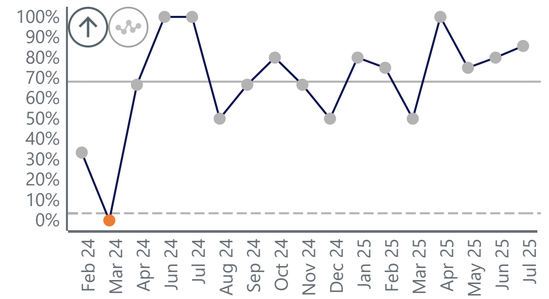
Patient Safety Incidents rated Low Harm & Above



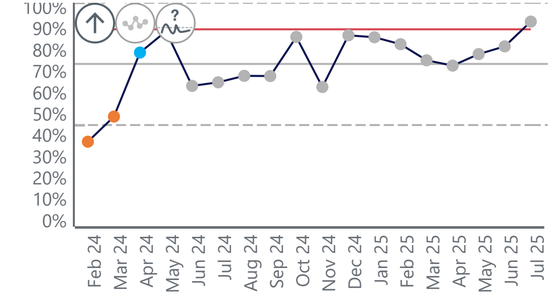
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

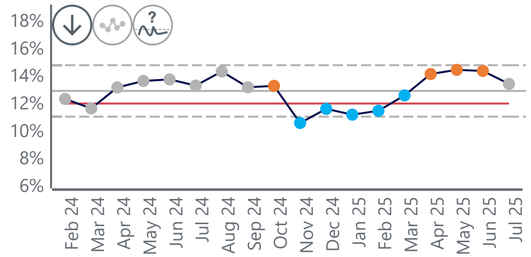


% PALS Resolved within 5 Days

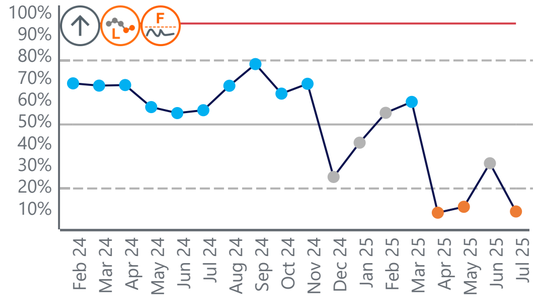


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

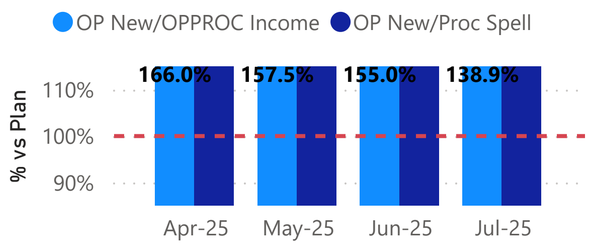


% of Clinical Letters completed within 10 Days

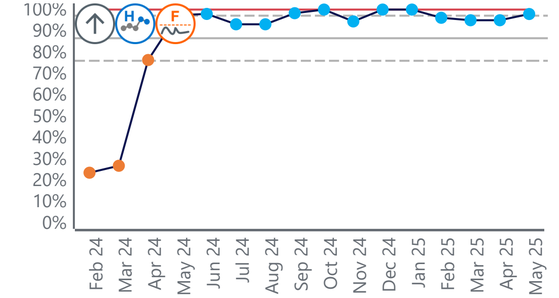


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

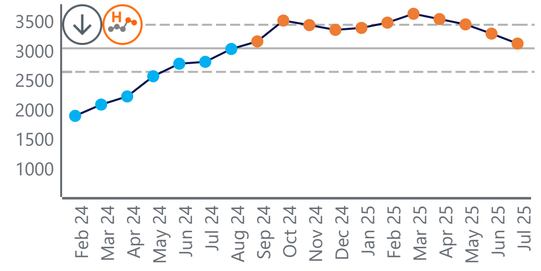
SLAM Performance



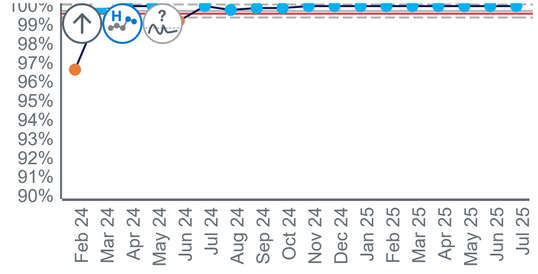
IHA: % complete within 20 days of referral to Alder Hey



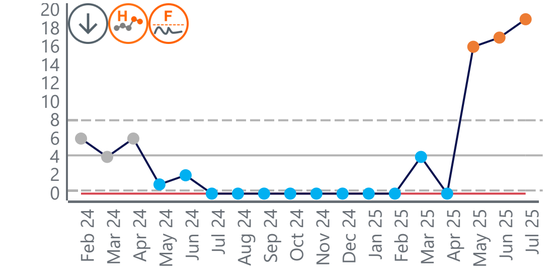
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



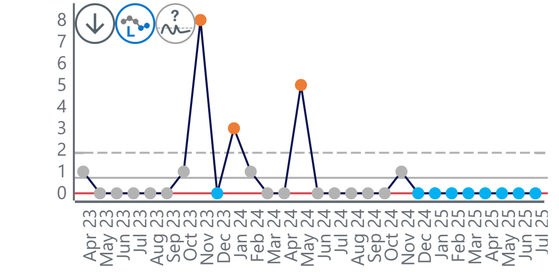
Percentage CYP suspected autism with contact under 13 weeks



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



Number of Paediatric Community Patients waiting >52 weeks



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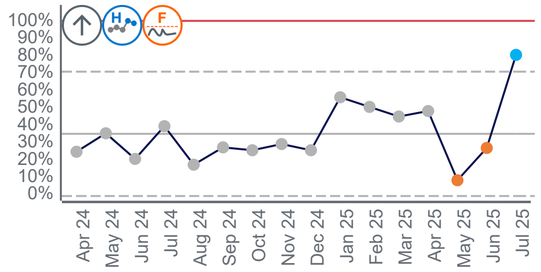
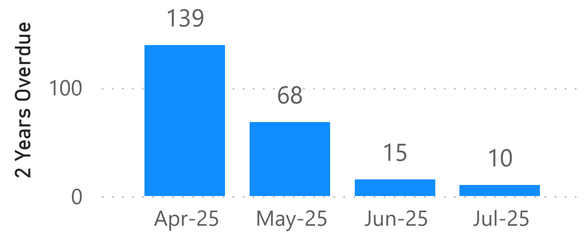
Divisional Performance Summary - Community & Mental Health

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

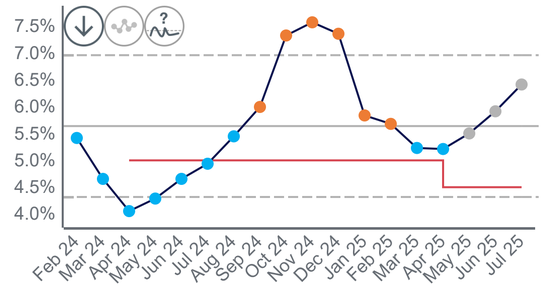


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

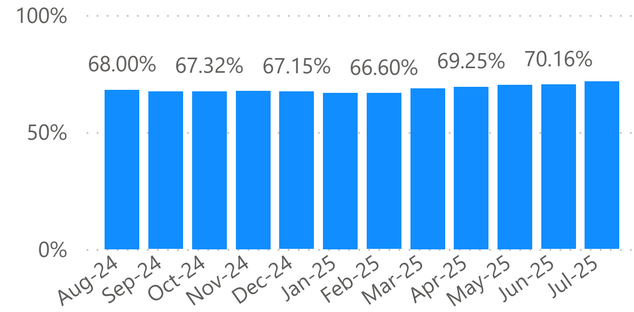
Vol overdue by 31st March 2026



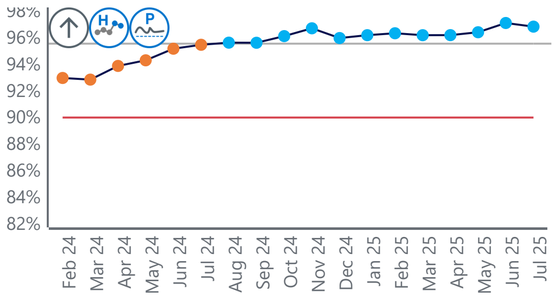
Sickness Absence (Total)



Workforce Stability

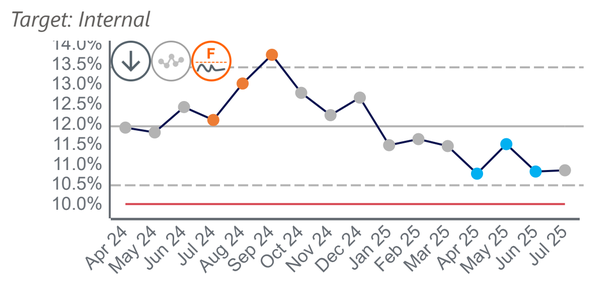


Mandatory Training

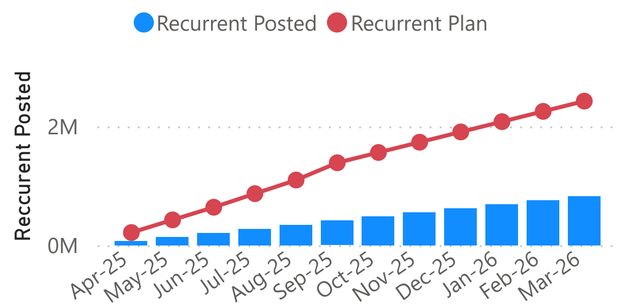


Staff Turnover

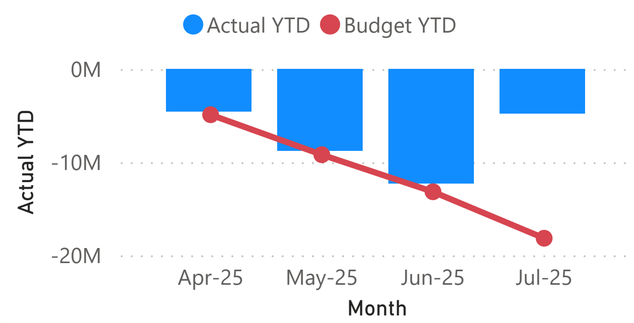
Target: Internal



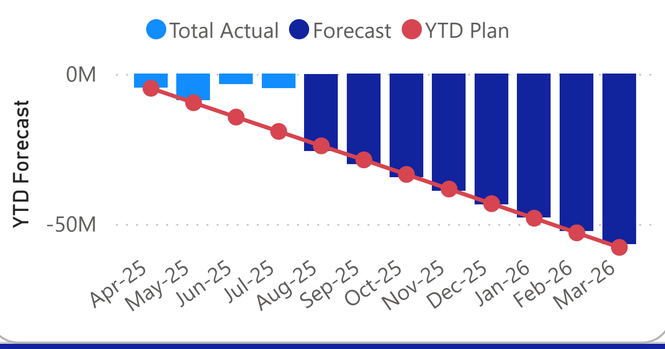
Recurrent Efficiency Plans Delivered (Forecast)



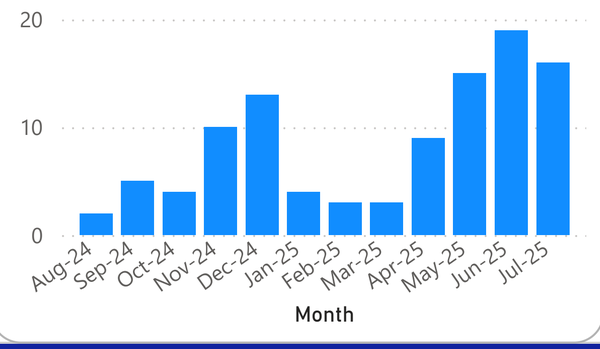
I&E distance from target (cumulative YTD)



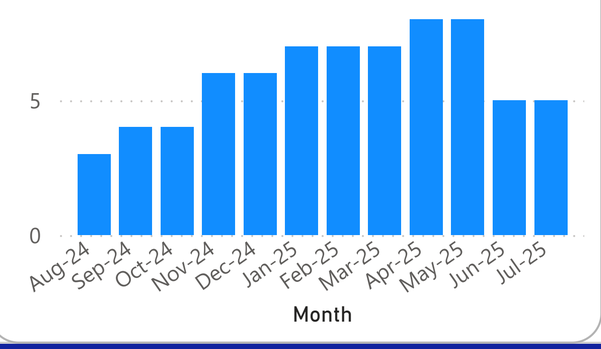
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

- Number of patients waiting over 52 weeks declined for 6th consecutive month (n=2 in July, June 24 n=77)
- Complaint responses 100% and PALS resolved within 5 days back to 100% in July
- YTD ED performance - 85.5%
- YTD activity at 99% with case mix resulting in £267k above plan
- Reduction in overdue follow ups was 1107 in Apr, 789 in Jul

Areas of Concern

- Mandatory training slipped to 93%
- Increase in staff sickness - 6.4%
- Ongoing challenge with delivery of CIP programme
- Medical theatre utilisation

Forward Look (with actions)

- Change in theatre schedules from 5th August 2025 with new theatre scheduling oversight meeting
- Senior oversight of sickness management
- Family led FU validation with ISLA Care
- Clinical FU validation in key specialities
- No Pre Op No Op in Gastro
- Review of approach to CIP management within division

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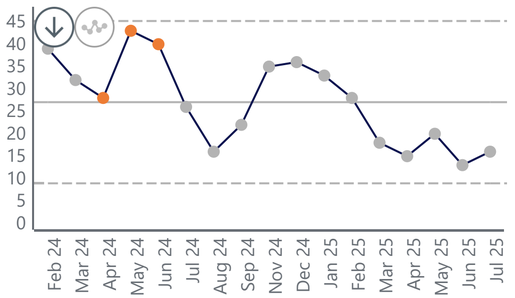
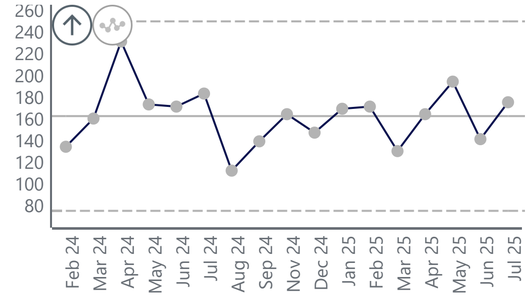
Divisional Performance Summary - Medicine

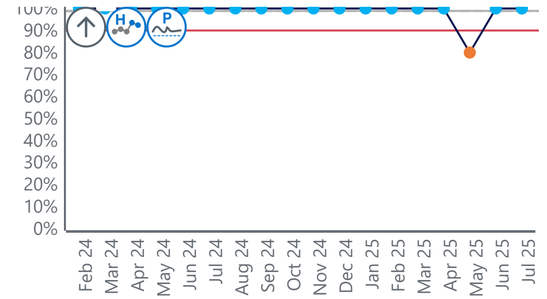
Patient Safety Incidents rated Low Harm & Above



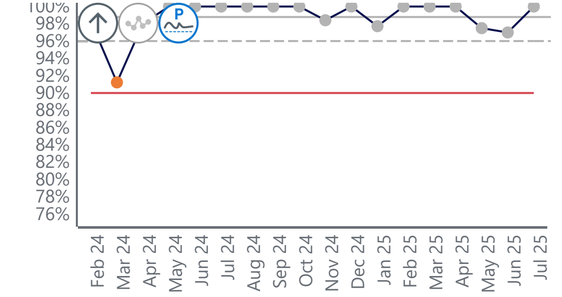
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

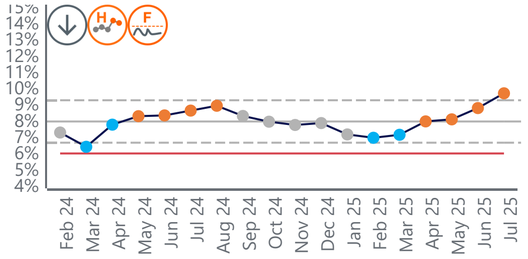


% PALS Resolved within 5 Days

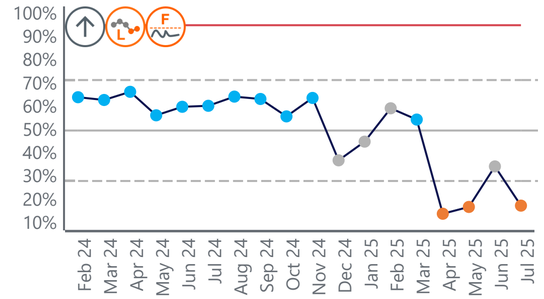


% Was Not Brought Rate (All OP: New and FU)

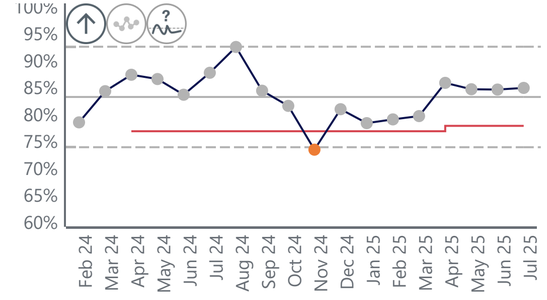
Target: Internal



% of Clinical Letters completed within 10 Days

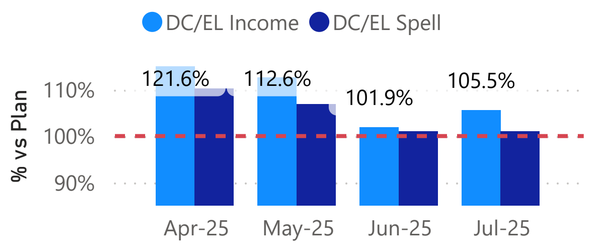


ED: % treated within 4 Hours



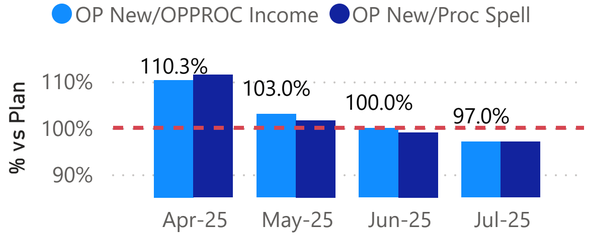
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

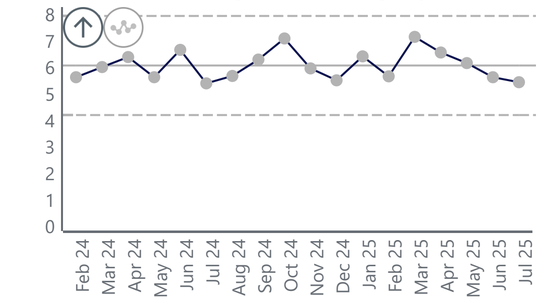


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

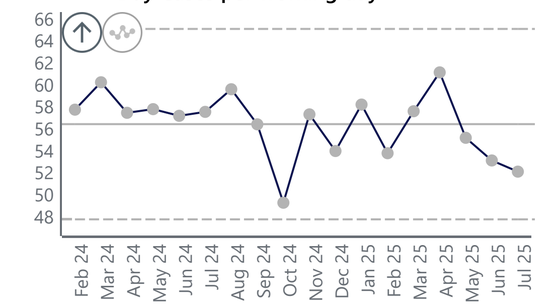
SLAM Performance



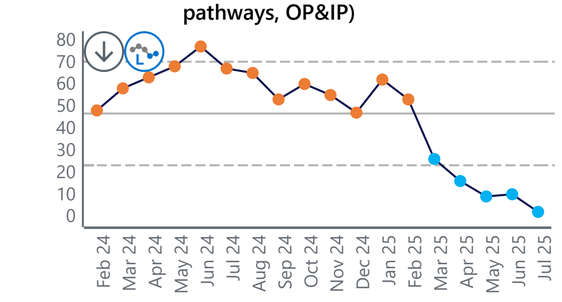
Inpatient Discharges per working day



Day Cases per working day



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



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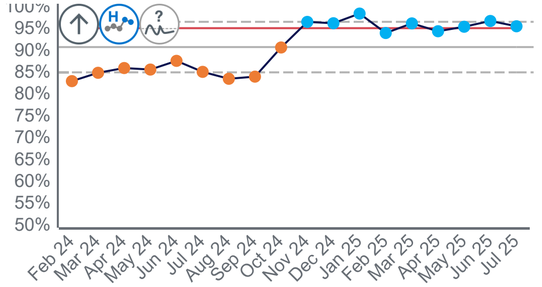
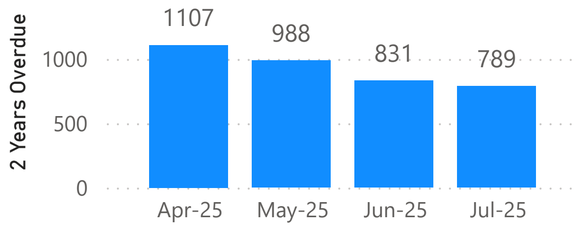
Divisional Performance Summary - Medicine

Diagnostics: % Completed Within 6 Weeks of referral

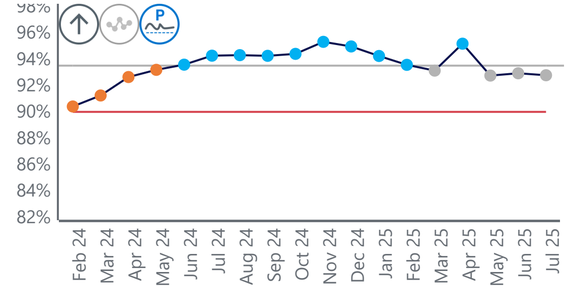


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

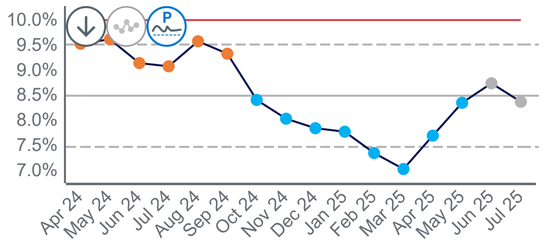


Mandatory Training

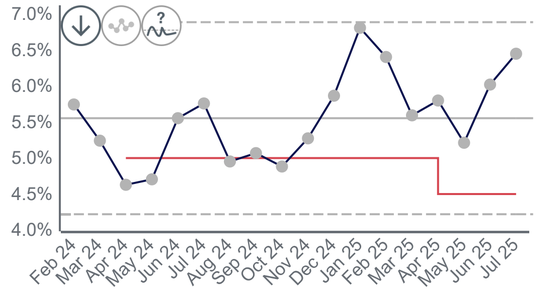


Staff Turnover

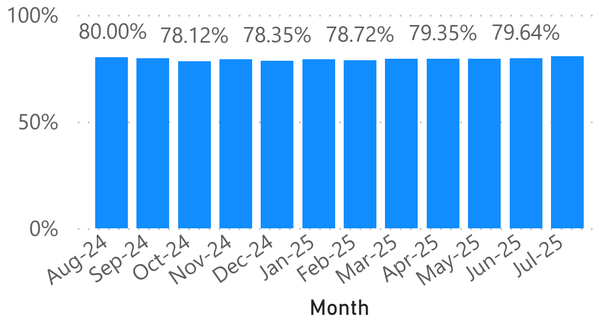
Target: Internal



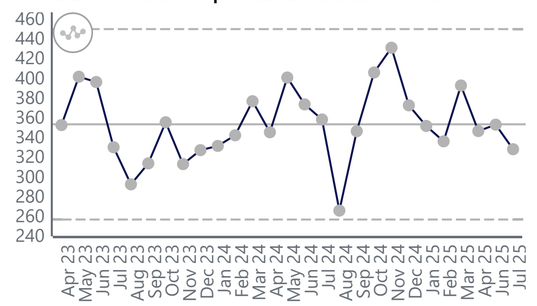
Sickness Absence (Total)



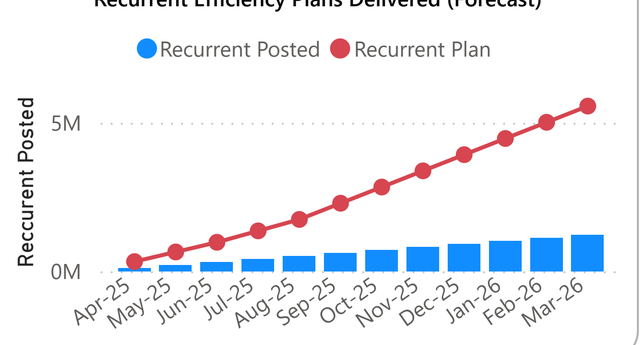
Workforce Stability



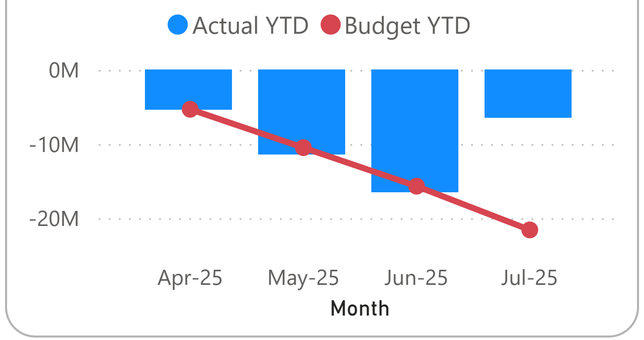
A&E Attendances per ED Consultant WTE



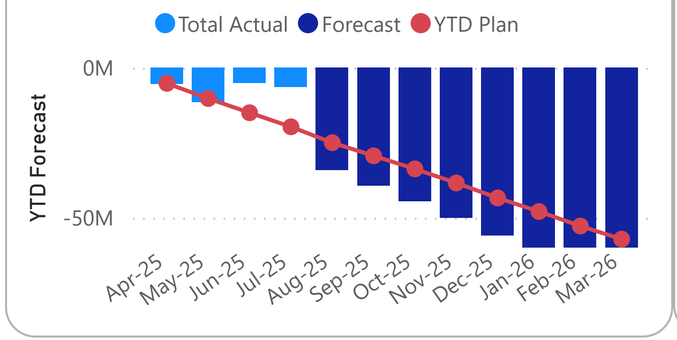
Recurrent Efficiency Plans Delivered (Forecast)



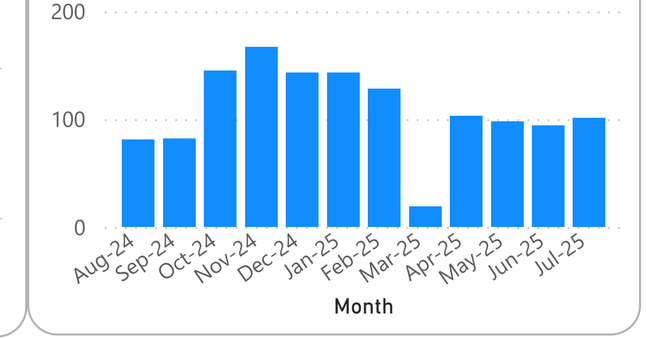
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division



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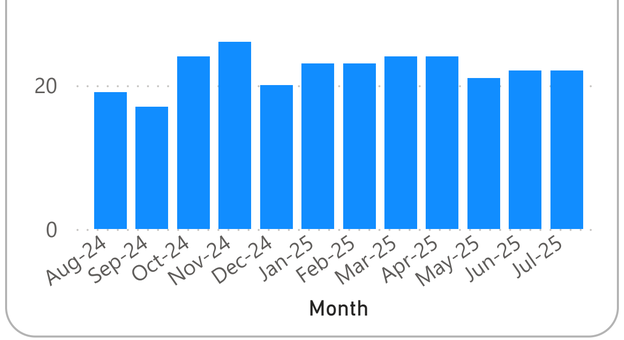

Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Income YTD exceeds plan for Elective & Daycase (101%) and Outpatient New and Procedures (105%). ERF activity pods are 99% of plan YTD.

• Day cases per working day remain consistently higher than previous years

• Mandatory training remains compliant with trust target at 94%

• PALS compliance at 98% and formal complaints compliance 100%

• Increased reporting in patient safety incidents rated no harm

Areas of Concern

• WNB rate increased in month at 10%

• The number of patients waiting over 52 weeks has increased, this is primarily in ENT and Dentistry & as a result of reduced WLI/insourcing capacity based on rate reductions.

• FU waits reduced in month but 2 years overdue remains high. Difficult balance between managing safe waits for CYP and FU activity overperformance.

• Sickness remains above target however a small reduction was seen in month. Hotspot areas mainly within theatres.

• Ongoing challenge with delivery of efficiency plans.

Forward Look (with actions)

• Continuous monitoring of activity performance to prevent significant overperformance in year based on capped plans.

• The WNB opt-in pilot in ENT and Dentistry is progressing well. We have verified the contact details of all patients who did not respond to the opt-in text message against the spine database. Those patients will receive an opt-in letter. We anticipate a reduction in WNB numbers in these specialties by September.

• No pre op – no op is being rolled out in ENT in August. The aim is to reduce same-day cancellations in theatre.

• All long-term sickness cases have been reviewed within the division and have supporting action plans.

• Tactical approach to CIP launched with a focus on sustainable strategy.

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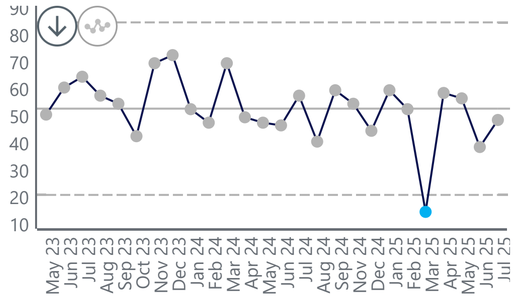
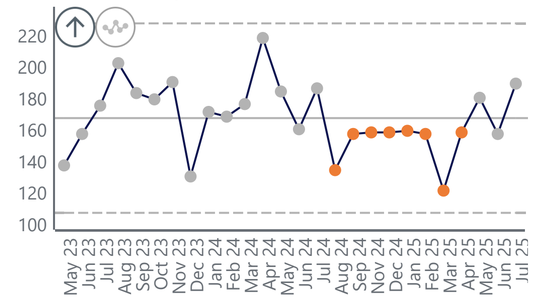
Divisional Performance Summary - Surgery

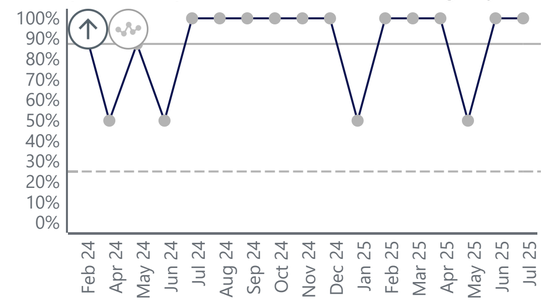
Patient Safety Incidents rated Low Harm & Above



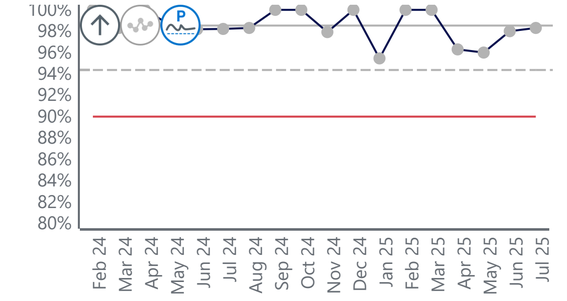
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

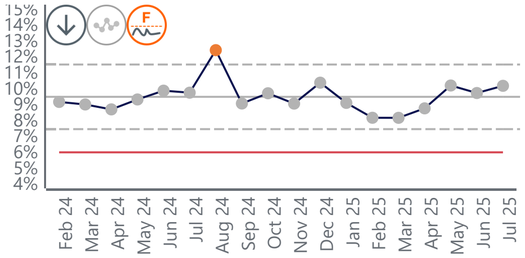


% PALS Resolved within 5 Days

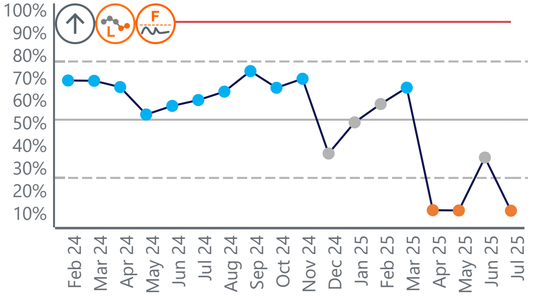


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

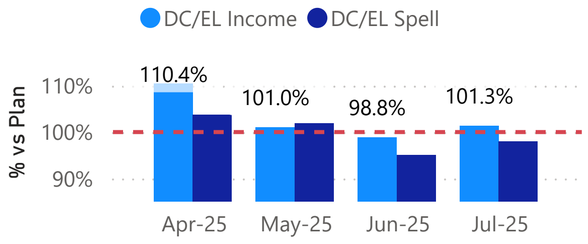


% of Clinical Letters completed within 10 Days



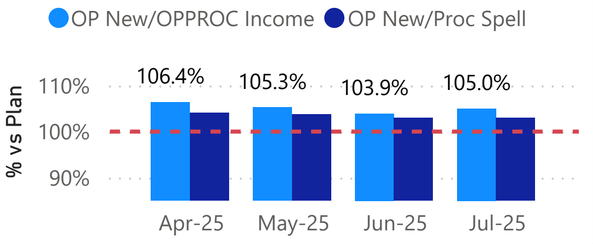
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

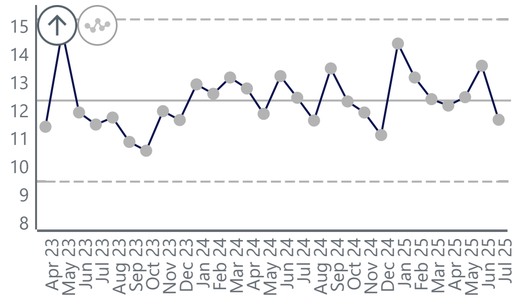


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

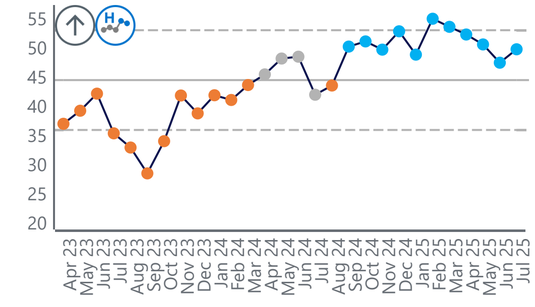
SLAM Performance



Inpatient Discharges per working day



Day Cases per working day



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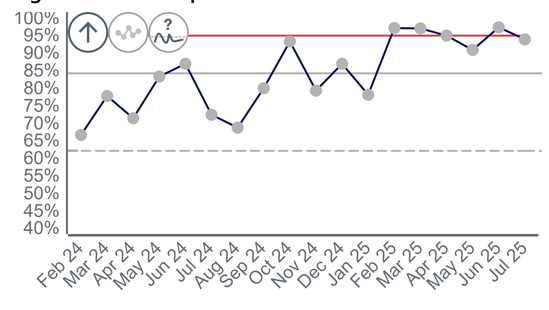
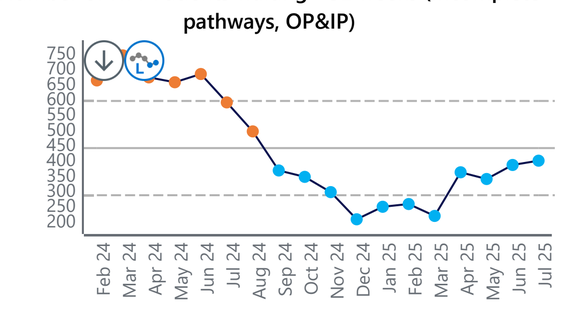


Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



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Divisional Performance Summary - Surgery

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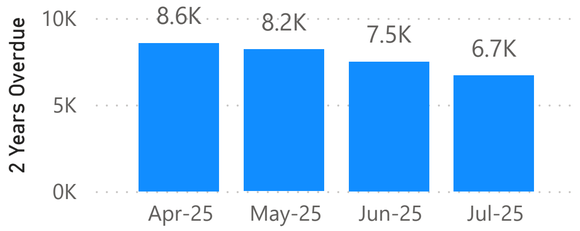
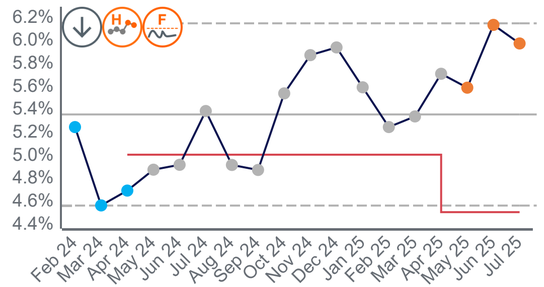
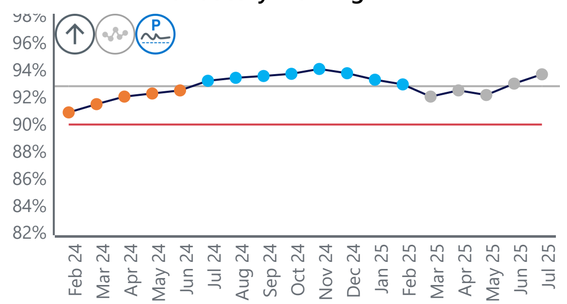
Vol overdue by 31st March 2026



Sickness Absence (Total)

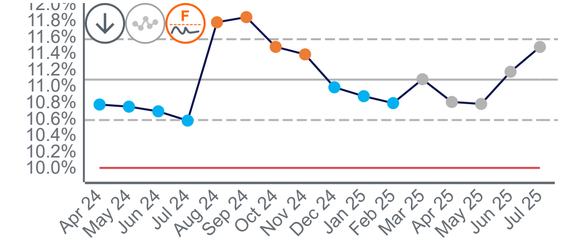


Mandatory Training

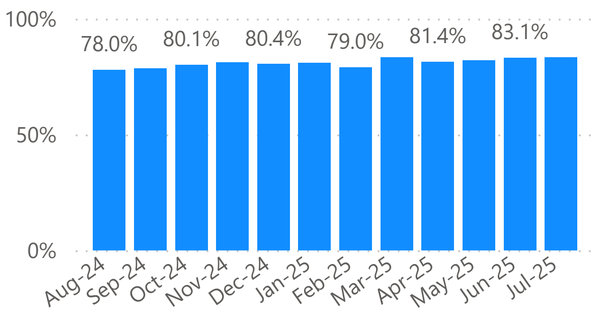


Staff Turnover

Target: Internal



Workforce Stability



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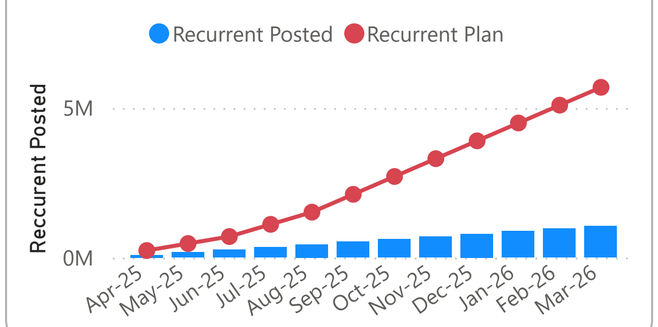
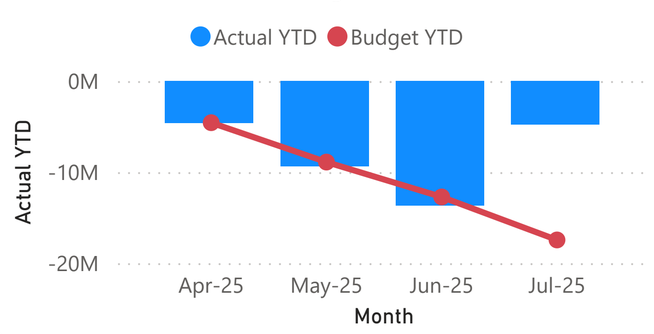
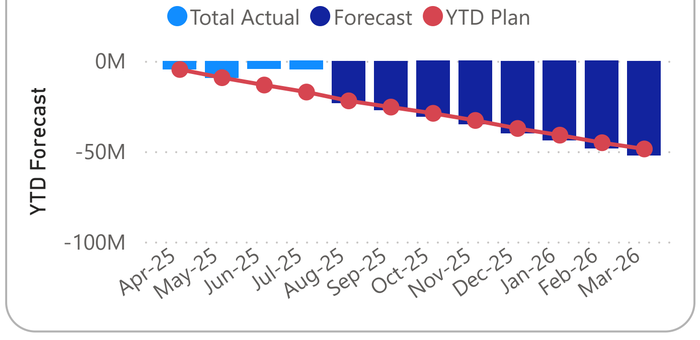


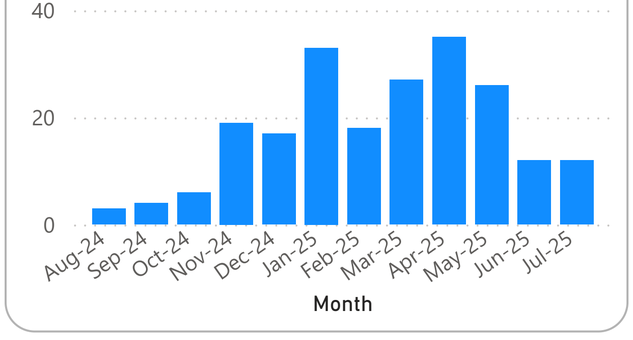
I&E distance from target (cumulative YTD)



I&E Year End Forecast



Research - Number participants by clinical division



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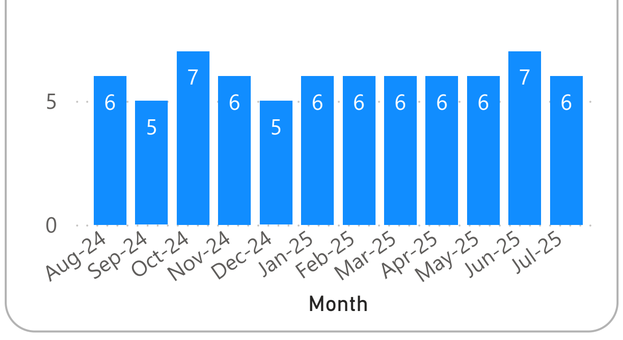

Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• No significant concerns with workforce metrics for Clinical Research Division

• All band 7+ PDRs completed by end of July with one exception for staff member who returned from mat leave on 22nd July and is currently on annual leave.

• All other highlights captured under pioneering breakthroughs section

Areas of Concern

• Captured under pioneering breakthroughs section

Forward Look (with actions)

• Captured under pioneering breakthroughs section

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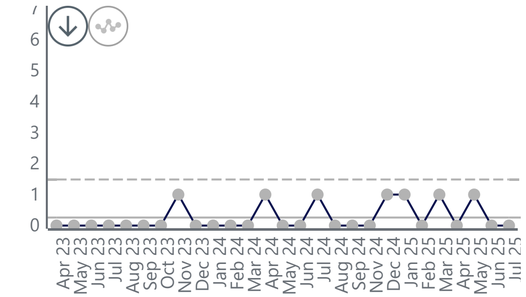
Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above



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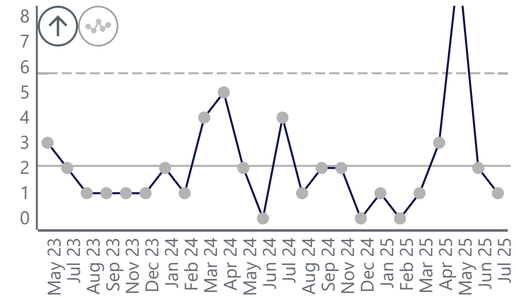
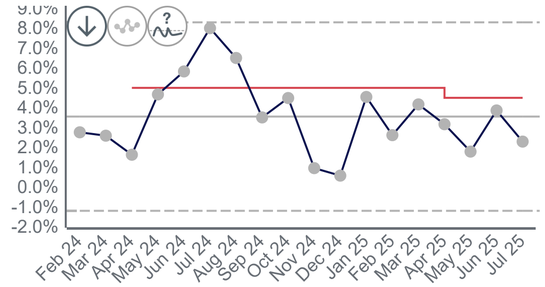


Staff Turnover

Sickness Absence (Total)



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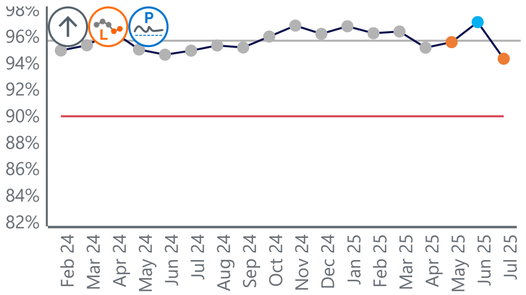
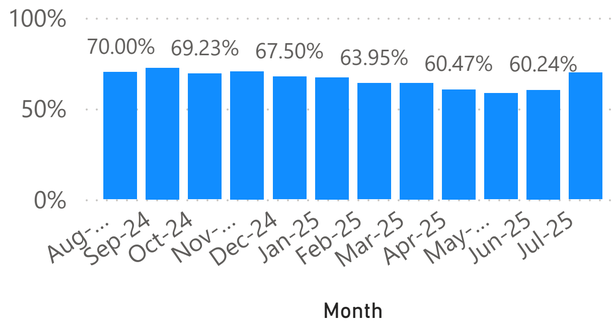


Workforce Stability



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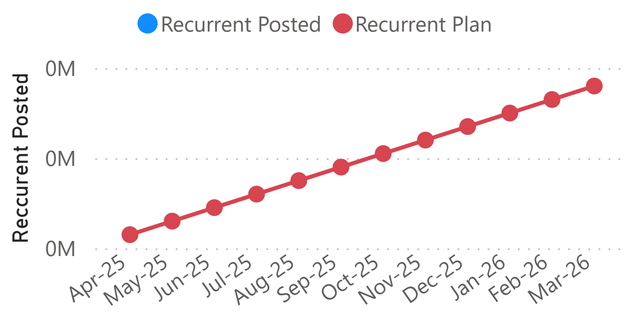
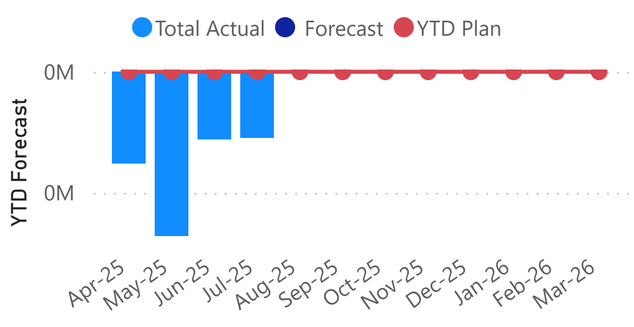
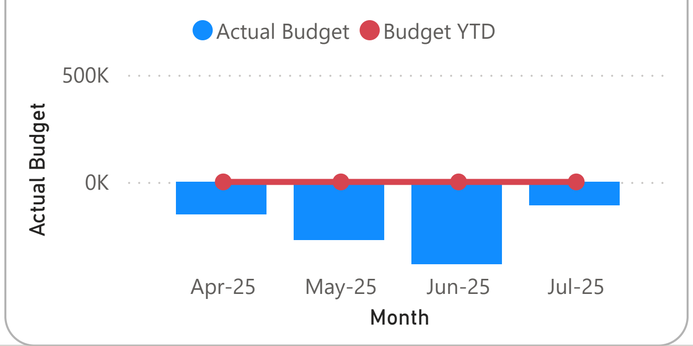


I&E Year End Forecast



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 does not meet during August due to summer leave, highlights from the July data include:

- Mandatory training remains above Trust target at 93%.
- Short term sickness absence currently at 1% which is within Trust target.
- The Corporate Collaborative identified plans and/or delivered a total of £4.3m, £4.5m recurrently.

Areas of Concern

- Overall PDR compliance 64%.
- Overall sickness outside of Trust target at 6.9%
- Return to work compliance dropped from previous month to 79% (from 89%)

Forward Look (with actions)

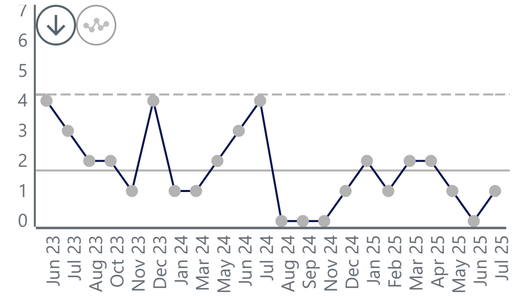
- Continued focus on financial position, system finance and internal controls/opportunities including WTE.
- Ongoing discussion to establish productivity measures for corporate services.

Integrated Performance Report | August 2025

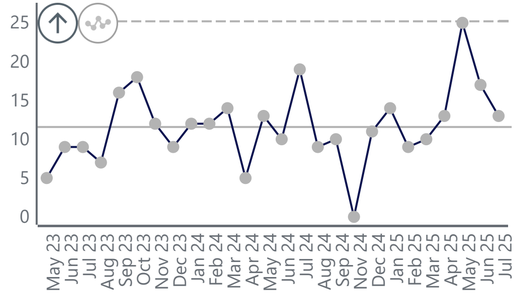
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

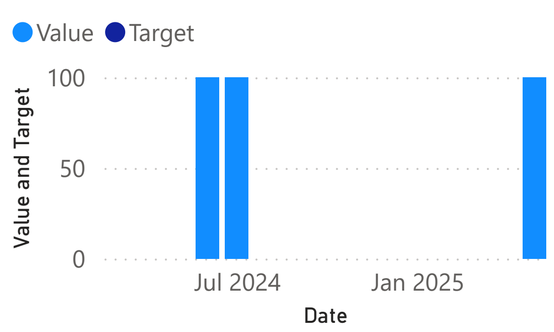
Patient Safety Incidents rated Low Harm & Above



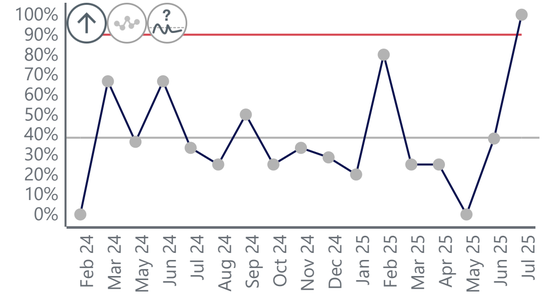
Patient Safety Incidents rated No Harm



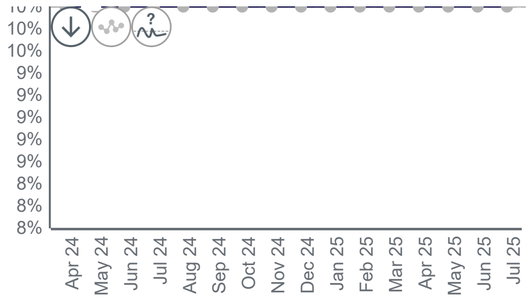
% Complaints Responded to within 25 working days



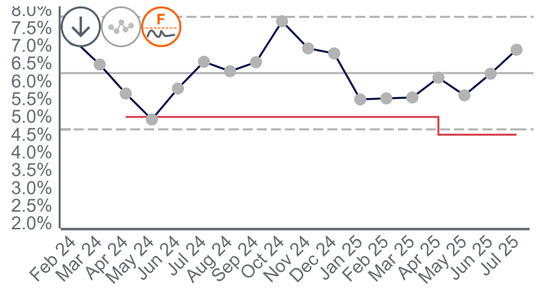
% PALS Resolved within 5 Days



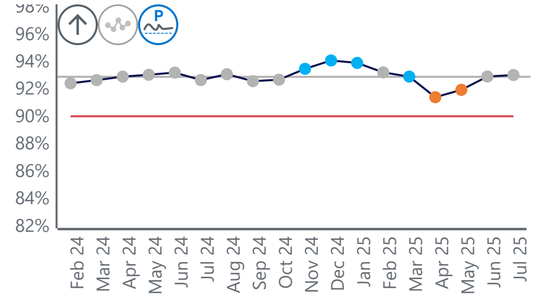
Staff Turnover



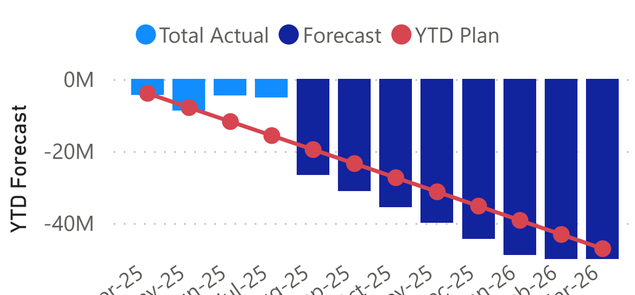
Sickness Absence (Total)



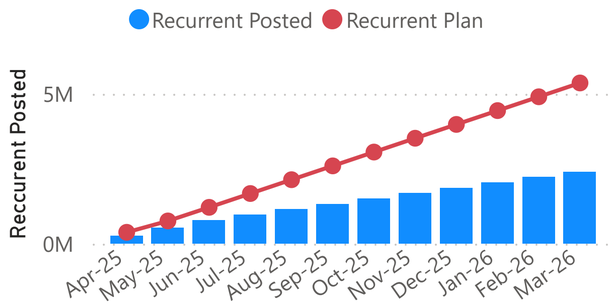
Mandatory Training



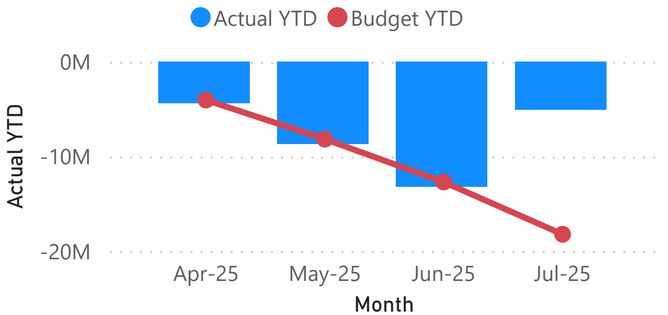
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

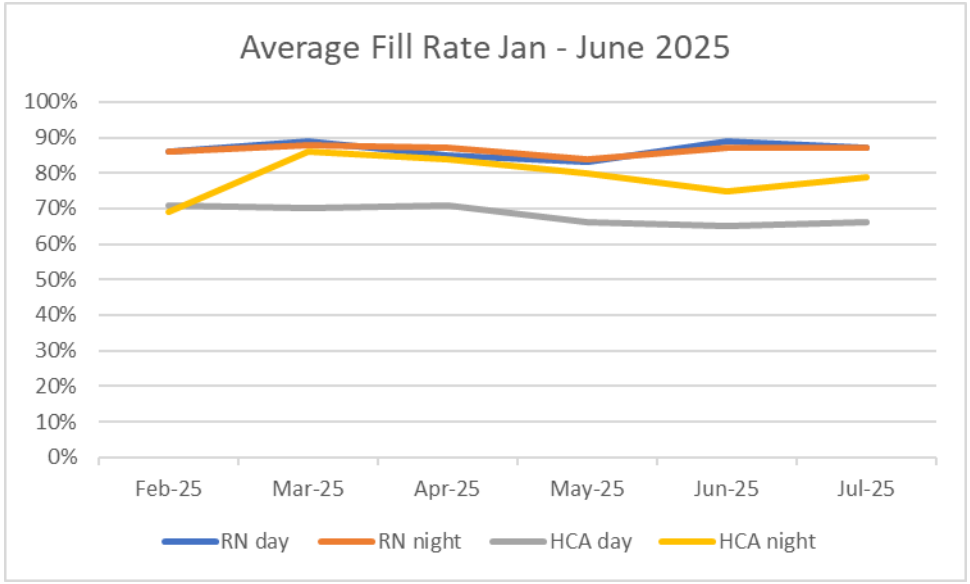
Safe Staffing & Patient Quality Indicator Report
July 2025 Staffing, CHPPD and Benchmark

	Day		Night		Patients	CHPPD	National benchmark	Availablity		Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT			Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate	Jan-25	RN - FTE	HCA - FTE	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	Pals	
Burns Unit	100%		102%		93	22.1	12.28	546.94	31	0.82	5%	0	0%	0.00	0.00%	0.00	0.00%	6	1.10%	0	0.00%	1	8	0	2	7	100%	0	0
HDU	74%	45%	70%	55%	137	54.9	28.46	2,192.60	58.9	-6.30	-8%	-3.43	-64%	1.53	2.50%	0.00	0.00%	153.65	7.01%	0	0.00%	8	48	0	0	0	0%	0	0
ICU	87%	81%	85%	55%	411	42.9	37.75	4,978.48	124	-0.28	0%	-0.17	-4%	0.00	0.00%	0.00	0.00%	85.32	1.71%	5	4.03%	16	75	0	0	1	100%	1	1
Ward 1cC	93%	90%	89%	74%	615	11.9	12.49	1,918.69	155.83	2.44	4%	-0.30	-6%	0.00	0.00%	0.00	0.00%	188.47	9.82%	13.23	8.49%	8	38	5	38	13	85.00%	0	0
Ward 1cN	91%	0%	103%		193	19.5	19.22	1,111.43	24.8	0.42	1%	-1.63	-67%	1.00	2.53%	0.00	0.00%	73.36	6.60%	4.8	19.35%	6	23	0	0	2	100%	0	0
Ward 3A	85%	61%	87%	115%	685	10.3	10.42	1,641.36	394.07	5.39	11%	-3.27	-20%	1.00	1.71%	0.00	0.00%	181.27	11.04%	90.54	22.97%	1	32	1	8	31	100.00%	0	0
Ward 3B	90%	60%	89%		326	15.9	16.06	1,299.32	147.64	-1.45	-3%	-0.52	-10%	0.00	0.00%	0.00	0.00%	117.42	9.04%	31	21.00%	1	19	1	1	3	100%	1	0
Ward 3C	78%	59%	81%	89%	587	13.6	10.88	1,833.20	397.63	-0.49	-1%	-6.43	-33%	0.00	0.00%	0.00	0.00%	100.21	5.47%	108.52	27.29%	13	87	0	1	14	93.00%	0	0
Ward 4A	88%	53%	90%	94%	808	10.5	10.65	2,121.64	148.39	0.91	1%	-3.72	-44%	0.00	0.00%	0.00	0.00%	231.19	10.90%	44.47	29.97%	6	47	0	5	31	100%	1	0
Ward 4B	88%	81%	78%	91%	587	14.2	11.84	1,138.48	1,138.57	7.85	26%	-10.04	-21%	0.00	0.00%	0.00	0.00%	68.65	6.03%	82.04	7.21%	4	69	1	8	6	67%	0	0
Ward 4C	80%	48%	88%	56%	509	11.8	10.7	1,835.02	316.61	6.65	13%	-1.48	-13%	0.00	0.00%	0.00	0.00%	131.32	7.16%	63.72	20.13%	7	54	0	1	21	95.21%	1	0

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Fill rates are produced by setting out the planned number of hours required for Registered Nurses (RN) across days and nights and the same for Health Care Assistants (HCA) for a full month period and is captured daily. The electronic roster produces the percentage fill for the month and accurately reflects the hours worked against the planned number. The percentage fill rates include any hours worked by bank staff. The benchmark for CHPPD for the above tables is based on January 2025 data, which is the latest information available from the model hospital so may not be comparable in regard to activity and acuity. All areas are close to the benchmark with 4A, 3B,3A and 1C marginally under. PICU, HDU and burns are all over benchmark which relates to low occupancy in July/

Nursing and care staff average fill rate July 2025	
Day and Night average fill rate	
Registered (%)	**Care Staff (%)**
87%	**67%** ↓

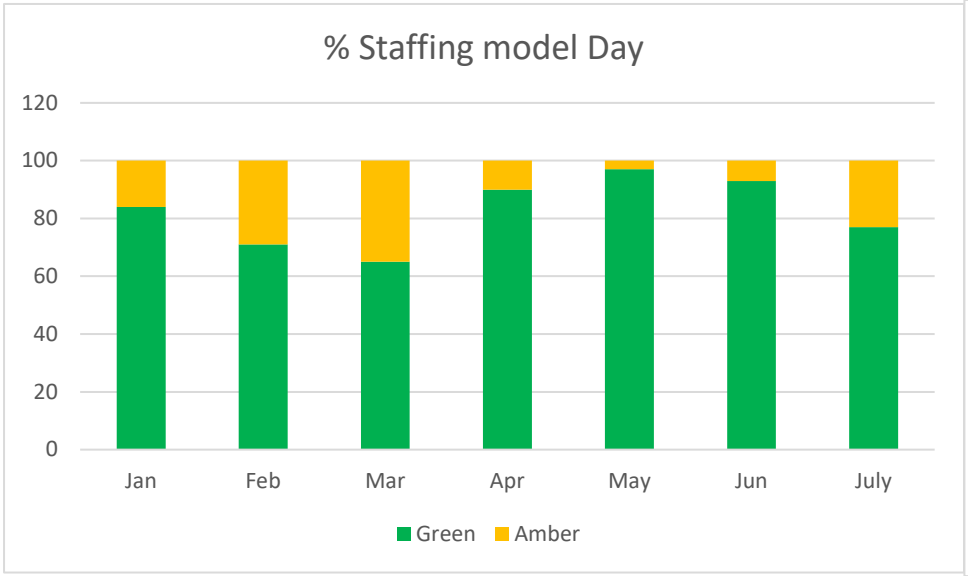
RN fill rate has stayed the same as previous month. There is a reduction in HCA fill rate which is consistent with previous months and due to vacancies in multiple areas.

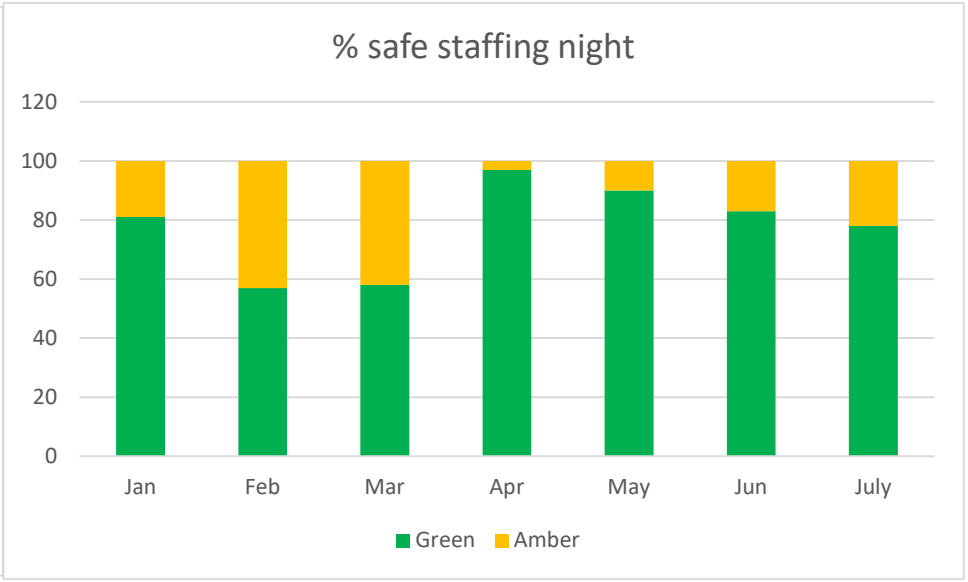

Average Fill Rate Jan - June 2025
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
RN day
RN night
HCA day
HCA night

Summary of Staffing models January – July 2025 Registered Nurses

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

July shows a slight decrease in green staffing status across both day and night shifts and a green staffing model being reported in just less than 80% of shifts on both days and nights. This correlates with a lower bed capacity and acuity of patients. To note we have seen an increase in sickness across the trust.



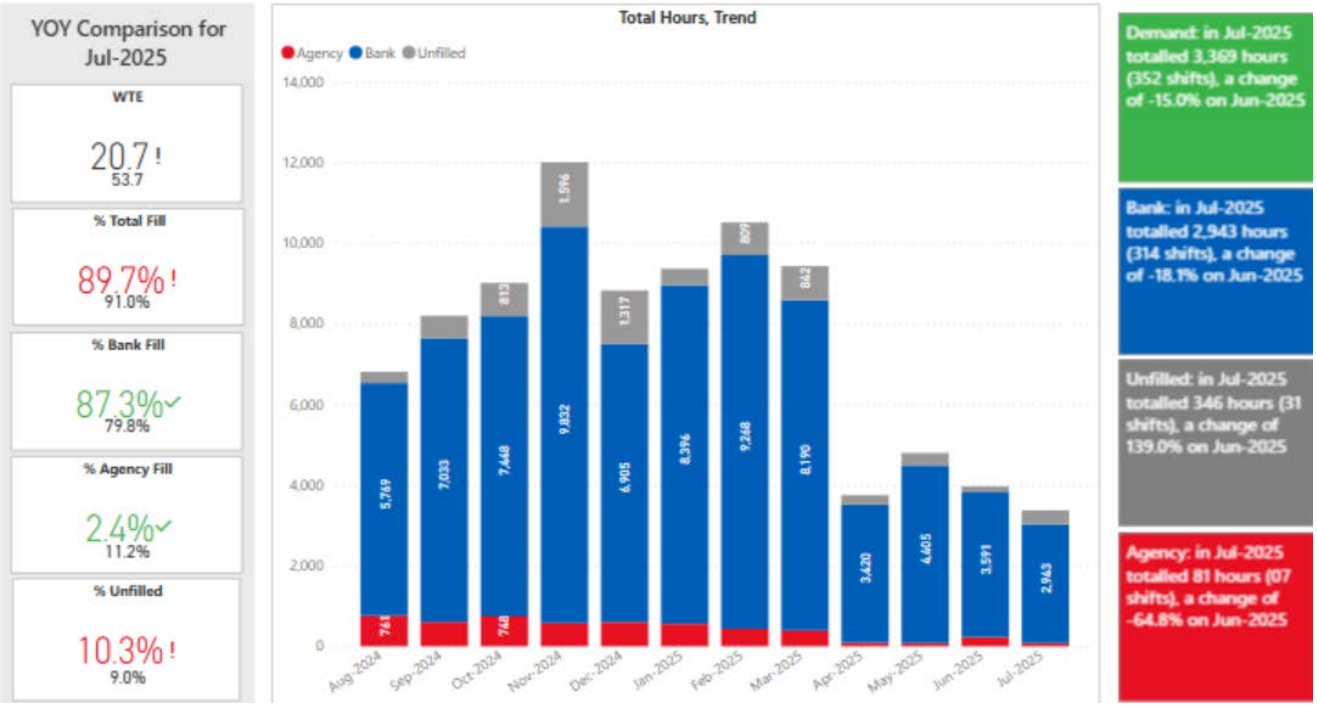


NHSP Bank Spend July 2025

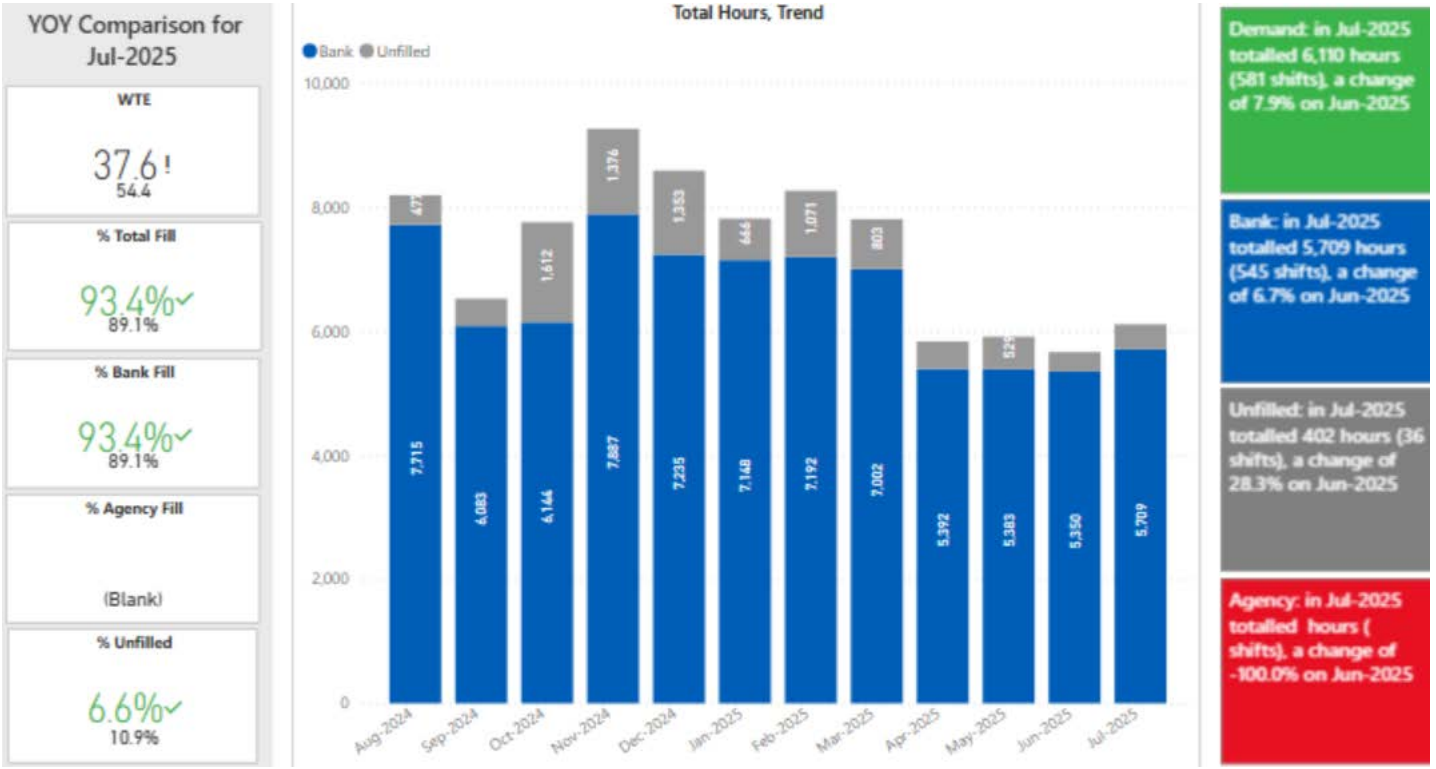
Temporary staffing is monitored closely with weekly oversight from Workforce Efficiencies group attended and represented by senior staff from various disciplines including nursing. This group developed trust and divisional dashboards to support the monitoring of bank and agency use across all areas and 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 the 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, in the last 12 months we have seen a significant reduction in bank and agency. Registered Nurse bank spend in July continues to reduce and we have seen the lowest temporary spend within the last 12 months There has been a deep dive reviewing the request for bank with the requirement for specific skills commonly listed as a reason .The senior nurses will continue to work together to address this and HON continue to have oversight and scrutiny in ensuring the request for bank has gone through the correct process. There has been a decrease in agency for the month of July. To note there is no agency within the wards and specialist nursing teams.
Unregistered Nurse Bank showed a slight increase of 6.7% from the previous month but correlates with the gaps in substantive health care roles and spend is mainly within budget.
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 have seen 3 new staff join their team in June with another 6 staff who have been redeployed from nursery and due to commence in role in September.

As a result of the active recruitment to vacant substantive posts we should see a further reduction in our HCA temporary bank spend by September.

Registered Nurse Bank Spend July 2025



Unregistered Nurse Bank Spend July 2025



KPI E-Roster 23rd June- 20th July 2025

RosterPerform 11 Overview														
KPI Description	The minimum no of days notice teams need to be given for shifts to be worked	% of changes made in roster since full approval	The number of contracted hours people owe or are owed (Negative = owed, positive = owes)		The % of shifts filled by temporary staffing	The total number of hours filled by temporary staff	The number of shifts created ontop of the establishment	The % of shits in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)		<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days **(23rd June 2025 – 20th July 2025)**	% 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	22.94%	80.00	-114.45	0.00%	0	1	34.33%	13.75%	6.51%	0.42%	12.71%	0.00%	33.39%
Accident & Emergency - Nursing (912201)	45	37.79%	720.00	192.82	0.20%	19.75	0	19.74%	13.18%	1.52%	1.00%	7.15%	7.36%	31.16%
Burns Unit (915208)	44	20.74%	140.00	14.82	7.06%	135.5	4	9.45%	19.13%	1.49%	0.86%	1.29%	10.75%	33.52%
Critical Care Ward (913208)	44	13.84%	1200.00	769.33	0.97%	172.5	2	17.84%	17.20%	3.08%	0.32%	1.85%	6.18%	28.63%
High Dependancy Unit (HDU) (913210)	44	19.04%	640.00	297.66	2.97%	218.5	0	28.24%	13.15%	2.28%	1.92%	9.08%	6.79%	33.22%
Medical Daycase Unit (911314)	48	21.67%	50.00	-5.2	0.00%	0	10	15.80%	14.37%	2.03%	0.75%	0.00%	0.00%	17.15%
Outpatients (916503)	45	31.80%	420.00	-199.15	4.57%	215.33	2	33.38%	11.58%	1.56%	2.56%	10.37%	2.41%	29.08%
Sunflower House (912310)	31	40.28%	190.00	-13.54	27.67%	1354.6	111	8.97%	9.88%	0.69%	4.88%	4.07%	2.99%	29.50%
Surgical Daycase Unit (915418)	44	35.13%	85.00	178.83	3.41%	84	1	34.26%	9.64%	0.49%	1.72%	15.20%	4.10%	32.17%
Theatres - Cardiac & Cardiology (915405)	44	18.39%	130.00	1	0.21%	4.5	0	11.97%	5.12%	0.40%	0.97%	3.93%	6.24%	16.65%
Theatres - Emergency (915420)	44	39.11%	230.00	29.95	3.32%	68.5	0	3.18%	13.10%	1.56%	0.00%	9.21%	0.00%	23.87%
Theatres - IP Anaesthetics (915423)	44	25.87%	82.00	-11.17	1.11%	39.5	0	10.09%	9.03%	0.43%	4.23%	6.39%	0.00%	20.08%
Theatres - IP Porters (915435)	44	47.55%	101.00	23.5	3.65%	45.25	0	12.60%	11.66%	0.00%	0.26%	12.32%	0.00%	24.24%
Theatres - IP Recovery (915422)	44	43.61%	103.00	-20.87	7.19%	113	0	10.33%	16.47%	3.04%	7.71%	1.02%	0.00%	28.24%
Theatres - IP Scrub (915424)	44	24.20%	128.00	5.5	0.82%	14.5	0	12.54%	5.71%	0.00%	1.02%	11.66%	6.00%	30.35%
Theatres - Ortho & Neuro Scrub (915436)	44	23.28%	37.80	-6	1.07%	24.5	0	15.44%	13.77%	1.38%	0.16%	13.07%	7.68%	36.06%
Theatres - SDC Anaesthetics (915429)	44	41.51%	58.40	-5.25	29.25%	276.25	0	23.48%	12.06%	3.08%	4.19%	2.09%	8.26%	29.68%
Theatres - SDC Recovery (915430)	44	42.75%	177.30	-4.6	4.84%	56	0	17.77%	13.08%	3.15%	1.31%	20.38%	7.62%	45.54%
Theatres - SDC Scrub (915421)	44	25.41%	532.00	-2.75	1.89%	44	0	18.46%	13.64%	0.06%	2.19%	19.22%	0.00%	35.11%
Ward 1C Cardiac (913307)	44	23.27%	361.00	165.17	4.74%	324.67	0	10.29%	14.64%	2.49%	1.44%	9.66%	6.39%	34.62%
Ward 1C Neonatal (913310)	45	40.73%	556.00	1803.76	0.00%	0	0	17.73%	13.68%	4.82%	2.43%	6.53%	7.16%	40.44%
Ward 3A (915309)	41	33.33%	371.00	93.22	16.74%	1154.42	24	15.77%	12.33%	4.20%	4.26%	13.55%	8.63%	43.41%
Ward 3B - Oncology (911208)	42	21.62%	555.00	608.85	2.39%	120.75	8	14.31%	12.05%	1.48%	0.82%	11.95%	1.32%	28.39%
Ward 3C (911313)	45	22.94%	607.00	228.03	1.21%	92	13	25.38%	12.78%	1.60%	2.73%	10.14%	3.36%	31.14%
Ward 4A (914210)	44	31.16%	634.00	398.57	7.47%	588.25	17	16.03%	11.28%	3.53%	1.09%	11.40%	1.28%	31.74%
Ward 4B (914211)	47	31.78%	533.00	216.26	9.26%	862.5	28	16.32%	13.78%	2.36%	2.32%	3.84%	3.23%	25.53%

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 increased to 44 days (KPI 42 Days).
- Net hours have decreased from 3650 to 4772 (KPI 9001 to allow for up to a day to owe or be owed).
- Bank/Agency has decreased from 7258 hours to 6089 hours.
- Additional duties made on the roster continue to decrease and have shown a positive reduction from 240 to 227 shifts.
- Sickness remains high at 8.8% (KPI 5%).
- Annual leave 12.5% (11%-17%) & other Leave 2% (<5%) all within the agreed KPIs.
- Study leave just outside KPI at 2.1% (KPI 2%) To note we have seen a decision to increase study leave over the summer period aligning with reduced capacity with a plan to reduce over winter period.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Care Quality Commission Inspection: Alder Hey Community Mental Health, ASD & ADHD Services**
Report of:	**Lisa Cooper, Director Community & Mental Health Services**
Paper Prepared by:	**Lisa Cooper, Director Community & Mental Health Services**

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
BAF risk 1.5	Since 2020 there has been a significant increase in demand for Specialist Mental Health Services at Alder Hey, which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours, there has also been an increase in the clinical urgency of referrals received. This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition, Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.	15

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

1. Executive Summary

An unannounced inspection by the Care Quality Commission (CQC) was conducted from 25–27 March 2025. This review focused on Alder Hey's Community Mental Health, ASD & ADHD Services for children and young people.

The CQC initiated this inspection in response to a major incident; however, no specific concerns had been raised regarding these services at that time. The purpose of the inspection was to confirm that Alder Hey continued to deliver its services safely and to provide assurance on the quality of care provided by the Trust.

These services were last inspected in January 2020, at which time they received an overall rating of Good, with an Outstanding rating in Caring.

Following the most recent inspection, the services have been rated as Outstanding overall, with recognition for being Outstanding in both Caring and Well Led.
A final copy of the published report is available Here

2. Key highlights and areas for continued improvement

The following are key highlights from the report:

- Feedback from children and young people was positive. They considered staff to be kind, caring and empathetic. They felt that staff treated them as individuals and were invested in their care and wellbeing. Children and young people were positive about their involvement in their care and treatment and felt empowered to give their opinions and views.

- CQC observations during our inspection supported this. They saw that staff had a positive, caring attitude towards people using the services. During appointments, staff involved children and young people, listened carefully to what they said and acted in a respectful, inclusive and compassionate manner.

- Children and young people were actively involved in decision making within the service. They told the CQC they were consulted on changes to the service and were involved in quality improvement projects.

- Staff managed risk well and staff that the CQC spoke with had a good understanding of the risks and risk management plans for the children and young people on their caseload. There were effective processes in place to ensure that risks were captured and regularly discussed and reviewed. However, the CQC found that the care records system did not always support this, and that risk information was not always easy to find.

- Following the inspection the Trust made immediate changes to the care records system. Improvements to Meditech now ensures that risk information is visible and easily accessible. A Risk and Care plan function had been developed which provides staff easy access to key risk documents and a chronology of risk activity. A Systematic Risk Management Document Tool had been developed for documents received from other organisations and providers which supports staff

to access to that information and could add key details directly into the risk assessment. The use of risk flags had been emphasised through the Special Indicators function which means that staff can now more easily put flags on the system and that flags were more prominently displayed to better highlight key risks. Managers and staff could access service user risk information through a Power BI dashboard that gives an overview of caseloads and risk levels.

Subsequent areas for continued improvement have been identified following review of the report:

- Continued review of risk assessment documentation in Meditech and suitability for use within the services including compliance audits.
- Continued implementation of national Patient and Carer Race Equality Framework (PCREF), to implement actions to reduce racial inequalities within services (Trust wide action).
- Clarify and implement a consistent approach to recording capacity assessments for young people aged 16 and above, and those below 16 years of age and the recording of consent on Meditech system (Trust wide action).
- Work with Meditech to develop the sharing of care plans with children, young people and families which reflect the individualised nature of care planning.
- Transfer of community-based services currently using EMIS to Meditech.

The above will be included in a robust action plan which will be monitored via the Community and Mental Health divisional governance arrangements and will report to the Trust's Safety, Quality and Assurance Committee as part of the divisional assurance arrangements.

3. Conclusion

The Trust Board is asked to note the contents of this report and Outstanding rating awarded to Alder Hey's Community Mental Health, ASD and ADHD Services.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Brilliant Basics Update**
Report of:	**Nathan Askew, Chief Nurse, AHP and Experience Officer** **Kate Warriner, Chief Transformation and Digital Officer**
Paper Prepared by:	Jennie Williams, Head of Improvement

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This report provides assurance on: - progress of the Brilliant Basics Delivery Plan 2025/2026
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	None

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

1. Executive Summary

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

- progress of the Brilliant Basics Delivery Plan 2025/2026

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

The key message in this report is one of continued progress towards mainstreaming continuous improvement into the core business of the organisation and focus on maximising all elements of the programme.

2. Background and current state

Progress on BB Delivery Plan 2025/2026

Trust Board approved the BB Delivery Plan (March 2025) and receives biannual updates for assurance against progress.

Table 1 below details trend analysis against the driver metric.

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

Alder Hey 2025/2026 Objectives

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

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

Progress has been made against all objectives. A clear plan for further enhancements for the remainder of 2025/2026, baselined against the original plans approved by board in 2019, is being agreed with SROs. The BB approach and principles will be

support application of the NHS Planning Framework and be incorporated into the Target Operating Model for the organisation.

The SRO has been accountable for all decisions regarding progress and change control during 2025/26.

3. Conclusion and Recommendations

Alder Hey's approach to improvement is increasingly more visible, becoming embedded in the way we work and demonstrating tangible benefits across the organisation. Improved evaluation of impact will be presented within the annual report.

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

The board is asked to:

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

Appendix One: 2025/2026 Plan Assessment.

OBJECTIVE	KEY OUTCOMES	PROGRESS
Continue to build capability and capacity for improvement across the organisation and build further measurement of impact using The Kirkpatrick Model by March 2026.	1. Learners positively evaluate session delivery 2. Demonstrable increase in improvement knowledge 3. Behaviour change to embed improvement into practice 4. Measurable change in improvement efforts	1. Mean 4.8 / 5 satisfaction achieved 2. Mean 3.5 / 5 increase in knowledge 3. Mean 4 / 5 behaviour change 4. Mean 3 / 5 results
Mainstream improvement tools, routines and leadership behaviours into Vision 2030 deployment measured by NHS IMPACT programme standards by March 2026.	• Consistent and systematically applied methodology • Depth of problem solving • Data driven decisions • Involvement of CYP&F • Involvement of staff closest to the work • Iterative testing and learning shared • Clear measurement of change	The BB team have been commissioned to undertake component parts of work within some Vision 2030 collaboratives. This has mainly focussed on gaining the voice of CYP&F and mapping out current state pathways at this stage. Assessment of opportunities to further mainstream are planned for Q3 utilising NHS IMPACT programme standards.
Plan delivery of our improvement approach against NHS IMPACT standards to ensure a shift up from each level by March 2026.	• Building and sustaining a culture of continuous improvement • Objective assessment on progress • Informs gaps and future delivery plans	There has been a shift from 'starting / developing' from initial assessment in November 2023 to 'progressing / spreading / improving & sustaining' in March 2025. The focus of the remaining 6 months of the plan year will be on increasing all component parts to 'improving / sustaining'.

ENDS

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Compliments, Complaints and PALS report – Q1 2025/26**
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 Q1 2025/26: • 3 day acknowledgement of formal complaints: average 80% compliance in Q1 • 25 working day response to formal complaints: average 87% compliance in Q1 • 5 working day response to informal PALS concerns: average 89% compliance in Q1 The main themes continue to be treatment and procedure, access to appointments and communication
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

Compliments, Complaints and PALS Report – Q1 2025/26: Trust Board 4th September 2025

Purpose	To provide update and assurance on the performance against complaints and PALS targets in Q1 2025/26 and a thematic analysis of the top reasons for complaints and PALS
Vision and Goals	The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. Where care and treatment does not meet the standard of care expected, the Trust has a duty to listen to their concerns, wherever possible resolve at the first point of contact, investigate concerns, and provide a full, appropriate, and compassionate response.

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

Figure 1: Complaints received Q1 25/26 by Division

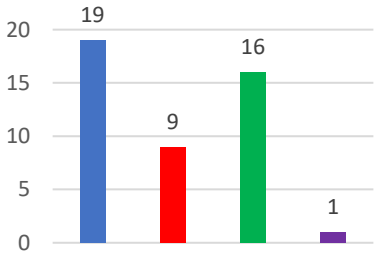


Figure 2: Number of complaints rolling 12 months

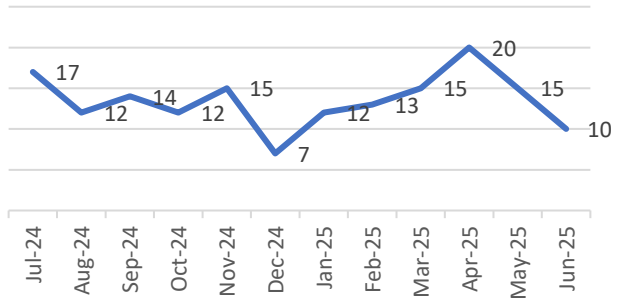


Figure 3: Primary category of complaints in Q1 25/26

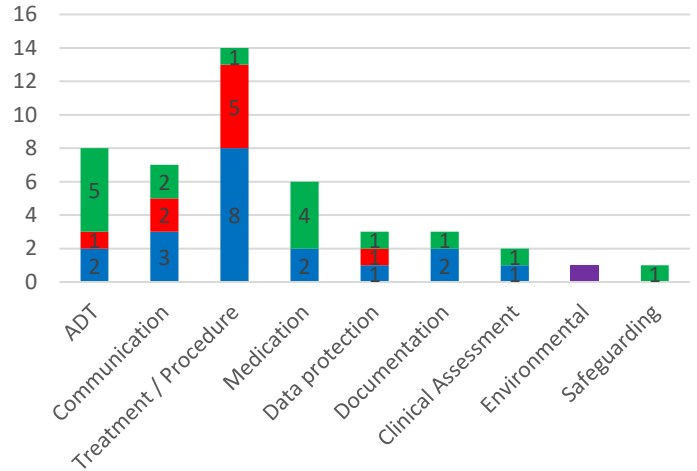


Figure 4: Compliance with 3 day acknowledgement of complaints rolling 12 months

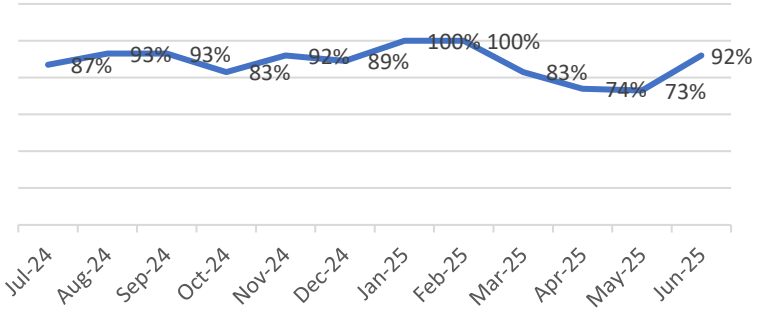


Figure 5: Compliance with 25 day response to complaints rolling 12 months

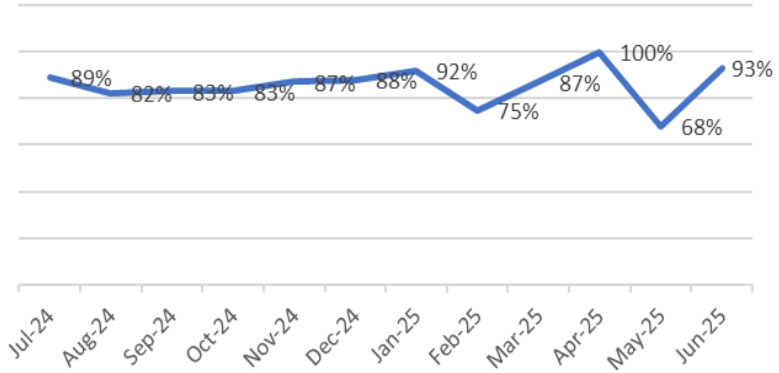
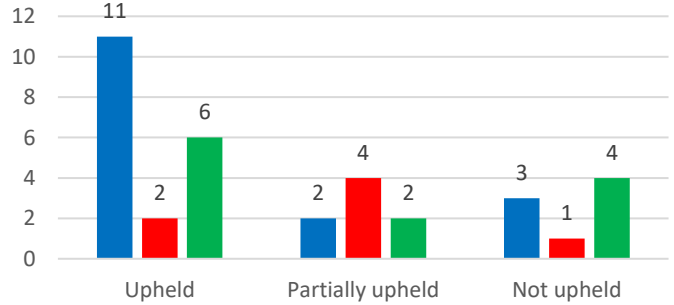


Figure 6: Outcome of complaints responded to in Q1 25/26



Complaints: In Q1, 45 complaints received. Main reason continues to be treatment and procedure accounting for 31% of complaints received. Trust overall not compliant with the 3 day acknowledgement; average 80% compliance. 35 complaints investigated and responded to. Trust overall not complaint with the 25 working day response; average 87% compliance. The Division of Medicine achieved excellent compliance of 93%; and the Divisions of Surgery and Community and Mental Health both achieved 85% compliance this is a significant improvement in Community and Mental Health Division. 19 complaints fully upheld (54%), 8 partially upheld (23%), and 8 not upheld (23%).

Compliments, Complaints and PALS Report – Q1 2025/26

Figure 7: PALS received in Q1 25/26 by Division

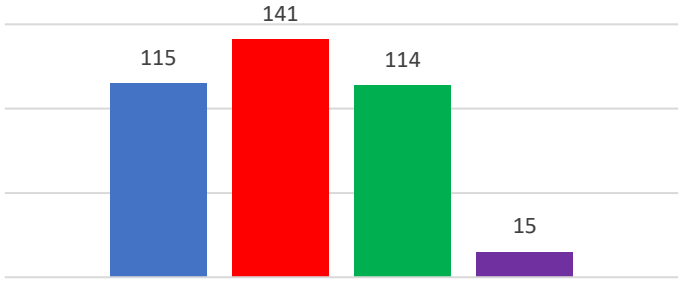
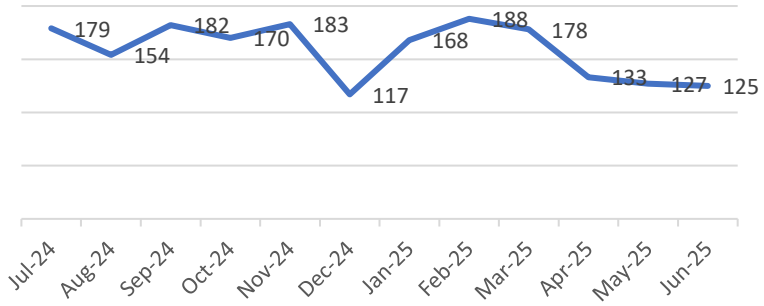


Figure 8: Total number of PALS rolling 12 months



PHSO: No new PHSO cases opened and no ongoing cases

PALS: In Q1, 385 PALS concerns were received which is a significant decrease from Q4 (534). The main themes continue to be access to appointments and communication. High standard of compliance with the 5 working day response; average 89% compliance. The Divisions of Medicine and Surgery both achieved excellent compliance of 98% and 96% respectively; Community and Mental Health achieved a sustained compliance of 79% compliance. Corporate services only achieved 21% compliance; this is now reviewed on a monthly basis by the Corporate Collaborative; the low percentage is also affected by the small number.

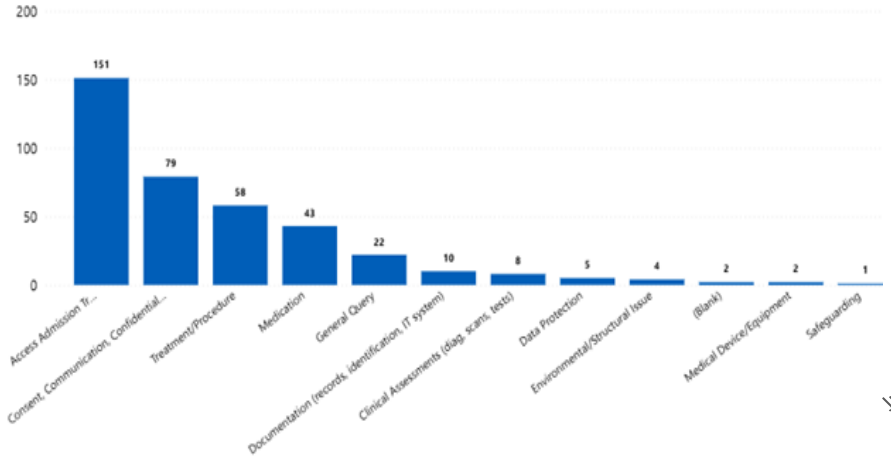


Figure 10: Trust overall compliance with 5 day response to PALS rolling 12 months

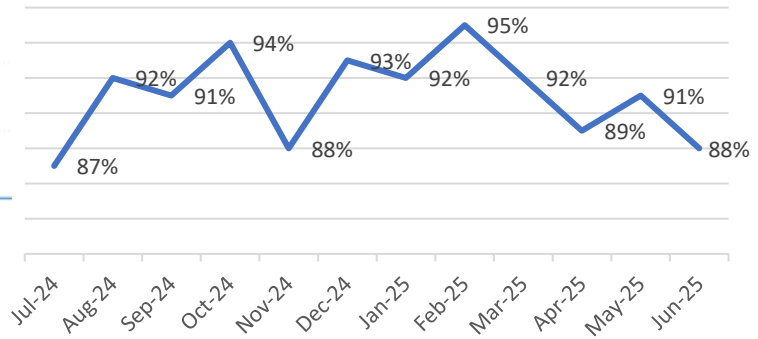
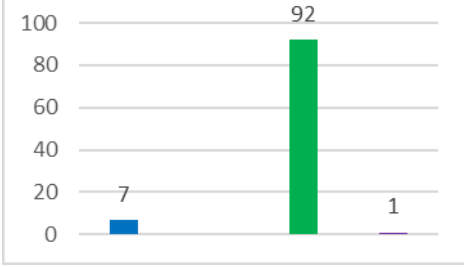


Figure 11: Compliments recorded by Division Q1 25/26



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

Success Highlights	• 87% of formal complaints responded to within 25 working days however there is room for improvement to ensure families receive a response in a timely manner • Continued excellent compliance in the Division of Medicine and Surgery in formal complaints and PALS response compliance and sustained improvement in compliance in Community and Mental Health Division particularly with formal complaints. The standard of complaint responses in the Community and Mental Health Division is acknowledged as excellent
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

BOARD OF DIRECTORS

Thursday, 4th September 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
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high-quality resilient IT services to staff, children, young people, and their families	16

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

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:

- Number of successful deployments
- Realisation of financial, safety and efficiency benefits
- Good progress with new Data Platform and Ambient Voice

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

2. National and Regional Updates

2.1 C&M ICB – Ambient Voice Technology (AVT)

Alder Hey are playing an active role in the plans to deliver Ambient Voice Technology, at scale, across Cheshire and Merseyside. A regional group has been established to drive this forward, and the Trusts Chief Transformation and Digital Officer is the Chair of the group.

Alder Hey hosted a joint visit with NHS England and ICB representatives in August, showcasing live AVT use in outpatient clinics and facilitating strategic discussions on regional rollout and clinical safety.

A bid for scaled deployment of AVT has been submitted to the North West Transformation Fund.

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

The Digital, Data and AI Collaborative progressing well and has delivered a number of successful initiatives since the last Board report. The Collaborative group continues to meet weekly to drive the following workstreams.

3.1 Enhancing Safety Through Digital

The project to integrated observations directly into the Electronic Patient Record is now successfully live across all areas. The deployment of new technology has been completed alongside the transition to the National Paediatric Early Warning Score framework for patient observations. The delivery has been a collaborative approach between Nursing, Digital and Medical Engineering. The successful delivery of the project enables financial sustainability and improved safety.

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 design of the solution is currently under review to ensure it meets the needs of the organisation.

3.2 Optimising Systems

The initial draft of the Business Case proposing an upgrade to the Trust's Electronic Patient Record is currently undergoing internal review and refinement. The case outlines a 12 month plan to transition to the latest platform which delivers significant benefits for Nurses and enhanced interoperability with technology such as AVT. The case will be presented to the relevant groups in September.

Personal Demographic Service, which integrates national demographic data directly into Alder Hey's Electronic Patient Record (EPR) system, is now live across the Trust. This will ensure that patient information such as name, address, NHS number, and contact details are accurate, up-to-date, and consistent across systems. It is hoped this will have a positive impact on Was Not Brought rates, through improved patient communication.

The CLEO project, which enables FP10 prescriptions, including controlled drugs, to be automatically routed to community pharmacies, is progressing through its initiation phase. Testing has been successful, and the new solution is scheduled to go live in September. It will deliver an improved service and financial efficiencies.

The Digital Team are currently working with Emergency Department colleagues to scope out the concept of check in kiosks for the department to help with patient flow. Discussions are ongoing and a plan will be agreed once a suitable solution has been identified. Finally, the Trusts Safeguarding Team have now successfully transitioned to full electronic documentation delivering efficiencies and an improved service.

3.3 Data Driven Care

Good progress is being made with the work to deliver a new data platform at Alder Hey. The new cloud-based solution will house and process all of the Trusts clinical, workforce, financial and operational data. The team are working in conjunction with Divisional colleagues to develop, review and approve each dashboard as it transitions to the new platform. The project is scheduled to complete in July 2026. The team also continue to work on meeting new statutory data submissions with the completion of a revised Commissioning Data Set since the last report.

Looking forward, discussions are ongoing around transforming how the organisation utilises its data. An initial session between Clinical and Digital colleagues facilitated by Strasys took place in July, which provided some initial ideas that need to be developed further into a robust strategy and plan.

3.4 Broadening Virtual Care Offers

The Patient Portal project is currently undergoing a review, to ensure the final solution meets all the needs of Children, Young People and their Families. An options appraisal assessing solutions has been developed and will be reviewed by Executive Committee in August. Given the strategic importance, once a solution is identified a phased delivery plan will be developed and mobilised immediately.

3.5 Advancing AI

The Trust's AI strategy was launched in July 2025, with excellent internal and external feedback.

Ambient AI pilot at Alder Hey continues to progress steadily, with a focus on scaling adoption, improving integration, and refining workflows. There are now over 300 users of the solution across various disciplines in order to get a broader range of feedback. The solution continues to progress against recently published NHS guidance and is expecting to be fully compliant in Autumn prior to a full-scale deployment.

The pilot of AVT was the subject of a recent Quality Assurance Round, where clinical, digital, innovation and research colleagues had the change to engage with Patients, Families and Youth Forum. Feedback from patients and families was extremely positive as they felt it enabled clinical staff to be more focussed on the patient.

The collaborative group is currently evaluating the trusts Microsoft Co-Pilot deployment. The initial phase has received positive feedback from various disciplines mainly relating to making staff more efficient. A formal evaluation paper will be developed and shared with relevant committees in September.

Finally, a new partner is being explored to deliver Artificial Intelligence Coding at Alder Hey. Initial discussions have been positive, and a partnership agreement is currently under review alongside governance arrangements. Proof of concept aiming to be underway this calendar year.

4. Digital Centre of Excellence and Performance

The Trust has supported two Business Cases to refresh both its Data Centres which were reaching their natural end of life. Orders have been place and plans in development to complete the work on both pieces of infrastructure by November.

The Windows 11 upgrade programme and is on track to deliver before Microsoft's end-of-support deadline on 14 October 2025. The Trust has now deployed to just under half of its device estate with a number of clinical and operational areas now live. Feedback on the new platform has been positive.

Cyber Improvement work is underway with the Trusts regional exposure scores improving. A Cyber Tabletop exercise was completed in 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. FOI compliance is currently 88% and Subject Access is at 93%.

Annual Data Security and Protection Toolkit assessment has now been completed, with the criteria widening this year making it more difficult for Trusts to attain higher levels of assurance. The Trust received a High risk rating which aligns to the position of the majority of Trusts across Cheshire and Merseyside. An improvement plan has

been developed and is being tracked via Digital Centre of Excellence and Audit and Risk Committee.

Finally, Clinical Coding continues to perform well and has hit the agreed deadlines since the last reporting period. The team are also supporting one of the key financial workstreams supporting the Trusts ‘closing the gap’ workstream.

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.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	Learning from Patient Safety Incidents Q1 April-June 2025
Report of:	Chief Nursing AHP and Experience Officer
Paper Prepared by:	Associate Director of Nursing Governance and Risk Patient Safety Incident Investigation Leads

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☑ ☐ ☐
Action/Decision Required:	To note To approve	☑ ☐
Summary / supporting information	The purpose of this report is to provide the Trust Board with a summary of activity and system-wide learning following the transition to the Patient Safety Incident Response Framework (PSIRF) for Q1 2025/26 and next steps, noting that this is an iterative process as we continue to transition and embed PSIRF.	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care **Support** our people **Pioneering** breakthroughs	☑ ☑ ☐ ☑ ☐
Resource Implications:		

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

1. Purpose

The purpose of this report is to provide the Trust Board with a summary of activity during Q1 April-June 2025 following the transition to the patient safety incident investigation framework (PSIRF) on 1 January 2024, highlighting any identified areas of system-wide learning and improvement and next steps.

2. Activity to date

2.1 Learning from Patient Safety Events (LFPSE)

The Trust continues to meet the reporting requirements of the LFPSE v5 with LFPSE v6 taxonomy due to be implemented by September 2025.

The NHSE request for organisations to validate the data in the local Risk Management System (Inphase) against data held in a national recorded data dashboard was completed in May 2025.

The first set of LfPSE organisational data (for Q3 2024/25) was published in May 2025 and refreshed in June 2025. This contained the number of patient safety incidents recorded, the median lag for recording these incidents, the total bed days in this quarter and recording rate (per 1,000 bed days) for NHS Trusts by region and by trust type.

Alder Hey reported 1,659 incidents, with a median day to report of 0, and rate per 1,000 bed days of 111.4, which placed the Trust 24th out of 176 trusts for reporting rates.

2.2 Commissioned Patient Safety Incident Investigations (PSIIs)

A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well-intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

During Q1 2025/26 the Trust commissioned **1** PSII for an incident which met the Trust's local patient safety priority criteria of deteriorating patient as per the Trust's Patient Safety Incident Response Plan.

- **PSII: Posterior spinal fusion surgery resulting in neurological injury (Local Priority).**

This incident related to a posterior spinal fusion surgery incident that occurred in March 2025 within the Surgery Division and met the following local patient safety priority: *'Delay in the identification of, escalation of, and response for the deteriorating patient in line with the PIER framework'*

The patient has undergone corrective surgical procedures. Unfortunately, there has been no recovery of sensory or motor function below the T8 level (the eighth thoracic vertebra in the spine). The patient continues to be an inpatient at the Trust.

A PSII has been commissioned and will be led by the Patient Safety Investigators with the family and key stakeholders. Terms of reference for the PSII were developed in conjunction with the Surgery Division and key questions shared by the family.

The draft report will be shared with the staff involved on 18 August 2025, for their comments and to verify its accuracy. It is anticipated that the report will be presented to the Executive Team for approval on 25 August 2025, before being shared with the patient's family. The investigation is expected to be completed within the specified timeline.

The following PSIIs commissioned in Q2/3 24/25 concluded during Q4 2024/25

- **PSII: Never Event (wrong site surgery): National priority**

This incident related to Botulinum toxin (Dysport) injection being given in the wrong limb and occurred in October 2024 within the Medicine Division in the Botox Injection Clinic in Outpatients. The incident met the Never Event criteria for a wrong site surgery.

A PSII was commissioned and concluded in March 25 within given timescales. The final report was presented at SQAC in May 25.

The investigation identified that at the time of the incident:

- The botox injection clinic did not use site markers to mark body parts for injection
- There were no systems in place within the botox injection clinic to detect that the wrong limb had been selected for injection.
- The process for obtaining consent was based on historical practice and did not align with current Trust protocol (written consent was obtained during 1st appointment only)
- The Spasticity, Tone, Assessment and Rehabilitation Service (STARS) service was experiencing shortages of staff with the appropriate skill mix.
- There was no standard operating procedure (SOP) established to outline the botox injection clinic's processes.

Key learning and recommendations from the PSII were presented at the weekly patient safety meeting and the Divisional Assurance Groups in June and July 2025. This report is now ready for Trust Board sign off in September 2025.

- **PSII: Wrong site medication administration**

This incident relating to the administration of medication given via a supra public catheter when intended for enteral administration (directly into the gastrointestinal tract) occurred in February 2025 within the Surgery Division. The incident met the Never Event criteria for a wrong route administration. The patient was immediately reviewed, observed and blood screen sent for infection and has since been discharged home.

As of 30 June 2025, the draft PSII report has been shared with staff who were directly involved in the investigation for factual accuracy and comment, prior to being shared with other key stakeholders, including the patient's family, for review.

2.2 Commissioned Learning Responses (excluding PSIIs).

During Q1 2025/26 there have been **6** learning responses (excluding PSIIs) commissioned by the weekly PSIRI panel to investigate those incidents initially reported as moderate physical or psychological harm or above.

To note: During the Trust's annual patient safety continuing professional development (CPD) session, a decision was made to rebrand the Patient Safety Response: MDT Review as a "Learning Together Review."

Learning Together Reviews will now be facilitated by the Trust's Patient Safety Investigators, rather than by individual divisions. This change aims to enhance opportunities for Trust wide learning from patient safety incidents where a Learning Together Review has been commissioned.

Table 1

Commissioned Learning Response Types Q1 2025/26	Number Commissioned	Number completed
After Action Review (AAR): A method of evaluation that is used to analyse what happened, why it happened, and how it can be done better by the participants, in the future. It is not an investigation process, but its purpose is to learn, support	**4**	**2**

effective teamwork, motivation and implement improvements in a timely manner.		
Learning Together Review (LTR): An LTR replaces previously named MDT and supports teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to obtain staff recollections of events either because of the passage of time or staff availability.	**2**	**0**
Thematic Review (TR): A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues.	**0**	**0**

2.3.1 Timescale Compliance for Learning Responses Q1 25/26

After Action Review (to be completed within 1 month of commissioned date)

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

Learning Together Review (to be completed within 3 months of commissioned date)

- There have been 2 learning together reviews (LTRs) commissioned by the PSIRI panel for Q1 2025/26, details of which are provided below:

- **Data Breach: InPhase ID: 22606**

June 2025: LTR commissioned for an incident relating to a data breach via the patient information portal. Terms of reference for the review were developed in conjunction with the C&MH Division and representatives from the Safeguarding and Digital teams. The initial report was drafted in June 2025, with a follow-up meeting scheduled for July 2025 to establish next steps.

- **Patient collapse InPhase ID: 16661**

June 2025: LTR commissioned for an incident relating to a patient who collapsed on induction of anaesthesia. The Patient Safety Investigators are currently facilitating meetings with stakeholders to establish the draft terms of reference for the review. The LTR meeting has been scheduled for 1st September 2025.

Thematic reviews

- There have been zero Thematic Reviews commissioned for Q1 2025/26.

2.3.3 System wide learning

2 Thematic reviews, reported in Q4 24/25, concluded in Q1 25/26. Findings and updates are outlined below.

- **Patients lost to follow up or overdue a follow up (AATD)**

The thematic review was conducted between Dec 2024- April 25 using incident and complaint data over a 15-month period. The draft report was presented at the Safer Waiting List Programme Board and the weekly patient safety meeting in June 2025. The key findings were:

- No demographic cohort has been impacted unproportionally
- 100% of incidents recorded as moderate harm or above related to follow ups overdue by 12 months or more
- 53% of incidents reported non completion or inaccurate completion of administration tasks. This number increased to 60% for incidents relating to long term follow up
- 24% of incident reports highlighted the lack of automated functions on EPR
- 26% of incident reports recorded insufficient staff to meet the volume of patients assigned to the service. This increased to 29% of incidents due to overdue follow up
- 15% of incidents were identified by staff auditing patient waiting lists
- 92% incident reports set or suggested actions in the report but only 4% of these actions were recorded in the InPhase action tab (making it difficult to monitor progress/improvement)
- Complaint data suggests an increase in the number of complaints received relating to overdue follow ups.

The thematic review also found that significant improvement work is taking place across the Trust to address the issue of AATD, however, the review team concluded that without addressing the following key issues, long term improvements are unlikely to be sustainable:

- Follow up demand exceeds capacity
- The existing follow up booking processes are complex increasing the risk of administration error
- No standardised approach for auditing and validating waiting lists.

The Patient Safety Investigators have developed an action plan based on the recommendations of the review which will be monitored at PSIRI panel.

It is anticipated that the report and action plan will be shared as part of the patient safety assurance update at Safety and Quality Assurance Committee (SQAC) in September 2025.

- **Data breaches**

A thematic review of data breaches concluded in Q1 25/26.

The recommendations from this review include:

- Developing opportunities to enhance staff awareness and understanding of data security.
- Establishing clear guidelines and responsibilities for data access and monitoring, including auditing compliance.
- Reviewing physical workspaces with the view to improving data security.
- Assessing IT systems and their interactions regarding verifying and updating patient personal data.

These recommendations have informed a broader quality improvement initiative led by the Data Breach Project Group, which was established to address and prevent harm from incorrect data sharing. The Trust's Head of Improvement oversees the project group.

Following a meeting between Chief Nursing, AHP, and Experience Officer and the Chief Digital Officer, a full action plan has been developed to address the findings, delivery of which is overseen by the Data Breach Project Group.

2.4 Training and Education

2.4.1 Patient Safety e-learning

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

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

Alongside our 2 Patient Safety Lead Investigators, the divisions of surgery, medicine and community/mental health now have a designated trained learning response and engagement lead meeting the PSIRF standards.

Currently our pool of learning response leads meeting PSIRF standards is 15 members of staff within the Organisation.

For engagement lead roles, 9 members of staff meet the PSIRF standards. A wider pool of staff members is being developed to build resilience into the engagement lead role.

Working with HSSIB, the Trust now has direct access to the online HSSIB booking system for training courses. This is a pilot project with HSSIB and has enabled our Patient Safety Specialist and Patient Safety Investigation Coordinator to directly book staff within the Organisation onto HSSIB accredited courses and with a log account of those staff members who have completed their courses.

4 members of staff members have complete specific AAR training with a drive to increase numbers within Divisions to enable consolidation of knowledge and facilitation of AAR.

2.5. Patient Safety Investigators

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

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

The team held a stall at the three corporate inductions held in the Q1 25/26, to introduce the Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Strategy to all new employees.

In May 25, the team conducted two PSIRF awareness sessions: one for High Dependency Unit (HDU) Band 6 staff, and one for the Clinical Education team as part of ongoing staff training and development.

A review of the PSIRF processes, including the roles and responsibilities of the Corporate Patient Safety Team, Divisional Risk & Governance Leads, Response Leads and Engagement Leads, was undertaken during Q1 25/25 and developed into a process flow diagram
It is anticipated that the process flow diagram will be taken to the Patient Safety Board for approval in Q2 2025-26.

2.6 Patient Safety Partners

In November 2024, the Trust successfully recruited 40 Patient Safety Partners (PSPs) through an active recruitment campaign, which was supported by our Children and Young Persons Forum. By the end of the Q1 2025-26, 34 PSPs had completed the recruitment process.

It is anticipated that the PSPs will begin their roles in Q2 2025-26. They will be actively involved in a variety of patient safety projects and workstreams to help the Trust implement the NHS Patient Safety Strategy.

2.7 PSIRF Annual Review of the Trust PSIRF Plan

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

A meeting with Cheshire and Mersey Integrated Care Board (ICB), held in April 2025, confirmed acceptance and ratification of the Trust's PSIRP by the ICB for a further 12 months.

3. Next Steps

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

An updated and revised PSIRF process flow diagram will be presented at Patient Safety Board for approval in Q2, 2025-26.

There will be increased focus on completion on respective learning reviews in line with established timescales which will be monitored through the weekly PSIRI meeting.

4. Recommendations

The Trust Board is asked to note the activity that has been undertaken during Q1 2025/26 following the Trust's transition to and embedding of PSIRF and next steps.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Infection Prevention & Control Trust Board Q1 Report** April 2025 – June 2025
Report of:	**Infection Prevention & Control**
Paper Prepared by:	Dr Beatriz Larru

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 oversight of Infection Prevention Control (IPC) activity and reporting for the Q1 period (1st April – 30th June 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 Q1, the IPC committee received reports from the following subgroups.

Clinical Advisory Group: No meetings held in Q1 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 Q1, 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 Q1 the group met on 15.04.25, 20.05.25 and 17.06.25 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

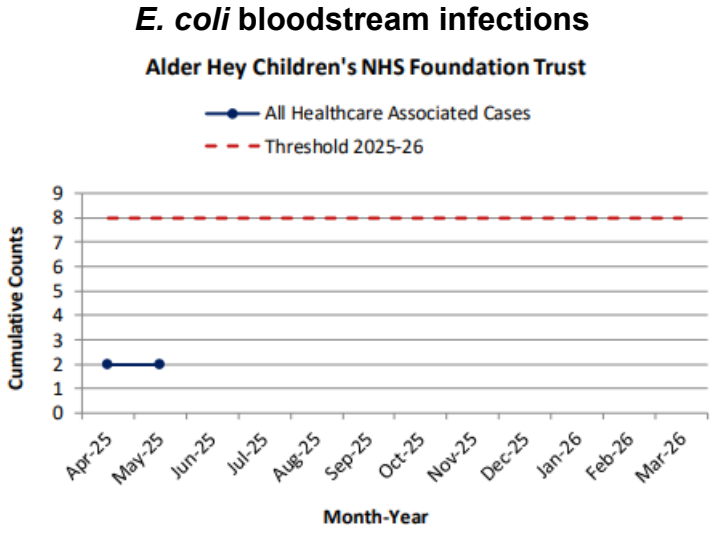
3.1 Bacteraemia Surveillance

3.1.1 Healthcare-associated Gram-negative Bloodstream Infections

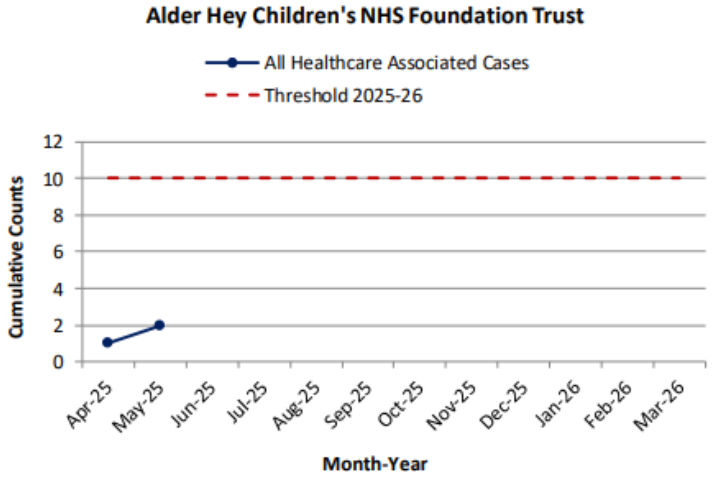
A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA (UK Health Security Agency) is shown below. During Q1, 2 patients had healthcare-associated Gram-negative blood stream infections. Cases were identified in Oncology (1), & Critical Care (1)

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.

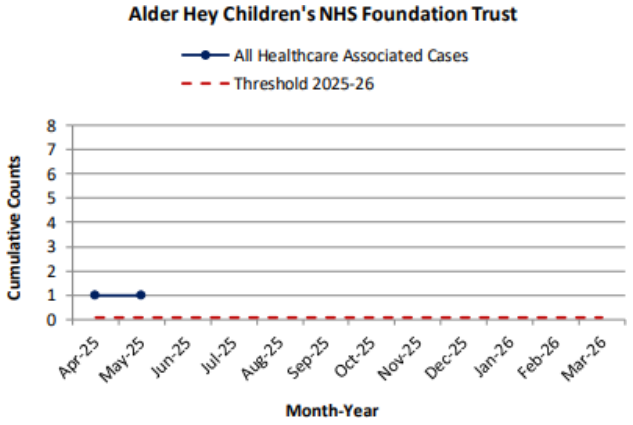
The workplan to reduce Central Line Related Line Infections (CLABSI (Confirmed central line associated bloodstream infection)) across the Trust has continued during Q1, with a closer collaboration between IPC and the Microbiology laboratory to include in our PIRs all significant blood stream infections (not just those subject to mandatory UKHSA reporting such as *E. coli, Pseudomonas aureginosa* or *Klebsiella spp.*) to engage with all stakeholders in the development of the CLABSI steering group.



Klebsiella spp. bloodstream infections



P. aeruginosa bloodstream infections



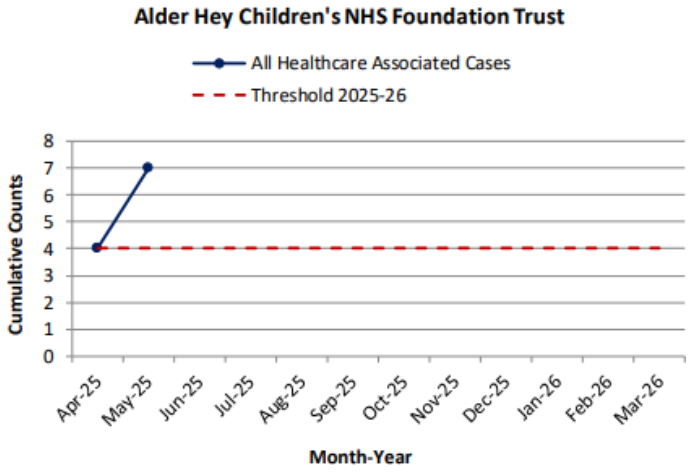
UKHSA HAIs monthly tables for Gram-negative bloodstream infections.
Note: Healthcare-associated infections include: 1) Hospital Onset-Healthcare acquired (**HOHA**) *(i.e.*, occurs in patients admitted >48Hr) and 2) Community Onset-Healthcare acquired (**COHA**) (*i.e.,* occurred in patients who have received healthcare in either the community or hospital in the previous 28 days).

3.1.2 Healthcare-associated *Staphylococcus aureus* bloodstream infections

During Q1, 5 patients had a healthcare associated MSSA blood stream Infections. The cases were identified in Critical Care (1), RDU (2), 3B (1) and 1 (3C). The post-infection review (PIR) prompted a review of ANTT processes for dressing changes.

During Q1, 0 cases of methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections reported.

3.1.3 C. difficile Infection

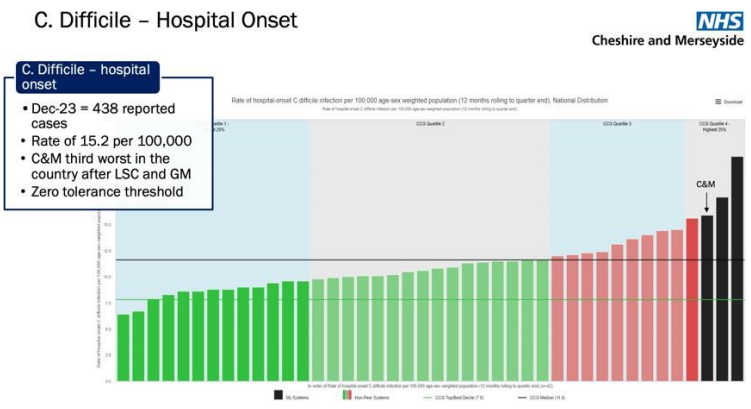


In Q1 there was 8 hospital-onset healthcare associated (HOHA), and 3 community-onset healthcare associated (COHA) *Clostridioides difficile* infections identified. Post Infection reviews confirmed that no lapses in care were identified. The affected individuals were long-term inpatients with prior exposure 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.

Lessons 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, the UK Health Security Agency (UKHSA) has reported a significant rise in **Clostridioides difficile (C. difficile) infections** across the UK, with no clear explanation for the surge. The **Northwest** ranks as the third most affected region.

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 Q1, a 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 conducts daily "isolation walks" across all areas of the Trust to reinforce appropriate infection prevention and control (IPC) precautions with staff. To support this, visual graphics have been developed to help identify contagious patients. Additionally, the team distributes monthly newsletters featuring key messages and updates and delivers tailored education sessions to specific areas

3.2.2 Gastrointestinal viral infections

During Q1, there was 6 cases of healthcare-associated Norovirus.
Given its rapid transmission, infection prevention measures were promptly implemented to contain 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*

There have been 4 cases of healthcare associated (HOHA) Group A *Streptococcus* identified during Q1 - 2 (3A), 1 (3C) and 1 (1C)

3.3.2 Measles

Quarter 1
April 2025: 0 cases
May 2025: 1 positive case (ED)
June: 7 positive cases (5, ED) (1, EDU) (1, 3B)

8 positive measles cases reported during Q1. The IPC department and DIPC closely collaborate with multiple teams across the trust, 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 Q1, 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 and outbreaks, 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 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.

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 to 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 fully recruited but awaiting start date for 1 candidate. Data Scientist started in March 2025. Successful recruitment of Clinical Audit & Hand Hygiene Lead. Service remains safe. Score to be reviewed with intention of reducing when post holders in place

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement 2025
Report of:	**Medical Appraisals 2024-2025**
Paper Prepared by:	Dr Z Bassi, Helen Blackburn

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:	Payments to appraisers

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 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement is a national requirement designed to ensure that Trusts maintain effective systems to record and monitor all medical appraisals. This report provides assurance that Alder Hey NHS Foundation Trust has established robust governance and processes to support the annual medical appraisal of all practitioners, in line with the Framework for Quality Assurance and Improvement set by NHS England North West

All medical practitioners with a General Medical Council (GMC) licence to practise and who have a prescribed connection to the Trust are required to participate in an annual appraisal process. In instances when an appraisal cannot be undertaken, this must be formally documented and confirmed by the Responsible Officer (RO).

For the appraisal year 2024–2025, Alder Hey NHSFT achieved an overall compliance rate of **98.02%**, demonstrating a high level of engagement across the medical workforce.

2. Background and current state

The Trust is required to submit an annual update to the Higher Level Responsible Officer to provide assurance regarding the quality and coverage of Annual medical appraisal. The annual appraisal forms part of a five-year cycle, which includes both a colleague and patient review. Following a successful round of appraisals, all the information is reviewed internally by the Trust Responsible Officer Advisory Group before Revalidation recommendations are submitted.

In 2024–25:

- **95 new doctors**, primarily clinical fellows on one-year contracts, were added to the system.
- A total of **405 doctors** had a prescribed connection to the Trust, including consultants, SAS doctors, and clinical fellows
- **75 trained appraisers** delivered an average of **5.4 appraisals per year**.

3. Annual Appraisal and Revalidation Summary (2024–25)

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	405
Total number of appraisals completed	396
Total number of appraisals approved missed	8

Total number of unapproved missed	1
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	106
Total number of late recommendations	1
Total number of positive recommendations	88
Total number of deferrals made	17
Total number of non-engagement referrals	0

4. Conclusion

The Trust has continued to maintain a high standard in the appraisal and revalidation process with a compliance rate of **98.02%**. This reflects strong engagement from doctors and effective oversight from the Responsible Officer and the Appraisal & Revalidation team.

Systems are in place to monitor, document, and follow up all appraisals. All revalidation submissions are quality assured through the Trust's internal governance processes.

5. Recommendations & proposed next steps

- Organise a **new appraiser training** session in 2025–26 to grow the appraiser pool.
- A Peer Review with local Trusts will be undertaken, this is required once every 5 years.

- The Appraisal and Revalidation policy will be reviewed and updated to reflect any changes in national guidance/ local process improvements.

2024-2025 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2025**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2024-2025 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Alder Hey Children's NHS FT
What type of services does your organisation provide?	Acute

	Name	**Contact Information**
Responsible Officer	Mr A Bass	Alfie.Bass@alderhey.nhs.uk
Medical Director	As above	
Medical Appraisal Lead	Dr Z Bassi	Zahabiyah.Bassi@alderhey.nhs.uk
Appraisal and Revalidation Manager	Helen Blackburn	helen.blackburn@alderhey.nhs.uk
Additional Useful Contacts	Carol Franklin, Appraisal Administrator	appraisallead@alderhey.nhs.uk

Service Level Agreement
Do you have a service level agreement for Responsible Officer services?
NO

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher-Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	N/A
Comments:	Mr Bass has maintained his role as RO.
Action for next year:	N/A

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes

Action from last year:	Renew contract for L2P to enable the Trust to manage appraisals and revalidation.
Comments:	We have a dedicated appraisal team. Consultant Appraisal Lead, Appraisal and Revalidation Manager and Administrator. The contract for L2P was renewed for three years.
Action for next year:	N/A

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	N/A
Comments:	We use L2P database to manage appraisals. Triangulating the information between L2P, GMC connections and staff in post list.
Action for next year:	Review list of clinicians who are linked to the Trust monthly to ensure that an accurate list is maintained.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Publish updated policy.
Comments:	The Medical Revalidation and Appraisal policy has been reviewed and updated.
Action for next year	Publish and ratify policy.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	Complete the peer review and implement outcomes from the review.
Comments:	The Peer review initial meeting took place on 10th December 24. Two further meetings will be arranged to enable the Trusts to review processes and practice.
Action for next year:	The final report for the peer review will be shared with the RO/ Board in September 25.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Continue to arrange face to face meetings and provide support
Comments:	The number of temporary or short-term contracts has increased slightly, we will continue to use the same processes to monitor appraisal compliance.
Action for next year	Continue to arrange face to face meetings and provide support for all clinicians.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Continue to use L2P and provide training updates to ensure that all appraisals meet GMC requirements.
Comments:	We continue to utilise L2P to manage appraisals. We also hold regular meetings between the RO, Appraisal Lead, Medical Staffing and Appraisal Managers.
Action for next year:	Follow same processes

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	Action will be taken as required and support provided, as necessary.
Comments:	There are relatively few Drs who do not manage to complete their appraisals. When this occurs, we discuss with the RO, we provide support as required. Regular meetings with the GMC Liaison officer to discuss concerns or issues. If appraisals cannot be undertaken, reasons are recorded on L2P.
Action for next year:	Follow same procedures.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	To review policy and update as required.
Comments:	The policy will be ratified by the People and Wellbeing Committee, on behalf of the Trust.
Action for next year:	Disseminate policy.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y
Action from last year:	Host another course to train appraisers.
Comments:	We decided that the number of appraisers was sufficient. Therefore, the intention to hold the course was deferred. Most appraisers undertake a minimum of 5 appraisals per year.
Action for next year:	Arrange an appraiser course to increase pool of appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Arrange update sessions to ensure that new information is cascaded and allow appraisers to provide feedback and network with this peer group.
Comments:	The appraiser update events were well attended. The agenda included an appraisal information update, coaching and provoked a lot of informal sharing of experiences and support.
Action for next year:	Arrange further training events. We host two per year, each appraiser must attend at least one update session.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	**Y**
Action from last year:	The appraisal updates are reported to the Board via the Integrated performance report every month.
Comments:	We send monthly updates of compliance to each divisional quality team and to the RO, clinical directors and HR who manage compliance rates.
Action for next year:	Follow same processes.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	ROAG meetings have been diarised, and all submissions are recorded locally.
Comments:	The ROAG group monitor all Drs under notice, if there are areas of concern support is provided. If the Dr is unable to complete the required data set appropriate actions will be discussed with the person and recorded.
Action for next year:	Follow same processes.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	**Y**
Action from last year:	ROAG meetings have been diarised, and all submissions are recorded locally
Comments:	We monitor all Dr's under notice to ensure that they have the required appraisals and MSF before recommendations are submitted.
Action for next year:	Follow same processes.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	**Y**
Action from last year:	**N/A**
Comments:	The Trust holds a weekly Patient Safety meeting. All divisions have robust governance infrastructure and Leads report back to Trust board. Appraisal information is sent to governance teams quarterly for action and information
Action for next year:	**N/A**

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	**Y**
Action from last year:	**N/A**
Comments:	Local Governance meetings and Maintaining High Professional Standards (MHPS) – monthly meeting. Membership includes Chief Medical Officer, Divisional Directors, Chief People Officer, Dir. Corp Affairs and HR Business Partners. All formal cases and any concerns discussed and monitored. Escalated to GMC if required.
Action for next year:	**Follow same processes**

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	N
Action from last year:	To liaise with IT dept to capture information in one place for each Dr.
Comments:	There have been several meetings to explore how to manage and maintain folders for the clinicians to access the relevant data**.** The work is on going and some new options are being explored.
Action for next year:	Find a solution to provide access to folders for all clinicians that includes all the information that they are required to include in their appraisals.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	**Y**
Action from last year:	The policy will be reviewed and updated in June 2024

Comments:	Maintaining High Professional Standards (MHPS) – monthly meeting. Membership includes Chief Medical Officer, Divisional Directors, Chief People Officer, Dir. Corp Affairs and HR Business Partners. All formal cases and any concerns discussed and monitored. Escalated to GMC if required. All cases have Executive and HR oversight. Formal cases have a nominated Non-Executive Director to ensure that processes are adhered to. Employees are all treated with respect and compassion in line with our Trust values and HANDLING CONCERNS ABOUT CONDUCT, PERFORMANCE & HEALTH OF MEDICAL & DENTAL STAFF POLICY.
Action for next year:	Implement updated policy

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	**Y**
Action from last year:	**N/A**
Comments:	A quarterly report is provided to the private business section of the Board of Directors meeting detailing the latest position regarding all employee relations issues including disciplinary cases relating to medical staff.
Action for next year:	**N/A**

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	**Y**
Action from last year:	Follow current processes

Comments:	The TOI requests are completed by the Revalidation Manager, shared with requesting Trust within 3 days of receipt. We communicate via email or telephone as required. TOI requests are escalated to the RO if concerns have been raised.
Action for next year:	Current practice will continue.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	**Y**
Action from last year:	**N/A**
Comments:	There are processes in place to ensure that clinical governance concerns are managed within the Trust's policies. The ROAG group meets to review cases, the group members are the Responsible Officer, Appraisal Lead, Revalidation Manager and Medical Staffing Manager
Action for next year:	**N/A**

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	**Y**
Action from last year:	N/A
Comments:	We source information from a variety of platforms, including NHSE, GMC, NHS Confederation. We also use network meetings and various journals and databases to inform changes to development requirements. Regular communications are sent to all appraisers and appraisees.
Action for next year:	To host two update training sessions for appraisers. We circulate updates to all clinicians and upload documents to the resources section on L2P. We also review and update policies and practice as required.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	**N/A**
Comments:	The People and Wellbeing Committee (PAWC) overseas the professional standards of staff within the trust.
Action for next year:	**N/A**

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	**Y**
Action from last year:	**N/A**
Comments:	The wider HR team and Clinical Directors manage the recruitment process. The processes follow national guidelines to ensure that all pre-employment checks are undertaken before employment contracts are issued.
Action for next year:	**N/A**

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	**Y**

Action from last year:	Monitor numbers of staff who attend courses.
Comments:	The Trust has a dedicated organisational development team, they have developed many programmes to support staff within the Trust. The attendance has been recorded and will be reviewed, a broad range of internal and external courses have supported the development of our staff.
Action for next year:	**N/A**

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	**Y**
Action from last year:	**N/A**
Comments:	We reflect the vision of the Trust through our Values. Innovation, Excellence, Openness, Respect, Together. All staff are also required to undertake EDI training.
Action for next year:	**N/A**

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	**Y**
Action from last year:	**N/A**
Comments:	The Trust has a values and behaviours framework, it is embedded in activity and training for all staff. The FTSU Guardian attends meetings within Divisions and her role and contact details are available on the Intranet. We also use feedback from the staff survey and GMC survey to improve our culture.
Action for next year:	**N/A**

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	
Action from last year:	**N/A**
Comments:	The Trust has a robust governance process and the policy, HANDLING CONCERNS ABOUT CONDUCT, PERFORMANCE & HEALTH OF MEDICAL & DENTAL STAFF POLICY. There are various groups who meet to monitor standards.
Action for next year:	**N/A**

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	**Y**
Action from last year:	Liaise with HR for data collection
Comments:	The Trust has a strong culture of EDI and does monitor levels of parity. We have an EDI manager who works across the Trust to provide advice and support.
Action for next year:	**N/A**

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	**Y**
Action from last year:	**N/A**
Comments:	We have various local networks with organisations whom we benchmark our standards and intend to hold a peer review this year. We also follow guidance from HLRO.

Action for next year:	**N/A**

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	405
Total number of appraisals completed	396
Total number of appraisals approved missed	8
Total number of unapproved missed	1
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	106
Total number of late recommendations	1
Total number of positive recommendations	88
Total number of deferrals made	17
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	22
Total number of trained case managers	5
Total number of concerns received by the Responsible Officer[2]	6
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	28 months
Median duration of concerns processes closed (working days)[3]	8 months
Total number of doctors excluded/suspended during the period	3
Total number of doctors referred to GMC	2
Total number of appeals against the designated body's professional standards processes made by doctors	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	95
Total number of new employment checks completed before commencement of employment	95
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld[4]	Case ongoing

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The Appraisal and Revalidation team has reviewed and updated the Medical Revalidation and Appraisal Guidelines. We have included two new templates, Appraiser Assurance Review template and Process for requesting a postponement. A Peer review has been undertaken with Liverpool Women's Hospital, The Walton Neurological Centre, Liverpool Heart and Chest Hospital. We have reviewed practice and processes and although there were no significant differences, Alder Hey does have 0-hour contracts which the other Trusts do not.
Actions still outstanding
To complete Peer review and disseminate findings to the Responsible Officer and update appraisers. Arrange appraiser training.
Current issues
Ensuring that appraisals are undertaken in the month that has been allocated. There has been an increase in the number of late appraisals. This will be addressed with the appraisers to encourage appraisees to confirm meeting dates. Emails will be sent to inform the appraisees of the importance of having their appraisal within the allocated month.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Review list of clinicians who are linked to the Trust monthly to ensure that an accurate list is maintained. The final report for the peer review will be delivered to the RO/ Board in September 25. Ratify, publish and disseminate Revalidation and Appraisal Guidelines policy Continue to arrange face to face meetings and provide support for all new clinicians. ROAG meetings have been diarised, and all submissions are recorded locally. Arrange further training events. We host two per year, each appraiser must attend at least one update session. Find a solution to provide access to folders for all clinicians that includes all the information that they are required to include in their appraisals. To host two update training sessions for appraisers. We circulate updates to all clinicians and upload documents to the resources section on L2P. We also review and update policies and practice as required.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
We continually review practices and processes, Benchmarking, we were encouraged to see that our compliance rate for appraisals was in the higher quartile. The 1.2% who did undertake an appraisal was due to long term sickness or Trust related processes. Appraiser updates, we held two successful events. They both included coaching, appraisers were paired together to enable them to practice their skills. Aspirations: We will host an Appraiser training course to replace appraisers who are relinquishing their roles and to broaden the range of appraisers within the Divisions. Letter of good standing template – was implemented in 2024 and has been well received by clinicians who are required to supply this information.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Chair's Report from the Safety and Quality Assurance Committee meeting held on 23rd July 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 23rd July 2025, along with the approved minutes from the 25th June 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 25.06.25	Minutes Approved
Divisional updates	Reports x4 noted
Liverpool Neonatal Partnership Monthly Update	Report noted
Mitie Responsiveness progress update report	Report noted
Coroners Statement of Events Guidance and Templates	Report Ratified
Patient Safety update	Report noted
Sepsis Quarterly Report	Report noted
Drugs & Therapeutics Committee Quarterly report	Report noted
Transition to Adulthood Annual Report	Report noted
Clinical Effectiveness and Outcomes Board Chairs Highlight Report	Report noted
Board Assurance Framework	Report noted
Clinical Audit Assurance Report	Report noted
Incident Communications Plan	Plan Ratified
Business Continuity Plan	Plan Ratified
HazMat CBRN Plan	Plan Ratified

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

There were no matters of concern to escalate to the Board

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 welcomed the Liverpool Neonatal Partnership monthly update
- SQAC welcomed the progress update regarding Mitie Responsiveness and welcomed a further update at the November 2025 SQAC meeting
- SQAC noted the good assurance provided within the Drugs & Therapeutics Quarterly Report
- SQAC welcomed the Patient Safety update
- SQAC received and Ratified the Coroners Statement of Events Guidance and Templates
- SQAC welcomed the Transition to Adulthood Annual report and welcomed the progress made to date
- SQAC welcomed the Clinical Effectiveness & Outcomes Board Chairs Highlight report
- SQAC welcomed the Board Assurance Framework
- SQAC welcomed the Clinical Audit Assurance Report
- SQAC received, Noted and Ratified the Incident Communications Plan
- SQAC received, Noted and Ratified the Business Continuity Plan
- SQAC received, Noted and Ratified the HazMat CBRN Plan

4. Issues for other committees

None

5. Recommendations

The Board is asked to note the contents of the report

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 25th June 2025
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing Officer	NA
	Kerry Byrne	Non-Executive Director	KB
	Lisa Cooper	Divisional Director	LC
	Gerald Meehan	Non-Executive Director	GM
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health	JP
	Laura Rad	Head of Nursing – Clinical Research	LR
	Jackie Rooney	Associate Director of Nursing & Governance	JR
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Melissa Swindell	Chief People Officer	MS
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Veronica Greenwood	Director of Allied Health Professionals	VG
	Ian Gilbertson	Deputy Chief Digital and Information Officer	IG
	Jill Preece	Governance Manager	JP
	Peter White	Chief Nursing Information Officer	PW
	Amy Tantum	Head of Nursing&Allied Health Professionals, Division of Surgery	AT
	Mark Jennings	Non Executive Director	MJ
25-26-65	Susan O'Neil	Head of Neonatal Nursing, Liverpool Neonatal Partnership	SON
25-26-66	Emily Gardner	Associate Programme Director	EG
25-26-67	Luke Oldland	Account Director, Mitie	LO
25-26-67	Lachlan Stark	Associate Chief Operating Officer Estates & Facilities	LS
25-26-70	Julie Grice	Mortality Lead	JG
25-26-71	Amy Tantum	Head of Nursing&Allied Health Professionals, Division of Surgery	AT
25-26-74	Rachel Isba	Clinical Lead for Improve My Life Chances	RI
25-26-74	Mia Hankinson	Medical Student	MH
25-26-75	Dr. Lindsay Neil	Clinical Lead for Children & Young People's Gender Service (Northwest)	LN
25-25-75	Rachel Thompson	General Manager, Children & Young People's Gender Service (Northwest)	RT
Apologies:	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	AB
	Alfie Bass	Chief Medical Officer	ABA
	Pauline Brown	Director of Nursing	PB
	Urmi Das	Divisional Director – Division of Medicine	UD
	Rachael Pennington	Associate Chief Nurse - Surgical Division	RP

25/26/60	**Welcome and Apologies** The Chair welcomed everyone to the meeting and apologies were noted.
25/26/61	**Declarations of Interest** - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.
25/26/62	**Minutes of the Previous Meeting** The Committee members were content to **APPROVE** the minutes of the meeting held on 21st May 2025.
25/26/63	**Matters Arising/Review of Action log** The action log was reviewed and updated.
---- Delivery of Outstanding Care ----	

25/26/64	**Divisional Updates** **Division of Medicine** CW presented the Medicine Division update and drew attention to a few key points from the report including: **Highlights:** • A&E -Trust was ranked second in national rankings: with 89.3% of patients seen within the target, the Trust has the second lowest numbers of patients waiting more than 12 hours • Document management had improved to 90%+ compliance **Challenges:** • The Division had experienced challenges regarding the Givinostat implementation for treatment for children with Duchenne Muscular Dystrophy. 50 eligible patients at Alder Hey had been identified who are eligible for Givinostat. Ensuring safety, the Division commenced with 5 children until September 2025, followed by a full review. Currently there are 2 children who had commenced treatment after pre consent and consultant evaluation. • A decrease in complaint responses within 25 days compliance was noted, (first breach in 18 months), learning had been identified. • Emergency Preparedness template is in development; submission of the template is expected in July 2025 • Clinical Letters Backlog had reduced from 9000 to 5000; target clearance by July 2025 FB referred to a theme across Divisions relating to clinical letters backlog and requested whether there is an update on this issue. CW confirmed that this is a challenge for divisions and that there is ongoing work to address. IG advised that there had been a significant backlog of clinical letters and advised that there were approximately a backlog of 9,000 letters as at mid-June. IG confirmed that there is a plan in place to address the backlog, and that there is currently a backlog of 5,000 letters. IG confirmed that the Trust is on trajectory to complete and clear the backlog by July 2025 and advised on the importance of maintaining and sustaining the position going forward. FB queried whether the backlog is linked to the use of the ambient AI. IG stated that there had been long term sickness within the team, this had been compounded with workforce restrictions and the inability to recruit to posts which is impacting all areas which is the significant cause of the backlog. GM referred to the on call in neurology and sought clarity whether there are any issues relating to this. CW confirmed that this issue had progressed and advised that the risk remains static until the on call re-commences. CW advised that on call will commence again in July 2025 and that the risk should start reducing in July 2025. NA expressed his thanks to the Medicine Division for the significant improvements made in month to improve out of date policies. **Surgery Division** AT presented the Surgery Divisional update and drew attention to a few key points from the report including: **Highlights:-** • The Vestibular infant screening programme was successfully launched in May 2025 – second globally. **Challenge:-** • Decrease in major trauma standards compliance – (Risk 179) - Risk increased and the action plan had been extended to include the Medicine Division, this risk is partially assured, training and monitoring is in place, with weekly monitoring via the Risk review meeting • 2 Patient Safety Incident Investigation cases are ongoing and are on trajectory • 2AARs/learning response had been completed (sepsis and AKI). • There was 1 Category 2 pressure ulcer reported in May, which had been identified under the orthotic device. The patient was closely monitored by the Tissue Viability Nurse and the area is healed. • 98% compliance in responding to PALS within 5 days

- Formal complaints - there were two breaches as the responses required further information during the quality assurance stage to enable a full response
- There was one PALS breach due to a delay in another division realigning to the surgical team
- Document compliance – there is ongoing work within the division to improve compliance
- EPRR – remains work in progress

GM referred to Sepsis non-compliance at 100 mins and sought clarity whether this was a critical issue. AM confirmed that this was an isolated issue and that overall, the Division do not have any concerns.

NA welcomed the improvements and advised that the Division of Surgery need to review risks, incidents and overdue actions to ensure that this is addressed ahead of the next SQAC meeting.

Clinical Research Division
LR presented the Clinical Research Divisional update and drew attention to a few key points from the report including:-
Highlights:-
International Clinical Trials Day was held on 20th May 2025, which was extremely successful.

Challenges:-
- CRF Fire Door misalignment – Division have ongoing concerns regarding the delay in fixing the Fire Door, this had been further escalated to Mitie on 11th June 2025, currently awaiting a response.
- Division had experienced further issues with DHL courier issues for commercial studies which had led to several samples breeching times and samples becoming unviable. The Division would move away from using DHL for sponsored studies.
- SOP compliance had reduced due to SOP updates on Ipassport, this would be ongoing whilst newly updated SOPs are added as each member of staff is required to read and confirm each new SOP. Daily reminders are sent to those who are out of compliance.
- Missing records incident – following presentation at Risk Management Forum and further update to PSIRI agreement had been made to close this incident and that the risk score would be reduced. No concerns had been raised from study sponsors and no further update would be provided to SQAC unless requested.

KB referred to fit testing and sought assurance that this is being addressed across the Trust.
LR confirmed that there is a working group in place.
CW advised that there are some challenges with regards to ensuring all staff are fit and compliant and advised that this is being addressed within the working group. CW stated that she envisaged that improvements are expected shortly.

Community and Mental Health Division
JP presented the Community and Mental Health Division update and drew attention to a few key points from the report including:-
Highlights:-
- A successful move from Sefton Carers/therapies team into Blossom House was noted.

Combined successes and challenges
- The Sunflower House team safely supported a complex child on the unit whilst they awaited a psychiatric intensive care unit bed. Division experienced challenges relating to the management of this complex child with damage to the High Dependency Unit within Sunflower House, the High Dependency Unit of the ward is briefly closed for repairs.
- Good progress is being made with regards to the setting up of the new neurodevelopmental service, with transformational work ongoing. There are challenges regarding digital work alignment, with complexities in ensuring that the referral platform, and RPA processes requires updating in the relevant order to ensure alignment in order that it is ready to go live.
- A risk had recently been added to the risk register regarding the challenges of being able to secure Outpatients from a security perspective, as it is a very open area. There had been an incident during the weekend with an intruder, with damage to a door, intruder was found to be in an area where they should not have been able to gain access to. There is ongoing work to repair the door, and to consider how the area could be made more secure, particularly out of hours.

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

25/26/65	**Liverpool Neonatal Partnership update** SON presented the Liverpool Neonatal Partnership update and drew attention to a few key points from the report including:- **Highlights:**- • 100% compliance in retinopathy of prematurity screening and parental consultation standards • Full compliance with BAPM standards for qualified -in-specialty nurses on shift on both sites • No moderate harm or no-harm incidents were reported in May 2025 • A strong reporting culture has maintained despite lower activity levels • Topping out ceremony for new neonatal unit was held on 23rd June 2025 • There is strong engagement with Alder Hey clinicians on clinical pathways and admission criteria, with positive feedback on presentations and collaboration • Skin injury reporting on the LWH site had increased, this is attributed to improved reporting culture, rather than actual increase in events. Neonatal skin and tissue viability wards rounds are ongoing • Joint daily huddles and shared learning was noted as working well • Positive impact was noted regarding the Patient Safety Incident Response Framework, and the shared learning culture strengthened through inclusive joint learning meetings and staff rotation. **Challenges**. • Staffing constraints due to bank spend restrictions at the LWH site, - redeployment of quality-focussed roles (feeding support) to clinical shifts – and potential impact on care quality, particularly in feeding support is being monitored • Breastfeeding rates at discharge are low despite early uptake success, only 2 of 10 babies discharged on breast milk were receiving maternal milk. Training and support initiatives are in place to improve sustained breastfeeding to discharge • Medication incidents had increased; (total of 11 incidents, 7 administration, 2 prescribing, 1 storage and 1 follow up) – a thematic review is underway to identify roote cause and improvement actions • Discharge delays – increase in delays related to transfer to other units. Term admissions to neonatal units are being monitored as part of a national programme to reduce avoidable admissions • Speech & Language Therapy recruitment is progressing, interest has been received from a neonatal trained candidate, SON is optimistic regarding successful recruitment and envisaged this risk being downgraded within the next 1-2 months. NA referred to a letter from NHSE regarding Maternity and Neonatal Services, with focus areas regarding safety, staff support and anti-racism. NA requested for a response to be drafted and shared at the July SQAC meeting **Resolved**: SON to prepare a draft response to NHSE letter re Maternity and Neonatal Services for SQAC to review at the July SQAC meeting. KB requested that future reports include further detailed IPC data regarding infection types, sources of infection – hospital acquired – versus community acquired, preventability and care lapses. SON confirmed that this data is available and would be included in future reports. FB referred to section 5.2 within the report and advised that the report refers to a mortality graph which is not included. FB requested this be rectified within the report being issued for Trust Board. GM queried whether the Patient Safety Incident Response Framework (PSIRF) is having an impact. SON confirmed that PSIRF is positive and advised on the joint daily huddle meetings for staff from both sites which is well received. **Resolved:** SQAC received and **NOTED** the Liverpool Neonatal Partnership update
25/26/66	**Gender Service National Provider Network update** EG, Interim Programme Director provided an overview of the Gender Service National Provider Network, and detailed a summary of the governance structure, membership and National MDT, host responsibilities, high level timeline of the mobilisation to date, details of current risks and future plans. The Gender Service went live in April 2024:- • Governance Structure - A formal governance structure has been established for the Gender Service, EG advised that the structure has a risk of some duplication with NHSE under the sizeable programme within national Specialised Commissioning team. The governance structure is kept under review to try and streamline as much as possible to ensure clarity on responsibilities for various workstreams

	• National Provider Network -This includes oversight and leadership by a designated chair and a multidisciplinary team (MDT) • Membership and National MDT - The network is chaired by Camilla Kingdom and includes representation from multiple providers. A national MDT has been convened to ensure consistency in clinical decision-making and service delivery. The Network is expecting two endocrine providers in Leeds and UCLH to become members • Host Responsibilities - Alder Hey serves as both the host and a member of the network. Responsibilities include coordination, facilitation of governance processes, and participation in the national MDTs • There are a number of workstreams that are still being held by NHSE that are due to be handed over to Alder Hey • There are 4 proposed risks identified with regards to ensuring consistency across different providers within the network: - Workforce capacity challenges, particularly in endocrinology. Risks had been uploaded to InPhase; with regular review of the risks' scoring and mitigation. • Future Plans -The network aims to strengthen collaboration, standardise care pathways, and address workforce challenges/gaps. Ongoing monitoring and governance will support the network's development and sustainability. • The National Provider Network does not have any decision making powers and there is no nationally agreed strategic approach to the long term commissioning of endocrinology, they do not yet have a separate service specification like the gender service does. • EG referred to the very limited consultant workforce in Leeds and Uclh and the risk for all providers, but for the network particularly, with the risk slightly highly rated at 12. GM sought clarity whether this body would have a specific dashboard or data set. EG advised that this requires development to enable a national data set to be developed and is an operational risk, EG advised that the longer term view of the network would hopefully to obtain national data set and standards **Resolved:** SQAC received and **NOTED** the Gender Service National Provider Network SQAC supported the approach to the governance of the Children & Young Peoples Gender Service National Provider Network ensuring alignment to Trust wide policies and procedures in Alder Hey Children's NHS Foundation Trust role as a host as well as engagement with Royal Manchester Children's Hospital and other stakeholders as required in their role as a member.
25/26/67	**Mitie: Facilities Management Service** LO, Account Director at Mitie provided an overview of the review of the responsiveness and performance of Hard Facilities Management (Hard FM) at Alder Hey which is provided by Mitie, with particular focus on reactive repairs and performance in theatres. LO confirmed that the review had demonstrated limited assurance. • Theatre areas was noted as below average in reactive performance due to complexity and access • Reliance on subcontractors; shift system is under review • New technical staffing model, new structure aims to insource technical expertise and improve shift coverage • Departmental dashboards and visibility improvements are planned to aid the visibility of job status • Monthly meetings with theatre teams were proposed. FB thanked LO for the update and welcomed the update confirming that there is a structured plan in place to address issues raised, particularly regarding performance and responsiveness. FB highlighted the importance of ensuring a clear and follow up process to monitor the implementation of the improvement plan and to receive clarity regarding associated timelines. FB stated that discussion regarding follow up actions and next steps should take place outside of SQAC meeting and for SQAC to receive an update on next steps and how actions would be tracked at the next SQAC meeting. LS referred to the Environment and cleanliness group which is chaired by the Director of Nursing and is a platform to review Hard FM. LS advised that staff are working to address these issues identified by Mitie and stated that the visibility of jobs is an important issue **Resolved:** Update to be received at July 2025 SQAC meeting **Cleanliness Update Report**

	LS presented the Cleanliness update Report which detailed activity levels, cleanliness standards and responsibilities, governance, audit findings & cleaning standards, performance by area and future actions • Partial assurance was provided for the cleanliness report • Staffing levels had decreased by 10 WTE since 2019, despite increased hospital activity. This reduction has impacted the ability to maintain cleanliness standards across all areas • Audit Findings - Functional risk levels are under review. Coordination of ventilation cleaning remains a challenge. Investment in floor scrubbers had been approved to support cleaning efforts • Key Challenges include reduced staffing, coordination issues with ventilation cleaning, and maintaining morale among domestic staff • Improvement Actions - Efforts are underway to improve engagement and recognition for domestic staff. Domestic staff morale is low, with ongoing engagement to foster a more positive work environment, with listening exercises underway. The team is also reviewing functional risk levels and investing in equipment to support cleaning operations. • Distribution of audit data to be improved. • Policy RM49 is under review following the Salford Review • LS provided an overview of future actions and advised that through the Environment & Cleanliness Group and Senior Nursing and governance Team the proposal is to widen the awareness and scrutiny of cleaning standards. LS advised that the recommended actions include strengthening the partnership working between Mitie, nursing staff and domestics, clarifying responsibilities and strengthening the review and learning from audit data. • LS referred to the financial challenges given the current financial climate. FB acknowledged the progress made and the structured action plan being implemented. FB emphasised the importance of establishing a clear follow up process to ensure that improvements are being made and that any barriers to progress are being addressed. **Resolved:** SQAC agreed to receive a Cleanliness update at the September 2025 SQAC meeting. JP referred to service users who are accessing buildings which are not owned by Alder Hey, and how Alder Hey ensure the same cleanliness standards. LS advised that this report only relates to Alder Hey site and that there are currently 43 leases, some of which are private and some NHSE. LS advised that this is being audited with planned benchmarking. GM referred to staff who undertake the cleaning, in terms of their morale, and whether they are feeling supportive and inclusive. LS stated that generally domestics and facilities staff feel like lower class citizens and that they do not feel fully integrated into the broader hospital team. This perception is compounded by ongoing pressures, including workforce reductions and increasing demands. LS stated that the team are under pressure due to efforts to reduce headcount in response to financial constraints and that activity across the hospital is increasing, which adds to the workload and stress on the cleaning staff. LS advised that the workforce is aging, and recruitment into these roles is increasingly difficult. LS confirmed that a listening exercise was conducted to understand the concerns of domestic staff, collaboration with HR is underway to explore new recruitment strategies and events such as Estates and Facilities Day are used to recognise and appreciate staff contributions (e.g., tea, coffee, cakes). Staff meetings are held across all shifts (AM, PM, night) to maintain communication and engagement. The team received an award for the most improved response rate in the staff survey, indicating successful outreach and engagement efforts. Despite these efforts, the staff still feel undervalued, a sentiment echoed by LS in his dual role, as a governor. LS advised that the team work hard but are navigating a challenging environment and that there is a recognition that the current model of centralised cleaning services may contribute to a sense of dehumanisation and detachment from clinical teams. FB referred to the staffing issues raised and queried whether this could be addressed. NA confirmed that this would be raised at the Environmental group meeting for discussion. **Resolved:** SQAC received and **NOTED** the Cleanliness update report and welcomed an update at September 2025 meeting.
	---- Safe ----
25/26/68	**Patient Safety Strategy update** JR Presented the Patient Safety Strategy Update from the Patient Safety meeting held on 29th May • The update highlighted a positive reporting culture with a continued trend of low harm incidents

	• Incidents of harm per 1,000 bed days remained low and show a downward trend, despite a slight peak in April 2025 • Complaints responded to within 25 days remain above target • Increase in restrictive practice incidents at Sunflower House attributed to one complex child • C. difficile cases increased, but no lapses in care were identified. All cases involved long-term patients with prior antibiotic exposure **Challenges:** • Approximately 4,500 patients are incorrectly labelled with penicillin allergy. Ward pharmacists are addressing this, but amber/red cases require referral to a single-consultant-led allergy clinic, posing capacity risks • Trauma and quality update highlighted non-compliance with external peer review standards (Risk 179). • Mortality reviews are affected by electronic patient record timestamps showing order time instead of sample collection time. This issue has been escalated to the digital team • The NatSSIPs (National Safety Standards for Invasive Procedures) paper has been delayed. A new decision document is being developed in coordination with the ICS and surgical division. • An updated statement of events for the coroner's guideline was deferred due to recent updates to the coroner's bench book and this would be presented at the next meeting for ratification. **Resolved:** SQAC received and **NOTED** the Patient Safety update
	----- Effective ----
25/26/69	**Infection Prevention and Control report & Annual Report** VG presented the Infection Prevention and Control Report & Annual Report on behalf of BL **Highlights** • All IPC policies are up to date and compliant • A unified IPC care plan had been implemented across the Trust • ICNET go-live is scheduled for July 2025, the digital platform will enhance infection surveillance and reporting and will streamline workflows and improve data accuracy. Integration with clinical systems is expected to enhance responsiveness • New roles recruited (data scientist, hand hygiene lead). IPC Team were subject to organisation change process, with some significant changes to roles within IPC • IPC committee meet regularly and reports on progress • SPC charts had been introduced to detect early trends and support decision-making and enable monitoring of infection rates and identify anomalies • Seasonal variation in infections, Retrospective data cleansing needed for long-term trends • Daily isolation rounds are conducted to ensure timely identification and management of infectious cases • IPC visibility and presence had improved across clinical areas, with staff engagement with IPC initiatives improving • IPC governance structures are robust and actively monitored • C. difficile cases had been reviewed and a toolkit developed to support prevention • Measles response protocols are in place and aligned with national guidance, further information would be provided in Quarter 1 with retrospective learning review FB expressed her thanks to VG and advised that the Committee received a great deal of assurance from the report. KB referred to the data within the IPC report, which is generally restricted to 1 year, and sought clarity whether it would be possible to provide data for a 5 year view. VG confirmed that this was the first iteration of the new reporting format, and that the IPC team was actively working on enhancing the data scope. VG stated that the newly appointed data scientists within IPC Team is currently working on retrieving retrospective data, however some of the historical data is incomplete or missing, particularly from the previous Meditech Expanse System. VG stated that the data would need to be cleansed before it could be reliably used. VG committed to presenting a longer term view once the data had been validated and cleaned. VG emphasised the importance of ensuring the accuracy of the data before sharing to avoid presenting misleading data. VG agreed that having a multi-year view would help distinguish between natural seasonal variation and emerging trends, which would enhance the Trust's ability to take timely and targeted IPC actions. VG confirmed that she would relay KB request to the IPC team.

	NA acknowledged that the IPC report had been overhauled, and that the data presented is extremely clear. NA expressed his thanks to BL and VG for ongoing leadership. **Resolved:** SQAC received and **NOTED** the Infection Prevention and Control report and Annual Report
25/26/70	**Mortality Report and Annual Report** JG presented the Quarter 4 Mortality Report 2024-25 • Mortality trends had become less predictable post-COVID, with seasonal patterns no longer consistent. Despite fluctuations, the average number of deaths remains stable year-over-year • A slight increase in 2021 was attributed to changes in reporting due to the Child Death Review process • Pre-hospital issues continue to emerge as themes, with variations across cases, the Trust is in dialogue with local ambulance services to address these issues • The Medical Examiner (ME) process had been implemented, with 90 deaths scrutinised and four incidents identified this year, one in the last quarter • A total of 81 deaths were reviewed during the reporting period. Of these, Four were deemed avoidable, through all were attributable to external factors, rather than internal failings. One death remains pending due to ongoing external investigations • PICU deaths remain within the safe zone, with benchmarking showing lower-than-expected mortality rates. 68% of deaths occurred in babies for whom no further treatment options were available, indicating appropriate end-of-life care decisions • Neonatal and Learning Disability Insights - A five-year audit of neonatal deaths is underway to support future service planning. Of the 25 neonatal deaths reviewed, 76% were due to congenital or genetic anomalies, 16% due to neonatal/perinatal causes and sudden unexpected death of infant. 68% of surgical neonatal cases had no further treatment options upon assessment • Learning disability deaths had ranged from for 20%–60% of reviewed cases over the past five years. Seven cases were coded as unexplained and are undergoing post-mortem review. All had underlying conditions, and recoding will occur once Postmortem results are available • Learning and Family Engagement - Complex cases increasingly require external expert input, enhancing diagnostic clarity. There had been a noticeable increase in family engagement and feedback. Feedback from families is actively sought and used to improve processes. • A summarised feedback tool has been developed to communicate findings sensitively • Co-ordination across complaints, mortality reviews, and safeguarding is being improved • Learning Disability Reviews -The number of deaths involving patients with learning disabilities remained consistent with previous years. This consistency supports the reliability of care pathways and review mechanisms for this vulnerable group. • The mortality review process continues to yield valuable insights. Key themes include the importance of early recognition of deterioration, documentation accuracy, and multidisciplinary collaboration. These lessons are being shared across teams to drive continuous improvement. GM praised the report for its clarity and detail, noting its value for assurance purposes. GM highlighted the shift in mortality patterns from 2019 to 2025, moving away from traditional seasonal trends, and expressed interest in understanding the reasons behind this change. GM referred to how the case review process is communicated to bereaved families, particularly the potential for confusion and distress caused by multiple overlapping review processes (e.g., ME, PMRT, Child Death Review) and sought clarity whether families are given clear timelines and explanations to help them understand the complexity and uniqueness of their child's case. JG acknowledged the concern and explained that while the Trust ensures processes are clearly communicated, the ME process being a legal requirement must begin within days of death, which can be overwhelming for families. JG stated that families may be asked for feedback multiple times due to overlapping processes, which can unintentionally raise concerns. To mitigate this, the Trust limits feedback requests where possible (e.g., only one request for PMRT/CDR) and uses a summarised feedback tool, reviewed by psychology and palliative care teams, to communicate findings more sensitively. JG emphasised that delays in responding to families, especially in complex cases, can lead to perceptions of concealment, even when the delay is due to the complexity of the case rather than any intent to withhold information. NA commended JG for the thoughtful and compassionate letters sent to families, noting how well they translate clinical findings into meaningful communication. NA suggested that the Trust consider incorporating the end-of-life and bereavement experience into the broader patient experience workstream and proposed that this area be revisited over the next 12 months to explore how the Trust can further support families through these complex processes.

	FB expressed appreciation for the clarity and depth of the report and acknowledged the complexity of the mortality review process and the care taken by the team in handling sensitive cases. FB noted that while the Trust provides strong support to families, there are challenges in coordinating responses especially when multiple processes are involved. FB emphasised the importance of timely and coordinated communication with families to avoid perceptions of delay or concealment. FB agreed with NA suggestion to explore how the end-of-life and bereavement experience could be better supported and proposed that this be considered within the patient experience workstream over the next 12 months **Resolved**: SQAC received and **NOTED** the Mortality Report and Annual Report
25/26/71	**Never Event Retained Surgical Instrument Action Plan** AT presented the Never Event Retained Surgical Instrument Action Plan and provided an update against each of the actions below, there are currently 8 actions ongoing/open:- • Action 12 - Observational audits and Moodle - training in progress • Action 5 - Noise levels during safety checks is due to be completed soon • Action 7 - Coaching junior staff - progress was delayed due to staff absence, but has now resumed and is being discussed at MMS meetings • Action 12 - Moodle training module – the module is in the final stages of creation and would be launched shortly • Action 14 - Safer theatre Initiative – further updates are pending • Action 16 - Simulation training – this had been paused due to financial constraints • Action 23 - Observational Audits of Safety Huddles – the Theatre lead is working on digitalising the audit process • Action 24 – Digital Capture of Huddles – Implementation is in progress FB thanked AT for her update and welcomed a further update at the September 2025 SQAC meeting **Resolved**: SQAC received and **NOTED** Never Event Retained Surgical Instrument Action Plan
25/26/72	**Clinical Effectiveness and Outcomes Board Chairs Highlight report** JR presented the Clinical Effectiveness and Outcomes Board Chairs Highlight report **Highlights:** • Continued improvement in oversight and learning from clinical audits • High rate of audits being progressed with strong divisional engagement. • Future reports will include metrics on overdue actions and assurance of implementation and embedding of learning • Significant progress in document management compliance, especially patient information leaflets • Collaboration with the patient experience team to align with national digital standards. • Targeted support being offered to surgery, community, and mental health divisions to improve compliance • Consent Audit - A trust priority audit on consent has led to the development of a questionnaire Recognizes different documentation practices in community and mental health settings. Questionnaire to be shared with divisional leads and added to the audit plan • A successful audit masterclass was delivered in early June during Clinical Audit Awareness Week, with over 40 attendees with excellent feedback received. Due to demand, an additional session is scheduled for December 2025. • The issue with National Renal Registry audit submissions has been resolved, thanks were extended to Ian Gilbertson and his team for enabling the fix. **Resolved:** SQAC received and **NOTED** the Clinical Effectiveness and Outcomes Board Chairs Highlight report
25/26/73	**Board Assurance Framework** ES presented the Board Assurance Framework • The BAF risk related to the Children and Young People's Gender Service had been reviewed. Given the service has now been operational for 12 months and national governance arrangements are in place, it was proposed that assurance responsibilities transfer from Trust Board to SQAC. This was welcomed by SQAC • The BAF continues to monitor the access risk, particularly in light of system pressures affecting waiting times and lists. Dental and ENT services remain key areas of concern, with potential for rising delays despite previous mitigation efforts

	• The most volatile and pressing factor currently influencing safety risks is the financial environment External constraints are limiting the Trust's ability to mitigate certain risks effectively • The potential safety implications of delayed communication (e.g., clinical letters) are being considered for risk assessment, particularly in terms of patient wellbeing and continuity of care **Deep Dive on BAF Risk 1.1 (Access to Care)** NA provided a supporting deep dive on BAF Risk 1.1, highlighting: • Improvements in IV antibiotic administration, though it remains a monitored gap in control • Ongoing challenges with the CQC framework transition • Strengthened strategy for patient experience, including a new EQIA process and the launch of the Clinical Cabinet to support clinical consensus with the first Clinical Cabinet meeting scheduled to take place on 30th June 2025. • The Trust Executive Team is actively monitoring the spread of risk across services and will revisit these issues at the upcoming Board meeting on 3rd July 2025 SQAC noted the importance of maintaining close oversight of access-related risks and the broader implications of financial constraints on service delivery and patient safety. **Resolved:** SQAC received and **NOTED** the Board Assurance Framework and the Deep Dive of BAF Risk 1.1 (Access to Care)
	---- Caring ----
25/26/74	**Improve my Life Chances Report** RI introduced Mia Hankinson, Medical Student to the Committee. RI provided a comprehensive update on the 'Improve My Life Chances' programme. Key highlights included a structural refresh of the programme to align more closely with Vision 2030, establishing a wider partnership group meeting quarterly and a business meeting every other month to monitor metrics. The update also included progress on recommendations presented earlier in the year to the executive team. A significant achievement noted was the improvement in the recording of ethnicity data for children and young people. This had been recognised by NHS England Northwest, who requested a case study from Alder Hey. The Trust aims to evolve this metric into a stretch target over the next three to five years. RI emphasized the need for additional capacity to accelerate progress, suggesting the addition of a new role or support resource. RI also highlighted the importance of collaboration with external stakeholders, including Liverpool City Council and other public health teams across Cheshire and Merseyside. Efforts are underway to enhance system-wide coordination and avoid duplication of work. The committee acknowledged the progress made and expressed support for the continued development and expansion of the programme. LC commended RI for the progress made in improving the recording of ethnicity data for children and young people and highlighted the following points: Mandatory Compliance Requirement **-** LC noted that under the Parent Carer Race Equality Framework, there is a mandatory requirement for mental health trusts and providers of mental health services to achieve 100% compliance in ethnicity data recording by the end of September. LC confirmed that the Community & MH division is working towards this target and expressed support for the broader organisational efforts. Research Collaboration Opportunity – LC stated that a contact from Liverpool University is interested in conducting a research project in partnership with the Trust. She has linked this individual with relevant internal contacts and suggested that RI be involved to explore further opportunities for collaboration in this space. Service Planning and Equity - LC emphasised that accurate and complete ethnicity data is essential for effective service planning and equitable care delivery. LC stated that there should be no reason why every child's ethnicity, along with lots of other things, are not recorded appropriately, and noted that such data would significantly enhance the ability to plan services more effectively. LC acknowledged that some areas within the organisation, such as CAMHS, are already performing well in ethnicity data capture, serving as examples of best practice. RC responded positively, agreeing with LC's points and noting that while some divisions are strong performers, the organisation-wide capture of ethnicity data still has room for improvement.

	FB acknowledged the breadth and depth of the report, noting the extensive activity underway within the programme. FB highlighted the importance of the programme's alignment with population-level health strategies and expressed support for its continued development and integration with broader public health efforts. FB welcomed further evolution of the programme and its impact across the organisation and region. **Resolved** SQAC received and **NOTED** the Health Inequalities Report
25/26/75	**Children & Young People's Gender Service (Northwest) Annual Report** Dr. L Neil, Clinical Lead presented the Children & Young People's Gender Service (Northwest) Annual Report **Highlights** • Successful recruitment and retention of staff, achieving near full staffing levels to support a safe service • Timely access to care: New transfers from the national waiting list are seen within the six-week target, with flexibility for family preferences • Strong safeguarding processes embedded from the outset, addressing prior concerns from the previous provider • Positive staff experience and CPD/training plans in place • Active participation groups involving children, young people, and families to inform service development • Positive feedback and compliments received from service users. **Challenges and Priorities** • Ethnicity data capture requires improvement; plans are in place to address this • Incident reporting culture needs strengthening; current reporting is lower than comparable services • Information governance issues identified with email communication; processes have been reviewed and updated • Continued focus on safeguarding oversight and data quality • The service is working with NHS England to define national quality metrics. In the interim, the following KPIs are proposed for reporting to SQAC: - Percentage of children and young people seen within six weeks of transfer from the national waiting list. - Percentage of children and young people with written individual plans within three weeks of agreement. - Number of children open to the service aged over 18 years and 3 months. - Demographic breakdowns including autism, learning disability, and children in care (subject to anonymity). • The service has updated its Board Assurance Framework risk to reflect improved visibility and reporting to SQAC. The impact score and controls had been reviewed. The service is also part of the national provider network and contributes to national MDT processes • The Children & Young People Gender Service (Northwest) has made significant progress in its first year of operation. The service is committed to continuous improvement, robust governance, and delivering high-quality, safe, and inclusive care to children and young people. KB commended Dr. Neil for a great report and acknowledged the progress made in the services first year. KB noted that as the number of service users grows, the ability to provide more detailed KPI data would improve. KB clarified that the key risk is not just visibility of the service, but understanding and ensuring that the committee have the right information to detect concerning trends. KB requested whether additional demographic indicators could be included in future reports such as sex of children and young people, and concerns regarding abuse, sexual preference, as these were noted as areas of concern in the previous Tavistock service and should be monitored for assurance. KB suggested developing KPIs aligned with the service specification including number and duration of appointments, expected exit points in the care pathway and variance from expected service use patterns as deviations from these expectations could signal capacity or quality issues. LC acknowledged KB suggestions regarding enhanced demographic and service specification reporting as helpful and valid and emphasised that the level of data reporting requested would require significant resources and effort and advised that such detailed reporting is not currently expected of other commissioned services. LC stated that the service pathways are still being established, which adds

	complexity to implementing detailed KPIs at this stage.LC advised that the service could report on key demographic indicators such as age and gender. LC committed to reviewing how to report on additional metrics like autism, safeguarding, SEND, and children in care, while ensuring data remains non-identifiable. LC raised concerns about the public nature of committee papers and the importance of avoiding the publication of data that could potentially identify individual children and young people. LC proposed a phased approach to data development, starting with a core set of metrics in the next quarterly report (due in September), and evolving the dataset over time to build a robust and sustainable reporting framework. LC advised that the team is working with national metrics being developed by NHSE, which would guide future reporting. LC noted that the Board Assurance Framework (BAF) risk originally framed as a "visibility" issue would be reworded to better reflect the need for assurance on quality and performance. An updated version would be brought to the next SQAC and Audit & Risk Committee. **Resolved**: SQAC received and **NOTED** the Children & Young People's Gender Service (Northwest) Annual Report
---- Effective ----	
25/26/76	**M19 – Animal & Pet Therapy Policy** **Resolved**: SQAC received, **NOTED** and Ratified the M19 – Animal & Pet Therapy Policy
25/26/77	**Guidance for staff exposures to Infectious Diseases in the Community** **Resolved:** SQAC received, **NOTED** and Ratified the Guidance for staff exposures to Infectious Diseases in the community
25/26/78	**Paediatric Capillary and Venous Blood Sampling Clinical Guideline** **Resolved:** SQAC received, **NOTED** and Ratified the Paediatric Capillary and Venous Blood Sampling Clinical Guideline
25/26/79	**C25 Hospital Visiting Policy** **Resolved:** SQAC received, **NOTED** and Ratified C25 Hospital Visiting Policy
25/26/80	**On Site Charity Partner Guidance** **Resolved:** SQAC received, NOTED and Ratified the On Site Charity Guidance
---- Well Led ----	
---- Any Other Business ----	
25/26/81	None Received
---- Board Assurance ----	
25/26/82	The key assurances and highlights report was presented to the Board meeting held on 1st May 2025.
Date and Time of Next Meeting: 23rd July 2025 at 9.30 – 11.30 am via Microsoft teams	

Liverpool Neonatal Partnership

Alder Hey Children's NHS Foundation Trust

LIVERPOOL NEONATAL PARTNERSHIP BOARD

18th August 2025

Paper title:	**Chairs report to LNP for onward reporting to Trust Board**
Report of:	**Co-Chairs of the LNP, Alfie Bass and Chris Dewhurst**
Paper prepared by:	Natalie Rixon, Project Manager AHCH and Vicky Clarke, Associate Director of Operations, LWH

Purpose of paper:	Decision / Assurance / **Information** / Regulation
Action / decision required:	**Note** / Approve

1. Purpose

This paper provides a summary of the key activities undertaken by the Liverpool Neonatal Partnership (LNP), a collaborative partnership between Alder Hey Children's NHS Foundation Trust (AHCH) and Liverpool Women's NHS Foundation Trust (LWH), in preparation of the opening of the new surgical NICU in March 2026.

2. Overview of partnership & activities in month

Programme overview

There are several items to highlight including:

- The LNP Clinical Director post has been appointed to, with a robust interim arrangement in place to maximise the skills and expertise required through the transformation phase.
- The LNP have successfully appointed a neonatal speech and language therapist. This post has been vacant for some time and therefore this is a fantastic enhancement for the partnership.
- The LNP governance review is advancing with experts from Corporate Governance and NHS England / ODN supporting the LNP board with the development of an operational policy and governance framework.
- The Head of Medical Engineering and the Chief Finance Officers are working with the Head of Nursing to agree an equipment loan plan, this will provide operational flexibility and delivery of equipment requirements in line with the agreed budget.
- The build programme continues to progress, but a number of potential issues and delays are being worked through by the capital projects leads and the contractors.

- The Chief Pharmacists and Chief Medical Officers have agreed that a memorandum of understanding will be developed to provide clarity on the accountability for management and supply of medicines
- The water safe workflows are progressing well, with a multidisciplinary approach adopted. The team are working closely with the national experts to develop the water safe workflows and supporting documentation.
- The LNP business case aligned to the national specification for AHP&P, Pharmacy and Diagnostic services, will be discussed at an executive subgroup of the board in mid-September, the aim being to review and agree next steps to progress the case with specialist commissioners.
- The integrated performance report continues to develop and will form part of the chair's summary report from October
- The LNP continues to make good progress to recruit to all agreed and funded posts across all disciplines.
- The Chief Nurses and Head of Nursing has agreed a standardised uniform, aligned to the national recommendations for uniform, across both units
- The simulation programme continues to run each week, with additional equipment added regularly to support the education plan
- There is a robust training and competency framework schedule in place that is reviewed on a monthly basis and remains 'on track'
- The Maternity and Neonatal Voices Partnership for a neonatal specific role is out to advert, with a view to appoint by end September.

LNP Partnership working

The corporate governance leads from AHCH and LWH, supported by a national expert in neonatal service delivery are working together to provide recommendations on key areas that will help strengthen the governance arrangements within the partnership. A detailed review of the working arrangements, legal framework and existing structures is underway with recommendations and the timeframe for implementation, to the Exec-to-Exec meeting in September.

Collaborative working, safety and culture

Meetings with surgical divisional leads to review pathways

The LNP clinical leads are engaging with all speciality teams within AHCH to ensure the pathways are clear for when the new unit opens. The leads also meeting with the response teams, patient flow and complex discharge to provide a seamless transition, once the surgical NICU is operational.

The LNP Clinical Directors will meet to establish the surgical neonates clinical reference group which will provide a forum for communication and engagement as well as a place to review and refine pathways as part of the long-term governance arrangements. The first meeting will take place in October/November.

Collaborative working, safety and culture

The Chief Medical Officers met with Organisational Development lead and members of the SLT and have agreed the requirements for the culture workstream. A summary of the delivery plan and trajectory will now be updated and shared at the next board meeting.

Build

The SLT continue to meet with the Senior Capital Project Manager on a fortnightly basis to help provide timely input and direction to the new build. The build timescales are reviewed regularly and quick action can be taken through the effective communication channels developed. The current build timeframe has increased by 8 weeks indicating that the first babies will transfer to the Surgical NICU in March 2026, but it is important to note that final date of completion is still to be formally agreed.

The Senior Capital Projects Manager will provide a detailed appraisal of the build schedule which will include the legal position, risks, issues and delays, potential impact to timescales and the mitigations being worked through, in preparation for the October board meeting.

Digital strategy

The LNP board have requested a digital strategy be developed to ensure all of the complex and detailed delivery requirements have been captured alongside any associated risk. The senior responsible officer for digital has highlighted a number of emerging risks with interconnectivity between Mindray and System C, as well as the implementation of HERO at AHCH.

Ready to occupy

The SLT in partnership with the Deputy Development Director, Senior Capital Project manager and acute ground floor team, have now established a group that will focus on the actions required to occupy the unit safely. A ready to occupy checklist is under development engaging all key stakeholders in the design.

In addition, a tactical response team will be deployed throughout the moving and settling in period to respond immediately to any concerns raised.

The SLT have identified a number of ‘in situ’ simulations that are to take place in advance of the unit opening, these include evacuation of the unit, medical emergency for a parent, medical emergency for a baby with the family room occupied.

Finance and Commissioning

There are three important pieces of work that the operational and finance leads are working through:

1. The LNP business case to ensure the team can deliver the agreed standards within the national specification

2. A capacity and demand review of the cots remaining at LWH
3. A review of the HDU/PICU capacity once the surgical NICU is operational

These items will be worked through and shared with specialist commissioners and commissioners from the Welsh Board.

Key risks / issues to escalate to LNP

- The risk associated with the build timescales is being carefully managed by the senior capital projects lead and all key stakeholders will respond as required, to help mitigate any further delays that may be identified.
- The LNP Governance recommendations will be presented to the Exec to Exec meeting in September to provide clear recommendations for the future governance arrangements.
- The need to fund the pay and non-pay requirements identified in the LNP business case, specifically AHP&P, Pharmacy, Diagnostics and Medical Engineering, has been identified as a risk due to the current financial climate and the availability of funds for investment. These posts are considered essential to deliver against the nationally approved service specification and are in addition to the original business case approved in 2018.

3. Recommendations

The LNP Board are asked to:

- Note the content of the report and key updates

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Wellbeing Guardian: Dashboard**
Report of:	**Wellbeing Guardian**
Paper Prepared by:	Jo Revill, Jeanette Chamberlain, Jo Potier and Sarah Robertson

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Paper presented to the Board
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None

1. Introduction

This paper is an update to the Board by the Wellbeing Guardian on the current progress of the Wellbeing Guardian Nine Principles with the action plan attached to this paper.

2. Background

The Wellbeing Guardian (WBG) is a Non-Executive Director who:

There are nine Board principles supported by the WBG and the recommended approach to implementation is:

Phase 1: Health and wellbeing has limited coverage at board level

- Undertake NHS Health and Wellbeing Diagnostic to assess current health and wellbeing performance and identify priority activities (Principle 1)
- Identify a wellbeing guardian
- Agree the priority actions to be included in the wellbeing guardian role description and how the nine principles will be phased in

Phase 2: Principles of wellbeing guardian role are largely embedded

- Wellbeing guardian role is established and functioning well within the board.
- Most of the nine principles are routinely evidenced at board meetings, including reference to supporting equality and inclusion in the workplace.
- A holistic health and wellbeing strategy is in place (either standalone or as part of a wider people strategy) and being delivered.
- Staff experience measures indicate a compassionate culture is in place or being created.

Phase 3: Health and wellbeing is routinely considered and included in board activity

- All board members routinely consider the holistic health and wellbeing of our NHS people in their strategic and operational plans and performance reporting
- The board regularly hears feedback, including in the form of staff stories
- All nine principles are being delivered
- The NHS Health and Wellbeing Diagnostic Tool dashboard is green

Alder Hey's appointed WBG, Jo Revill, is working with SALS, Organisational Development and HR to advance and oversee the implementation of the nine Board principles. The Board was previously advised that the NHS Health & Wellbeing Diagnostic had been completed for Alder Hey, and the Board formally approved the priority actions and the move to Phase 2 of implementation.

The Wellbeing Steering Group created a Dashboard to summarise the action plan for the nine principles supported by the WBG, which was first presented to the Board at its meeting on 29th September 2022. The updated version of the Dashboard was presented in September 2024, demonstrating significant progress that has been made to implement the nine principles of the Wellbeing Guardian. Attached is the most recent Dashboard demonstrating further progress demonstrating that we consider we have moved into Phase 3, with the aim of approving the

implementation of the nine principles of the Wellbeing Guardian. The People Committee will continue to monitor the Dashboard and action plan.

Attached to this summary is the current action plan and next steps that the team are currently working on.

The Board is therefore asked to:

(i) Note the actions and
(ii) Approve the current action plan and comment where required.

Health & Wellbeing Strategic Group

	Wellbeing Principle Description	Initiatives currently in Place	RAG	Progress	Next Steps	Lead(s)
Principle One	The health and wellbeing of our NHS people and those learning and working in the NHS should not be compromised by the work they do for the NHS.	Development of SALS Pals Network, and review of sustainability completed. Strengthening me session offered to teams to support awareness of mental health. Spotlight focus on 'Community' for Mental Health Awareness Month in May. Live psychoeducation session offered for men's mental health. Attending Trust briefings. 7 minute briefings shared. Revised and reviewed intranet. Included details on support after a traumatic incident and updated with new Occupational Health Provided.		SALS Pals signed off by Board and rolled out further. SALS Pals Sustainability Service Evaluation Completed. New SALS Pals recruited and trained. Resources updated and shared widely on the Trust intranet.	Staff Advice and Liaison Service to continue to build partnerships across the Trust in development of new People Hub. Development of Masterclass for trauma-informed welfare support for staff which will be offered to trauma saturated areas. Development of Alder Active Health and Wellbeing Coaching. Ongoing development and training of embedding more SALS Pals across the organisation continues.	**SALS**
Principle Two	Where there has been a particularly distressing event the Board creates space to discuss this event, it's impact and the actions that have been put in place to offer support within the organisation as a whole. Where an individual or team is exposed to a particularly distressing clinical event, there are well established governance structures within the organisation that will offer learning and support to teams in order to help them at difficult times. If required board time can be made available to assure the board and the Wellbeing Guardian that the wellbeing impact on those NHS staff and learners has been enacted upon and is ongonig for as long as required.	Debriefing SOP developed and shared. Debriefing after traumatic clinical incidents. Reflective practice spaces being offered to teams that request it. Major incident response plan has now been developed and enacted. The Trust has embedded clinical governance structures which enable divisions and divisional leads to support with any distressing events and the impacts of those events. There is opportunity for Trust Governance Leads and/or Divisional Directors to bring incidents to the attention of the Board should they be required.		Jo Potier is part of the Patient Safety Board to help drive and inform how we support staff through distressing clinical events. Jo Potier embedded in new role as Director of Culture offfering Psychological Input to Patient Safety Team as part of PSURF. Good links and visible Freedom to speak up Guardian who also is approachable in terms of supporting staff through difficult incidents. Support offered in relation to the Southport Incident and 'One Year Since' which included a coordinated response across the Trust with Clinical Health Psychology, Spiritual Care, and the Alder Centre. Two Trust Wide Reflective Spaces were offered focused on 'Traumatic Loss'.	**Complete**	**SALS/Jo Revill**
Principle Three	Regular assurance will be provided to the wellbeing guardian to ensure that wellness induction (previously wellbeing 'check-in') are being provided to all new NHS people on appointment and to all learners on placement in the NHS, as outlined in the 2019 NHS Staff and Learners' Mental Wellbeing Review's recommendations.	Physical health and workstream progressing. Menopause Support group.		Health and Wellbeing Conversation for New Starters has been devised, and developed. This forms part of the new induction policy which has now been ratified at PAWC. We have also developed a Health and Wellbeing Conversation around Menopause which is part of the menopause policy & the PDR paperwork has a Health and Wellbeing conversation Attached.	**Complete.**	**Jeanette Chamberlain/Darren Shaw**
PrPrinciple Four	The wellbeing guardian will receive assurance that all our NHS people and those learning in the NHS have ready access to a self-referral, proactive and confidential occupational health service that promotes and protects wellbeing.	Staff can be referred to Occupational Health by their Line Managers and also make a self referral		New Occupational Health contract signed. Working collaboratively with HR and SALS.	**Completed**	**Occuapational Health/HR**
Principle Five	The death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.e death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.	Reviewed NHS Employers postvention guidance and toolkit shared within SALS and HR.		Agreement has been made to use the National Toolkit locally at Alder Hey. Dr Jo Potier and Sharon Owen are agreed leads. Dr Sarah Robertson leads on psychoeducation on suicide awareness day on the 10th September annually.	**Complete.**	**Jo Potier/Sarah Robertson**

	Wellbeing Principle Description	Initiatives currently in Place	RAG	Progress	Next Steps	Lead(s)
Principle Six	The NHS will ensure a supportive, safe environment to promote psychological and physical wellbeing	Health and Wellbeing Forum brings together all staff involved in Staff Support across the Trust to collaborate and share ideas. Forum also includes leaders from the Trust enabling initiatives to be shared aross the Organisation. Staff networks well established and promoted within the Trust. SALS available for staff to access for emotional support, also supported by a network of SALS Pals. Collaboration between OD/SALS and Clinical Health Pyschology to develop a debriefing SOP which is now used in terms of suporting any teams who need additional support following distressing or traumatic events. Patient Safety Board established to ensure staff are supported through difficult incidents and events that may occur.		Established wellbeing forum which is well attended within the Trust, which has developed a staff support handbook to support staff (Supporting our People Toolkit) to enable accessing the right support at the right time. Staff are able to access a range of support including SALS. Debriefing SOP implemented and teams are able to request and access support when required. The Health and Wellbeing forum have now established regular wellbeing days in the Trust and fitness classes which are receiving positive feedback from staff. Patient Safety Board is now established and staff safety considered as part of this. SALS Pals invited and in attendance.	**Ongoing**	**Wellbeing forum which all staff involved in staff suport and wellbeing attend.**
Principle Seven	The NHS will ensure that the cultural and spiritual needs of our NHS people and those learning in the NHS are protected, and equitable and appropriate wellbeing support for overseas NHS people and learners working in the NHS.	EDI lead in post and overseeing several of the staff networks which all look at promoting the spiritual and the cultural needs of our organisation.		Evidence can be collated, reviewed and enacted, via staff survey, EDI, WRES data. Staff networks are now established. Strong Foundations focuses on cultural and spiritual needs of the organisation. Partnership working between all areas of staff support across the organisation, including networks, chaplaincy, EDI lead, SALS, OD, HR to ensure inclusivity.	***EDI lead now in place and making good progress in establishing networks as well as a EQI Board of which Jo Potier attends.***	***EDI/SALS/OD***
Principle Eightr	The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010 (including consideration for how intersectionality may impact wellbeing).	EDI lead to input. REACH network developed and set up. Reasonable Adjustments Policy developed.		Staff Networks developed.	**EDI lead now in place and making good progress in establishing networks as well as a EQI Board**	**(EDI lead/HR/SALS)**
Principle Nine	The wellbeing guardian will provide suitable challenge to the board to be assured that the organisation is working with system leaders and regulators, to ensure that wellbeing is given the same weight as other aspects in organisational performance assessment.red that the organisation is working with system leaders and regulators, to ensure that wellbeing is given the same weight as other aspects in organisational performance assessment.	Jo Revill is involved in multiple conversation at Board and the Strategy Board to ensure the wellbeing of staff is given the same weight as other aspects. Wellbeing is firmly enshrined in the work to launch new human-centric values. Discussions about wellbeing are embedded in decisions around workforce efficiencies, and in the cultural sustainability work which forms part of BAF. The Thriving Staff index and other initiatives come through the People Committee and there's been a strong theme around supporting morale across the divisions. It's also now a key theme in our internal communications plans, where Jo Revill works with the comms team closely, and then reflects into Board.		Good progress, conversations flowing through to Board level.	**Ongoing**	**Jo Revill to report**

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Thriving Culture Programme: Overview & Progress Report**
Report of:	Chief People Officer
Paper Prepared by:	Jo Potier, Director of Culture & OD
Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	To present to the Board an overview of the Thriving Culture programme including progress and areas for development
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
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	12

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

Thriving Culture Programme:
Overview and Progress Report

Culture in healthcare

At Alder Hey, we are driven by a single, powerful mission: to create a happier, healthier, and fairer future for children and young people and a happier, healthier, fairer working community where everyone belongs, and everyone thrives. Exceptional care begins with exceptional people and Alder Hey thrives when we provide needs-led, exceptional experiences for all.

Our culture – the way we do things – is in our hands. The way we behave and the values we uphold every day, in every interaction, shape our experience of work and each other and shape the experience of being cared for by us. The evidence about the importance of culture in healthcare is clear. Whilst a good culture will not guarantee that we always succeed in our mission - healthcare is a technically and emotionally complex endeavour in a complex and ever-changing world - a bad culture will almost guarantee our failure.

And a culture where we can all thrive can only happen if we all feel safe. Safety (patient and staff) is at the heart of a culture where everybody thrives, and safety culture has been a recurring theme in every major NHS inquiry. Since the first major NHS scandal, involving abuse of patients at Ely Hospital in Cardiff, was reported in 1969 there have been over 100 formal inquiries and investigations into health and care services.

The 2015 Department of Health publication on “Culture change in the NHS: applying the lessons of the Francis Inquiries” laid out a framework for improvement organised around four themes: preventing problems, detecting problems quickly, taking action quickly and ensuring robust accountability, and ensuring staff are trained and motivated.

Preventing problems means creating the right workplace conditions to enable people to function and perform well and thrive which includes having the right resources, compassionate and effective leadership, value congruency at all levels, providing multiple and effective sources of intelligence, effective and restorative people processes, networks of compassion and belonging, learning and development, and robust systems of decision making and accountability.

All the above help to develop a “problem-sensing” culture (Dixon-Woods, 2023) so that when problems arise, we can detect them quickly and determine which of the many signals being sent through the organisation need action. This means that we need systems that enable hard and soft signals to be heard and understood so that action can be taken quickly and effectively.

Thriving at Alder Hey

Though we have made huge strides at Alder Hey over the past 10 years to build and sustain a better culture, we cannot rely on our history and need to continue to find ways to be informed about our culture, adapt where we need to, learn from and encourage excellence, and maintain a level of worry that keeps us all alert to the fact that things will and do go wrong whilst also having courage and confidence to learn and make repair when they do. We need to intentionally nurture a positive culture and make collective efforts to build a safe and thriving culture of care.

A safe and thriving culture of care is how we can deliver on the promises that we have made to children and young people (outlined below) and achieve our mission to create a happier, healthier, and fairer future for children and young people and a happier, healthier, fairer working community where everyone belongs, and everyone thrives.

Our evidence based Thriving culture programme is built on the things that we have heard, year on year, about working here and the things that we have identified as being important in achieving our mission. It is the recipe for thriving as individuals, teams and as an organisation and is critical to the development of a positive and adaptive safety culture for all.

It comprises work focussed on individual, team, leader and organisation levels that is values-based and empowering. It is data informed with a focus on data being built in not bolt on, locally owned, and using both “hard” and “soft” intelligence. By being “problem-sensing”, it enables early intervention and prevention where things are going wrong and learning from excellence where they are going well. It rests on effective and genuine connection at all levels (maximising trust) as the foundation for effective communication.

Connection & Communication

Running through the Thriving culture programme is the critical importance of our connections with each other at Alder Hey. Strong connections help to build a climate of trust which is the foundation for effective communication and for all the other elements of a healthy, adaptive and proactive culture.

The current operational and financial challenges have meant that our connections have suffered. These challenges have been unsettling at best and anxiety-provoking at worst and have had a detrimental impact on morale. At the same time, the continuing evolution of the organisation towards Vision 2030 is bringing wider changes relating to organisational design and culture, transformation and change, and digital innovation, all set against the backdrop of a new set of values.

When our connections suffer, our communication suffers. A renewed focus on the connections between our senior leaders and the organisation is now a priority. Focussing on connection will help to secure trust which will in turn help with communication.

Connected Leadership is an approach that is focussed on strategically building and strengthening connections and trust between the executive and senior leadership team and the organisation by increasing and aligning engagement, visibility and communications in a way that demonstrates consistency of purpose, clarity of story and intent, and aligns with and reinforces the new values.

Connected Leadership as an overarching approach aims to:

- Build and strengthen genuine connections with teams and the organisation

- Develop trust through meaningful engagement and two-way visibility
- Increase opportunities and spaces for listening, dialogue and transparency in communication and reinforcement of key messages
- Reduce misunderstanding, “noise”, and division
- Increase psychological safety and belonging
- Open conversations which show the alignment between the executive and senior leadership role, their values, their vision, and the work being done
- Show the new values in action
- Role model and develop connected leadership for all leaders in the organisation

A proposal was taken for discussion at the executive team meeting on the 7th of August to develop a Connected Leadership approach which: reframes executive visibility as executive connection; which connects all the current executive engagement methods and initiatives together, bringing rigour and consistency; and which also incorporates new initiatives and approaches.

The proposal is for a new rhythm and focus of connection and communication which complements the work underway in the communications team on developing our key messages in the context of a broader internal communications strategy[1]. Below are the proposed changes with a monthly outline in Appendix 1:

Exec Briefing/Connecting Leaders
A new rhythm of communications to include opportunities for briefing (Ask the Execs to become Exec Briefing/Connecting Leaders which is mandated for all leaders and managers) followed by opportunities for dialogue. Ask the Execs then becomes a Connecting Alder Hey session which provides space for dialogue with the aim of increasing clarity and reducing misunderstanding. Key to this new approach is ensuring that key messages are communication and cascaded with support offered through the leader sessions to develop their own communication and connection skills.

Team Connect/Ask for an Exec
Team Exec & NED Connect/” Ask for an Exec” programme to be developed where teams can request exec (with option of NED) connection in the form of a conversation with a clear purpose and process. Teams and execs/NEDs would be given guidance on the purpose of the conversation (what it is and what it is not) and offered questions and suggestions to prompt their thinking in advance of the conversation. Questions could include:

How much do you know of the key things happening now in this organisation?
What are we not talking about that you think we should be talking about?
What would you like more clarity/information about?
What do you want to highlight as a team (strengths and challenges)
What could we (execs) start doing or stop doing that would make it better to work with us?

The sessions would provide an opportunity to clarify key messages and dispel myths that may be causing anxiety, enable two-way visibility and build psychological safety through open discussion and feedback. The sessions would also crucially help to inform the wider communications strategy so that it could be more responsive to need and tuned in to what is happening on the ground.

[1] See *Transformation: Change Communications Strategy*

Sessions would be promoted and coordinated by SALS & Comms together with the possibility for each session attended by a member of the SALS team and a member of the Comms team. SALS would use their strong existing networks of relationships to promote the sessions, be present during the conversations to help to build a compassionate atmosphere based on active listening and ensure that any actions and learning are taken up. Comms would be there to bring their expertise to the sessions and gather feedback to inform ongoing communications around key issues.

Evaluation and monitoring will be embedded into the process from the beginning, with teams and team leaders asked for standardised post-event feedback on the event efficacy and impact. Subsequent feedback will be collated from the teams, in addition to close recording of ad hoc and anecdotal responses.

New Leader/New Starter Connect
CEO/Chair/Exec team first 100 days check ins with new leaders and/or new starters.

Values & behaviours

Our culture is built on attracting, nurturing, and empowering individuals who embody and uphold our values. Our values (what matters to us) and behaviours (how we show what matters to us) define who we are and what we stand for. They set clear expectations, shaping every decision, action, and interaction.

The new values were agreed at Trust Board in April 2025 and a corresponding set of high-level definitions has been developed since then in consultation with stakeholder members of a new values working group.

Critical to the successful implementation of the new values is a sustained focus on living our values with a stronger emphasis on *showing* rather than *telling.* Since the new values were agreed in April, they have been previewed, received with enthusiasm, and are already becoming embedded across the transformation agenda, notably in the Organisational Design collaborative where they have informed a new set of values-led design principles. They have been frequently referenced in executive meetings and have also formed the basis for the ground rules of the newly established Clinical Cabinet. They are also informing the approach to the communications with staff regarding the financial challenges and actions.

The executive team are amongst the range of early and enthusiastic sponsors who are putting the values into action through their own communications and interactions. Our communications team are also putting the values into action and have created new values

based judging criteria for the forthcoming Staff Awards. The new values have also been presented to the Governors who have received them with interest and enthusiasm which has led to increased involvement in the values working group.

Working towards a formal launch date of the 19th of September 2025, to coincide with the annual Staff Awards event, a values working group has been established to further develop the values and embed them across the organisation. The group comprises representatives from: Organisational Development, Staff side, FTSU, ED&I, Communications, SALS, Learning & Development, HR, Facilities, Transformation, Nursing Retention. The working group meets once every two weeks and has the role of steering group, values champions, critical friends, role models and sponsors. The Charity are now also on board and are kindly supporting the design of the new values and production of new lanyards for all staff.

Aside from the general engagement activities noted above, the values working group has two current main areas of focus: Communications & Values in Action. Work is progressing well in both areas and there has been rich engagement in the Values conversations being held across the organisation. Groups engaged with include our staff networks, Ward Manager's meetings, Children and Young People's forum, Radiology Wellbeing Group, and community teams. The team are also responding to invites from other teams and areas to attend their meetings as required. A smaller subgroup of Values Messengers is also being developed to include our SALS Pals and volunteers who can also talk to staff and help to gather more feedback. Data gathered through these conversations will inform the development of a values in action framework and toolkit which will enable teams, leaders and all staff to bring the values to life and provide support around Values based behaviours.

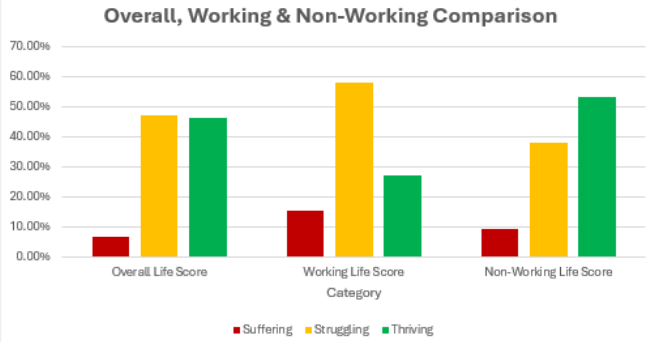
Staff experience & empowerment

Staff experience and empowerment is critical to a healthy working culture and includes staff engagement & morale, belonging, wellbeing, and speaking up. Currently we have a number of different methods for understanding staff experience and empowerment which include: the NHS Staff Survey (annual), People Pulse (quarterly), the newly developed Thriving Staff Index (TSI), SALS data, FTSU data and the many avenues of "soft" intelligence which come through everyday formal and informal interactions and the other networks of noticing that exist across the Trust (including staff networks, SALS Pals, FTSU champions).

The newly developed Thriving Staff Index will become an important source of information about staff wellbeing and will provide insight into how our people are at work and in their personal lives and their level of hope for the future. On the first day of the launch of the Index, there were 119 responses, with 7% saying that they were suffering, 47% struggling, and 46% thriving. When looking at the differences between working and non-working lives, the results were as follows, showing a higher percentage of people struggling at work than at home.

Overall, Working & Non-Working category comparison- %

Category	Suffering	Struggling	Thriving
Overall Life Score	6.72%	47.06%	46.22%
Working Life Score	15.13%	57.98%	26.89%
on-Working Life Score	9.24%	37.82%	52.94%



The range of data relating to staff experience and empowerment is not currently connected in one place. SALS data is considered in the context of organisational health and wellbeing and reported to People Committee, FTSU data is reported separately to Board, Staff Survey and People Pulse data are reported separately to People Committee. These data sources and networks of noticing are all valuable sources of intelligence that are able to show themes, trends and areas of concern. Bringing this data together in one place via this report quarterly will provide a clearer picture of staff experience and empowerment across the organisation, illustrating how the information is routinely used "on the ground" by SALS and others to detect problems quickly and intervene effectively.

Safety culture

A feature of a healthy culture is one that actively seeks out weaknesses in systems and behaviours relating to quality and safety, using multiple techniques and sources of organisational intelligence, and attentive to staff and patient voice (Dixon-Wood, 2023). This is the group of behaviours characterised by "problem-sensing". At the same time, we need to improve how we understand and develop positive safety cultures, both for patients and for staff.

Working in partnership with the Patient Safety Lead and Director of People Services, work is underway in developing a more robust and adaptive safety culture in relation to staff safety and patient safety, and in understanding and developing the links between the two. The shift to a focus on restorative, just and learning processes and practices, central to the new Patient Safety strategy and PSIRF, has brought opportunities to review patient safety and people practices within the lens of avoidable harm and ensure that there are more systematic approaches to debriefing and learning, checking wellbeing and enabling repair where harm occurs.

A new Safety Culture training will support teams to both understand, review and improve the culture in their team. This will be supplemented with safety culture data which will be central to the developing Thriving Teams Index (see below), and which will empower leaders by

giving them the tools and support to prevent problems and detect them early when they arise. This work is being led by the Patient Safety Lead and Director of Culture & OD and reports into the Patient Safety Strategy Board.

Thriving teams

Our team is the reality of our experience at work and there is an abundance of evidence about the link between being in a "real" team (Michael West), high performance, clinical impact and staff wellbeing. A real team is one where there are clearly defined roles and responsibilities, with structures and practices that increase psychological safety and trust and minimise uncertainty and distress.

Understanding which teams are functioning well and which are struggling is critical in developing a healthy and adaptive (safety) culture. Currently, we have data from the Staff Survey once a year which gives us an insight into how some teams are functioning, but this is only available for those teams with more than 11 members and those where there have been sufficiently high response rates. This data helps leaders to understand their team and take action where needed to address areas of concern, with or without support from the corporate services who have expertise in this work. However, this data is not available for all teams and is also not connected to other sources of data (such as HR data or patient safety data) which helps to give a fuller picture of team functioning and impact.

The well-established Thriving Teams MDT, chaired by the Director of Culture & OD, provides an essential forum for sharing "soft" intelligence about teams between those services whose role it is to provide support, including OD, HR, Learning & Development, FTSU, Retention leads, Brilliant Basics. This not only helps to build more a full picture of a team but also helps to highlight and escalate areas of concern and ensure that any planned interventions are coordinated, well sequenced and more effective.

An area of priority development now is a Thriving Teams Index. This will be a new measure for Alder Hey that builds on the already existing Working Safe & Well Team Temperature Check used in OD which includes 9 safety culture questions from the Staff Survey along with questions relating to all 7 of the NHS People Promises. Currently, the tool is administered by the OD team and accessed via QR code. Data is then analysed and a report produced (see Appendix 2) which outlines areas of strength and areas of concern.

We are now working alongside the Patient Safety team and the iDigital team to refine and further develop this tool into a Thriving Teams Index which will provide a team-based measure of staff experience and empowerment, safety culture, teamwork and leadership along with relevant HR and patient safety data. The Index will include a range of self-report questions and data from other sources including:

- 9 safety culture questions from the Staff Survey
- People Promise key questions from the Staff Survey (covering teamwork, learning, leadership, compassion and psychological safety, inclusion and belonging)
- Incidents of harm reported
- Patient Safety training rates
- FTSU referrals
- Turnover/stability
- Sickness
- Thriving Staff Index

The Thriving Teams Index will be developed in a way that it can be locally administered and owned but centrally visible to the OD and Patient Safety teams (and others as needed). A guide and toolkit will be developed to help leaders to make sense of their data and take action to improve the culture in their team and/or access support. The proposal is for all teams to administer the tool in March every year with all small teams completing the tool a second time in September when the Staff Survey fieldwork is active for larger teams. Further discussions will take place as part of the development work to agree how the division and organisation level data from the Thriving Teams Index will be shared and reported. Standard-setting, monitoring and mechanisms for modification where there are concerns identified will be crucial to the role of the Thriving Teams Index in improving culture.

The Thriving Teams Index will, over time, help to identify areas of strength and concern and those teams that may be showing deterioration or improvement over time. By demonstrating curiosity about this data at a team and organisation level, we can ensure that appropriate methods are used to determine the factors contributing to the situation so that appropriate actions can be taken to improve. The Thriving Teams Index will also identify teams where leaders may be struggling, or leadership is problematic and so will offer the opportunity for support teams to reach out and support before problems worsen.

Thriving Leaders

Leaders are both the architects and the carriers of culture. Significant work has been done since 2019 to improve how our leaders and managers are developed and supported, and the benefit of this work is evidenced by the improving results year on year for compassionate and inclusive leadership in the Staff Survey.

Our current Thriving Leaders programme of work includes:

- Strong Foundations
- Management Essentials
- Clinical Leadership (role design and development)
- Leadership Induction
- BAME Aspiring Leaders Programme
- Operational Leader Programme
- Consultant Induction
- Leadership Faculty AND
- The newly developing Connected Leadership programme

As we develop our leadership offer further, we are ensuring that we remain connected to the national programme of work which is still in development following the Messenger (2022) and Kark (2019) Reviews. The key commitments nationally are:

- Roll out of NHS leadership competency framework for board members (Autumn 2024)
- NHS England will introduce a new Management and Leadership Framework (by Summer 2025 – now delayed) that will comprise:
    - a code of practice to set out the values and behaviours expected of all leaders and managers in the NHS and social care
    - the professional standards that leaders and managers must demonstrate

    - the competencies which underpin the standards and outline the specific skills, knowledge and abilities individuals need to perform effectively at each level
- Following the above, NHS England will develop:
    - A new accredited leadership and management development curriculum which will describe the requirements for delivering high quality training and development.
    - Refreshed leadership development programmes which update current Leadership Academy programmes against the new standards.

In preparation for the above, and in consultation with the North West Leadership Academy, we are ensuring that our internal programmes cover the same competencies that are outlined as part of the national programme. Our developing Thriving Teams Index will include questions about leadership which will help us to gain a clearer picture of leadership impact and functioning across the organisation.

APPENDIX 1: Connected Leadership programme outline

Month 1

Week 1

Using key messages determined in **Key Messages Meeting** from previous month end (see below) we develop and send out a **One Page Brief** to **all staff** via email.

Brief contains three key messages we need the organisation to hear, understand and action this month, using the three-horizon model, and focussing on timely action-based information.

Week 2

Execs, Leaders and Managers session – '**Connecting Leaders'** – one-hour long Teams meeting. Mandatory attendance, with designated deputies indicated, and compliance tracked and followed up.

Managers and leaders invited to discuss and question the Key Messages and actions list, to raise issues and get help as needed.

Execs to use 'show and tell' model, giving managers/leaders active support to help deliver against messages.

'Make it make sense', placing decisions and actions into strategic context.

'Toolkit' given to attendees afterwards, containing key messages again, advice and guidance as raised in session, further – but carefully limited – information, figures, data that support them to understand, cascade and act.

Managers/leaders challenged to cascade quickly, effectively and against plan. Cascade will be tested in **Connecting Alder Hey** event in week 3, through surveys and spot checks, and through other Exec 'Connected Leadership' activities.

Commitment from all attendees to '**make a connection'** following the meeting – reaching out to a colleague they don't know, or colleague who expressed interest/need for support in relation to their area, putting time and space in to meet, talk and learn. Execs to lead this action and model behaviour.

Week 3

All hands Q&A session **'Connecting Alder Hey'** – 30mins on Teams, dedicated to key messages and answering questions from colleagues. Conversational style supported and/or facilitated to keep informality and flow effective.

Two-way dialogue – test and understand, Execs to ask, "do you know what's going on", "have you heard the key messages", "how does it work for you/your team" etc.

Week 4

Key Messages Meeting – all execs, chaired by John, joined by SALS/OD, Comms, DMO, other leads as needed. One hour in person session, reviewing in-month actions and deciding next month key messages.

Ongoing

Other listed Exec Connected Leadership activities as per wider plan to take place throughout month, both planned and ad hoc. '**Team Connect' –** or 'ask for an exec' programme always on, with teams requesting exec presence in a facilitated session, in person preferred, throughout organisation and services. Commit to changing behaviour and support informal leadership, such as unannounced visits, joining team/Team meetings, eating lunch in cafeteria/with teams, 'make a connection' meetings, etc.

Evaluation and Monitoring

Overall, the schedule will be monitored against the number of events that take place, attendance at each relevant session and Exec colleague individual feedback/input into the programme.

Throughout all activities one key question to be repeated in every forum – "how connected do you feel now/how connected did this [event, meeting, message] make you feel?".

Each Connected Leadership action will have its own evaluation and monitoring package:

- One Page Brief – simple email opening metrics (where able), key message testing throughout all other actions ("have you heard the key messages this month?" etc.)
- Connecting Leaders – attendance monitoring, post event survey, ad hoc feedback
- Connecting Alder Hey – attendance monitoring, post event survey, ad hoc feedback

APPENDIX 2: SAMPLE TEAM TEMPERATURE CHECK

TEAM TEMPERATURE CHECK – MARCH 2024

Average total score: 3.45

SUMMARY

X number of staff members from *area* responded to the survey between *insert dates*. *This represented X different professional groups.*
The team scored an average of **3.45/5** across all indicators, which indicates a marked improvement from the last team temperature check, which was 2.45. *Area* improved on every single indicator on the team temperature check. The greatest positive change was made on morale which increased by nearly 2 full points. The other key areas that showed improvement were.... . The least improved areas were... With regards to patient safety...
X% of staff reported that in the last month they had seen errors, near misses, or incidents that could have hurt staff and/or patients/service users, compared to **X%** in the last temperature check.

KEY	
1/5	Urgent Action needed
2/5	Clear need for improvement
3/5	Okay, but room for improvement
4/5	Performing well
5	Doing very well

STAFF SAFETY AND WELLBEING

Top 5		Lowest 5	
The people I work with are kind and treat each other with respect	3.48	I feel burnt out because of my work	2.52
I am supported to learn and improve in my team	3.55	I am able to make improvements happen in my team	2.56
I feel well at work	3.67	When people speak up in this team things change	2.58
My team takes positive action on health & wellbeing	3.70	I feel valued for my work	2.63
I haveexperienced discrimination at work	3.88	I am considering leaving this team	2.85

PATIENT SAFETY

My organisation treats staff who are involved in an error, near miss or incident fairly	3.67
I am confident that my organisation would address my concern	3.73
I would feel secure raising concerns about unsafe clinical practice	3.79
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	3.82
We are given feedback about changes made in response to reported errors, near misses and incidents	4.0
My organisation encourages us to report errors, near misses or incidents	4.12
My organisation acts on concerns raised by patients / service users	4.24
If I was concerned about unsafe clinical practice, I would know how to report it?	4.42

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Strategic People Update**
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Sharon Owen, Jo Potier and Katherine Birch

Purpose of Paper:	Decision ☐ Assurance ☑ Information R Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	To provide a strategic update to the Board of the key people issues during July and August 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:	

Does this relate to a risk? Yes ☑ No ☐

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

Risk Number	Risk Description	Score
#384	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	15
#395	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	12

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

1. Introduction

People issues are a strategic priority for the Board, and so the purpose of this report is to provide the Board with an overview of emerging issues and how the Trust is responding to those issues. This report will cover activity completed and insight and intelligence gathered during July and August 2025.

The Trust is currently experiencing significant pressure in relation to meet its challenging financial targets, alongside the need to maintain patient safety, activity and ensure our children, young people and families have the best experience whilst in our care. The cumulative impact of these pressures and subsequent changes for our people can lead to uncertainty, impact on morale, wellbeing and attendance.

2. Colleague Engagement & Culture

- **Staff morale**

Morale is an emotional state and refers to our enthusiasm, confidence, optimism, motivation, and commitment to work. It also reflects our capacity to maintain belief in our work, particularly in the face of challenge. At the “sharp end” of the organisation, that is frontline clinical (especially nursing) staff, patient facing administrative colleagues, staff in facilities, morale is being impacted by the ongoing impact of the NHS financial environment. Staff are worried for their jobs, struggling with personal finance, uncertain about the future and feeling more vulnerable due to loss of agency and control. The increase in sickness absence rates across the organisation is an indicator of this with higher reported levels of anxiety and stress. In this context, any gap in communications relating to the financial situation creates further worry with staff more prone to imagine the worst about their situation wherever there is a vacuum of information.

At the sharp end, there is also an observed and reported rise in clinical complexity and (psychological) trauma. With the risk of burnout and trauma saturation in these areas already high, the sense of being asked to do “more for less” can have an even more significant and negative impact on morale, with a corresponding rise in change fatigue.

Our managers and leaders are also showing signs of higher stress and lower morale in this context. Tasked to integrate, the experience for some is of being torn and overwhelmed. Many of them are themselves worried for their jobs and future whilst having to make sense of the financial context and implications for their teams. They are also struggling to balance the immediate and near-term demands relating to finances with the longer term transformational and integrative thinking required of them. They are being asked to collaborate more when the human instinct when faced with anxiety and stress is to withdraw and disconnect.

We are seeing impacts on morale for our senior leaders across the organisation. The immediate context for them is of increasing complexity, accountability, and uncertainty but with loss of autonomy and control in the financial context. There is a reported increased sense of burden and moral distress which is the consequence of having to make decisions that conflict with deeply held values or feel morally or ethically wrong.

As the collective stress increases in the organisation, compassion, connection and community are more critical than ever and are protective in the current climate. The response from staff to the new values conversations is enlightening and a source of hope. Feedback is that the new values resonate and reconnect staff with their core purpose and motivation. There has been wide engagement in the conversations which itself is hopeful and a clear sense of commitment and community in many parts of the organisation.

The continuing antidote to increased stress, where the stressor itself cannot be directly changed, is to ensure that staff are well informed and briefed regarding the financial situation, have spaces to talk openly about the impact on them of any changes that come, and places where they can access increased support. Compassion is key.

Key over the coming months will be communications that are balanced and address both the financial changes and challenges but also focus on values and thriving. Whilst we are unable to control much of what is happening outside of the organisation from a financial perspective, we can continue to understand and manage the impacts. Reinforcing and showing the new values in all of our interactions and wider communications is important as they are protective in the current climate. We need to prioritise building connection through transparent communications and ensure that, through our many networks of noticing, we are responsive to signals of lowered morale or increased distress and ready to intervene. Conveying messages that validate the immediate distress but also convey real hope and optimism for the future is critical now and a key part of the new communications and culture strategy.

We will have a more clear and broad measure of morale as the Thriving Staff Index and Thriving Teams Index continue to develop along with data relating to morale in the next Staff Survey (launching in September).

3. Education, Learning & Development

Reflective of both the NHS 10-year plan, and our own strategic clinical priorities, work is ongoing to ensure that we have a responsive and targeted development offer for all staff groups. We have expanded our range of development opportunities (all of which can be accessed via a central prospectus), and the scope and focus continues to evolve reflective of existing and emerging needs. Full details are provided to Education Governance and considered at People Committee; highlights include:

- A core group are working on the design and development of a refreshed digital skills offer and a new AI CPD programme, mapped to staff group and role. In addition, we are in the latter stages of establishing new strategic partnerships with external partners to augment our own knowledge and capacity and which will lead to enhanced programmes in areas such as Virtual Wards/Virtual Care.
- As part of Futures activity, the launch of a Thriving Operational Manager programme took place in July 25. Part of this offer provides attendees with access to a suite of 19 HFMA modules as well as face-to-face delivery, project work and group support sets. We also have a refreshed offer to support the development of early and mid-career researchers, and an associated offer is currently being developed in terms of innovation and knowledge transfer/exchange.
- The L&D team continue to progress the development hub offer. The current areas of focus are the skill scan and career pathways.
- A series of new masterclasses / development sessions are currently being devised, reflecting insights arising from both the annual TNA and wider qualitative discussions (see previous section relating to staff morale), commencing October 25.

Medical Education: Quality Review / GMC Survey Feedback

In June 2025, Alder Hey was subject to a routine NHSE/GMC quality visit in respect of our postgraduate education. The panel heard from resident doctors, supervisors and our wider leadership teams and the review explored a number of elements which combine to impact on the quality of our postgraduate education. Informal comments were provided to us on the day, and we are currently in the process of factually checking the final report which was received last week. Very positive feedback was received in respect of the experiences of specialty trainees, which reflects the range of enhancement work undertaken across the year. Less positive feedback was received in respect of resident doctors' experiences in general paediatrics, including one patient safety concern. This was escalated immediately both to the CMO and to Divisional Leads and further investigation undertaken, with an associated action plan put in place to address the more general themes within the feedback. The action plan has been shared with NHSE and agreed. To note also, the recent business case linked to general paediatrics, and particularly the addition of new Clinical Fellow posts will contribute to mitigating several of the issues raised.

Since the review in June, we have also received the results of the GMC survey. Whilst there is still room for improvement, we were delighted that our work has been reflected in the survey results. Indeed, we have been commended by the Head of the School of Paediatrics (NHSE North West) as the results demonstrate **an improvement in our scores in all areas** and we have no 'red' ratings.

Changes to Apprenticeships

Board is asked to note the recent announcement by government that, from January 2026, new Level 7 (Master's level) apprenticeships in England will **no longer be eligible** for government funding through the apprenticeship levy for those aged 22 and above. Existing apprentices and those aged 16-21 will still be able to access funding for these programs. Employers will need to fund Level 7 apprenticeships commercially for those over 21 if they wish to continue using this pathway.

Given the concerns raised across the health sector of the consequences of this in terms of workforce upskilling, NHS England (NHSE) and the Department of Health and Social Care (DHSC) have announced a secured commitment to continue funding Level 7 apprenticeships until 2029 in **five professions,** seen as critical to delivering the Government's 10 Year Health Plan. From April 2026 funding will be available, subject to eligibility criteria, for the following apprenticeships:

- Advanced clinical practitioner
- Specialist community public health nurse (SCPHN)
- District nurse (Community Specialist Practice Qualification)
- Clinical associate in psychology (CAP)
- Population health intelligence specialist (PHIS)

The Apprenticeship team, together with L&D and divisional colleagues, are currently reviewing the consequences of this announcement and are also supporting colleagues who had expressed an interest in undertaking a postgraduate apprenticeship outside of these 5 subjects to determine and agree next steps.

Further announcements are expected in February 2026 regarding the use of the levy, which is changing from an Apprenticeship levy to a **Growth and Skills Levy**. Whilst comments

have been made by Ministers in respect of the intention for the levy to be used more flexibly, details as to what this comprises, and how this will be achieved / managed have yet to be announced.

3. Employee Relations & Wellbeing

The Trust current sickness position as of August 2025 is 6% (the majority of which is long term absence) and significantly higher than the Trust target of 4.5%. This higher than target absence rate is impacting on the use of premium spend and service delivery, thus requiring specific interventions alongside the current management processes.

The HR team have implemented the 90-day attendance improvement approach (initially implemented by East Cheshire NHS Trust), as an additional intervention to support the management and reduction of sickness absence. An appreciative inquiry approach will be undertaken to compliment this. This will be built into existing meetings with managers and staff side colleagues. Colleagues who have recently returned from sickness absence will also be contacted for their input and feedback, where appropriate.

The 90-day Improvement Plan is on track, with key updates being:

- Update to the pregnancy risk assessment (an increased reason for absence)
- Development of the sickness dashboard improving the use and insights easily available from sickness absence data (to launch in September)
- The return-to-work process has been updated to ensure that all return-to-work conversations entered into the roster are captured for reporting to remove residual frustration around this process.
- Manager guidance developed with SALS, OH and HR around the management of work-related stress

Additional actions have been put in place in support of specifically the long term the sickness management process, with additional OH support for our most challenging circumstances.

Next steps focus on the appreciative inquiry, relaunch of the sickness absence training, and targeted work specifically around long term sickness absence.

Industrial Action

There was confirmation that there would not be any strike action from resident Drs during the month of August, but the dispute has not yet been resolved and there has no further notification as to action beyond August 2025. The BMA are balloting the Consultant and SAS Drs for industrial action which closes on the 1st September 2025.

4. Establishment Control Measures

Total Workforce WTE (whole time equivalent) has continued to be scrutinised both internally and externally.

In August, a new weekly workforce establishment and vacancy panel was formed, by merging the previous Executive Vacancy Panel with the Workforce Efficiencies Group. The panel is chaired by the Chief People Officer. The remit of this group is to ensure strategic and operational scrutiny of all elements of workforce establishment that may adjust the Trust WTE, impacting both premium and substantive pay. This group also ensures the Trust delivery of key workforce actions that emerge from the Financial Oversight meeting for the system, that is held every two weeks and is chaired by the Chief System Improvement and Delivery Officer for Cheshire and Merseyside.

Table 5.1 shows the Trust Workforce WTE for July 2025 (month 4).

Table 5.1

	Actual	Actual	Actual	Actual	Actual
	M12 24/25	**M01 25/26**	**M02 25/26**	**M03 25/26**	**M04 25/26**
Substantive	4,136.71	4,079.84	4053.46	4051.37	4054.61
Trainees	178.20	172.86	165.21	169.41	163.97
Bank	140.71	101.17	98.54	91.03	94.18
Agency	8.11	6.49	4.64	5.69	5.76
Total Workforce	**4,463.73**	**4,360.36**	**4,321.85**	**4,317.50**	**4318.52**
Plan	4,273.40	4,481.85	4,490.85	4486.16	4454.36
Difference	***-26.27***	***92.85***	***169.00***	**168.66**	***135.84***

Whilst the above position in respect of WTE numbers against plans, shows a positive variance, there is still the requirement to ensure the reduction of a further 100 WTE by the end of the financial year. Significant achievements have been made thus far in respect of reducing bank, agency and overtime, within the implementation of specific controls and there are further programmes of work to be explored to address the financial and WTE gap.

5. Recommendations & Board Actions

The board are asked to note the content of the report and support the actions being taken by the people services teams to support colleagues and mitigate the risks.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Equality, Diversity, and Inclusion Progress Update**
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Angie Ditchfield, Head of Equality, Diversity, and Inclusion

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. Introduction

This paper aims to update the Trust Board on our progress in delivering the six High Impact Actions (HIAs) outlined in the NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan. It will also outline the planned actions to support continued delivery, highlight areas for further improvement, and set out the next steps. Additionally, it provides an overview of key strategic and operational initiatives that are shaping the organisations approach to EDI.

2. Background

The Trust remains committed to promoting equality, diversity, and inclusion. While we have made meaningful progress, we recognise the need to go further in addressing discrimination, closing inequality gaps, and fostering a culture of inclusion, and belonging. By embracing collaboration, ensuring accountability, and maintaining a focus on equity, we aim to build a Trust that is fair, compassionate, and inclusive to all. Published in June 2023, the NHS EDI Improvement Plan sets out six targeted high-impact actions, designed to challenge and change discriminatory behaviours, policies, practices, and cultures across the NHS. We have mapped these actions against our current equality initiatives to identify gaps and improve standards where improvement is needed.

3. Success in implementing the NHS Improvement plan

The Trust has made significant strides in implementing the NHS EDI Improvement Plan, with demonstratable progress across all six HIA's. Progress to date demonstrates a strong organisational commitment to embedding EDI across all levels of the Trust. Key activities have been implemented in line with national expectations, and further actions are planned to sustain momentum. To date, EDI objectives have been embedded at Board level, we have launched a Mutual Mentoring Programme, inclusive recruitment practices are under review, and targeted leadership development programs are underway. We have initiated reporting on both gender and ethnicity pay gaps, strengthened wellbeing support through new policies and staff-led initiatives, and enhanced onboarding for internationally recruited staff. Our commitment to creating a safe and inclusive workplace is reflected in the adoption of the North West BAME Assembly Anti-Racist framework, bespoke EDI training, and strengthened Freedom to Speak Up mechanisms. These actions are underpinned by our new Trust values; Courage, Commitment, Compassion, and Community, and monitored through established governance structures to ensure sustained progress and impact.

4. Liverpool City Region Public Sector Race Equality Working Group

Alder Hey remains actively engaged in supporting the Liverpool City Region (LCR) Anti-Racism Strategy through our participation in the Public Sector Race Equality Working Group. This collaboration ensures our contribution to regional efforts is both

meaningful and inclusive, with a particular focus on amplifying the voices of children and young people in the strategy's development. The group is currently supporting communications professionals across the region by providing inclusive messaging and proactive content that celebrates diversity. A leadership forum for CEOs and executive leaders from public, private, and voluntary sectors is scheduled for 2nd September, designed to strengthen senior-level sponsorship of race equality. We are also contributing to the development of a Black Talent Pool, aimed at increasing access to employment and leadership opportunities for Black, Asian, and Minority Ethnic communities, with NHS Trusts encouraged to support this initiative. Broader community engagement is being explored, with efforts to ensure NHS organisations are actively involved. Alder Hey has already taken a leading role in targeted recruitment initiatives in partnership with the LCR Race Equality Hub, including participation in community events and the planning of a refugee recruitment event this September. These initiatives align closely with the NHS EDI Improvement Plan, particularly in the areas of inclusive recruitment, leadership accountability, and community engagement. They also support progress against key WRES indicators by helping to reduce disparities in representation and access to opportunity.

5. **North West BAME Assembly Anti-Racism Framework**

Our Anti-Racist Statement represents a clear and public commitment to making Alder Hey a place where everyone can thrive. It serves as a call to action for all staff to recognise, challenge, and actively oppose racism whenever and wherever it occurs. As part of our ongoing journey, we are preparing to apply for bronze status later this year, with valuable one-to-one support from the BAME Assembly to ensure our submission is evidence-based and robust.

To strengthen our application, we have implemented a series of initiatives that demonstrate our commitment to anti-racism and inclusive leadership, including:

- The launch of our organisational Anti-Racist Statement
- Delivery of Anthony Walker Foundation training through the 'Thriving Leaders' programme
- Reflective sessions in collaboration with Freedom to Speak Up, supporting staff in exploring anti-racist practices.
- Development of a new Safe and Respectful Behaviour Policy
- Introduction of the Mutual Mentoring Programme
- Creation of a tailored leadership programme for internationally recruited staff

These actions reflect our determination to embed anti-racism into our culture and practice, and to ensure that Alder Hey is a safe, respectful, and inclusive environment for all.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
August 2025

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Chair's Report from The People Committee meeting held on 24th July 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:	This paper provides a summary from the recent People Committee meeting held on 24th July 2025, along with the approved minutes from the 22nd May 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						
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.

- Board Assurance Framework: Risk Appetite/ BAF Risks 2.1, 2.2 & 2.3
- Internal Communications Update
- Monitoring Progress Against the People Plan
- Trust/Divisional Metrics Update
- Values – Progress Update
- Raising Concerns/FTSU Update
- Nurse Workforce Report (shared for information)
- Managing Overpayments
- Workforce Efficiencies Update
- Annual Health & Safety Report
- Equality, Diversity & Inclusion Update

- Volunteer Policy - ***APPROVED***
- Special Leave Policy - ***APPROVED***
- Pay Protection Policy – ***APPROVED***
- Pay Progression for Constant Policy ***- APPROVED***
- Equality, Diversity & Husman Rights Policy ***– APPROVED***

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

- In order to meet the Trust's efficiency targets, the overall WTE needs to be reduced by 100, through temporary spend controls, stricter vacancy controls, and continued divisional collaboration.
- Payroll overpayments have increased. Plans to resolve include improving manager guidance, sending process reminders, exploring automation, and enhancing communication with affected staff.
- Sickness rates remain above target, mainly due to stress and anxiety. 90 day sickness sprint plan was approved and has commenced, which includes a focus on return to work processes, manager training and reasonable adjustments.
- CAMHS Tier 4: the team have experienced a period of high levels of patient-related violence and aggression incidents. Colleagues in Sunflower House receive significant support to manage these, plus training. Reporting is thorough, and risk assessments with support systems are regularly reviewed.
- Freedom to Speak Up – Anonymous Concerns. The rise in anonymous cases presents challenges for resolution. It was recommended that the Guardian establishes a comprehensive framework for addressing anonymous reports and enhances communication regarding the limitations of the current FTSU process.
- Financial pressures are affecting workforce sustainability at both national and local levels. To address these risks, financial controls have been added to risk registers, workforce efficiency programmes have been implemented, and regular reviews of risk appetite and thresholds are conducted.

4. Positive highlights of note

- Launch of new joint nursing and AHP workforce strategy
- Very low nursing vacancy rate and successful targeted recruitment
- Significant reduction in bank spend in Medicine Division
- Positive NHS England/GMC quality visit and survey results for trainees.

- Progress on EDI Training, successful Navajo Charter Mark revalidation
- Launch of new organisational values and engagement pan.
- Comprehensive discussion about all three workforce risks and risk appetite. Agreement reached on workforce risk appetite levels and agreement to increase risk scores for risks associated with culture and workforce sustainability, to reflect the current organisational challenges.

5. Issues for other committees

- There has been an increase in overpayments, many of which have been highlighted by the Finance & Audit Committee, including some high-value cases caused by delayed notifications and process inefficiencies. Efforts are underway to enhance manager compliance and to assess the potential for automation to address these issues.

6. Recommendations

The Board is asked to note the Chair's Highlight report for the People Committee meeting that took place on 24th July 2025.

Alder Hey Children's NHS Foundation Trust

People Committee
Minutes of the meeting held on 22nd May 2025
Team

Present:

Jo Revill	Non-Executive Director **(Chair)**	(JR)
Nathan Askew	Chief Nursing, AHP and Experience Officer	(NA)
Alfie Bass	Chief Medical Officer	(AB)
Pauline Brown	Director of Nursing	(PB)
Garth Dallas	Non-Executive Director	(GD)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
Chloe Lee	Associate Chief Operating Officer – Surgery	(CL)
Sharon Owen	Deputy Chief People Officer	(SO)
Erica Saunders	Chief Corporate Affairs Officer	(ES)

In attendance:

Angela Ditchfield	Head of EDI & Inclusion	(AD)
Joe Fitzpatrick	Internal Communications Manager	(JF)
Jill Preece	Governance Manager	(JP)
Gill Foden	Head of Learning & Development	(GF)
Jo Potier	Associate Director of Organisational Development	(JP)
Jason Taylor	General Manager – Research	(JT)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Apologies:

Katherine Birch	Director of Alder Hey Academy	(KB)
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)
Veronica Greenwood	Director of Allied Health Professionals	(VG)
Lisa Cooper	Director of Community & Mental Health Services	(LC)
Carolyn Cowperthwaite	Acting Associate Chief Nurse – Surgery	(CC)
Urmi Das	Director, Division of Medicine	(UD)
Kate Warriner	Chief Transformation and Digital Officer	(KW)
Melissa Swindell	Chief People Officer	(MS
Sarah Leo	Associate Chief Operating Officer – Research	(SL)
Adam Bateman	Chief Operating Officer/Deputy Chief Executive	(AB)
Fiona Beveridge	Non-Executive Director	(FB)
Sian Calderwood	Associate Chief Operating Officer - Medicine	(SC)

24/25/122 **Declarations of Interest**

No declarations were declared.

24/25/123 **Minutes of the previous meeting held on 12th March 2025**

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

24/25/124 **Matters Arising and Action Log**

Action log was updated accordingly.

24/25/125 **Terms of Reference & Workplan**

The Committee received the Terms of Reference and approve the document.

The committee received and approved the workplan document.

Resolved: The committee APPROVED the contents of the Terms of Reference.
The committee APPROVED the contents of the Workplan.

24/25/125 **Internal Communications Update**

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

The nominations for the Alder Hey Star Awards opened in April 2025 and reached an approx.108 by May 2025 which formed part of the biggest celebration held to date. Focus remains on improving the nomination process to ensure this is more accessible and inclusive.

The Chair asked if there will be an opportunity in obtaining sponsorship. JF confirmed that sponsorship efforts have been successful with a recent achievement of securing £10k. JF added efforts are being made to ensure sponsorship for the event.

Resolved: The Committee received the Internal Communications Report.

24/25/126 **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.

SO outlined the progress on the people programmes core workstreams which aims to evolve organizational culture and create conditions for staff to thrive and continues in making good progress.

The following workstreams are under development:

- Management Essentials
- Clinical Leadership
- BAME Aspiring Leaders
- Consultant Induction
- Leadership Faculty

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

24/25/126 **Organisational Design Against the People Plan**

The Committee received the Organisational Design Against the People Plan.

SO provided a detailed update on the current progress of the organisational design transformation collaborative which explained how this strategic initiative aligns to the People Plan and reviews Alder Hey's structure, culture and workforce.

Discussion on the organisational design emphasized the need for a thoughtful approach to structuring the workforce to enhance efficiency and effectiveness. Efforts are being led to improve leadership structures and workforce efficiency which involves evaluating current practices and identify areas for optimization. Benchmarking is being used to understand best practices and set standards for workforce efficiencies. This includes comparing processes and outcomes with other organisations to identify gaps and opportunities for improvement.

Resolved: The Committee received the Organisational Design Against the People Plan

24/25/127 **Trust Wide Metrics**

The Committee received the Trust Wide metrics report (April 2025 data). SO highlighted the following to the committee:

- Sickness absence levels remain challenging. Action plans remain in place to manage, maintain and stabilise across services.
- PDR performance shows a slight increase in compliance. A deep dive analysis is being conducted to understand the trends over the past 18 months.
- Agency usage has decreased. Services continue with efforts to reduce cost across the organisation.

SO added staff engagement levels are being monitored, and efforts are being made to ensure fast and effective decision-making ensuring high level of engagement is maintained across all service provisions.

Action: A detailed paper will be prepared for July's Committee with containing a deep dive into sickness absence and its impact across the Trust.

The Trust Wide Metric report highlighted the ongoing efforts to manage workforce challenges and improve overall performance within the trust.

Resolved: The Committee received Trust Wide Metrics Report.

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (April 2025) data and noted progress to date. RG highlighted the following:

- Staff Survey results showed improvement. Action plans remain in place to help understand current position of staff engagement and areas needing attention.
- Sickness Absence remains challenging on sickness absence levels and there are ongoing efforts to address supported by HR Leads.
- Bank & Agency spend shows a decrease in data across both agency and bank spending. Efforts are being made to manage high sending areas effectively.

RG added assured the division continues to work on addressing challenges and planning for future work, ensuring that they are prepared to meet upcoming demands and opportunities.

Resolved: The Committee received the metrics for the Community and Mental Health Division.

Medicine

The Committee received the Medicine Division metrics report (April 2025) data and noted progress to date. CL highlighted the following:

- Mandatory Training reported at 95% to date.
- Sickness Absence showed a slight increase in long term sickness absence. All Senior Leaders continue to monitor and managed supported by HR Leads.
- Bank & Agency shows a reduction across the division. Divisional Leaderships continue to work with HRBPs to support all alternative avenues for non-clinical bank overage.
- MARS Scheme supported a total of 12 MARS applications within the Medicine Division to support the reduction in WTE and workforce plan.

Resolved: The Committee received the metrics for the Medicine Division.

Surgery Division

The Committee received the Surgery Division metrics report (April 2025) data. CL highlighted the following:

- Sickness absence continues to be stabilised across departments with plans in place to maintain supported by all Senior Leaders.
- The division is activity working on a trajectory to continue bank and agency reduction for the next six months.
- The division is working to maintain high levels of staff engagement to ensure quick decision-making to keep staff motivated and involved.

These metrics highlight the division's efforts to make workforce challenges to reduce costs and maintain high levels of staff engagement

Resolved: The Committee received the metrics report for the Surgery Division.

Clinical Research Division

The Committee received the Clinical Research Division metrics report (April 2025) data and noted progress to date. SL highlighted the following:

- Efforts are being made to understand workplace availability and map existing skills within the Clinical Research Team. This include looking at demographics

and identifying skilled staff whose abilities may not be fully utilized in their current roles.

- There is focus on staff engagement and quick decision making to maintain high levels of involvement and productivity within the Clinical Research Team.

Leadership & Workforce Efficiencies: Leadership structures and workforce efficiencies are being reviewed and improved to support clinical research activities effectively.

These points highlight the ongoing efforts to optimise workforce utilisation, maintain engagement and address challenges within the clinical research team.

Resolved: The Committee received the metrics for the Clinical Research Division.

Corporate

The Committee received the corporate metrics report (April 2025) data and noted progress to date. ES drew the committee's attention to the following:

The Corporate Services Collaborative meeting met this month which provided good engagement

- Turnover continues to be monitored across the organisation.
- Sickness absence remains challenging with action in place to stabilise.
- PDR compliance continues to be monitored to ensure timely completion is done effectively.

These points provide a comprehensive overview of the corporate metrics focusing on key areas such sickness absence, agency and bank usage, PDR completion and staff engagement.

Resolved: Committee received the Corporate Services Metrics Update.

24/25/130 **Thriving Teams Index Update**

The Committee received the Thriving Teams Index Update and noted the contents. JP drew the committee's attention to the following:

The Thriving Teams Index was designed to provide resource and support for staff in different categories aimed at improving wellbeing.

The index pilot results showed a positive outcome. The index provided valuable data on staff well-being. The development process faced challenges, but these have been addressed and the tool is now ready for implementation. There is a suggestion that integrate the thriving teams index in the PDR process to ensure regular reflection and discussion on staff wellbeing.

Resolved: The Committee received the Thriving Teams Index Update.

24/25/128 **Staff Survey Results**

The Committee received and noted the content of the Staff Survey Results. JP provided the committee with the Staff Survey report and highlighted the following:

- The staff survey results have been shared and the team is actively working on analysing and addressing the feedback.
- The results are being used to identify area for improvement and to develop action plans.
- DS has formed an Action Group with the aim to drive continuous improvement.
- There remains 5 initial workstreams identified to focus on specific areas of improvement based on the survey results. These workstreams are designed to address the most critical issues highlighted by the staff.
- The survey results indicate that teams with effective leadership tend to thrive while those with less effective leadership struggle. This insight is being used to develop targeted interventions to support leaders and improve team dynamics.
- The organisation is focusing on enhancing its culture by using the survey data to inform its strategies. This includes fostering a positive work environment and addressing any cultural challenges identified in the survey.

Resolved: The Committee received the Staff Survey Results Update

24/25/131 **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 highlighted efforts are being made on improving leadership structure and workforce efficiencies. This involves evaluating practices and identifying areas for optimisation and remains in development. Senior Leaders are focusing on benchmarking to understand best practices and set standards for workforce efficiencies. This includes comparing processes and outcomes with other organisations to identify gaps and opportunities for improvement. Significant progress has been made with the reduction of bank and Agency.

The discussion highlighted that workforce efficiencies are heavily connected with other areas such as leadership, digital transformation and asset management. These streams need to be aligned to achieve overall efficiency.

The organisational design emphasized the need for a more thoughtful approach to structuring the workforce to enhance efficiency. This includes considering the impact of design changes on staff and operations.

Resolved: The Committee received the Workforce Efficiencies Update.

24/25/130 **Mutually Agreed Resignation Scheme (MARS) Update**

The Committee received the Mutually Agreed Resignation Scheme (MARS) Update

The mutually agreed resignation scheme opened on 7th January 2025 to 21st March 2025 designed to support workforce sustainability and cost savings across the trust. A

total of 39 applicants were approved resulting in a net workforce reduction of 21.29 WTE. The scheme aims to provide a structure and voluntary process for employees to resign which can help manage workforcereductions in a fair and transparent manner.

There was a discussion on the financial aspects of the scheme, including the need to balance cost savings with fair compensation for departing employees. The scheme will be reviewed regularly to ensure it meets its objectives and can be adapted based on feedback and changing organisational needs.

Resolved: The Committee received the Mutually Agreed Resignation Scheme Update.

24/25/133 **Occupational Health Update**

The Committee received the Occupational Health Update and noted the contents.

The Occupational Health update included a tried and tested methodology for assessing and improving occupational health within Alder Hey. SO shared with the committee details of the new Occupational Health provider, further to a full tendering exercise run by Health Procurement Liverpool.

The update acknowledged challenges to maintain and improve occupational health. The organisation is investing resources to address these challenges effectively. Effective communication is crucial for the success of occupational health initiatives. This includes clear messaging and regular updates to keep staff informed and motivated.

Resolved: The Committee received the Occupational Health Update.

24/25/134 **Workforce Planning Audit**

The Committee received the Workforce Planning Audit and noted the contents, MIAA's audit concluded with substantial assurance.

The Workforce Planning Audit aims to assess the availability of colleagues and their skills ensuring that the organization can effectively utilize the workforce.

The audit involved analysing demographics of the workforce to identify areas for improvement including opportunities for better resource allocation. The Audit focuses on mapping the skills of staff, recognizing that many have skills that may not be utilized in their current roles. This helps in identifying potential for redeployment or additional training. This also acknowledges challenges within the workforce planning, particularly in ensuring that staff skills are matched to organisational needs.

This audit is part of Alder Hey's ongoing efforts to improve workforce planning and to address identified gaps to enhance overall efficiency.

These points provide a detailed overview of the workforce planning audit, highlighting the focus on workplace availability, demographics, skill mapping challenges and future work.

Resolved: The Committee noted the Audit

24/25/134 **Health & Safety Dashboard**

The Committee received the Health & Safety Dashboard and noted the contents.

The Health & Safety Dashboard was taken as read.

Resolved: The Committee received the Health & Safety Dashboard.

24/25/135 **Equality, Diversity & Inclusion Annual Report**

The Committee received Equality, Diversity and Inclusion Annual Report.

The report highlighted the presence of active networks that support EDI initiatives emphasizing their role in fostering an inclusive environment. The discussion included key focus areas such as workforce representation, inclusion practices and addressing any disparities identified in the report.

The report acknowledged the challenges faced in achieving EDI goals but also noted the progress made and the commitment to continuous improvement. The discussion included future plans to enhance EDI efforts, ensuring that the organisation remains committed to creating a diverse and inclusive workplace.

These points provide a high-level corporate overview of the division on the EDI annual report, covering its importance active networks key focus areas challenges progress and future plans.

Resolved: The Committee noted the contents of the Equality, Diversity & Inclusion Annual Report.

24/25/136 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

The Committee received and acknowledged the February 2025 Board Assurance Framework.

The committee noted the contents of the Board Assurance Deep Dive risk 2.2 which reported a current risk score of 9 with a target of 4

ES led a discussion on the examination of the organisation's risk appetite, particularly on workforce risks and how this influences decision making and risk management strategies currently in development. The framework includes action plans to address identified risks, ensuring that appropriate measures are taken to mitigate the risks and support workforce stability and development.

The discussion acknowledged challenges in managing strategic workforce risks such as long-term sickness and agency usage and highlighted the solutions being

implemented to address these issues. There remain various controls in place to address and review all ongoing and remaining risks under the supervision of our senior leaders to ensure all measures of action plans and next steps are in place.

Resolved: The Committee noted the Board Assurance Framework.

24/25/136 **Sign-Off Annual Report to the Trust Board**

The Committee received the Sign-Off Annual Report to the Trust Board. The

Sign-Off Annual Report was submitted to the committee for ratification.

The review process involved multiple committees and stakeholders to ensure that the report was accurate. This included feedback and comments from different departments to address any gaps or areas needing clarification.
The discussion on the sign-off of the annual report to the trust board focused on ensuring that all necessary updates and reviews were completed before final approval.

The report included updates on various strategic areas such as gender pay gap, long term sickness and corporate metrics. These updates were essential for providing a comprehensive overview of the organisation's performance and areas of focus.

Final adjustments/updates to the report were discussed, ensuring that the document was up to date and reflected the latest data and insights. This included bringing certain sections up to speed with current performance.

The final steps involved the formal approval of the report by the Trust Board followed by its submission to the People Committee. This step was crucial to maintain transparency and accountability within Alder Hey.

Resolved: The Committee APPROVED the Sign-Off Annual Report.

24/25/136 **Board Assurance Report**

The Committee received the Board Assurance Report and noted the contents.

The board assurance report was discussed to provide an update on the organisation's risk management and assurance processes. This includes a review of key strategic risks and the measures in place to mitigate them.

The discussion highlighted the organisation's risk appetite, particularly in relation to workforce risks. This involved examining how the organisation balances risk and opportunity in its strategic decision making. These metrics covered areas such as thriving staff index, sickness absence levels and agency usage. These indicators help in assessing the overall health and stability of the workforce.

The report detailed action plans to address identified risks. This includes specific measures and initiatives aimed at mitigating risks and supporting workforce stability and development.

The discussion acknowledged the challenges in managing strategic risks, such as long-term sickness and agency usage and highlighted the solutions being implemented to address these issues

Resolved: The Committee noted the Board Assurance Framework

24/25/137 **Policies for ratification**:

- **Safe & Respectful Behaviour Policy and Toolkit Policy**

The Committee received the Safe & Respectful Behaviour and Toolkit Policy and noted the detailed overview of recent updates.

- **Manual Handling of Loads & People Policy**

The Committee received The Manual Handling of Loads & People Policy and noted the detailed overview of recent updates.

- **Recruitment & Selection Policy**

The Committee received The Recruitment & Selection Policy and noted the detailed overview of recent updates.

- **Relationships at Work Policy**

The Committee received The Relationships at Work Policy and noted the detailed overview of recent updates.

Resolved: The Committee APPROVED all policies set out as above.

24/25/138 **Health & Safety Committee Minutes**

The Committee received the approved minutes of the H&S meeting held on (January 2025)

24/25/139 **LNC Minutes**
The Committee received the approved minutes of the LNC meeting held on (December 2024)

24/25/140 **JCNC Minutes**
The Committee received the approved minutes of the JCNC meeting held on (March 2025)

24/25/140 **Education Governance Committee**
The Committee received the approved minutes of the EDISG meeting held on (February 2025)

24/25/140 **Equality, Diversity & Inclusion Steering Group (EDISG) Minutes**
The Committee received the approved minutes of the EDISG meeting held on (January 2025)

24/25/141 **Any Other Business**

Nothing to report.

24/25/142 **Review of Meeting – Chair's Report to Board**

Workplan & Terms of Reference:
The Workplan and Terms of Reference was approved by the People Committee membership

Organisational Design:
The committee noted the level of detailed discussed in relation to the design concept, focusing on the interconnection of various elements such as leadership, workforce efficiencies and asset management.

Internal Communications:
Internal Communication continues to make good headway in terms of staff engagement and communication including Alder Hey Star Awards.

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

Divisional Metrics:
The metrics was highlighted on sickness absence leaves and agency usage across areas.

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
- Safe & Respectful Behaviour Policy and Toolkit
- Manual Handling of Loads & People Policy
- Recruitment & Selection Policy
- Relationships at Work Policy

Date and Time of Next meeting.
Thursday 24th July 2025 at 2pm – Tony Bell Boardroom, Institute Building

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common**
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	Cheshire and Merseyside Provider Leadership Board

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	To secure Board agreement and sign up to the CMPC Joint Working Agreement and Committee in Common
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:	n/a. Collaboration is expected to be more efficient and should result in a more pragmatic response to any financial challenges within C&M.

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
BAF 3.5	System Working to deliver 2030 Strategy					4x4=16
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common

1. Purpose

To secure Board agreement and sign up to the CMPC Joint Working Agreement and Committee in Common.

2. Summary

Cheshire and Merseyside (C&M) providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. CMPC has come about through a process borne from bringing together its two forerunners CMAST and MHLDC to focus on work of shared provider delivery: acute, specialist and community services. Working together has achieved real and tangible benefits since the pandemic and been consolidated since. All providers consider this next step will provide further opportunities and opportunities for at scale working where this makes sense.

Following a review requested by the system leaders and sponsored by Trust CEOs, Trust company secretaries have engaged in a process of seeking to build upon the established and available collaboration mechanisms within C&M that have been shown to work and support a track record of collaboration.

In identifying, promoting and championing the benefits of collaboration NHS England have encouraged all providers to build on local successes through provider collaborative structures where these can be shown to work.

C&M cosecs have worked together and drawn upon the expertise and advice of Hill Dickinson to support the redrafting and reframing of a CMPC Joint working agreement and Committees in Common terms of reference. This approach continues the chosen route of governing collaborative delivery and ongoing potential within the system.

The CMPC Leadership Board recommends the enclosed documents for adoption by Trust Boards. The updated documentation follows a review and redrafting process to reflect broadened arrangements and scope of the collaboration.

Primary content:
All providers within C&M have some familiarity and individual experiences of differing means of the proposed way of working. This report therefore seeks to briefly orientate an approach and structure of the two documents and then goes on to highlight, at a headline level, changes and areas of development as proposed by Hill Dickinson or Trust company secretaries to aid clarity, understanding and to respond to the current and changed environment.

Joint Working Agreement (JWA), further detail, and to be read in conjunction with CiC ToR:

- Covers: vision; function; priorities and headline areas of focus
- Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making
- Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach

Committee in Common - Terms of Reference (CiC ToR), further detail, and to be read in conjunction with JWA:

- Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach
- Committees in Common: Staged levels of Committees in Common decision making; rules based approach; will underpin clear and consistent communication supporting Board awareness and assurance
- Sets aims and objectives of CiC

- Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement
- Quorum
- Annex A establishes potential activities delegated to the CiC when in scope of the CiC work as set in the JWA
- To note: NWAS is proposed as a participant of the meeting rather than as a Member

Changes and variation from previous documentation (or familiar approaches): further detail, and to be read in conjunction with JWA and draft CiC:

Terms of References:
- Updates of names and terminology – organisations, CMPC etc
- Added definitions – to reflect content of documents at request of company secretaries
- Refer to the full breadth of CMPC responsibilities – including community – but also not seek to restrict nor curtail future Trust Board choices
- Additional words without altering meaning of sentences to support clarity
- Reframing of section 2.1 (ToR) to reorder theme stated aims and objectives.
- Add to ICB reference 'and regulator or those charged with performance management'
- Specifying MS Teams or equivalent as an option for a CiC meeting

Joint working agreement:
- Provide further clarity on the route for determining any costs arising from collaborative arrangements (section 6)
- Provide further clarity on the route for calculating any exist costs or transition arrangements arising from a cessation of collaborative arrangements (section 6)
- Additional parameters on timescales for stages of any dispute resolution (section 10)

A request was also made from one Trust for definition and adoption of an information sharing agreement (something explored on numerous occasions in the past by Leadership Boards). If the will exists for this it is proposed that this is developed by Trust Company Secretaries (with legal support and input) and proposed to Leadership Board for adoption.

The documentation provides outputs that represent the culmination of a period of engagement and development with C&M Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of C&M's preferred way of operating.

The document delivers both a foundation and framework for CMPC development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMPC develops and the ask of the system, for it, expands, varies or diminishes.

3. Recommendation

The Board is asked to endorse and agree the CMPC Joint Working Agreement and Committee in Common as proposed.

Erica Saunders
Chief Corporate Affairs Officer

CMPC TOR and JWA comments

Comment	Response	HD response
Terms of Reference		
Section 1.1 Is the CMPC agreement no longer called a Joint working agreement? (we just need to be consistent as later in the TOR we refer to it as a JWA again)	It is still called the JWA and this is consistent with what has been stated in the past x2 – we can change if the will exists	Note that in the delegation (Appendix A) we have revised to refer to the CMPC Agreement. It is defined as the joint working agreement between the parties but the name can be revised if desired as noted in the response.
Can the definition on CMPC CiCs be simplified to make it easier to interpret? Appreciate this is probably the legal wording but feels a bit clunky especially as there is also then a Trust CiC definition further down the list? An alternative?	a committee of each Trust meeting individually in common (simultaneously) with meetings of peer organisations to consider a common issue.	Change is not really necessary but have suggested simplified wording.
Do we also need a simple definition of the CMPC Leadership Board in the glossary?	A regular informal meeting of Trust CEOs across C&M which can (when business demands, and responsibility is delegated) be called as a CMPC CiC	The term is used once in the ToR in the below context: **CMPC Leadership Board:** *the CMPC CiCs meeting at the same time and place to consider matters of shared interest in line with these Terms of Reference.* *Have also added:* *The Leadership Board is a regular meeting of Trust CEOs across C&M* which can (when business demands, and responsibility is delegated) be called as a CMPC CiC
Why do we use 'meeting lead' rather than 'meeting chair' OR 'chair of the meeting'?	The lead is convening potentially 16 simultaneous individual meetings they therefore can't be the Chair x16.	As per the response – this is for clarity because each Trust CiC has its own Chair.
We refer to ICS here but then in the document (e.g. 2.1.5) we refer to ICB? Do we need to amend/ add to 1.1?	think ICS reference is helpful but ICB could be added too.	The ICS refers to the wider integrated care system in total whilst the term ICB refers to the statutory body the Integrated Care Board. We can insert a definition of ICB if this is felt necessary.
Do we really need the definition for what a working day is?		This term is used 4 times in the terms of reference. The advice is it should be defined as it is used term
Section 1.2 feels like it would be better to say that collectively the Trusts are putting in place the governance structure and then go	Can see the logic of what is being said but these are individual Trusts CiCs not a shared document. So, leave as is.	Agree with the response.

onto 1.3 which is individual 'Trust' specific.		
Section 1.4 Is different membership of each CMPC CiC right? (note section 7 seems to imply consistent membership of CEO or nominated Deputy). Do we need to be specific that the CiC is a committee of the Trust Board or is this now for local interpretation? (just conscious of consistency) agree with the earlier comments submitted by Karen in terms of the need for consistency with section 7. Could this paragraph be amended to state … except that the membership of each CMPC CiC in line with Section 7.	Commit to reviewing this as while I don't, personally, see the confusion it is clearly causing some	The membership of each Trust CiC is different as they each relate to separate Trust committees with different individuals (as opposed to a joint committee). Section 7 refers to the membership of the Trusts committee rather than the other Trusts in CMPC. We have suggested a couple of additional words in Section 1.4 to hopefully remove any confusion.
Section 2.1 states aims and objectives, but I wonder if some of these are guiding principles/ ways of working and if they are all measurable and achievable? (may be helpful to group them?)	<u>Leadership</u> Provide strategic leadership, oversight and delivery of new models of care through the development of CMPC and its workstreams. Set the strategic goals for CMPC, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts; <u>Delivery</u> Consider different employment models for service line specialities including contractual outcomes and governance arrangements; review the key deliverables and hold the Trusts to account for progress against agreed decisions; Ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress; Establish monitoring arrangements to identify the impact on services and review associated risks to ensure	

	identification, appropriate management and mitigation; Improve the quality of care, safety and the patient experience delivered by the Trusts; Deliver equality of access to the Trusts service users; and Ensure the Trusts deliver services which are clinically and financially sustainable. <u>Collaborate</u> Receive and seek advice from the relevant Professional (reference) Groups, including Medical, Nursing, Finance, Strategy, Human Resources, Operational and governance; Receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board; Review and approve any proposals for additional Trusts to join the founding Trusts of CMPC; Ensure compliance and due process with regulating authorities regarding service changes; Oversee the creation of joint ventures or new corporate vehicles where appropriate; Review the CMPC Agreement and Terms of Reference for CMPC CiCs on at least a biennial basis;	
Section 2 As per Karen's comments, agree that this would benefit to overarching principles so that these can be measured as part of any effectiveness review.	Happy to explore reframing and grouping. See proposals in new section 2.1	Agree with the response.
Section 2.1.5 inconsistent reference to ICS and ICB – can we stick to one or define the difference in the definition section.	I consider them to be two different things with different meaning but can weave a review through the document	As per the above this was a specific reference to the ICB as a statutory body rather than the ICS. It is not inconsistent.

CMPC TOR and JWA comments

Section 2.1.7 f we are going to include a list then I think we should also add the other professional groups likely to be called upon including Co Secs? Can we split Clinical Groups into Nursing and Medical together with including Company Secretaries.	Ok – add: Medical, Nursing, Finance, Strategy Human Resources, Operational and governance.	Revised.
Section 2.1.8 is this a new reference to receiving and seeking advice, and do we also need NHSE in here or is this a more defined relationship with the ICB?	no new reference. Can add 'And regulator or those charged with performance management'	Amended.
Section 2.1.11 does this relate to any joint ventures or new corporate vehicles within individual trusts – can we clarify 'where appropriate'. For example, would the establishment of UHLG require the approval of CMPC?	No	No, it refers to the Trusts collaborating together under the CiC – so doesn't constrain any other Trust activity.
Section 2.1.12 is an annual review an appropriate timeframe? (appreciate this is good practice for the TOR but I don't know if the JWA was reviewed this frequently?)	Suggest we go for biennial. Can also take and received feedback from any annual reviews Trust's may do	Embedded
Section 2.1.12 What is the process and timeline for the annual review of the Terms of Reference? Will Trusts have the opportunity to propose amendments?	It's been suggested that review be less often than annual, but the documentation has never been reviewed without member Trusts being engaged and commenting.	As above, for discussion.
Section 2.1.14 Is this deliverable as it is not something that is delivered within C&M or any other health system currently.	My understanding is that this remains an aspiration of the systems and Trust leaderships though acknowledge focus is challenging at present	This was selected as an aim/objective in the original ToR and is described as such here.

CMPC TOR and JWA comments

Section 2.1.15 given the current deficit across C&M, is it possible for this to be delivered by this group?	Accept the point but again this is an aim and there are examples of where programmes have supported this albeit CMAST / CMPC hasn't delivered either in totality or to conclusion	As above.
Section 3 states the CiC will just be the Trust name but I'm conscious that Trusts may have other JCs or CiCs so I think we need to be more specific on the name even if it's just TRUST CMPC CiC…?	Support this change.	Revised – note that existing CMAST CiCs will need to adopt the new ToR and rebrand accordingly.
Section 6.1 this is specific in referencing the Private agenda of the Board of Directors. Should 6.2 and 6.3 specify either public or private? Also agree with Karen's comment on this being a summary of the minutes as opposed to the full minutes.	I advocate we should be taking informal leadership board minutes to Boards, but we circulate to CEOs and cosecs. This supports localised briefing. There is a specific point here about these provisions relating to the enactment of an actual CIC which hasn't happened as yet.	Linked to CiC enactment.
Section 6.2 & 6.3 I'm not sure we are consistent here as to whether minutes are reported and/or a Chairs report (it would be good to agree, and I think a summary 'Chair's' report would be the most effective from the 'CMPC Leadership Board' with minutes maybe for information like we do with our own committees?	Ok but the distinction is this related to if a CIC is called – this function hasn't been used in anger – yet. I don't think nor advocate we should be taking informal leadership board minutes to Boards, but we circulate to CEOs and cosecs.	Linked to CiC enactment.
Section 7.4 4 is there an option to state that the meetings are of Trust CMPC CiCs rather than a meeting of the TRUST CiC (feels a bit unusual to talk about quoracy and voting of an individual TRUST CiC when in theory it is one member and might be easier to say there has to be a member present for this?). This also makes 7.5 confusing as its one member will be nominated to chair. (sorry if it's just my reading). Also applies to section 10 quoracy and voting. In relation to LUHFT/LWH	ok agree re CMPC reference. Unsure on legal position / advice on voting member of the member present votes? 7.5 is a provision linked to more than one Trust member – when originally drafted the system wanted to retain opportunity for Trusts to be represented by just a CEO or a CEO plus Chair.	This relates to the committee in common structure – these are ToR for the individual Trust committee and they exist legally separately. We can lose the requirement for a "chair" of the individual Trust committee if this is helpful. It may be that we run a session to explain the principles of how committees in common operate.

CMPC TOR and JWA comments

Section 8 non-voting probably just needs to be clearer on 'having a right' to attend vs be in attendance at the request of xxx?	Noted	Again under 8.1 this is the principle of the committee in common that the other Trusts committee members are each in attendance. We discussed the right of the Chairs of the Trust for CMAST and this was added as a request from the group.
Section 9.4 says meetings will be held in public but what does this actually mean in practice and why would items then be taken to private Board meetings? (refer 6.1). I'm assuming that due to the nature of the discussions held the leadership board doesn't intend to hold its meetings in public. Is this a change to holding future meetings in Public as I understood that the current arrangements meant that meetings were not open to the public. If there is a move to holding in public, this section should state that papers will be published on the C&M website in advance of the meeting.	Distinction between CIC and Leadership Board meetings Relates to my earlier point re actual CIC meetings vs Leadership Board meetings.	Linked to what is happening in practice as the original intention was reflected in 9.4 as it was felt that if the CMAST group could be taking core decisions outside of the boards then there should be some accountability.
Section 10.2 can we clarify that where a member is representing more than one statutory organisation, they will be able to vote to ensure that each Trust CiC is considered.	I don't think this requires clarification it is a committee in common and where, for example James or designate is in a meeting he has 3 votes and 3 committees sitting concurrently. It's the way CiCs work as vs JCs	Agree with the response.
Section 10.4 refers COI but would it be easier to say that if a member has a COI and therefore is 'disqualified' from voting that a Deputy needs to be present? (I'm not sure there could be a quoracy of one member who then can't make a decision)	Covered by wider provisions	There is the nominated deputy already (7.2)

CMPC TOR and JWA comments

Section 11 where a member representing the Trust has a potential conflict, if excluded the meeting would no longer be quorate.	I accept this and anticipate it would be worked through before. The Trust either sends a deputy or In effect wouldn't be making a decision in such a scenario.	Please see the nomination of the deputy which can be used if there is an individual conflict.
Section 12.2 Is 12.2 just a complicated way of saying that meetings can be held on 'Teams'?	Agree – if the will of the group is for a wider definition	No barrier to changing but the wording allows meetings by a combination of means telephone/video and is not specific to Teams.
Appendix A Delegated authority: Can you clarify the scope of decisions that the Committees-in-Common (CiCs) can make independently versus those requiring full Board ratification especially in relation to statutory organisation operating within a Group Model. I would want to explore sections 9 and 10 to ensure these do not conflict with the Joint Working	This is not a new list and we have discussed before I don't see this as actual delegation now (and that has previously been confirmed by Rob) but areas of potential delegation to be proactively determined by a Board when a given issues arises. It's the mechanisms to transact rather than the actual doing of it.	To discuss – these items were meant to be delegated to the Trusts relevant CMAST committee by the Trusts to allow the operation of CMAST as committees in common. If needed and requested we can check the UHLG agreement to ensure that this doesn't conflict, but we may need to cover this again for all the Trusts.
Joint Working Agreement		
Competition-sensitive information: How will the CMPC ensure compliance with competition law, especially in the absence of a finalised Information Sharing Protocol (Appendix 19)?	If the will of the group is for one to be developed, then we can look at this. The position has been reviewed a number of times by CEOs who stated there was no need. If you want to volunteer some skills or capacity, I am sure that would be welcome? Pls see comments in ISA annex	This could be considered though the application of competition law to the Trusts may not impact the NHS services being delivered by the Trusts. We can provide a template though the Trusts will also presumably have their own.
What safeguards are in place to ensure that shared data (especially financial or workforce-related) is handled in compliance with GDPR and FOIA obligations? Should a breach of data submitted by a Trust to CMPC incur, who is liable for any costs involved? I will seek clarification be supplied.	As a membership organisation all cost are currently shared equally Pls see comments in ISA annex	As per Response – save that if a Trust is responsible for a data breach (or fails to take appropriate measures to keep data secure) it will be accountable to the Information Commissioner.
The exit plan outlines cost-sharing obligations for Trusts that leave the agreement. How will these costs be calculated and capped in practice?	To be defined by DOFs on a per case basis. NHSE has many precedents on this.	As per the Response though further detail can be added if required.

CMPC TOR and JWA comments

If a Trust exits, what happens to its involvement in any joint ventures or shared service arrangements initiated under the CMPC?	To be defined by DOFs on a per case basis. NHSE has many precedents on this.	As per the Response though further detail can be added if required.
What is the expected timeline for resolving disputes under the CMPC model, and how binding are the outcomes of the dispute resolution process – other sections such as Termination set a clear timeline, and would it be beneficial to specify?	Ok. You will have seen clause 10.5 mentions 15 days. We can work to establish a time frame thereafter. This will usually be within one calendar month and no longer than 6 weeks unless, In such circumstances, as all parties agree to a longer time frame.	As per the Response.

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Assessing provider capability: guidance for NHS trust boards**
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	NHS England

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The Board is asked to note the new requirement by NHS England to undertake an annual self-assessment against the 6 domains in the *Insightful Provider Board* and timetable for completion (22nd October 2025 deadline).
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:	n/a.

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
All 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

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Assessing provider capability: guidance for NHS trust boards

Publication (/publication)

Content

Introduction

As part of the NHS Oversight Framework (https://www.england.nhs.uk/nhs-oversight-framework/) (NOF), NHS England will assess NHS trusts'* capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across 6 areas derived from The insightful provider board, namely:

- strategy, leadership and planning
- quality of care
- people and culture
- access and delivery of services
- productivity and value for money
- financial performance and oversight

These will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on

a set of key expectations related to their core functions as well as encourage an open culture of ‘no surprises’ between trusts and oversight teams. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation’s capability.

This document is designed to help boards make this self-assessment, set out the process and what organisations can expect along the way.

* NHS trust is used throughout this document to refer both to NHS trusts and NHS foundation trusts. The expectations set out in the document apply equally to both types of organisation.

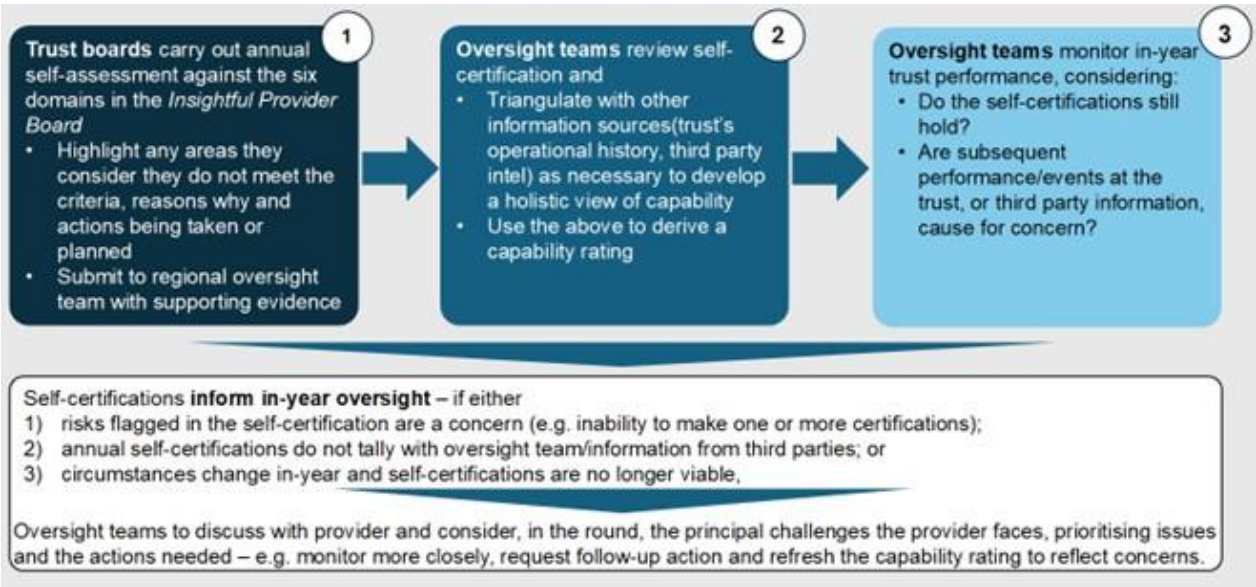
The self-assessment

This process set out here should not be seen as a ‘tick box’ exercise. As outlined above, the purpose is to promote self-awareness and transparency at NHS trust boards regarding their organisation’s capabilities, strengths, weaknesses and the challenges they face. It also provides a consistent framework for regional oversight teams to engage with NHS trusts, identify key risks and, over time, assess management’s track record in delivering performance and/or identifying and addressing issues to ensure strong, sustainable organisations able to deal with challenges as they emerge. Trusts will have 8 weeks to carry out this self-assessment and return it to regions.

Where boards already conduct effectiveness reviews, they should consider the degree to which these overlap with this self-assessment. In addition, and to avoid duplication, relevant evidence gathered to support NHS trusts’ annual governance statements can also support the self-assessment.

Summary of the capability assessment cycle

Figure.1: the capability assessment process



(https://www.england.nhs.uk/wp-content/uploads/2025/08/Image-showing-a-summary-of-the-capability-assessment-cycle.png)

Accessible text:

Figure 1 above sets out the self-assessment process which will take a number of stages across the year:

1. NHS trust boards carry out an annual self-assessment against the 6 domains in The insightful provider board and:

- highlight any areas for which they consider they do not meet the criteria, the reasons why and the actions being taken or planned then, within 2 months
- submit the completed self-assessment template to their regional oversight team with supporting evidence

2. Oversight teams review the self-assessment and:

- triangulate this with other information including the trust's recent operational history and track record of delivery and third-party intelligence (see below) as necessary to develop a holistic view of capability
- assign a capability rating to the trust

Oversight teams will discuss the capability rating with the NHS trust and consider, in the round, the principal challenges the organisation faces, prioritising issues and the actions needed – for example, monitor something more closely, request

follow-up action(s) and/or refresh the capability rating to reflect concerns if necessary.

3. Oversight teams will, across the financial year, use the capability assessment to inform oversight, for example where:

- risks flagged in the self-assessment are a concern (for example, inability to make 1 or more certifications), or
- annual self-assessments do not tally with oversight team's views or information from third parties, or
- subsequent performance/events at the trust or third-party information are a cause for concern such that elements of the self-assessment are no longer valid and, in order to assess 'grip', teams may wish trusts to review the basis on which they made the initial assessment.

The self-assessment

Below we provide indicative examples of the evidence boards should use or lines of enquiry they might consider taking to assess whether they can positively self-certify against each criterion. **These should not be seen as exhaustive, and we expect trusts will have developed specific approaches to gain assurance in particular areas.**

I. Strategy, leadership and planning

Self-assessment criteria	**Indicative evidence or lines of enquiry**

1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners.	• Are the trust's financial plans linked to and consistent with those of its commissioning integrated care board (ICB) or ICBs, in particular regarding capital expenditure? • Are the trust's digital plans linked to and consistent with those of local and national partners as necessary? • Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy? • Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?
2. The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England.	• Is the trust currently complying with the conditions of its licence? • Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?

3. The board has the skills, capacity and experience to lead the organisation.	• Are all board positions filled and, if not, are there plans in place to address vacancies? • What proportion of board members are in interim/acting roles? • Is an appropriate board succession plan in place? • Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?
4. The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.	• Is the trust contributing to and benefiting from its NHS trust collaborative? • Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system? • Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?

II. Quality of care

Self-assessment criteria	**Indicative evidence or lines of enquiry**

5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	• The trust can demonstrate and assure itself that internal procedures:
	  ◦ ensure required standards are achieved (internal and external)
	  ◦ investigate and develop strategies to address substandard performance
	  ◦ plan and manage continuous improvement
	  ◦ identify, share and ensure delivery of best practice
	  ◦ identify and manage risks to quality of care
	• There is board-level engagement on improving quality of care across the organisation.
	• Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients.
	• Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community.
	• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust.
	• Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.

6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.	• Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience? • Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities? • Is the board satisfied that it receives timely information on quality that is focused on the right matters? • Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this? • How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance? • Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns? • Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?

III. People and culture

Self-assessment criteria	Indicative evidence or lines of enquiry
7. Staff feedback is used to improve the quality of care provided by the trust.	• Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement? • Does the board engage with staff forums to continually consider how care can be improved? • Can the board evidence action taken in response to staff feedback?
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	• Does the trust regularly review skills at all levels across the organisation? • Does the board see and, if necessary, act on levels of compliance with mandatory training?

9. Staff can express concerns in an open and constructive environment.	• Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience? • Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required? • Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns? • Is there a safe reporting culture throughout the organisation? How does the board know? • Is the trust an outlier on staff surveys across peers?

IV. Access and delivery of services

Self-assessment criteria	**Indicative evidence or lines of enquiry**

10. Plans are in place to improve performance against the relevant access and waiting times standards.	• Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? • Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement?
11. The trust can identify and address inequalities in access/waiting times to NHS services across its patients.	• The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place.
12. Appropriate population health targets have been agreed with the integrated care board.	• Is there a clear link between specific population health measures and the internal operations of the trust? • Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?

V. Productivity and value for money

Self-assessment criteria	Indicative evidence or lines of enquiry
13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.	• Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to: ◦ review its performance against peers ◦ identify and understand any unwarranted variations ◦ put programmes in place to reduce unwarranted negative variation. • The trust's track record of delivery of planned productivity rates.

VI. Financial performance and oversight

Self-assessment criteria	Indicative evidence or lines of enquiry

14. The trust has a robust financial governance framework and appropriate contract management arrangements.	• Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data. • Have there been any contract disputes over the past 12 months and, if so, have these been addressed? • [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?
15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes.	• Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? • Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? • Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?

16. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.	• Is the board contributing to system-wide discussions on allocation of resources? • Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? • Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?

Inability to make a positive self-assessment

The board may not be able to make a positive self-assessment either because it considers the risks in a specific area are too great or its organisation is already manifestly failing in a specific area (for example, delivering on access targets). In these situations – and in line with the 'no surprises' ethos – in the self-assessment template boards should provide:

- the reasons why a positive self-assessment cannot be made against specific criteria and the extent to which these have been outside the trust's control to address (for example, industrial action, system-wide factors)
- how long the reasons have persisted
- a summary of any mitigating actions the trust has taken or is taking
- if not already shared with oversight teams, a high-level description of trust plans to address the issue, how long this is likely to take and KPIs or other information the trust will use to assess progress

Oversight teams will use this information to form their view of the overall capability of the trust and tailor their oversight relationship with it.

Material in-year changes

In addition to the annual self-assessment, if the board becomes aware in-year of a significant change to its ability to meet any of the self-assessment criteria – for example, an external report reveals material quality risks or an unforeseen cost

will affect its financial performance – it should inform the oversight team along with the actions it is taking to address the issue. Such in-year changes will likely inform the ongoing regulatory relationship with the NHS England region.

The NHS provider trust capability rating

Regional oversight teams will review the trust's submitted self-assessment and consider the statements and evidence. Using a range of considerations, including the historical track record of the trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the trust's capability rating and share this with it, including the rationale for the rating.

Rating: Green

- High confidence in management.

Indicative criteria

- No concerns evident from the self-assessment or subsequent performance.
- No concerns arising from third-party information.
- High confidence in the trust's ability to deliver on its priorities based on track record over past 12–24 months.

Rating: Amber–green

- Some concerns or areas that need addressing.

Indicative criteria

- After discussion with the trust, some concerns emerging across more than 1 domain, but these as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS.
- Trust has prepared plan(s) to address any problems with associated timeframe for delivery.
- Historical issues/track record mean NHS England does not (yet) have full confidence in the board.

Rating: Amber–red

- Material issue needs addressing or failure to address major issues over time.

Indicative criteria

- Issues with self-assessment or subsequent issues across multiple domains.
- Failure to deliver on agreed plans to address a material issue.
- Potentially in breach of licence.

Rating: Red

- Significant concerns arising from poor delivery, governance and other issues.

Indicative criteria

- Material or long-running concerns at the organisation that management has been unable to grip.
- NHS trust in breach of licence or likely to be.

Third-party information

As set out in the NHS Oversight Framework, third-party information relating to the organisation's governance and risk profile, staff morale and quality of care provided may inform NHS England's view of NHS trust capability. We expect that where **trusts receive information that impacts on their self-assessment** they should share this with NHS England. Relevant third parties include:

- **other bodies with regulatory responsibilities**, where concerns can reflect weaknesses in internal governance and systems of internal control and oversight – including the Information Commissioner, Human Tissue Agency and NHS Blood and Transplant
- **professional representative bodies,** reflecting issues with working conditions, staff morale, operating culture and safety – including the General Medical Council, Nursing and Midwifery Council and Royal Colleges
- **patients and the public,** reflecting issues in areas such as patient experience and culture via groups like Healthwatch
- **staff information,** reflecting issues in internal culture and inability to speak up, for example via staff survey or whistleblowers
- **integrated care board partners,** covering areas like the trust's willingness to collaborate and deliver shared goals
- **other NHS England teams,** reflecting knowledge from central programmes like quality, cyber assurance or digital maturity
- **relevant oversight groups,** including joint strategic oversight groups (JSOG) and system and regional quality groups

- **other sources** as relevant to the NHS trust, including coroners, Parliamentary Health Service Ombudsman, local government and Social Care Ombudsman, Ofsted, the trust's internal and external auditors and even the police

For further information on relevant information from third parties please see annex 1.

Annex 1: Bodies with relevant information on NHS trust capability

NHS England

Responsibilities

- Uses the conditions in the NHS trust licence it issues to NHS foundation trusts (and which also applies to NHS trusts in shadow form) to regulate trusts across a range of areas, including delivery of services, quality governance and efficiency, economy and effectiveness of management.
- Oversees the training of healthcare staff. Trusts liaise with it on matters like resident doctor training and NHS England has the power to remove resident doctors from trusts if conditions are unsatisfactory.
- Operates a cyber assurance service to build cyber security across the NHS, assessing alignment to key standards relating to the cyber assessment framework and indicators of good practice.

Considerations/areas to look at for NHS trust capability

- Meeting national standards.
- Compliance with the NHS trust licence.
- Resident doctor survey.
- Delivering NHS objectives.
- Collaborating with NHS trusts.
- Cybersecurity.

Care Quality Commission

Responsibilities

- Registers organisations to provide care in England, sets regulations covering the care trusts provide, runs an inspection and monitoring regime and publishes NHS trust ratings.

With NHS England:

- Provides joint strategic leadership and alignment for quality through the National Quality Board (NQB).
- As co-signatories of the NQB guidance for system quality management, work together as part of a culture of open and honest co-operation to identify opportunities for improvement, early warning signs, concerns and risks, and take collaborative action, working with systems to mitigate and manage quality.
- Ensures coherent oversight arrangements are in place for systems, integrated care boards (ICBs) and NHS trusts to ensure services are safe and effective.
- Shares learning and information about quality risks/concerns in a timely and proactive way, through system quality groups, regional quality groups and wider discussions, and respecting regulatory frameworks.

Considerations/areas to look at for NHS trust capability

- Quality of care – are any sites or services operated by the NHS trust classed as ‘inadequate’?
- Governance and culture – are there concerns for NHS England arising from the CQC’s well-led review across the whole organisation?

Medicines and Healthcare products Regulatory Agency

Responsibilities

- Regulates medicines, medical devices and blood transfusion components.

Considerations/areas to look at for NHS trust capability

- Systems in place to ensure proper and safe use of medical equipment.

Human Tissue Authority

Responsibilities

- Regulates the removal, storage, use and disposal of human bodies, organs and tissue.

Considerations/areas to look at for NHS trust capability

- Systems in place to safely and legally handle human tissue.

The Human Fertilisation and Embryology Authority

Responsibilities

- Regulates and inspects all clinics in the UK providing in vitro fertilisation (IVF), artificial insemination and the storage of human eggs/sperm/embryos – this may include some trusts.

Considerations/areas to look at for NHS trust capability

- Systems in place to meet standards associated with IVF and related procedures.

The Health and Safety Executive

Responsibilities

- Has a national remit over matters like workplace safety, estates conditions which covers trusts.

Considerations/areas to look at for NHS trust capability

- Systems in place to ensure staff, patients and the public work in a safe environment.

The Information Commissioner’s Office

Responsibilities

- Has a national role to uphold information rights in the public interest May be in contact with trusts regarding patient confidentiality, for example setting data requirements.

Considerations/areas to look at for NHS trust capability

- Systems in place to manage data securely and in compliance with all relevant standards.

NHS Counter Fraud Authority

Responsibilities

- Investigates reports of fraud, bribery and corruption across the NHS.

Considerations/areas to look at for NHS trust capability

- Systems and culture in place to ensure zero tolerance of fraud, bribery and corruption at the NHS trust.

Professional regulators

- General Medical Council
- Nursing and Midwifery Council
- General Chiropractic Council
- General Dental Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health and Care Professionals Council
- Social Work England

Responsibilities

- Together with NHS England, ensure proper standards of practice in respective professions to protect, promote and maintain the health and safety of the public.
- Most have responsibilities across the UK and all regulate professionals regardless of whether they work in the NHS or the independent sector.
- As a designated body, NHS England has a statutory duty under the responsible officer regulations for GPs on the national performers list and for responsible officers from designated bodies across a wide variety of sector organisations.
- NHS England must inform professional regulators where professionals fail to meet the standards. This can lead to an investigation and potentially sanctions such as conditions on practice, suspension or removal from a professional register.
- Responsible for quality assuring the education and training of healthcare professionals. Most can inspect organisations that commission, oversee or provide education, and they have powers to withdraw approval from training programmes, posts or NHS trusts if they are not satisfied that education or

training is being provided in a safe or effective way. In April 2023, NHS England took on the previous powers of Health Education England to regulate training NHS trusts and placement hosts.

Considerations/areas to look at for NHS trust capability

- Staff can work in and contribute to a safe, sustainable environment that ensures good morale and a healthy working culture that supports high quality care.

Local government and Social Care Ombudsman
Parliamentary and Health Service Ombudsman

Responsibilities

- Provide an independent complaint handling service.

Considerations/areas to look at for NHS trust capability

- Evidence of patient or staff concerns at health and care NHS trusts.

Health Service Safety Investigations Body

Responsibilities

- Investigates serious patient safety risks that span the healthcare system, operating independently of other regulatory agencies.

Considerations/areas to look at for NHS trust capability

- Quality assurance arrangements at NHS trusts.

Healthwatch

Responsibilities

- Shares learning and information through system quality groups, regional quality groups and the NQB to ensure that the views and experience of people and the public informs quality improvement and risk management discussions.

- Note: The Dash Review recommends abolishing Healthwatch. If followed through, this will need to go through a number of steps before being enacted in legislation, likely in late 2026/early 2027. Until then, Healthwatch will continue to gather patient views and evidence and work together with NHS trusts and commissioners to improve local services.

Considerations/areas to look at for NHS trust capability

- The NHS trust uses patient and public information in reviewing the care provided at the organisation.
- Is there any evidence of patient concerns that might indicate issues with the provision and oversight of care provided?

Ofsted

Responsibilities

- Investigates education settings, including secure children's homes and SEND services.

Considerations/areas to look at for NHS trust capability

- Is there any evidence of patient concerns that might indicate issues with the provision and oversight of care provided at specific sites managed by the NHS trust?

Coroners

Responsibilities

- Coroners investigate deaths that are unnatural or violent or where the cause is unknown or that took place in prison, police custody or another type of state detention, such as a mental health hospital.

Considerations/areas to look at for NHS trust capability

- Is there any evidence of concerns or issues – for example, organisational culture or governance – that may have led to a death at the institution?

Royal Colleges

Responsibilities

- The professional bodies that oversee and regulate various medical specialties. These colleges set standards for training, examinations, and continuing professional development for doctors in their respective fields. They also play a role in policy and advisory work related to their specialties.

Considerations/areas to look at for NHS trust capability

- Do information from Royal Colleges – for example, anonymised data from surveys of their members – highlight cultural, quality of care or patient safety concerns at the trust?

Local authorities

Responsibilities

- Along with other roles, local authorities help develop the population health needs assessment. Trusts are expected to work with system partners to meet these needs.

Considerations/areas to look at for NHS trust capability

- Is there any evidence that the trust is not an effective system partner across its geography?

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BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Chair's Report from ARC meeting, 17th July 2025**
Report of:	**ARC Chair**
Paper Prepared by:	**ARC Chair**

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action / Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Minutes from the meeting on 19th June 2025
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☑
Resource Implications:	None

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

Risk Number	Risk Description	Score

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

1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board and provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

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

- Presentation on risk management processes within CAMHS
- Presentation on lessons learned from the rollout of Risk Appetite and Tolerances within CAMHS
- Board Assurance Framework with a specific focus on FTPC BAF risks
- Risk Management Forum Update including Chair's Report
- Corporate Risk Register
- Trust Risk Management Report
- Risk Horizon Scanning (discussion)
- Internal Audit Progress Report, including the outcomes of audits of Conflicts of Interest (Substantial Assurance) and Cyber Assurance Framework (CAF) Part 2 (Limited Assurance)
- Internal Audit Follow Up Report
- Update on the Action Log from the effectiveness reviews of ARC, Internal Audit, External Audit and the Counter Fraud Service.

The Annual Assurance Reports and Forward Plans for Clinical Claims and Non-Clinical Claims which were due to the April 2025 meeting have been deferred until the September meeting due to issues with the data available from NHS Resolution which is required to produce the clinical claims data and due to capacity issues in the team to produce the non-clinical claims data.

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

None

4. Positive highlights of note

Following the introduction of an agenda item relating to horizon scanning for emerging risks, the Committee agreed to provide a summary of this discussion to the Execs Meeting so that they can consider if any updates are required to the BAF or CRR.

We undertook a deep dive session on cyber security after the conclusion of the formal agenda. This was presented by Kate Warriner and Ian Gilbertson and, in addition to the ARC NEDs, Mark Jennings and Garth Dallas also attended.

5. Issues for other committees

We undertook a deep dive review of the FTPC BAF risks. A paper summarising the Committees comments will be provided to FTPC to consider any potential updates to the risks.

6. Recommendations

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

Appendix 1 – 2025/26 Internal Audit Plan

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

The following audits related to 24/5 but were reported in 25/6:

Audit	Assurance Outcome	May be of interest to…
Cyber Assessment Framework Part 2	Limited	FTPC
Clinical Governance		Board

MEETING OF THE AUDIT AND RISK COMMITTEE

Confirmed Minutes of the meeting held on **Thursday 19th of June 2025 at 2:00pm**
Teams

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mr. G. Meehan	Non-Executive Director	(GM)
In Attendance:	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
	Miss. J. Preece	Governance Manager	(JP)
	Ms. E. Kirkpatrick	Associate Director of Finance	(EK)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Mr. D. Spiller	Senior Manager, Ernst & Young	(DS)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRO)
	Mr J. Kelly	Non-Executive Director	(JK)
	Mrs. E Rees	Executive Assistant (minutes)	(ER)
Apologies:	Mrs. R. Lea	Interim Chief Financial Officer	(RL)

25/26/40 Welcome and Apologies

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

KB mentioned that the agenda had been stripped down to focus primarily on the Annual Report and Accounts, with only a couple of additional reports from Clinical Audit and Internal Audit included. This decision was based on the significant discussions held relating to the external audit of the accounts in the past couple of years, but this year's audit turned out to be more straightforward than previous.

25/26/41 Declaration of Interest

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

25/26/42 Minutes of the Previous Meeting

The minutes from the meetings held on the 17 April 2025 were agreed as an accurate record of the meeting.

25/26/43 Matters Arising and Action Log

It was noted that the Action Log items would be discussed at July's meeting.

25/26/44 E&Y External Audit Year End Report on the Trust's Accounts

The Committee received the External Audit Results Report for year ended the 31st of March 2025. DS presented the Audit Results Report, highlighting the findings and scope changes since April. He summarised the findings of the Report, noting that the work was broadly completed with only a few review points

outstanding. He mentioned that the EY team were working through the final steps of the audit, including obtaining signed documents after the Board meeting.

DS explained the changes in materiality, which moved from £8.5m to just over £9m due to an increase in gross revenue expenditure. The reporting threshold also increased from £300k to £452k, aligning with the NAO's updated triviality level.

DS highlighted two uncorrected misstatements, including a £2m issue related to the Elective Hub. He explained that this was a cut-off issue where capital expenditure had been capitalised before the assets were fully completed. The other uncorrected misstatement related to the car lease scheme, which was expected to be corrected before the final report.

DS discussed the control recommendations, including issues with unsigned contracts and IT controls. He noted that the IT control issues had been raised last year and were still unresolved. EK explained that the person responsible for addressing these issues had gone on maternity leave, and the disaggregation of the service between the Trust and another entity might have contributed to the oversight. Plans were in place to address these issues going forward.

EK mentioned that training was planned for the Finance Team in July to improve control account reconciliations. Additionally, an internal audit of the controls over the main components of the Balance Sheet is being considered to identify whether any wider problems exist.

Additional Audit Fees

KB and the Committee discussed the additional audit fees proposed by EY, including fees for PPE and component auditing.

DS mentioned that the additional fees for PPE were flagged in the Audit Plan, with an estimated range of £2,250 to £8,000. The actual additional work amounted to £1,500, which was lower than the estimate.

HR explained that the Trust was selected as a sampled component for the NAO's Consolidated Provider Account Audit, requiring additional procedures and reporting.

25/26/45.1Action:
KB requested a meeting with EY and Finance to discuss the additional fees in detail and make a decision outside the Committee meeting. She emphasised the need for detailed discussions before the meeting to avoid surprises in the future.

KB recognised the significant amount of work the Finance Team has done on the Accounts this year and thanked them for their hard work. HR also expressed his thanks to the Team.

Resolved:
The Committee approved the E&Y Year End Report subject to the resolution of the audit fee discussion.

25/26/45 Letter of Representation

DS emphasised that the Letter should not be signed until as close to next Thursday as possible, ideally on Thursday, to ensure it is within the 5-day window of their opinion.

The Letter will be updated to reflect the corrected audit differences, particularly the removal of the car leasing scheme adjustment.

KB requested that any changes to the Letter of Representation be sent in a track changes version to avoid re-reading the entire document.

Resolved:
The Committee approved the Letter of Representation subject to the changes mentioned.

25/26/46 Trust's Annual Report and Accounts 2024/25

KB acknowledged JP's efforts in coordinating the Annual Report, noting that the document was still subject to formatting updates and reviews. She had read the sections relevant to the Audit & Risk Committee and had minor queries which she would send to JP outside the meeting.

Resolved:
The Committee approved the Trust's Annual Report for 2024/25 for presentation to the Board.

25/26/47 Salary Sacrifice Control Account Update

EK explained that the car lease control account issue had built up over a few years due to an oversight. The control account should have accounted for the costs incurred by the Trust for car leases and offset them with the income from employees and reductions in NI and pension. However, the NI and pension deductions were not accounted for, leading to a £1.5 million discrepancy.

EK outlined the actions taken to address the issue, including training for the Finance Team on control account reconciliations, a new quarterly senior review of control accounts, and (as mentioned earlier) a potential internal audit of the balance sheet. She also mentioned that the Trust had received verbal permission from NHS England to adjust the Accounts to correct the error.

Resolved:
The Committee discussed the proposal to adjust the Accounts and agreed with recommendation to correct the error this year. They also confirmed their approval of the additional controls and the internal audit of the Balance Sheet.

25/26/48 Understand how the Audit and Risk Committee gains assurance from Management

The Committee was provided, for information, with the letter of response from the ARC Chair relating to a number of questions posed by E&Y on certain matters relating to the financial statements.

Resolved:
The Committee received and noted the responses.

25/26/49 Final Head of Audit Opinion

GB advised that there were no significant changes since April except for updates to the Cyber Assessment Framework.

KB advised that report owners would be invited to the Committee to present and that a deep dive into cyber security with KW had already been arranged for July.

Resolved:
The Committee received and approved the Final Head of Audit Opinion.

25/26/50 Outcome of Client Service Questionnaires

KB reported positive and valuable feedback received from auditees. She met with GB about benchmarking and suggested MIAA provide more detail on their activities, noting that KS personally handles follow-ups which are typically assigned to junior staff.

Resolved:
The Committee received and noted the Outcome of Client Service Questionnaires.

25/26/51 Clinical Audit Annual Report for 2024/25

JRo presented the Clinical Audit Annual Report and highlighted the delivery of clinical audit activity, including participation in 14 national audits and 5 Confidential Inquiries. She noted that the Trust had an 86% participation rate in national clinical audits and 100% in Confidential Inquiries.

JRo mentioned that IT issues affecting the submission of the UK Renal Registry Audit and the Respiratory Paediatric

Asthma Secondary Care Audit had now been resolved and the Trust was now submitting full datasets for these audits. She outlined several improvements in the audit process, including the introduction of learning from national and trust priority audits, fortnightly oversight meetings with Divisions, and the development of a compliance calculator for auditors.

JR advised that it was an excellent report and asked that, “thinking about strategies going forward, so much is working across communities so have discussion begun around how we can develop joint audits of primary care that might not be developed yet?”. JRo replied that not as yet but this is something that we will look at with Patient Safety Leads to understand themes.

KB stated that it was great that the IT issues were resolved and asked whether we were able to resubmit the missing data. JRo confirmed that we were unable to do this as the audits had finished and noted that earlier notice of the issues from the responsible teams would have been helpful in this regard.

KB advised that, in attending the Clinical Outcomes & Effectiveness Board where this report had previously been presented, she had asked JRo to develop a process to provide formal assurance as to whether the actions raised from audits within the Trust Clinical Audit Plan are implemented.

25/26/51.1 Action:

JRo to develop a process for monitoring and providing assurance on the completion and embedding of actions from clinical audits in the Trust Clinical Audit Plan.

Resolved:
The Committee received and noted the Clinical Audit Annual Report for 2024/25.

25/26/52 Clinical Audit Annual Plan for 2025/26

JRo advised that the Plan includes this year's nationally mandated audits. The NHS contract lists a total of 20 national mandated audits and 27 local priority audits. Some gaps have been identified in the documentation. Feedback is pending on Liverpool Neonatal Partnership and spinal audits; once confirmed as relevant, they will be added to the database. Several Divisional priority audits have been submitted, and updates to the Plan are forthcoming. The Plam was presented to SQAC, and Appendices 1 and 2 were approved, detailing the audits.

Resolved:
The Committee received and noted the Clinical Audit Annual Plan for 25/26.

25/26/53 Audit and Risk Committee Annual Report for 2024/25

Resolved:
The Committee received and approved the Audit and Risk Committee Annual Report for 2024/25.

25/26/54 Committee Annual Reports for 2024/25

KB advised that the series of reports were reviewed and found to be straightforward and informative. It may be beneficial to provide these to new NEDs upon joining. There are a couple of important points to highlight: each report consistently includes assurance from the Committee Chair regarding their oversight of the BAF risks and outlines how this oversight is carried out. There is also additional SQAC assurance from regarding its oversight of Clinical Audit activities (which are undertaken on behalf of ARC). Other than these observations, there were no further issues to raise.

Resolved:
The Committee received and approved the Committee Annual Reports for 2024/25 for:

- Finance, Transformation and Performance Committee
- Safey and Quality Assurance Committee
- People Committee
- Futures Committee

25/26/55 Any Other Business

There was none to discuss.

25/26/56 Review of the Meeting

KB advised that the meeting had ran smoothly with less pressure; aim for the same next year. DS was unsure about next year's timetable—pencil it in for now.

There has been a suggestion of shortening the timescale by a week next year, though this may create issues in meeting this deadline. EY asked to be informed of any ICB updates as they will require consideration.

Date and Time of Next Meeting: Thursday 17th of July at 2pm via Teams

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Confirmed Minutes of the meeting held on **Monday 30 June 2025 at 1:00pm**
Teams

Present:	Mr J. Kelly	Non-Executive Director (Chair)	(JK)
	Dame. J. Williams	Non-Executive Director	(JW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Mrs. R. Lea	Interim Chief Financial Officer	(RL)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mr. A. Bateman	Deputy Chief Executive/ Chief Operating Officer	(AB)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance:	Mr. N. Askew	Chief Nursing Officer	(NA)
	Mr. A. McColl	Associate Director of Finance	(AMc)
	Ms. J. Halloran	Deputy Development Director	(JH)
	Ms. N. Palin	Director of Transformation	(NP)
	Mr. G. Wadeson	Associate Director of Finance	(GW)
	Ms. E. Kirkpatrick	Associate Director of Finance	(EK)
	Ms. A. Chindiya	Associate Finance Director	(AC)
	Mrs. E. Rees	Executive Assistant (Minutes)	(ER)
	Mr. I. Gilbertson	Deputy Chief Digital and Information Officer	(IG)
	Dr. A Prendergast	Associate Director of Strategy and Partnerships	(AP)
Apologies:	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mr. M. Jennings	Non-Executive Director	(MJ)

25/26/044	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
25/26/045	**Minutes of the Last Meeting** The minutes of the last meetings held on 21 May 2025 were approved.
2526/046	**Matter Arising and Action Log** There were no matters arising and the action log was updated.
25/26/047	**Declarations of Interest** There were none to declare.
25/26/048	**Top 5 Risks** **Top Risks and Financial Performance:** RL presented the top risks and latest position for the month, noting the challenges both internally in relation to the divisional performance and CIP

shortall but also within C&M system with the turnaround and improvement work that is ongoing..

Campus Update
JH presented the latest position with the campus project.

Capital Prioritisation
EK provided an overview of a capital prioritisation process recently undertaken for the capital programme planned for the year, noting that the total capital request was £36.9m against an anticipated funding envelope of £29.1m. Of this, £25.1m is already committed, leaving £4 million of funding available against £11.8m of requests. The prioritisation exercise reduced the gap to £3.9m. The proposal is to proceed with items ranked as priority one immediately and seek agreement in principle for priority two items, pending further actions to identify additional funding or reduce costs.

RL mentioned that SF from the charity joined the capital prioritisation workshop, which was beneficial as it allowed her to understand the challenges, particularly around the assumptions built into the original case for SDEC/NICU. These assumptions now need updating to reflect the actual expenditure. SF is fully aware of these challenges, and the team is working closely with her to address them.

KW emphasised the criticality of the timing for decisions on the digital business cases, given their alignment with other partners and the stability and resilience issues related to aging infrastructure.

JG highlighted the need for a strategic view on medical equipment, given the challenges of replacing equipment delivered together when the hospital opened. EK noted that the risk of medical equipment has been slightly mitigated by pulling forward a considerable amount of spending into the last financial year.

JW suggested considering the phasing of some items, such as the pharmacy medicine cabinets, to provide more flexibility. NA added that the capital prioritisation group is managing the risks associated with each item and that the replacement program aims to stretch the replacement timeline to avoid similar challenges in the future.

RL summarised that the team is working on rapidly developing business cases for the prioritised items and exploring options for securing additional funding through brokerage with other trusts. JK suggested creating room for external funding and grant opportunities, as well as considering the charity's support for capital funding.

Resolved:
The committee approved the approach outlined in the paper and for allocations of capital to be given as proposed for the rank 1 and rank 2 schemes pending the actions outlined in the paper.

Transformation Programme and Collaboratives
JK and JG discussed the transformation programme, focusing on the benefits, governance, and the need for a three-year plan. They emphasised the importance of aligning the collaboratives with the financial improvement programme and ensuring ambitious benefits and commitments

	Resolved: The Committee noted the Top 5 Risks.
25/26/049	**Finance Report** **M2 Financial Position** The organisation reported in line with the plan for month two, despite facing challenges. The initial numbers indicated significant challenges, particularly within the medicine division. The gap was closed by releasing over £170K of the annual leave accrual from the balance sheet. The CIP (Cost Improvement Programme) was £1.2m behind plan year-to-date, with a gap of £500K in month. Some of this gap was closed in month three through a review of non-recurrent underspends in various divisions. The system overall reported in line with the plan, which was crucial for receiving deficit support funding. However, the national and regional teams have not yet released the deficit support funding due to perceived risks in the plan. **Workforce Metrics** These was received for information. **Resolved:** The Committee received and noted the Financial Report.
25/26/050	**Financial Improvement Programme (FIP) Update** **Resolved:** The Committee received and noted the FIP update.
25/26/051	**25/26 Financial Plan Update** The organisation has made positive progress in Q1, including hitting the month one and two targets and posting £12 million of green in-year savings, which is 50% of the overall savings target. There is a remaining gap of £7 million in red schemes, with £3.6 million of that attributable to the transformation gap. Ten strategic themes have been identified to close the overall £6-7m gap, including digital initiatives, productivity gains, and medical workforce changes. These themes are aligned with the collaboratives to ensure focus on transformational benefits. Short-term actions include a detailed review of spend and budgets, focusing on areas where spending can be stopped or delayed, and increased scrutiny on temporary spend. The headcount has been reduced by 160 compared to month 12, with significant reductions in temporary spend.There has been extensive communication and engagement across the organisation to raise awareness about financial performance and the importance of managing the money effectively. The stretch target of £3.8m remains unidentified in the plan for M12. Work is ongoing in the system identifying improvement opportunities that will meet this gap, however it was noted that this is a significant risk and one that will need to be discussed at the Trust Board on Thursday. The PwC report on the system's financial position is expected, which will likely result in PwC providing external intervention at both provider and system levels.

	Resolved: The Committee noted the 25/26 Financial Plan update.
25/26/052	**M2 Integrated Performance Report** **Resolved:** The Committee received and noted M2 Integrated Performance Report.
25/26/053	**Acute Care Floor Business Case** AB advised that the business case aims to implement a new paediatric same day emergency care centre and improve the acute care model. This involves relocating urgent care clinics to proper consulting rooms and reducing the number of children admitted to wards. **Key Benefits**: • **Reduction in Admissions**: The new model is expected to reduce the number of children who need to be admitted overnight. The plan includes reducing 20 beds by March next year, with 10 beds already closed. • **Improved Care Delivery**: The model will shift care to the ground floor, enhancing the efficiency and effectiveness of acute care services. • **Alignment with Best Practices**: The model is informed by the successful practices at Sheffield, which has a significant assessment unit capacity. **Financial Implications**: • **Net Neutral or Small Savings**: The investment is expected to be net neutral following investment into the new facility although ambition to generate saving and full financial benefits will continue to be refined. • **Recruitment and Resource Allocation**: The plan includes going out for recruitment and reallocating resources to support the new model. **Timeline**: • **Implementation by March Next Year**: The new model is expected to be operational by March next year, with the new space being handed over and operationalised. **Support and Approval**: • **Executive Approval**: The business case has been reviewed and approved by the executive team, with a focus on ensuring the benefits are strong enough to justify the investment. • **Committee Backing**: The proposal seeks backing from the committee to proceed with recruitment and resource allocation. **Challenges and Considerations**: • **Short-Term vs. Long-Term Benefits**: There is a recognition that the immediate reduction in beds may be temporary, and the long-term vision includes finding better ways to utilize the space with greater income and treating more children and young people. • **Alignment with Strategic Vision**: The case aligns with the broader strategic vision for urgent care and acute care services, aiming to enhance care delivery and efficiency. JK emphasised the need for a compelling long-term vision and the importance of aligning short-term actions with the broader strategic goals.

	RL highlighted the timing considerations and the need to ensure that the initiatives align with the availability of beds and resources. NA pointed out the risks associated with decommissioning beds and the challenges of re-staffing them in the future. **Resolved:** The Committee received and approved the Acute Care Floor Business Case.
25/26/054	**Digital and Data Collaborative** **Lyrebird** IG and KW discussed the progress and plans for scaling up the Lyrebird ambient voice technology, noting the benefits in reducing admin burden and improving consultation quality. They highlighted the need for further data at speciality and consultant levels to understand the time and financial benefits. IG provided an overview of the progress and plans for scaling up Lyrebird. NA emphasised the need for more data at the specialty and consultant levels to understand the time and financial benefits. MS highlighted the positive impact on the quality of consultations and the experience for clinicians and patients. KW discussed the commercial conversations and the broader AI approach for Cheshire and Mersey. **Coding** IG provided an overview of the plans to improve clinical coding validation, noting the importance of accurate coding for reflecting the complexity of care. IG provided an overview of the proposed plans and the importance of improving clinical coding accuracy. RL emphasised the need to ensure that the complexity of services is recognised in contracts and the importance of accurate coding for financial planning. **Resolved:** The Committee received and noted the Lyrebird and Coding reports.
252/26/55	**Organisational Development Collaborative** MS outlined the phases of the organisational design collaborative, focusing on workforce efficiencies, leadership and management costs, and the future shape of the workforce. She emphasised the need for a thoughtful approach to organisational design to meet Vision 2030. The Organisational Design Collaborative is structured into three distinct phases, each with specific focus areas and timelines. **Phase 1 (Q1-Q2 2025)** concentrated on immediate workforce efficiencies. This phase aimed to reduce costs through initiatives such as banking agency

	overtime, 10% plans, and the Mars scheme. The target was to achieve £4.4 million in workforce efficiencies, though a gap remains. **Phase 2 (Q3-Q4 2025)** will address the remaining gap of approximately £2 million through targeted initiatives. Key areas of focus include reviewing and potentially reducing leadership and management costs, evaluating and optimizing the Allied Health Professional (AHP) workforce, tightening the vacancy control process, assessing and optimizing the corporate nursing structure, reviewing and optimizing support services, and bringing in additional resources to help with the medical workforce review. Plans are to be completed by Q3 with delivery starting in Q4. **Phase 3 (Q4 2025 and Beyond)** will develop a comprehensive organizational design to align with Vision 20-30. This phase will focus on standardizing governance, clinical leadership models, management structures, and ensuring synergies and efficiencies. The goal is to create a future-ready organization that meets the needs of children and young people. RL emphasised the importance of making bold decisions to achieve financial targets and the need for a comprehensive approach to organizational design. JW suggested discussing various options at the September Strategy Board, considering Vision 20-30 and other strategic initiatives. DJ highlighted the importance of aligning with external factors and ensuring career pathways and opportunities for staff. Challenges and considerations include ensuring that digital initiatives are integrated into the organisational design, reviewing management layers and potentially restructuring divisions to align with long-term goals, and considering external factors such as shared services and system-wide collaboration. In conclusion, the Organisational Design Collaborative is focused on immediate workforce efficiencies, closing the financial gap, and developing a long-term organizational design aligned with Vision 2030. The initiative involves multiple phases, each with specific targets and timelines, and aims to create a future-ready organization that meets the needs of children and young people. **Resolved:** The committee noted the Organisational Design Collaborative.
25/26/056	**Improving Access to Care in the Current Financial Environment** The discussion on improving access to care focused on addressing the challenges related to waiting times and the impact of reduced weekend activity. AB highlighted that the data showed a decrease in activity volumes for June, running at about 85-90% across medicine and surgery for electives. This reduction is linked to the decision to align waiting list initiative (WLI) payments with the ICB's standardized rate, which starts from July 1st. The surgery team quickly responded to this change, recognizing that without weekend activity, approximately 1,500 patients would be affected. To mitigate this, the team proposed increasing outpatient utilisation and addressing productivity opportunities. However, in specialties like ENT and

	dentistry, the productivity gains alone would not be sufficient to close the gap. Therefore, the proposal included reinvesting some of the savings from reduced premium rate work into growing the team, specifically by adding theatre staff and medical posts to build sustainable capacity. The proposal was reviewed by the Operational Board and included high-level financials and numbers. The recommendation was to secure some of the savings as CIP while reinvesting a portion into the team to recover the lost weekend activity. Additionally, negotiations with theatre staff and insourcing companies were ongoing to explore creative ways to maintain weekend work. JW emphasised the importance of addressing waiting times, noting that it is a significant focus for the ICB and that failure to manage this could lead to serious consequences. DJ added that the issue had been raised with the turnaround director and CNM, acknowledging the need for a broader system conversation about the 65-week challenge for children. RL mentioned that a waiting list initiative medical group had been set up within Cheshire and Merseyside to standardise rates and governance around WLIs. This group is working on aligning consultant WLI rates across the patch, which will impact the financial modelling of the proposal. NA pointed out that the proposal could positively impact the future direction of the hospital by moving towards a seven-day operating model, which is essential for developing more specialist services. **Resolved:** The Committee received the Improving Access to Care in the Current Financial Environment.
25/26/057	**Board Assurance Framework** The Committee received and noted the Board Assurance Framework.
25/26/058	**Workplan for 25-26** RL advised that there is a work plan and will circulate it after the meeting to check on frequency and if members can review and provide any comments back to her. **Action:** **RL to share the Workplan with the Committee.**
25/26/059	**<u>Review of the Meeting</u>** We had a timely discussion about interpreting the post-Q1 reset and its impact on both short and long-term transformation, including integration with GO. This topic is important and should continue into Part 1 and Part 2 at the Board on Thursday. JK expressed his thanks to SA as this was her last meeting, for all her input and support to him as Chair of the Committee during the last couple of years.
	Date and Time of Next Meeting: Tuesday 22 July at 2pm in Room 7.

25/26 FTPC Key Risks – Month 4 Position

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M4
Trust Financial performance	Challenging 25/26 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time. Plan assumes delivery of £22.7m recurrent savings. Highest level set in any one year. Delivery contingent on both BAU and transformation savings	High	Month 4 position reported £0.3m surplus in month, and £1.5m deficit YTD which is off plan due the impact of industrial action. Pressures arising from measles outbreak have been absorbed. ERF in month performance was lower than plan (£97k), offset by a backdated gain from M3 (£320k). ERF position is being closely monitored as commissioner expectation is that we perform in line with plan. CIP delivery is £0.6m ahead of plan in month 4 and on track YTD. Total savings of £11.9m have been transacted (green) , forecasting to deliver £16.9m (green and amber). The full year target of £22.7m is expected to be met in full, through additional actions identified in "Closing the Financial Gap" Action Plan.	High
System financial performance	Challenging 25/26 plan for C&M System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High	TBC	High
Campus and Capital Programme	Limited CDEL allocation in 25/26 Complex campus programme across multi sites, with several key buildings opening in year (Neo/Alderpark).	High	Capital – M4 capital spend is £1.3m behind plan (£0.4m YTD), however this is purely a budget phasing issue. It is highly likely that the Trust will spend its full capital allocation in year. It is expected given limited CDEL allocation, and cost pressures being raised in Neo and Elective Hub, that the capital plan for 25/26 will be extremely tight. A capital prioritisation workshop occurred in June 2025 which confirmed priority 1 items (building to complete and statutory/H&S obligations) to go ahead immediately, with a number of priority 2 items also agreed in principle subject to resolution of funding options. Discussions ongoing with providers across the system re capital brokerage options. Data centre included in priority 2 items, but noted need urgent resolution to ensure economies of scale of working collaboratively are not missed. Campus – Ongoing review of demolition, infrastructure and car park budgets vs priority works given constrained budget to meet Trust contractual arrangements for completion and hand back of Springfield Park to LCC, and to meet planning obligations for delivery of the ED car park as part of the Neo-Natal/Emergency Floor project. Bi-weekly in place to monitor Neo and Infrastructure progress.	High
Transforming Alder Hey	Transforming Alder Hey (ways of working, futures, AI & Digital)	High	Risks have been raised to both the Board and FTCP regarding the current portfolio of programmes and the financial benefits they are expected to deliver in-year. These concerns have led to the prioritisation of collaborative actions aimed at bringing greater simplicity and focus to delivery. To support this, the **Closing the Gap programme** has been introduced to provide targeted attention on high-impact financial value programmes. This initiative is designed to close the current forecast gap of £6m and ensure delivery of the £22.7m CIP plan. It includes prescriptive actions across key workstreams—such as workforce, procurement, diagnostics, and productivity—with clear financial targets and urgent timelines. Collaborative groups have been mobilised to accelerate delivery of these high-impact actions, ensuring alignment and pace across the transformation portfolio. The programme is being tracked through strategic command and will be integrated into the transformation oversight framework	High
Operational	National focus on productivity and	Medium	The trust's performance regarding patients waiting over 52 weeks continues to be a challenge. A proposal has been submitted and	

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Board Assurance Framework Report (July 2025)**
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Monthly BAF Reports
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
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 July 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 14 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
1.6	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People Committee
3.1	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	Finance, Transformation and Performance Committee
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	Finance, Transformation and Performance Committee
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	Finance, Transformation and Performance Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People	Futures Committee
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	Finance, Transformation and Performance Committee

3. Summary of the BAF at 19th August 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 not having 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
1.6 LC	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board	4x3	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	**4x4**	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	3x4	2x3
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 July 2025 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk has been reviewed and current controls and gaps in control remain. Financial environment continues to be of concern and is monitored both through SQAC and FTPC.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  Review of BAF risk undertaken. Ongoing national shortages remain with ADHD medication. Meeting with NHS England 08 July 2025 was held and updated provided regarding ongoing issues. Risk remains the same.

- ***Children and young people have timely and safe access to elective, urgent and follow up care (AB).***
  July performance against 2025/26 targets
  - - Acute (78%) - ED performance remained above target at 85%
  - - RTT (63% by March 2026) - Improvement of 0.8% compared to previous month (58.8% in month)
  - - Pts >52 weeks (1% by March 2026) - remains at approx 2% however the number is increasing. The surgical division is restarting outpatient clinics in August via insourcing model to reduce long waiters.
  - - DMO1 (95%) - Performance achieved 95%

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***
  Pipework Remediation Initiative: formal agreement reached regarding the repair and replacement of corroded pipework.

  Legal Drafting Underway: Terms are being transcribed into a formal document.

  Planning Phase Ongoing: Internal Trust staff, external consultants, and Project Co reps are collaborating to shape the next steps, including testing procedures and replacement scope.

  Survey & Planning Discussions: all stakeholders have been informed next steps being discussed.

  Operational Oversight: Water Safety Group and key operational teams continue to actively monitor progress through scheduled meetings.

  Tap Filters: Tap filters and associated safety measures in place and monitored as above through safety group.

- ***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 remains the same. Publication of CQC report planned for 06/08/2025.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***
  With a risk score of 16, this risk is closely monitored due to the impact on the workforce as a result of addressing the national and regional financial pressures. The inaugural workforce establishment and vacancy panel will take place on 7th Aug, which brings together the work of the exec vacancy panel and the workforce efficiencies group, reviewing all establishment changes, whilst closely assessing any impact and risk.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).***
  Risk reviewed. All actions reviewed and actions updated to reflect progress in work on communications and engagement, new values, leadership and data insights.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***

  Risks reviewed and 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).***
  We continue to balance the ambition of Vision 2030 with the immediate requirement to support the in-year financial position. Transformation programmes have not yet delivered the level of in-year savings needed to meet CIP targets, leaving a residual gap. To address this, targeted actions within programmes are being accelerated and a single, aligned plan with strengthened governance is being established. As part of the savings programme, a risk is being held on the ability to appoint a Head of Experience, which is being impacted by the need to control WTEs. Risk score remains at 12.

- ***Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***
  Risk reviewed with no change to the risk score at 20. Additional control added and updates provided to both actions and controls to reflect latest position. The risk score of 20, reflects the uncertainty and risk on delivery of this years financial plan largely due to CIP but also the ICB recovery programme. Further mitigations have been put in place during the month, including a focused programme reporting through FTPC on actions required to meet the financial gap. FPTC continues to oversee and `deep dive` into the financial forecast to gain assurance on delivery.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk, control and actions reviewed and no additional updates. No change to risk rating in month, and we continue to acknowledge the uncertainty in the current NHSE and ICB commissioning environment.

  The NHS 10 Year Plan has now been published, and the full effect of its recommendations are being reviewed.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  Risk score remains 9. Comms plan now underway and on tract for Sept deadline. POIZ agreement now signed and primary financial risks relate to MRI and RPA underachievement (specific risks on department risk register). Clinical capacity continues to be challenging in restricted financial environment - actions updated.

- ***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 and remains at 16. Both Data Centre business cases have been approved and the main order for the core data centre business case has been placed. Expecting implementation to be completed within 3-4 months. Governance and reporting arrangements for the service to be reviewed in August. Small number of resource constraints still remain especially in IT Ops, recruitment is underway.

5. Corporate risks (15+) linked to BAF Risks (as at 4th August 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 (I x L)	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	The risk is that 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.	5x4	Medicine	2.1	Jul 2021	Mar 2024
2719	Then the Paediatric Neurology Service becomes unsustainable due to vacancies within the Consultant team, causing a reduced service offer.	4x5	Medicine	2.1	Apr 2023	June 2024
027	Fragility of Inherited Metabolic Disease Service (IMD)	5x4	Medicine	1.2	Jun 2023	Dec 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
409	Inability to provide safe staffing levels (legacy risk ID 2100)	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

Risk	Risk Title	Score (I x L)	Division	Linked	Date opened	Increased to Corporate
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
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
2623	Then there is no access to CT scans for the entire trust. the trust is unable to provide CT scans for all patients, including major trauma patients, deterioration inpatients, elective patients, forensic patients and ED attendances.	5x3	Medicine		Apr 2022	May 2025
179	Lack of compliance with major trauma standards	3x5	Surgery		Apr 2024	May 2025
173	Business Continuity Incidents disrupting the Trust’s ability to maintain statutory duties	3x5	Corporate Services		Mar 2024	Mar 2024
362	Lack of psychology support in the Emergency Department	3x4	Medicine		May 2025	May 2025
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
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	4x4	Corporate Services	2.1	Dec 2024	Apr 2025
289	Delay in Building Works within the Rainbow Centre required for SARC Accreditation	4x4	Community		Nov 2024	Feb 2025
293	Staffing in Biochemistry	4x4	Medicine	2.1	Dec 2024	May 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

Risk	Risk Title	Score (I x L)	Division	Linked	Date opened	Increased to Corporate
1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)						
	None					
1.4 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)						
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
1.6 Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (4x3=12)						
	None					
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. (4x4=16)						
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.	5x4	Medicine	1.1	Jul 2021	Mar 2024
297	Transcription delay and increase of turnaround times	4x4	Corporate Services	1.1	Dec 2024	Apr 2025
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.	4x5	Medicine	1.1	Apr 2023	June 2024
409	Inability to provide safe staffing levels (legacy risk ID 2100)	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

Risk	Risk Title	Score (I x L)	Division	Linked	Date opened	Increased to Corporate
288	CAMHS Planned Safeguarding Supervision	3x5	Community	1.1	Nov 2024	Nov 2024
027	Fragility of Inherited Metabolic Disease Service (IMD)	5x4	Medicine	1.2	Jun 2023	Dec 2024
293	Staffing in Biochemistry	4x4	Medicine	1.2	Dec 2024	May 2025
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 (3x4=12)						
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff (GIDS).	4x4	Community	1.1	Feb 2023	*Apr 2023
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	1.1 & 2.1	Aug 2022	Jan 2024
2.3 Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (4x3=12)						
	None					
STRATEGIC OBJECTIVE: Collaborate for children and young people						
3.1 Failure to fully realise the Trust's vision for the Park and Alder Hey campus (4x2=8)						
	None					
3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (4x4=16)						
	None					
3.4 Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments. (4x5=20)						
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Programme	4x4	Surgery		Aug 2022	Feb 2024
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						

Risk	Risk Title	Score (I x L)	Division	Linked	Date opened	Increased to Corporate
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	PIMP end-of-life server which is no longer supported by the supplier	4x4	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
368	Digital infrastructure capacity and age	4x4	Corporate services		May 2025	May 2025

* risk movement data not available pre-move to InPhase

6. Recommendation

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

Erica Saunders
Chief Corporate Affairs Officer

Inability to deliver safe and high quality services.	
Risk Number	**Strategic Objectives**
1.1	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Nathan Askew

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

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

Control description	Control assurance (How is this control monitored?)
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.
Administration of IV antibiotics within 1hr for CYP with suspected sepsis	Monitored monthly through SQAC
Brilliant Basics	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.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Internal: Patient safety meeting actions monitored through SQAC External: Care Quality Commission (CQC), MIAA
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
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.
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.	Internal: Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes. External: Care Quality Commission, MIAA, NHS Improvement
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.
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
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.

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	August 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	
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	
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	
4. Patient Experience	4. 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	

Children and young people not having 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		Adam Bateman

Risk Rating		
Actual	**Target**	**Assurance Committee**
15	4	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 standards is 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.

Control description	Control assurance (How is this control monitored?)
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	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
Controls for 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
Our controls for delivering timely care 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 - 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 - Ii) Acute, Diagnostics and Urgent Care	Daily reports to NHS England -Daily situational reports and patient flow meetings - Staffing reports reviewed at staffing huddle meetings - Daily Performance summary -@ monthly ED performance report to Operational delivery group -@ Performance reports to FTP Board Sub-@Committee

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	August 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 transformation plans for urgent care includes the following high-impact changes: 1. Expanded Paediatric 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 the 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	4	Finance, Transformation & Performance Committee

Description

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

Control description	Control assurance (How is this control monitored?)
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.
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
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	

Gaps in Controls / Assurance

Remedial Works not yet completed; lack of confidence in timescales being met.

Action	Description	August 2025	
		Due Date	Action Update
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	31/03/2026	

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	4	Safety & Quality Assurance Committee

Description

Since 2020 there has been a significant increase in demand for Specialist Mental Health Services at Alder Hey, which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours, there has also been an increase in the clinical urgency of referrals received.
This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times.

Control description	Control assurance (How is this control monitored?)
Business case for investment submitted to Liverpool and Sefton Place and approved. This is is now being fully implemented.	Business case (attached)
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
Existing BI Dashboard developed to support management of open caseload	Open caseload dashboard routinely reviewed by clinical leads and assistant clinical leads with practitioners
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
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.
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
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
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)

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	August 2025	
		Due Date	Action Update
Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	30/09/2025	
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	30/09/2025	
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	30/09/2025	

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
Safe		Lisa Cooper

Risk Rating		
Actual	Target	Assurance Committee
12	4	Trust Board

Description

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

Control description	Control assurance (How is this control monitored?)
Alder Hey external website updated to reflect the information we have	Website information is reviewed and updated as there are changes in medication availability.
High frequency huddles established with ADHD nurse team / developmental / paediatrics / pharmacist / prescription team / operational management.	ADHD medication stock levels monitored by the Pharmacy Team and uploaded to the ADHD /Developmental Paediatrics Drug Shortage Teams Channel and huddles are stepped up or down depending on stock levels.
Move to one item per FP10 so that partial fulfilment is possible.	Monthly report of PALS and Complaints relating to medication is presented at the Divisional Medication Safety Subgroup which would highlight any issues with inability to fulfill all or part of a prescription if this action isn't taken.
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	ADHD medication stock levels monitored by the Pharmacy Team and uploaded to the ADHD /Developmental Paediatrics Drug Shortage Teams Channel and huddles are stepped up or down depending on stock levels.

Gaps in Controls / Assurance

- A shortage of raw ingredient
- Issues with manufacturing across Europe
- Significant (unexpected) increase in demand since 2020

Action	Description	August 2025	
		Due Date	Action Update
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
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

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**
16	4	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 development practices to improve workforce diversity and progression
4. Not developing a Trust wide approach to succession planning and talent management
5. The Trust would be unlikely to successfully achieve the vision set out in both the People Plan and Vision 2030 if the right workforce is not available
6. Impact of national financial pressures on workforce numbers to deliver patient care
7. Not having a sustainable workforce will impact upon culture

Control description	Control assurance (How is this control monitored?)
Apprenticeship Strategy implemented	
Attendance management process to reduce short & long term absence	Sickness Absence Policy
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
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
Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030	
Financial Improvement Programme	
Health and Wellbeing Forum	Health and Wellbeing Forum Terms of Reference
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
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
Monthly monitoring through Ops Board, Board, Execs and People Committee	Regular reporting of delivery against compliance targets via divisional reports
Nurse Retention Lead	Bi-monthly reports to PC
Nursing Workforce Report	Reports to People Committee, SQAC and Board
PDR and appraisal process in place	Monthly reporting to Board and PC
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board
People Policies	All Trust Policies available for staff to access on intranet
Recruitment Strategy currently in development	progress to be reported PC
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes

Gaps in Controls / Assurance
1. Training/development 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 and progression opportunities across the organisation 7. The national and regional requirements to reduce NHS financial deficit, which is directly impacting on WTE

Action	Description	August 2025	
		Due Date	Action Update
2. Sickness absence levels higher than Trust Target	Ongoing interventions remain in place to support the management of sickness, which have increased to 6% from a Trust target of 4.5% A detailed review of sickness absence has been undertaken and presented to people committee and Executives, and the next action is to implement a 90-day attendance Improvement Programme, based on the principles of the improvement project undertaken at East Cheshire NHS Trust, through appreciative inquiry.	30/11/2025	
7. Training and Development Action Plan	Head of Learning and Development to establish action plan for addressing areas/subjects of low compliance in mandatory training for specific staff groups and/or subjects	30/11/2025	
3. Future Workforce	3. Establishment control in place. A task and finish group will be set up with finance, HR and Ops colleagues to establish a 3-yr workforce plan, which will be shared with the ICB. In addition, the work of the Organisational Design Collaborative will shape the future leadership structure, as well as review the structures across other professional staff groups to meet changing organisational pathways and patient need.	31/12/2025	
4. Lack of Robust talent and succession planning	The Professional Development hub to establish a comprehensive talent and succession management programme, aligned to vision 2030. Identifying both talent and skills gaps and addressing priority organisational need over the next 12 months, as well as establishing longer term plans, that will complement the 3-year workforce plan	31/03/2026	
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.	31/03/2026	
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.	03/03/2027	

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
12	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 and adapt well to other significant external and internal organisational changes.
- Failure to create a happy, healthy, fair place to work for staff that is trauma informed and based on restorative, just and learning principles
- Failure to communicate effectively with staff and have the right intelligence to be responsive to their unmet needs
- Failure to design, develop and support compassionate and effective leadership at all levels

Control description	Control assurance (How is this control monitored?)
Action Plans for Staff Survey	Stored on Trust Intranet and accessible for staff
Alignment of staff safety and patient safety work via developing safety culture training, developing Restorative Just & Learning culture strategy and focussed work on Avoidable Employee Harm with People Services	
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. Plan delivered moved into business as usual.
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Director of Culture in post focussed on staff experience, safety culture, leadership, & high performing teams	Director of Culture feeding into People Committee and Board
Employment Policies	
Freedom to Speak Up programme	Board reports and minutes
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to People Committee
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Occupational Health Service	Referral data, key themes and outcomes reported to People Committee as part of the People Paper
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to People Committee
Partnership working	
People Pulse results available	People Committee reports
Regular communication channels	
Regular Schwartz Rounds in place	Steering Group established
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to People Committee as part of the People Paper
Staff Networks	
Staff surveys analysed and followed up (shows improvement)	2024 Staff Survey Report - main report, divisional reports and team level reports
The People Plan Implementation	Monthly Board reports Bi-monthly reporting to People Committee
Thriving Leadership Programme	Strategy implementation as part of the People Plan
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.	Teams and issues of concern discussed at quarterly meetings with Divisional leads but not currently formerly reported through to People Committee
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered

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 - lack of aligned communications approach that is responsive to organisational needs - lack of control of system decisions and pressures regarding the financial environment

Action	Description	August 2025	
		Due Date-	Action Update
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	
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.	31/10/2025	Meeting arranged with Chief Digital Officer and Patient Safety lead to discuss technical expertise and support available internally to support the development of a team measure to include safety culture metrics. Thriving Staff Index launched on 1st July 2025. Implementation plan developed to ensure both organisational and more targeted approaches and uses of the tool.
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.	03/11/2025	Regular meetings with Patient Safety Lead and working group to be established to progress this work. Decision document approved at Patient Safety Strategy Board. Focussed work in development as part of Deteriorating Patient workstream to be presented and agreed at workshop in October
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.	10/11/2025	Draft National NHS leadership and management competencies developed. Gap analysis being conducted by Head of OD (in liaison with L&D) to scope read across to competencies being developed as part of current Thriving Leaders framework with a view to identifying steps to address gaps identified. Awaiting clarity from national work as to how the core competencies will be developed and whether this will be centrally available or the responsibility of individual organisations.
Restorative just and learning culture	Restorative just and learning principles to be embedded through patient safety work and all people practices. Consultation on approach to be provided to patient safety leads and investigators to support the implementation of PSIRF and to help to facilitate learning reviews where indicated. Work to be progressed about Avoidable Employee Harm with HR, staffside and other key stakeholders through workshops, consultation, policy review and training	30/01/2026	Second AEH workshop planned with HR, Staffside and FTSUG to progress this work
2. Financial environment and culture	Attend Financial Improvement Programme tactical command meetings to reflect evolving understanding of the impact of financial controls on staff and work with the group to try and address these impacts. Ensure executive team are well briefed as to intelligence gathered from staff via listening routes such as SALS that pertain to the financial environment to help to shape communications and relevant interventions	31/03/2026	
Responsive communications	Links to be strengthened with communications team to ensure that communications are responsive to organisational need, values based and aligned to the culture. To be achieved via attendance at newly developed Communications Board and via closer links with comms team in values working group and other relevant fora	31/03/2026	New executive visibility and engagement proposal drafted with input from lead for internal comms and with reference to the Comms Transformation plan. To be presented to CEO on 5th August for discussion and approval
Values and behavioural framework review, update and implementation	New values and behavioural framework to be developed and embedded across the organisation.	31/03/2026	New values formally announced to the organisation on 23rd July with invitations to all staff to be part of consultation programme to develop framework and toolkit. Comms plan (design work and branding) still to be agreed in view of resource requirement for this work.

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 attract, recruit, and retain a workforce which reflects the demographics of the local population.
- Failure to foster an inclusive work place where staff feel respected, valued, and are able to contribution fully as an individual.
- Failure to provide equitable access to career development, progression, and leadership opportunities.
- Failure to meet statutory obligations under the public sector equality duty and wider equality obligations.

Control description	Control assurance (How is this control monitored?)
Actions taken in response to EDS22	Reported to EDI Steering Group, People Committee, and Patient Experience Group
Actions taken in response to Gender Pay Gap	Gender Pay Gap action plan, reports to People Committee and is part of the High Impact Actions
Actions taken in response to the North West BAME Assembly Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to the WRES/WDES	monthly recruitment reports provided by HR to divisions to incorporate WRES/WDES actions and report to People Committee
Collaborating across the Liverpool City Region to align regional and system wide practices	Building strong partnerships across the city region to ensure the EDI work aligns and that we share best practice, utilise opportunities and resources and relationships that will support the EDI work.
EDI Steering Group established - Chaired by NED	Minutes reported into People Committee. Membership has grown and will include Divisional Representation
Education and training for staff in relation to EDI	Mandatory EDI Training for all staff. current compliance above Trust target of 90%. Management Essentials Introduction to EDI Launched 2024, Thriving Leaders Programme includes module on EDI. Extensive online EDI training programme available for all staff to access. Anthony Walker Anti-Racism training provided as part of Thriving Leaders programme and also to certain identified areas. Neurodiversity training also delivered to certain areas and as part of the Thriving Leaders Programme.
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives Policy just updated.
Full time Head of EDI now in place	Full time Head of EDI and part time EDI officer. HR advisors/managers identified to support each of the staff network and also support the implementation of EDI projects embedding EDI into HR practices.
Inclusive People Policies and training	People Policies (held on intranet for staff to access). Recruitment and Selection training launched incorporating inclusive practice. Staff Networks support policy develop and are invited to EPRG
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 6 of delivery, continues to include a focus on inclusive leadership. Development of a targeted leadership programme for our Internationally recruited staff
NHS England EDI Improvement Plan supported by Trust Board, and associated high impact actions	NHSE EDI Improvement Plan reported to Board
Organisational approach to equality analysis, which includes EDI audits and more robust demographic data collection process	Equality Impact Assessments undertaken for every policy & project the process is being reviewed and revised and a staff resource being developed to support application EDS 22 Publication working in collaboration with Patient service leads
People Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	- bi-monthly reporting to Board via People Committee on diversity and inclusion issues - monthly Corporate report (including Workforce KPIs) to the Board
Staff Networks, providing continuous support to grow and contribute to embedding EDI	All networks have appointed chairs, supported by Head of EDI are members of EDI Steering Group and report bi-monthly into the group. All staff networks have an executive sponsor
Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	Monitored through People Committee. Staff Survey Action Group developed to support the implementation of initiatives that will support Staff Survey.
Work with Communications colleagues to ensure that messaging is inclusive, supported by a dedicated communications plan, fostering a culture of belonging across the organisation	Work with communications to ensure that we are providing the organisation with the right messages. Support with all EDI related events. Head of EDI supports staff awards judging, communications colleagues are members of the EDI steering group. Development of a clear communication plan.

Gaps in Controls / Assurance

1. Recruitment practices are not accessible and inclusive and do not target diverse communities
2. Lack of inclusive leadership behaviour and accountability for embedding cultural change.
3. Informal processes that limit equitable access to career development and advancement of opportunities.
4. Limited organisational awareness, training, and governance around legal duties.

Action	Description	August 2025	
		Due Date	Action Update
Informal processes that limit equitable access to career development and advancement of opportunity	Mutual Mentoring programme launched. Alder Hey part of the LCR Leadership Shadowing programme. Development of Grow to Lead Leadership Programme targeted at International recruited staff, including sponsors to support candidates. Closer monitoring of uptake of CPD uptake	15/07/2025	
Lack of inclusive leadership behaviour and accountability for embedding cultural change	Inclusive training for managers launched as part of the Thriving leaders Programme. Support from staff networks which include regular feedback. Mutual Mentoring Programme launched with staff networks. Staff Survey Action Group developed, focusing on targeted EDI results, High Impact Actions plan is being implemented.Trust EDI Objectives co-produced with staff networks.	15/07/2025	
Limited organisational awareness, training, and governance around legal duties	Review and revise the Equality Impact Assessment process, developing a toolkit to support staff in undertaking the process. Publication of Trust EDI objectives. HR advisors and managers to provide added resource and support to successfully embed EDI initiatives	15/07/2025	
Recruitment practices are not accessible and inclusive and do not target diverse communities	Accessible and Inclusive Recruitment Practices working group established. Recruitment and selection training launched, incorporating EDI throughout. Recruitment and Selection Toolkit currently being revised which includes support and guidance on inclusive recruitment practices. Review of recruitment materials to ensure inclusivity.Target recruitment campaigns in under represented community groups working in collaboration with Liverpool City Region Race Equality Hub	15/07/2025	
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.	21/10/2025	
1. Multi-factoral issues spanning training and education	EDI training programme launched. Training needs continue to be assessed and identify learning needs. Inclusive recruitment and selection training has been developed and launched which includes EDI. Neurodiversity training delivered to specific clinical areas.	28/10/2025	
3. Cultural awareness and understanding	- Introduction of Staff Networks - develop and implement education and awareness programmes - Foster a learning culture -Launch Mutual Mentoring -Strengthen workforce engagement	28/10/2025	

Failure to fully realise the Trust's Vision for the Park

Risk Number	Strategic Objectives
3.1	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Safe		Rachel Lea

Risk Rating		
Actual	Target	Assurance Committee
8	4	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.

Control description	Control assurance (How is this control monitored?)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
CEO Campus Highlight Update Report	Fortnightly Report
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
Exec Design Group	Quarterly Minutes of Exec Design Reviews
Meetings held with Liverpool City Council at key stages	public meetings held
Monitoring reports on progress	Monthly report to Board and FTP Stakeholder events / reported to Trust Board and CoG
Monthly reports to Board & FTP	Highlight reports to relevant assurance committees and through to Board
Neonatal Programme Board	monthly meeting
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision
Planning application for Neonatal and Urgent Care	Full planning permission gained
Programme and plan (agreed with LCC and LPA) to return the park back by March 2024 (phase 3).	Updates on progress through Campus report.
Strategic Estates and Space Allocation Group	Chaired by Exec, meets quarterly
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
Weekly Programme Check.	The Development Team run a weekly programme check.

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	August 2025	
		Due Date	Action Update
Adoption of the SWALE by United Utilities	Engaged with planning consultants to assist with planning requirements.	30/06/2024	
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	
Park Handover	Preparation of certification, warranties and legal documents for full handover to LCC following completion of phase 3	30/11/2025	
Stakeholder Engagement	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.	31/03/2026	
Funding availability and potential market inflation	Continual monitoring of market inflation	31/03/2026	
Weather conditions causing potential delays	Dry season now upon us – all works now in accordance with revised programme and on target.	31/03/2026	

Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	
Risk Number	**Strategic Objectives**
3.2	Collaborate for children & young people

CQC Domains	Linked Risks	Owner
Well-Led		Kate Warriner

Risk Rating		
Actual	**Target**	**Assurance Committee**
16	4	Finance, Transformation & Performance Committee

Description

Risk of failure to:
- continue to deliver the ambitions of Vision 2030 given multiple competing demands of the system coupled with variable capacity, balancing short-term versus long-term decision making on priorities and investment.

Control description	Control assurance (How is this control monitored?)
Assurance and support mechanism framework for transformational collaboratives	
Executive Portfolios all incorporate elements of Vision 2030 delivery	
Executive sponsor roles within the programme	
Operational Plan incorporates Vision 2030 deliverables (2025/26)	Operational Plan
Portfolio Board	Portfolio Board
Reports to Board and FTPC	
Transformational collaboratives with Divisional SROs	Programme assurance framework

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	August 2025	
		Due Date	Action Update
5. Risk of mission creep associated to the Strategy	Sharp focus at Strategy Board on core mission	12/12/2023	
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	01/07/2025	

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	4	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.

Control description	Control assurance (How is this control monitored?)
Active engagement within ICB, NHSE both regional and national.	- Attendance at system forums. - Cascade of system and national information on a regular basis. - Advocate for CYP - Hosting of Beyond programme
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'). Clear escalation to FTPC where required for high risk areas.
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 and Trust Board. 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.
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 rollout to all budget holders with all information readily available in one place.
Focused programme on closing the financial gap in year and realising the recurrent benefits.	8 key areas including in year transformation programme, with executive lead to drive financial benefits at pace to close the CIP gap in year Reporting into FIP and strategic command fortnightly with decision documents on financial savings.
Organisation-wide financial annual plan monitored throughout year by Board and sub-committee to ensure delivery.	- Specific Reports submitted monthly and annually as part of business plan process.(i.e annual plan reviewed by FTPC) - Monitored through IPR and the monthly financial report that is shared with FTPC and Trust Board.
Transformation Programme & benefits realisation	Weekly meetings are in pace for the transformation collaborative which includes benefits realisation and cost reduction and savings. Reported to FTPC as a top 5 key risk. Enhance reporting through FIP and strategic command for 2 of the areas to accelerate in year financial savings.

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	August 2025	
		Due Date-	Action Update
Inflationary pressures	Monitor closely impact of inflation increases working with HPL to obtain data on supplier increases and inflation avoidance through negotiations.	31/03/2025	
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. Reporting into FTPC and Board. Capital remains a key risk on FTPC	31/03/2026	
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 commissioning	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	
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	

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	4	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 2030.

Risk of constantly changing relationships and key personnel due to destabilisation of the commissioning environment.

Control description	Control assurance (How is this control monitored?)
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). Update: New CEO & leadership arrangements at RMCH - exec to exec scheduled for July 25
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.
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy.
Continual reflection of the impact of delegation of specialist services into ICBs. Routine reflection of the risks / opportunities for SYP.	Children's Hospital Alliance proposals (under development). On current CHA agenda in March 25
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
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board
Impact of changing NHS finance regime, commissioning intentions (described in BAF 3.4)	See BAF 3.4 (financial environment)
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 Update Jun 25: Further embedding of the partnership priorities/leadership within the Tx Clinical Collaboratives
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	Reporting through Strategy Board Update Jun 25 : Strategic Pships governance within new 'GO' Committee developments
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
Maintain existing 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
Membership of CMPC Provider Collaboratives - to ensure CYP voice high on agenda	Membership of CMPC provider collaboratives.
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES Partnership Plans developing with CYP focus. Update Jun 25: High disruption of Places due to ICB new model - however Alder Hey continued commitment in all 3

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	August 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	
2. Impact of delegation of Specialist Commissioned services into ICBs	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2026	
3. Stakeholder & Partnerships Plan - Phase 2 of Vision 2030	3. 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	
4. National mandates & system finance forcing us to prioritise unexpected programmes of work	4. Horizon scanning. System scanning (e.g. via assigned ICB leads in turnaround) and local capacity scanning (via Portfolio Board, TX Programme & Executives)	31/03/2026	

Failure to deliver against the trust strategy and deliver 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	Risk Rating		
			Actual	Target	Assurance Committee
▪ Caring ▪ Effective ▪ Safe ▪ Well-Led		John Chester	9	4	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.

Control description	Control assurance (How is this control monitored?)
Clear management structures and operational accountability within Futures including the Clinical Research Division, Innovation team and Futures aspects of Education and Digital	Reports to Operational Board
Data governance via Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOP
External communications via internet, social media etc facilitated through Marketing and Communications team	Communications Strategy and Brand Guide
Futures Committee Additional oversight of financial and commercial aspects of R&I activity	Reports to Trust Board via Futures Committee
Futures Management Board Delivery and performance measurement of various R&I activities	Reports to Futures Committee
Protection +/- exploitation of intellectual property	Reports to Futures Committee
Risk registers	Reports to Risk Management Forum
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
Strategic commercial partnerships with industry partners and commercial vehicles	Reports to Futures Committee

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	August 2025	
		Due Date	Action Update
3. Comms Strategy for Futures	Development of Futures comms approach	30/09/2025	
2. Capacity and capability	Create an R&I enabled workforce through the Futures Develop Pillar	31/03/2026	
1. Financial Model	- Securing external investment (Grow and Discover Pillar) - Building capacity and capability funding through commercial research, NIHR grant applications, AH charity partnership and and other external funding which attracts indirect costs (Grow, Discover and Develop Pillar) - Supporting cost saving initiatives across the Trust through adoption of innovative technology (Tranform Pillar)	31/03/2026	

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
▪ Effective ▪ Safe		Kate Warriner

Risk Rating		
Actual	**Target**	**Assurance Committee**
16	4	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.

Control description	Control assurance (How is this control monitored?)
Clinical and Divisional Engagement in Digital Strategy	Divisional CCIOs and Digital Nurses in place.
Digital Centre of Excellence in place & fully resourced - Chaired by Trust CCIO	Digital Centre of Excellence tracking delivery
Digital Data and AI Collaborative Established as part of transformation programme	Multidisciplinary leadership roles identified. Delivery programme in place.
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
Executive level CIO in place	Commenced in post April 2019, Deputy CDIO in place across iDigital Service
External oversight of programme	Strong links to system, regional and national digital governance via internal and external relationships.
Formal change control processes in place	Weekly Change Board in place
High levels of externally validated digital services	HIMSS 7 Accreditation
Monthly digital performance meeting in place	iDigital performance meeting in place. Performance reported as part of Corporate Collaborative.
Regular update to Trust Board on digital developments, Monthly update to FTP	Board agendas, reports and minutes

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	August 2025	
		Due Date	Action Update
Experienced Resources	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce	30/06/2025	
Cyber Assurance Framework & Strategic review of Cyber Security	This has replaced the action around Cyber Essentials +.	31/07/2025	
2. Mobilisation of Digital and Data Futures Strategy	Mobilisation of Y1 of Digital and Data Futures Strategy	29/08/2025	
Digital systems review	Digital systems review	31/03/2026	
Investment plan for programme and business as ususal resource		31/03/2026	

BOARD OF DIRECTORS
Thursday, 4th September 2025

Paper Title:	Corporate Risk Register Report (CRR)
Report of:	Associate Director of Nursing and Governance
Paper Prepared by:	Risk Management Manager / Facilitator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ■
Summary / supporting information:	Corporate functions' risk registers via the InPhase electronic risk management system. Divisions' risk registers via the InPhase electronic risk management system.
Action/Decision Required:	To note ■ To approve ■
Strategic Context: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Implications:	Resources identified to support management of risks as required.

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

1. Purpose

This paper provides the Trust Board with a summary of the estimated trend analysis of high-risk metrics for the 12-month reporting period 1st June 2024– 31st July 2025, based on available data at the time of reporting.

2. 12 Month Summary CRR (June 2024-July 2025)

Table 1

High risks	1st June - 31st July 2025	1st May - 31st May 2025	1st March - 30th April 2025	1st - 28th February 2025	1st December 2024 -31st January 2025	1st September - 30th November 2024	1st July - 31st August 2024	1st - 30th June 2024	1st - 31st May 2024
Total number of high risks	24	23	23	20	21	22	19	27	27
Number of new high risks reported	3	2	5	0	0	2	0	1	3
Number of high risks closed or removed	1	0	0	0	0	0	0	0	1
Number of high risks with increased risk score	3	1	3	2	2	9	2	2	2
Number of high risks with decreased risk score	1	2	3	2	4	4	2	3	2
Number of high risks overdue review	0	0	1	0	1	2	2	0	6
Number of high risks with no agreed action plan	1 (2643)	5 (289, 341, 297, 140, 292)	5 (289, 341, 297, 140, 292)	1 (229)	3 (271, 288, 253)	3 (271, 288, 253)	0	3 (2643, 151 & 2077)	2 (140 & 178)
Number of high risks with actions past expected date of completion	5	8	5	6	6	4	6	9	7
Number of high risks with static risk scores	21	22	18	18	17	10	13	26	25

- **Total High Risks** show a gradual increase, indicating accumulation, slow resolution or identification of new high risks.
- **New high risks** have shown a fluctuation in reporting, with a peak in March -April 2025 (5 new risk) and low in February 2025 (zero) suggesting variable reporting and emerging of risks linked to operational or seasonal factors
- **Closures of high risks** are minimal, with only one risk closed by July 2025, indicating possible challenges in resolving high risks or delays in mitigation.
- **Risks with increased risk score** peaked in July 2025 (3 risks), suggesting worsening conditions for some risks possibly due to evolving concerns and limited opportunities for mitigation.
- **Decreased Risk Scores** peaked in February 2025 (4 risk), showing some mitigation success early in the year.
- **Overdue Reviews** are mostly under control, with only one instance in March-April 2025.
- **High risks with no agreed action plan** show a fluctuating trend with a peak noted in April-May 2025(5)**,** indicating inconsistent action planning by risk owners.
- **High risks with actions past expected completion date** are noted to be generally high, ranging from

4 to 8 suggesting delays by risk owners in completing risk mitigation actions

- **High risks with static scores** show a fluctuating trend indicating, suggesting risks are not being reevaluated or mitigation are unresolvable

- Details of high risks on CRR as of 31 July 2025 are outlined fully in appendix 1

3. Next steps

Continued oversight of all high risks on CRR at risk management forum (RMF) gaining assurance of mitigation and escalation to Audit and Risk Committee of any concerns identified.

Ongoing programme of risk deep dives at RMF to gain assurance and oversight of mitigation including overview of agreed risk process within and across divisions/services

Programme of risk appetite roll out across the organisation following successful pilot within Community and Mental Health division.

Ongoing embedding of risk management via monthly risk oversight meeting with all risk owners/divisions

4. Recommendation

The Trust Board is asked to note the estimated trend analysis of high-risk metrics for the 12-month reporting period 1st June – 31st July 2025 and next steps in ongoing risk management.

Appendix 1
TABLE 3: THEMES

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Compliance and Regulatory							**Apr-25**	**May-25**	**Jul-25**
173	Corporate	Emergency Preparedness	22/03/2024	15 (5x3)	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties. The risk is the potential for the Trust being unable to meet its obligations in alignment with legislation, NHS England national policy, local guidance, and good practice, impacting on staff, patients, finance, reputation, and the wider health economy	Trust overarching business continuity plan. Workshops delivered to support business continuity plan (BCP) authors in the creation of their BCPs aligned to NHS England Framework. 2024 EPRR Core standards deep dive theme was to seek additional assurance on cyber security arrangements. Trust's IM&T Team have a Data Security Protection Toolkit (DPST) Plan in place for the Trust. All Trust local and divisional BCP's to follow NHSE Themed developed and adopted toolkit. Divisional reports / debriefs of BC incidents, including lessons identified, lessons learned and subsequent changes to business continuity plans. EPRR centralised lessons learned action plan following large disruptive events. Trust has an Incident Coordination Centre SOP in place. The Trust has a generic Incident Response Plan.	15	15	15

This risk has been reviewed, and the risk remains the same. Ongoing work through EPG and enhanced reporting. SQAC oversight in place to support assurance.									
289	Community & Mental Health	Rainbow - SARC (Sexual Assault Referral Centre)	28/11/2024	16 (4x4)	Delay in Building Works within the Rainbow Centre required for SARC Accreditation. SARC accreditation delayed or not attained due to building works required within the Rainbow Centre to meet ISO 15189 standards	Alterations to Rainbow Centre discussed with Estates and being costed.	16	16	16
Air Flow reviewed and re-balance completed, further information needed as to next steps, await update from Mitie. Building work date for partition still not set, await update from Mitie.									
341	Community & Mental Health	Rainbow - Children In Care	28/02/2025	16 (4x4)	Trust is not compliant with Intercollegiate Document: Looked After Children (Children in Care) December 2020	Clinical Director for Safeguarding and Statutory Services in post from 01/12/2024 is providing support to the Associate Director for Safeguarding and Statutory Services and Named Nurse for Children in Care in respect of urgent medical queries.	16	16	16
Vacancy for Named Doctor for Children in Care is back out to advert. No further update currently.									

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Financial - Investment							**Apr-25**	**May-25**	**Jul-25**
2643	Surgery	Medical Devices Safety	15/08/2022	16 (4x4)	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program	£50k emergency equipment fund. A process has been developed to risk access the priority of device replacements. Escalation of risks and area lead engagement - Ongoing concerns requiring escalation will be reported via the Capital Committee. Area leads will be given more responsibility for identifying and managing their capital replacement priorities.	16	16	16
No changes to risk.									

368	Corporate Services	IM&T	22/05/2025	16 (4x4)	Digital Infrastructure Capacity and Age	Prioritised servers so system criticality taken into account in event of data centre loss. Intercity to produce an 18-month plan for resolution but will require investment from the Trust. Work will shortly commence on producing a Business Case to support for both core switches and wireless. Work planned with Intercity to replace the telephony switchboard hardware and upgrade to the latest version. Databases backed up to Rubrik.	12	12	16
Risk consolidated with: 366 - Outdated hardware/software running clinical databases.									

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Quality - Effectiveness							**Apr-25**	**May-25**	**Jul-25**
2590	Medicine	Radiology	25/04/2022	15 (5x3)	If the only CT scanner within the trust continues be intermittently out of service at increasing frequency, then there is no access to CT scans for the entire trust. The trust is unable to provide CT scans for all patients, including major trauma patients, deterioration inpatients, elective patients, forensic patients and ED	There is a high-cost maintenance package with the current CT scanner to avoid any downtime. Phillips engineers are required to be on site within 4 hours to support resolution. The maintenance package involves regular maintenance checks. Action Card is available for staff detailing what to do when the CT scanner goes down. Four of the staff are trained to perform CT with the gamma so until the other team members are trained in August, the trained members will be available to call if this issue happens and the risk comes to light.	10	10	15
CT scanner in a Van is in place and apps training continuing. We now have business continuity from 28th July 2025. Weekly CT progress meetings in place for updates on building works with a project lead to facilitate.									

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Quality - Safety							**Apr-25**	**May-25**	**Jul-25**
179	Surgery	Major Trauma	08/04/2024	15 (3x5)	Lack of compliance with major trauma standards	Peer review action plan in place-working through since 2023. Trust was 80% compliant with Major trauma standards with an action plan to work towards compliance of the remaining 20%. The action plan has now stalled, and evidence now shows a decline in our compliance with standards from the 80% position.	9	15	15
Progress remains stalled. Peer review action plan reviewed by network team 19/06/25. Supporting letter provided.									
293	Medicine	Laboratory Medicine	10/12/2024	16 (4x4)	Staffing in Biochemistry	POC devices can be used for urgent electrolyte testing. Clinical scientist on call can support with advice around other testing requirements and offsite referral if needed.	12	12	16
Benchmarking for specialist workforce in progress. 2 new recruits training progressing well. Organisational change document to be drafted to introduce on call / standby.									
288	Community & Mental Health	Rainbow - Safeguarding	21/11/2024	15 (5x3)	CAMHS practitioners who hold specific and ongoing responsibility for safeguarding children may not receive timely and reactive safeguarding supervision and will not receive planned supervision they require to support safe and effective safeguarding practice	Communications sent to all CAMHS Practitioners to advise that planned supervision has been temporarily suspended, however reactive supervision is still available daily via the Safeguarding Duty Team. CAMHS Practitioners have been directed to seek immediate and reactive safeguarding supervision as required via the Safeguarding Duty Team which is available Monday - Friday between 8am-6pm.	15	15	15
The CAMHS Safeguarding Practitioner is now due to be off work until the end of August. Contact made with the CAMHS Clinical Leads to arrange time to meet to discuss a plan going forward.									

27	Medicine	Metabolic Disease	20/06/2023	20 (5x4)	The Metabolic Disease service is fragile and could fail to deliver the appropriate standard of care needed by our patient cohort	Hub and Spoke model with Manchester Consultant attendance at Alder Hey 2/7 days. The metabolic service have identified patient cohorts in order to safely manage the patients moving forwards. A patient database of all metabolic prescriptions has been established. Sourced 2PA worth of General Paediatrics consultant time for the Metabolic Service.	20	20	20
No PALS or complaints since the last review. There have been two additional incidents since the last review. One around clinic capacity and another on blood spot training for families. Both incidents are being reviewed and responded to. Costings for a proposed SLA have been sent over and meeting held with Manchester on 06/08/2025 to discuss further. Service Manager is reviewing costings, and a further meeting is planned for September.									
229	Corporate	IM&T	20/06/2024	16 (4x4)	Alder Hey Pathology reports are sent electronically to primary care organisations. This process utilises an end-of-life server which is no longer supported by the supplier	Pathology IT team monitor the reporting systems daily to ensure they review any failed reports.	16	16	16
Exploring opportunities to secure finding but at present this hasn't been successful. At present there is no identified funding stream.									
2740	Medicine	Radiology	06/02/2023	16 (4x4)	If an Interventional Radiologist is unavailable, there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed	Previous interventional radiologists have agreed to provide cover when the sole IR consultant has planned leave. Emergency pathway developed for reference and sent out to trust staff. Hours are restricted on contract and IR taken off radiology oncall to reduce out of hours work. Weekly email being sent out with current situation and process to follow if IR is required.	16	16	16

					expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post				
Belfast and Manchester IR consultants to cover non-vascular intervention when AH consultant has leave in the next couple months - Leave dates confirmed so planning can commence for additional cover and to ensure theatre time is given. Weekly corporate communication giving IR cover options for that week. Noted in Surgery Risk 179 - lack of compliance with major trauma standards. Physician Associates undertaking Induction in Radiology to support booking and facilitation of IR.									
2431	Community & Mental Health	ASD/ADHD	23/07/2021	16 (4x4)	Children and young people will not receive the outcome of their ASD assessment within the agreed timescale (90% of cases within the 65 weeks Trust standard)	Clinical review of waiting list completed monthly and appointments allocated to longest waiters first. Regular performance reports provided to ICB to monitor compliance with standard Service is fully staffed to capacity (recurrent funding). ASD Administrative Staff Review completed, and additional Assistant Operational Manager post is in place to oversee the Admin Team. Bank staff being used to cover any gaps in clinical rota. SOPs in place to standardise assessment and administrative processes.	16	16	16
Transformation programme ongoing and due to be completed in September 25. Longest waiters for ADHD Neurodevelopmental now have been collated and added to full Neurodevelopmental list so can be seen in appointment date order.									

2650	Medicine	Haematology	26/08/2022	16 (4x4)	If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4	Lead for haemoglobinopathies and laboratory being covered by other haematology consultants. Additional waiting list initiative clinics put on to ensure elective work is completed in a safe and timely fashion. 1x substantive haematology consultant post advertised. Additional Specialty Doctor and 2 WTE Fellow recruited.	16	16	16
Successful at recruiting a Haematology Clinical Fellow who is due to start at the beginning of August 25. The plan is that this candidate will be suitable to interview for a substantive consultant post in the coming 18 months to 2 years. At present this is the only viable option we have to support this service.									
2685	Medicine	Neurology	04/11/2022	20 (4x5)	There is a risk to being unable to provide a safe, effective and timely service for tertiary Neurology patients. This includes the ability to diagnose, treat and manage patient demand	Permanent post in place. Locum consultant in post (0.6 WTE). Locum sessions to existing consultants for on-call controlled out of hours provision. Trust Improvement programme to review current provision and support development of alternative Neurology model. Additional consultant appointment will offset leaver. Locum consultant in post and Specialist Doctor. Introduction of Patient Pass to support local DGH timely review for urgent requests. Current consultant workforce to provide extra clinics to reduce waiting times.	20	20	20

Email to be sent to Director of Medicine Division and Clinical Director for Medical Care Group to suggest lowering score from 20 to 16. We haven't had any complaints or incidents since the last review. MDT is established and now in trial phase. We are also out to recruit a further consultant to join the workforce.									
2419	Medicine	Pathology	06/07/2021	20 (5x4)	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres and ECMO.	Close working established with Cardiac surgery team, ECMO and PICU, and Liverpool Womens (neonatal unit). 2 x Band 7 staff filling 1 rota place to help ensure service continuity. 1 x Band 5 BMS is being trained in blood transfusions and will undertake out of hours shifts in the presence of the Acting Haematology Manager later in October. 1 x Band 6 BMS has just started and is being fast tracked through competency assessments in haematology. Fortnightly meeting with HR support and divisional management.	20	20	20
Rota to move to 1 in 6 from September. Band 6 expected to be signed off in October. 1 in 7 rota from November. Band 5 starting end of August, Band 6 starting October. 2 on maternity leave, 1 on long-term sick.									
292	Corporate	IM&T	04/12/2024	15 (5x3)	Inappropriate sharing of demographics	Process in place for adding Safeguarding flags to records e.g. confirming who information should be shared with. Safeguarding Policies and Procedures in place. Information Governance Policies and Procedures in place. Mandatory Safeguarding Training. Mandatory Information Governance Training.	15	15	15

Actions that have been taken via the group are stated as below: - Process owners – operational colleagues best placed to collectively manage the new process - were agreed to be Chief Administration Information Officer, Head of Safeguarding and Statutory Services or nominated safeguarding team member and Head of Information Governance. A streamlined process for front-line colleagues to document parental responsibilities and communication requirements based on parental responsibilities identified. Understand processes and system around demographics checks, changes and alerts by December 2024. Achieved. Design an enhanced process by December 2024 Achieved. Align changes into existing PDS project to be taken forwards by February 2024. Achieved Governance. To be presented to PSIRI panel by February 2024. Achieved. Week of the 03/06/25 discussion to take place for implementation to go along with PDS training.									
335	Medicine	Radiology	14/03/2025	15 (3x5)	Radiology Report Addendums are not visible on Meditech	Fix being investigated by PACS manager and IT. Any critical addendums should be communicated to the referring clinician.	15	15	15
Meeting with interface team - potential fixes identified. Will require building and testing.									
297	Corporate	Transcription Pool	23/12/2024	16 (4x4)	Transcription delay and increase of turnaround times	Daily reporting on activity levels, and also the fulfilment of bank hours to cover vacant hours impacting on productivity. Cease further onboarding of additional clinicians onto Lyrebird until the new year to reduce impact of manual transcription. Resolution of remote access solution for Transcription Team to be able to undertake bank hours from home which will increase productivity and support increased uptake of bank hours. Ensure as much dictation as possible is managed via the outsourced transcription workflow to mitigate as much in-house transcription as possible at this point in time.	16	16	16
. Backlog is now accruing again at a rate of 230 letters per day. Revised recovery and sustainability plan is being documented to be presented to Execs in the next 2 weeks. It is anticipated the current backlog will reach 12,500 letters by 15th August.									

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Reputation							Apr-25	May-25	Jul-25
2745	Community & Mental Health	Community Division - Division Wide	10/02/2023	16 (4x4)	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff	Strategy agreed at GDS North Programme Delivery Board and Trust Board. A GIDS North Programme has been established. There is a supporting governance structure that engages with the South Hub to ensure a consistent national service, as well as regular engagement with NHS England. A gateway review process is also in place. There is a national communications group, with North hub representation and a regular meeting in place with the PMO and communications lead. Process in place for directing queries regarding the service to NHSE. External organisation and SME commissioned to support the Trust. Service will continue to work to the NHS England Clinical Policy, media queries to be diverted to NHSE where appropriate.	16	16	16

Risk reviewed and scoring remains the same due to ongoing potential future media attention about the research trial which is not yet live. Actions and controls in place and ongoing remain unchanged.

Risk	Division	Service	Date Added	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
Workforce - Sustainability							**Apr-25**	**May-25**	**Jul -25**
409	Corporate Services	Human Resources	31/01/2020	16 (4x4)	Staff ill health and absence higher than the Trust absence target of 5% (2024/25). Risk of inability to provide safe staffing levels due to absence	Sickness Absence Policy in place HR Business Partners and Advisors provide support to mangers across the divisions within the Trust, managing absence in accordance with policy. Additional Staffing is made available through the bank, which is provided by NHSP. This provides cover largely for registered and unregistered nurses. Corporate report monitors Trust absence level. Occupational Health Service available to all staff. Early intervention available via team prevent. Monthly Health and Wellbeing team meetings, which focus on improving employee wellbeing. Reviewing analysis of current data and feedback through, Staff, Managers, Occupational Health, HR, Psychological Services and Health and Safety. A staff availability group has been set up and chaired by the HR Director, specific actions are in place and monitored by this group - which reviews the impact of sickness amongst other factors contributing to staff availability.	16	16	16

						Trust has deployed a Tactical Command structure in response to the industrial action.			
Paper on sickness absence presented at People Committee in July and was positively received, and the 90-day improvement plan work has commenced. Sickness has however gone up again and is 6.1% in July 25.									
2602	Medicine	Radiology	11/05/2022	16 (4x4)	Risk to business continuity of radiography services trust wide due to staffing availability and skill mix resulting in interruption to elective services and delay to non-elective services.	Two radiographers working over their hours on a regular basis to sustain specialist business activity. Weekly rota meeting to review what theatre lists are running in the weeks ahead to highlight any lists that cannot be supported with a radiographer. Radiographers are working over their hours to support elective work. Strengthening Me session with SALS booked. Agency staff currently in post. Radiology has a fully established training programme to support new staff on recruitment to train in the above specialties.	16	16	16
Organisational Change launched 1st August 2025. Consultation period due to complete 1st September 2025. 5 WTE radiographers to be recruited. Trust has agreed to increase payments temporarily until the Organisational Change can be implemented. This will ensure that radiographers continue to provide a 24/7/365 service to the Trust.									

362	Medicine	Emergency Department	17/05/2025	15 (3x5)	Lack of psychology support in the Emergency Department	Until a resolution is found, the Emergency Department (ED) will need to request ad-hoc debriefs for cases. The department has an established wellbeing team consisting of different staff groups. Daily highlighting of nursing staff affected by difficult cases in the allocation book, so as to assist with them not going back to similarly challenging cases (whether that be resus/ NAI/ mental health) and to aid recognition by well-being team of those staff needing support.		15	15
Meeting held on 23rd July Further meeting planned with SALS.									
2455	Community & Mental Health	Developmental Paediatrics	16/09/2021	16 (4x4)	Disruption in patient's supply of medication and / or treatment	Prescription rota in place.. Online form in place to allow timely requesting of prescriptions by parents / carers. Overtime provision available for clinicians if needed to ensure cover for the prescription rota. Additional capacity can be provided by Registrars to do prescriptions if required. Prescription turnaround time audit to assess timeliness. Prescription productivity audit. BI periodic reporting strategy and dashboard.	16	16	16

Shortage of medication ongoing. Digital developments - RPA now live. Impact to be reviewed 4 weeks from go live date. Cleo EPS estimated to go live in September.

Table 4: NEW HIGH RISKS

Risk No	Risk	Date Opened	Risk Score	Risk Category	Reason / Comment
Medicine					
293	Staffing in Biochemistry	10/12/2024	16 (4x4)	Quality - Safety	Current risk score increased from 12 to 16 on 13/06/2025.
Benchmarking for specialist workforce in progress. 2 new recruits training progressing well. Organisational change document to be drafted to introduce on call / standby.					
2590	If the only CT scanner within the trust continues be intermittently out of service at increasing frequency, then there is no access to CT scans for the entire trust. The trust is unable to provide CT scans for all patients, including major trauma patients, deterioration inpatients, elective patients, forensic patients and ED	25/04/2022	15 (5x3)	Quality - Effectiveness	Current risk score increased from 12 to 15 on 09/06/2025.
CT scanner in a Van is in place and apps training continuing. We now have business continuity from 28th July 2025. Weekly CT progress meetings in place for updates on building works with a project lead to facilitate.					

Risk No	Risk	Date Opened	Risk Score	Risk Category	Reason / Comment
Corporate					
368	Digital Infrastructure Capacity and Age	22/05/2025	16 (4x4)	Financial - Investment	Current risk score increased from 12 to 16 on 13/06/2025.
Risk consolidated with: 366 - Outdated hardware/software running clinical databases.					

Table 5: CLOSED HIGH RISKS

Risk	Risk	Date Closed	Reason for Closure
Corporate Services			
140	Out of hours there may not be Anaesthetic attendance at cardiac arrests if the anaesthetist is busy (i.e. emergency surgery). Consequently, there may not be anyone with advanced airway skills to assist during a resuscitation attempt/ 2222 call	02/06/2025	Pathway agreed. Risk closed.

Table 6: RISKS WITH DECREASED SCORES

Risk	Risk	Score	Reason for Decrease
Community & Mental Health			
271	There is a risk that the Safeguarding Nursing Team will be unable to provide a service for children/young people and/or staff in the hospital due to staffing rota gaps	**15 DECREASED 12**	Risk score reduced to 12 on 30/06/2025. Band 6 roles have commenced in Post as of 1st March and 1st April 2025. Specialist Nurse for Safeguarding role has now been shortlisted, and interviews being arranged. Specialist Nurse for Children in Care has also been advertised and post closed 31/07/2025 with shortlisting 01/08/2025. Maternity Cover for 1 WTE Band 7 has been agreed. Currently progressing through vacancy authorisation. Named Nurse for Children and Young People Gender Service (CYPGS) now in post as of 19/05/2025.

Table 7: LONG-STANDING HIGH RISKS (greater than 12 months since identification as a high risk)

Risk	Risk Owner	Risk Score	Risk	Date Identified	Review Update
Community & Mental Health					
2431	Lisa Cooper	16	Children and young people will not receive the outcome of their ASD assessment within the agreed timescale (90% of cases within the 65 weeks Trust standard).	Jul-21	Transformation programme ongoing and due to be completed in September 25. Longest waiters for ADHD Neurodevelopmental now have been collated and added to full Neurodevelopmental list so can be seen in appointment date order. **Theme: Capacity and demand**
2455	Lisa Cooper	16	Disruption in patient's supply of medication and / or treatment.	Sep-21	Shortage of medication ongoing. Digital developments - RPA now live. Impact to be reviewed 4 weeks from go live date. Cleo EPS estimated to go live in September. **Theme: National drug shortage outside of organisational control**
2745	Lisa Cooper	16	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients, and staff.	Feb-23	Risk reviewed and scoring remains the same due to ongoing potential future media attention about the research trial which is not yet live. Actions and controls in place and ongoing remain unchanged. **Theme: Reputational**
Medicine					
2650	Urmi Das	16	If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4.	Aug-22	We have been successful at recruiting a Haematology Clinical Fellow who is due to start at the beginning of August 25. The plan is that this candidate will be suitable to interview for a substantive consultant post in the coming 18 months to 2 years. At present this is the only viable option we have to support this service. **Theme: National workforce shortage**

2685	Alf Bass	20	There is a risk to being unable to provide a safe, effective and timely service for tertiary Neurology patients. This includes the ability to diagnose, treat and manage patient demand.	Nov-22	Email to be sent to Director of Medicine Division and Clinical Director for Medical Care Group to suggest lowering score from 20 to 16. We haven't had any complaints or incidents since the last review. MDT is established and now in trial phase. We are also out to recruit a further consultant to join the workforce. **Theme: National workforce shortage**
2419	Adam Bateman	20	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO.	Jul-21	Rota to move to 1 in 6 from September. Band 6 expected to be signed off in October. 1 in 7 rota from November. Band 5 starting end of August, Band 6 starting October. 2 on maternity leave, 1 on long-term sick. **Theme: Workforce shortage**
Surgery					
2643	Raymond Lewis	16	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program.	Aug-22	No changes to risk. **Theme: Financial**
Corporate					
409 (legacy risk ID 2077)	Melissa Swindell	16	Staff ill health and absence higher than the Trust absence target of 5% (2024/25). Risk of inability to provide safe staffing levels due to absence.	Jan-20	Paper on sickness absence presented at People Committee in July and was positively received, and the 90-day improvement plan work has commenced. Sickness has however gone up again and is 6.1% in July 25. **Theme: Staffing**
173	Nathan Askew	15	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties. The risk is the potential for the Trust being unable to meet its obligations in alignment with legislation, NHS England national policy, local guidance, and good practice, impacting on staff, patients, finance, reputation, and the wider health economy.	Mar-24	This risk has been reviewed, and the risk remains the same. Ongoing work through EPG and enhanced reporting. SQAC oversight in place to support assurance. **Theme: Regulatory**

BOARD OF DIRECTORS

Thursday, 4th September 2025

Paper Title:	**Summer 2025 Governor Election Results**
Report of:	**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	The purpose of this report is to provide the Council with the outcome of the summer governor election round.
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:	The cost of running the summer election round is estimated at £8,600.

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

1. Executive Summary

The purpose of this report is to provide the Board with the outcome of the summer governor election round.

2. Background and current state

In July 2025 the Trust issued election notifications for the following governor seats:

Constituency:

- Public: Merseyside (2 to elect)
- Patient: Merseyside (1 to elect)
- Patient: Rest of England and North Wales (1 to elect)
- Public: Rest of England (1 to elect)
- Staff: Nurses (1 to elect)
- Staff: Other Staff and Volunteers (1 to elect)

Following a successful election process which concluded on Friday 29th August 2025 we would like to welcome the following Governors to the Council:

Elected unopposed:

Staff: Nurses – Jacqui Pointon
Public: Rest of England – Daniel Casson *(re-elected)*
Patient: Merseyside – Ava Kilbride

Elected via a public vote

Public: Merseyside – Jenny Devine
Staff: Other Staff and Volunteers – Geoff Bagnall

Two vacancies remain within the patient constituency, one representing Merseyside and the other representing the Rest of England and North Wales. A further election will be held in the coming months to try and fill these seats and ensure we have the patient voice represented on the Council.

Appointed Governor Update

The Board will be aware that Appointed Governor, Barbara Murray resigned from the Council recently to assume her role as Liverpool's Lord Mayor. Councilor Joanne Kennedy has been appointed by Liverpool City Council as Barbaras replacement.
Subsequently, resignations were also received from Councilor's Lila Bennet and Liz Parsons; these vacancies are being discussed at the Council meeting in September 2025, the outcome of which will be shared with the Board once available.

Erica Saunders
Chief Corporate Affairs Officer