BOARD OF DIRECTORS PUBLIC MEETING
Thursday 2nd October 2025, commencing at 11:45am
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
PATIENT STORY (11:45am-12:00pm)							
1.	**25/26/175**	**12:00 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**25/26/176**	**12:01 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**25/26/177**	**12:02 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meetings held on: **4th September 2025.**	**D**	Read enclosure
4.	**25/26/178**	**12:04 (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.	**25/26/179**	**12:05 (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.	**25/26/180**	**12:15 (5 mins)**	**Strategy Board Update.**	J. Grinnell	To receive an update from October's Strategy Board.	**N**	Verbal
7.	**25/26/181**	**12:20 (10 mins)**	**Creating the Future Shape of Alder Hey - Progress Update.**	J. Grinnell	To receive an update on the current position.	**A**	Read report
8.	**25/26/182**	**12:30 (10 mins)**	**2025/26 Financial Plan update; including:** • **C&M financial position update.**	E. Kirkpatrick	To receive an update on the current position.	**N**	Read report/ Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Lunch (12:40-13:10)							
Performance Against Annual Plan							
9.	**25/26/183**	**13:10 (35 mins)**	**Evidence of Our Performance:** • **Flash Report, M6** • **Integrated Performance Report for M5, 2025/26:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.**	A. Bateman N. Askew A. Bateman J. Chester M. Swindell A. Prendergast E. Kirkpatrick 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**	
10.	**25/26/184**	**13:45 (10 mins)**	**2025/26 Capital Plan Update.**	E. Kirkpatrick	To receive an update on the 2025/26 Capital Plan.	**A**	Read report
Unrivalled Experience							
11.	**25/26/185**	**13:55 (5 mins)**	**Mortality Report, Q1.**	A. Bass	To receive an update on the current position.	**A**	Read report
12.	**25/26/186**	**14:00 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 24.9.25.** - **Approved minutes from the meeting held on the 23.7.25**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 23.7.25.	**A**	Read enclosures
Collaborating in Communities							
13.	**25/26/187**	**14:05**	**Collaborate for Children and Young People: Partnerships**	A. Prendergast/	To receive an update on the current position.	**A**	Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
		(10 mins)	**Update; including:** • **Integrated Health Organisation.** • **Tripartite.** • **LCR Test and Learn/Public Sector reform.**	M. Ashe			
Supporting our People							
14.	**25/26/188**	**14:15 (5 mins)**	**People Plan Strategic Update.**	M. Swindell	To receive an update on the current position.	**A**	Read report
15.	**25/26/189**	**14:20 (5 mins)**	**People Committee:** • **Chair's Highlight Report from the meeting held on the 25.9.25.** • **Approved minutes from the meeting held on the 24.7.25.**	J. Revill	To escalate any key risks, receive updates and note the approved minutes from the 24.7.25.	**A**	Read enclosures
16.	**25/26/190**	**14:25 (10 mins)**	**Freedom To Speak Update.**	K. Turner	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
17.	**25/26/191**	**14:35 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 18.9.25.** - **Approved minutes from the meeting held on the 17.7.25.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 17.7.25.	**A**	Read enclosures
18.	**25/26/192**	**14:40 (10 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's verbal update from the meeting held**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 22.7.25.	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			on the 29.9.25. - **Approved minutes from the meeting held on the 22.8.25.** - **2025/26 Top Key Risks,(M5).**				
19.	**25/26/193**	**14:50 (10 mins)**	**Board Assurance Framework Report; including:** • **BAF Policy.**	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/D**	Read reports
20.	**25/26/194**	**15:00 (5 mins)**	**Risk Appetite and Tolerance Update.**	E. Saunders	To receive an update on the current position.	**A**	Verbal
21.	**25/26/195**	**15:05 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
22.	**25/26/196**	**15:09 (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, 6th November 2025 at 2:00pm, LT1, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in August 2025 430: Deed of Variation – Laidrah One Limited

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M5, 2025/26	R. Lea
10 Point Plan to improve resident doctors' working lives	M. Swindell

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 4th September at 10:30am**
Lecture Theatre 1, Institute in the Park

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)
	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)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Observing	Dr. B. Singham	Senior Clinical Fellow on HDU	(BS)
Item 24/25/138	Ms. M. Ashe	Policy Lead/Advisor to EO	(MA)
Item 24/25/139	Ms. M. Ashe	Policy Lead/Advisor to CEO	(MA)
Item 24/25/ 139	Mrs. N. Palin	Director of Transformation	(NP)
Apologies:	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. D. Powell	Development Director	(DP)

25/26/133 Welcome and Apologies

The Chair welcomed everyone to the meeting and noted the apologies received. It was acknowledged that September's Board is Shalni Arora's last meeting in her role as a Non-Executive Director (NED) for the Trust.

25/26/134 Declarations of Interest

Non-Executive Director (NED), Gerald Meehan, declared that he is the Independent Chair of Liverpool's Children's Services Improvement Board, and Mark Jennings (NED) declared that he is the Chief Solutions and Services Officer for Strasys.

25/26/135 Minutes of the previous meeting held on 26th June and 3rd July 2025.
Resolved:
The minutes from the meetings held on the 26.6.25 and the 3.7.25 were agreed as an accurate record.

25/26/136 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 24/25/149.1: *Wellbeing Guardian Dashboard (Integrate Freedom To Speak Up in the next iteration of the Wellbeing Guardian Report)* – This action has been completed. **ACTION CLOSED**

Action 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)* – Guidance is yet to be published. **ACTION TO REMAIN OPEN**

25/26/137 Chair's and CEO's Update

The Chair commenced the meeting by recognising the significant financial challenges currently confronting the organisation. The discussion highlighted workforce-related concerns, particularly regarding morale and strategies to enhance engagement, visibility, and communication within the Trust. It was noted that understanding and empowering staff to achieve optimal performance may require consolidating information and thoroughly reviewing vulnerable service areas. Furthermore, it remains essential to identify where additional support is warranted and to consider implementing a zero-tolerance approach in cases where morale is compromised.

The Board was informed that the Integrated Care Board (ICB) is undergoing major changes amid financial pressures, with a new CEO recently starting and recruitment underway for a Chair. A number of providers are exploring deficit reduction strategies to improve system performance and Alder Hey is contributing towards these goals.

The Chair shared a staff story to illustrate the dedication of employees and the positive impact of staff across all roles, reinforcing the organisation's commitment to its values. The Chair also introduced the meeting's agenda, which covered updates on the NHS 10-year plan, the organisation's response to national changes, and the need to align operational and financial planning with staff and patient requirements.

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

25/26/138 NHS 10-Year Plan

The Board received a comprehensive update on the NHS 10-Year Plan, noting its origins in Lord Darzi's diagnostic of the NHS and the evidence base for change, especially for children and young people (CYP). It was pointed out that Alder Hey's Vision 2030 is well-aligned with the plan's priorities, particularly in prevention, innovation, and public health, and that the Trust is ahead in several transformation

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

- *What needed to change:* Structural and policy changes.
- *NHS change:* Devolution and Mayoral powers.
- *New NHS Operating Model:* Provider autonomy and new models of care.
- *Transparency and performance:* NHS Oversight Framework 2025/26.
- NHS workforce updates/concerns.
- *Provider capability (NHS Boards self-assessment):* New metrics for boards.

A question was raised about the implications of reducing Integrated Care Systems (ICSs) by 50% and increasing mayoral influence, suggesting a move toward mayoral footprints and asking if this is being considered nationally and locally. It was reported that ICSs are clustering in some areas, but not all regions have mayors, and the approach is still evolving.

It was agreed to circulate the presentation to governors and continue aligning Alder Hey's strategy and planning with the evolving national policy landscape.

25/26/138.1 Action: KMC

Resolved:
The Board noted the update on the NHS 10-Year Plan.

25/26/139 Future Shape of Alder Hey

The Board was advised of the approach to progress Alder Hey's in year and medium term plans between August and December 2025. It was reported that the agenda focuses on moving beyond traditional cost improvement programs to a broader transformation program, emphasising clinical leadership, integration, and the voices of CYP. A number of slides were shared that provided information on the following areas:

- *In-year and medium plan development;*
  - In-year plan: Closing the Gap Programme.
  - Medium-term planning:
    - NHSE guidance.
    - V2030 Blue Prints.
    - Target Operating Model (TOM).
    - Integrated Health Organisation (IHO)
- *Closing the Gap - Medium-Term Planning (Board accountability):* The Trust is working toward a five-year plan, with formal approval expected in December. This includes developing strategic, operational, and financial plans. Ensuring strong clinical leadership and collaboration and aligning plans with commissioned activity and system strategy.
- *Blueprints and Engagement:* There are three blueprints being developed; Get Me Well, Personalise My Care, and Improve My Life Chances, with drafts undergoing wider engagement and clinical input in September. A deeper dive is planned for October's Strategy Board.
- *TOM:* Work is underway to define a new operating model, using a sprint framework and clear governance. The approach is iterative,

with a case for change being approved and a focus on clinical safety, improved outcomes, and financial sustainability.

- *IHO:* The Trust is pursuing the opportunity to hold the whole health budget for a local CYP population as an IHO. The Trust is aiming to be part of a national test in the first wave in April 2026 and is seeking partners to support this model.
- *Next Steps;*
  - Closing the Gap in Year Programme delivery.
  - Blueprints and TOM continued rapid progression.
  - IHO evolving developments.
  - Planning group to be established to curate medium term plan.

It was pointed out that the programme is designed to support effective transformation by integrating all elements into a unified framework for next year's initiative, with comprehensive programme support.

The need for a pragmatic/iterative approach was emphasised, linking recruitment and operational decisions to the evolving model, and acting urgently to commit to targets rather than waiting for a finalised plan.

Resolved:
The Board noted the contents of the report and supported the following proposed approach:

- 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.
- Trust Board and Strategy Board to provide input into the blueprints, Target Operating Model and emerging IHO work.
- Board of Directors to formally approve the medium-term plan in December 2025.

25/26/140 System Wide Update; including C&M Financial Position

A system-wide update was provided to the Trust Board, highlighting significant progress over the summer in advancing the organisation's Vision 2030 priorities, particularly through neighbourhood and community initiatives. Three Neighbourhood Place pioneer bids have been submitted with the outcome due in September 2025. The Connected Care for Children model for Liverpool was piloted in partnership with primary care via two exploratory MDTs with three Primary Care Networks. Alder Hey has continued to strengthen collaborations with the Liverpool City Region, Liverpool City Council and the Tripartite (Mersey Care, and Liverpool University Hospitals Trust). The update also noted the alignment of three-year blueprints for children's services, and advancements in academic partnerships and digital strategy. It was concluded that:

- The Trust's partnerships continue to pave the way for real impact and are creating and refreshing key wider relationships.
- Alder Hey is well positioned for CYP, for example, The Trust's CEO is a member of the national NHSE IHO Development Group.
- The Trust has seen a palpable shift in focus on CYP in C&M; opportunities as well as risks

- The scale of the programme and the organisation's role in the system will only continue to grow.
- The Trust is adapting and looking at innovative ways to support but can't underestimate the scale alongside operational pressures.
- The Trust is prioritising the wealth of neighbourhood work but is also highly focused in CYP MDT/respiratory.

Financial Position

At the end of M4, the Cheshire and Merseyside (C&M) system is £2 million behind plan. Contributing factors include the financial effects of industrial action, lower activity levels impacting income, and some providers not achieving their Cost Improvement Plan (CIP) targets. Alder Hey is £270k off plan in M4 as a result of industrial action that is unfunded.

Weekly CIP submissions and monthly financial forecasts are now required by the ICB, and work is ongoing with PWC regarding the formal turnaround process. The system continues to be monitored closely, with efforts underway to address risks and improve financial performance. Leadership changes have been reported, with Andrea McGee set to begin as interim Chief Financial Officer (CFO) within the next two weeks.

Resolved:
The Board noted the system wide update and the C&M financial position.

25/26/141 Integrated Operational Plan Progress Update

The Board was provided with an update on the progress of the Integrated Operational Plan for 2025/26, detailing performance against four key priority areas and national operational priorities. It was reported that 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. Attention was drawn to the following points:

- Key clinical service transformation highlights include the redesign of urgent and acute care (*expected to be operational by March/April next year*), significant neighborhood service efforts, and the development of a Centre of Excellence for cardiology.
- Financial sustainability remains a challenge, with a £3m in-year gap and a £9 million longer-term gap still to be addressed.
- The Trust continues to focus on future opportunities, such as the Paediatric Open Innovation Zone (POIZ) grant and the IHO initiative.
- 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.
- Performance is strong in emergency care, cancer care, and mental health access, with a segment one rating (*15th out of 134 trusts*), but elective care access remains a challenge.
- Recruitment controls are in place to support financial sustainability.

Resolved:
The Board noted the content of the Integrated Operational Plan and the progress to date.

25/26/142 Winter Plan and Board Assurance Statement

The Board received the 2025/26 Winter Planning Document which provides 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. Attention was drawn to the following points:

- It was confirmed that capacity is maintained at last year's levels, with contingency plans in place for extreme scenarios.
- Alternatives to admission include expanding virtual wards, enhancing the Paediatric Assessment Unit (PAU) model with a more robust seven-day cover, and opening a new Eating Disorder service.
- Staff vaccination rates currently stand at 50%. Efforts are underway to consider strategies aimed at increasing vaccine uptake among staff.
- The Board was advised that the Board Assurance Statement is required to be signed and submitted to NHS England (NHSE) by the end of September. Due to time limitations, the Board resolved to complete this process virtually.

25/26/142.1 Action: AB

The Chair questioned how staff vaccination rates could be improved, noting last year's efforts and asking if additional learning could be applied. It was reported that the Trust is going to liaise with its new Occupational Health provider on this matter. Additionally, the Trust has received a formal letter requesting a 5% increase in staff vaccination rates.

Reference was made to RSV, and it was suggested enhancing vaccination efforts via the Trust's partnership with the Liverpool Women's Hospital and maximising this collaboration.

A discussion took place about the possible impact of measles during the winter. An overview was provided of how the Trust managed the breakout of measles in July and the learning review that took place following this. There was a consensus on the need for a broader, system-wide approach to vaccination, including engaging public health, primary care partners and schools.

Resolved:
The Board noted the contents of the 2025/26 Winter Plan.

25/26/143 Evidence of Our Performance

Flash Report, M5

The Board received the Flash Report for M5. The following points were highlighted:

- ED performance is at 89.8% for being treated within 4 hours. This marks the sixth consecutive month with performance maintained above 80%+.
- Diagnostic performance is at 94.8% with a high proportion of tests being completed in six 6 weeks.
- The percentage of patients waiting within 18 weeks for treatment is at 59.8%. This is the fifth consecutive month of improvement for the percentage of patients waiting under 18 weeks for treatment, though further progress is required.
- The number of RTT patients waiting more than 52 weeks is 409.

There are initiatives to improve elective care include implementing ambient voice technology, overbooking patient slots to compensate for no-shows, and piloting machine learning triage of referrals in Ear, Nose and Throat (ENT). These initiatives are expected to increase capacity and reduce waiting times.

The Board was advised of the national incentive fund that has been established to reward trusts that reduce waiting lists and meet targets. The top ten performing trusts will receive an allocation from this fund, with £2 million available for each qualifying trust. It was confirmed that Alder Hey is actively working to improve its 52-week wait performance to compete for this incentive funding.

Integrated Performance Report (IPR)

Outstanding Care and Experience – Safe and Caring

- There have been no Grade 2 pressure ulcers been reported for two months.
- 97% of PALS concerns were responded to within 5 working days and 96% of formal complaints were responded to within 25 working days, resulting in the majority of families receiving a timely response to their concerns.
- The Trust had the highest number of Friends and Family Test (FFT) responses in July compared to the last 12 months, which correlates with the shorter questionnaires going live, however, FFT responses for ED continues to be below 95%.
- The EPRR framework currently demonstrates 77% compliance, indicating a notable improvement.

Pioneering

- *Foundation Chair (Liverpool Institute of Child Health and Wellbeing)* – Interviews have been scheduled for the 24th and 26th with four candidates having been shortlisted. An update on the outcome of the recruitment process will be provided during October's Board.

Support our People

- Time to hire (TTH) has been outperforming the target since April 2025.
- *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 and Vacancy Panel meeting, and Organisation Design Collaborative

Financial Sustainability: Well Led

- The Trust reported a £0.3m surplus in month, £1.5m deficit year to date (YTD) and is off plan by £0.3m due to the impact of industrial action.
- 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.

Community and Mental Health Division

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

Division of Medicine

- The Biochemistry department is currently encountering challenges similar to those faced by the Haematology department in the previous year; consequently, the lessons learned from Haematology are being implemented within Biochemistry to address these issues.
- *Metabolic Service* – The service is currently experiencing operational difficulties due to the recent retirement of a consultant. A review of the SLA is being undertaken, along with funding and inhouse resolutions.

Division of Surgery

- It was reported that there are workforce challenges in Cardiology that may impact on-call services. Recruitment for a new service lead is underway, which is expected to improve the situation.
- Saturday work is currently paused, though trauma lists have continued this provision will stop at the end of September. It was felt that further progress in this area will require an organisational change within theatres.

Resolved:
The Board:

- Noted the Flash Report for M5.
- Noted the content of the IPR for Month 4.

25/26/144 Capital Plan, 2025/26

The Board received an update on the 2025/26 Capital Plan. The following points were highlighted:

- £2m additional CDEL has now been agreed for 2025/26 but a gap of £1.7m remains .
- Discussions are ongoing with the Integrated Care Board (ICB) and other trusts to secure additional CDEL to close the remaining gap.
- Revised CDEL for 2025/26 is now £31.1m (£23.8m confirmed, £5.3m pending).
- *Prioritised capital requests and committed schemes (Rank 1 and 2)*
  - £31.9m of capital has now been approved and a further £1.9m 'Priority 2' schemes remain, awaiting business cases and formal decisions on any further funding available from ICB or further brokerage.
  - A number of capital schemes are currently on hold pending confirmation of additional CDEL funding.
- An update will be shared with FTPC and the Board in October 2025.

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

25/26/145 CQC Inspection: Alder Hey Community Mental Health, ASD and ADHD Services

The Board received an update on the outcome of the unannounced inspection by the Care Quality Commission (CQC) in March 2025 of Alder Hey's community mental health, ASD, and ADHD services. CQC initiated this inspection in response to a major incident; however, no specific concerns had been raised regarding these services at that time.

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.

Attention was drawn to the report's highlights, including the positive feedback from CYP, robust risk management, and effective Board oversight, as well as areas for continued improvement such as consistent risk assessment documentation and the transition of community-based services to Meditech. It was confirmed that there is an action plan in place to address the identified improvements which will be monitored by the Safety and Quality Assurance Committee (SQAC).

On behalf of the Board, the Chair commended the team's achievement and noted that the organisation will apply the lessons that have been learned.

Resolved:
The Board noted the contents of the report and the and Outstanding rating awarded to Alder Hey's Community Mental Health, ASD and ADHD Services.

25/26/146 Brilliant Basics Update

The Board received a mid-year update on the progress of the 2025/26 Brilliant Basics Delivery Plan. The following key points were highlighted:

- Progress continues towards mainstreaming continuous improvement into the core business of the organisation and maximising all elements of the programme. It was confirmed there are no risks to escalate.
- The Board was advised of the pause of further updates for six months, with plans to review and showcase grassroot-level improvements in the annual report and their impact. Consideration is also being given to transitioning Brilliant Basics to business-as-usual reporting, without losing oversight of NHS impact progression.

The Chair proposed aligning Brilliant Basics more directly with workforce and service interventions, focusing especially on areas identified as needing further support, such as fragile services. Additionally, the Chair suggested establishing a method to assess the necessary level of intervention in specific areas to ensure optimum effectiveness.

Thanks were offered to the Brilliant Basics team for the work that has taken place to date.

Resolved:
The Board noted the Brilliant Basics update.

25/26/147 Compliments, Complaints and PALS report

The Board received an update on the performance against complaints and PALS targets in Q1, 2025/26.

Attention was drawn to the continued downward trend in formal complaints which is attributed to revised divisional processes. The Trust is also fostering a more collaborative approach to addressing concerns through initial contact with families. This approach aims to resolve issues in partnership with families reducing the need for formal complaints.

Resolved:
The Board noted the Compliments, Complaints and PALS report for Q1.

25/26/148 Digital, Data and Information Technology Update

The Board was provided with an update on progress relating to Digital, Data and AI and its contribution to Vision 2030. The following points were highlighted:

- A number of successful deployments took place in August 2025, notably the project to integrate observations directly into the Electronic Patient Record (EPR), and the transition to the Paediatric Early Warning Score (PEWS) framework for patient observations which recorded around thirty thousand observations in four weeks and delivered financial efficiencies.
- The Trust is working with the ICB and Mersey Care on a solution for the Patient Portal and has initiated a project with Blinx, a local company also supporting primary care.
- Strategic priorities include scaling up the deployment of digital platforms such as Lyrebird, the Patient Portal, advancing to Alder Care 2.2 in 2026, and implementing a new data platform.

The Board discussed the need to accelerate technology deployment to support transformation, ensuring digital benefits are quantified and aligned with TOM. Reference was made to the business case proposing an upgrade to the Trust's EPR system, noting its integration with EMIS and the associated investment required. It was emphasised that a timely approach is essential to prevent any disconnect arising from insufficient technological capacity to support the planned changes.

A question was raised regarding the temporary suspension of Lyrebird during efforts to manage the transcription backlog. Clarification was sought on the rationale for this decision. It was noted that a short-term recovery plan is now in place to address the backlog, and the next phase of Lyrebird's implementation will involve clinicians utilising the system.

Resolved:
The Board received the Digital, Data and Information Technology report and noted the progress to date.

25/26/149 Learning from Patient Safety Incidents, Q1.

The Board was provided with a summary of activity and system-wide learning following the transition to the Patient Safety Incident Response Framework (PSIRF) for Q1 2025/26. The following points were highlighted:

- It was reported that work is taking place to improve the timeliness of patient safety incident reviews.
- Following the first twelve months of 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. It was reported that the ICB confirmed its acceptance and ratification of the Trust's PSIRP for a further 12 months.
- Attention was drawn to the details of the completed reviews and lessons learned included in the report.

The Chair asked as to whether the Trust has conducted benchmarking against other organisations. It was reported that this is challenging due to differences in the implementation of PSIRF, however the Trust received a substantial assurance rating from a recent MIAA audit. It was confirmed that this area of work continues to be monitored by SQAC.

Resolved:
The Board noted the activity that has been undertaken during Q1 2025/26 following the Trust's transition and embedding of PSIRF and next steps.

25/26/150 Infection, Prevention and Control Report, Q1.

The Board was provided with oversight of Infection Prevention Control (IPC) activity and reporting for the Q1 period from the 1.4.25 to the 30.6.25. The following points were highlighted:

- It was reported that nationally, norovirus infections have increased, which is reflected locally. The Board was advised that the Trust has established strict protocols on the wards to manage cases appropriately, with recent examples demonstrating successful management.
- Attention was drawn to the importance of having high standards of hand hygiene and water safety, particularly in paediatric areas. There is an ongoing focus on the campaign for compliance and good practice, including staff adherence to wearing scrubs.

Resolved:
The Board noted the content of the IPC report for Q1 and the actions being taken to ensure the Trust is compliant with the expected Health and Social Care Act 2008: IPC code of practice.

25/26/151 Framework of Quality Assurance and Improvement

The Board received assurance that the 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. The following points were highlighted:

- For the appraisal year 2024/2025, the Trust achieved an overall compliance rate of 98.02% for appraisals and mandatory training.
- The Job Planning Committee is in the process of undertaking a comprehensive review of all job plans to address inconsistencies and improve workforce planning.

The Board acknowledged the ongoing efforts and the importance of this work in supporting effective and consistent job role management across the Trust.

Resolved:
The Board received and noted the annual submission to NHS England North West: Framework for Quality Assurance and Improvement 2025.

25/26/152 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 25.6.25 were submitted to the Board for information and assurance purposes. It was confirmed that there were no issues to escalate.

Resolved:
The Board noted the approved minutes from the meeting held on the 25.6.25.

25/26/153 Liverpool Neonatal Partnership Board

The Board received an update on 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 March 2026. The following key points were highlighted:

- Recruitment for the Speech and Language Therapy (SALT) role has presented some challenges but an appointment has been made with the successful candidate having a neonatal specialist background.
- It was confirmed that efforts are underway to strengthen the parent and family voice.
- Development of the dashboard is progressing, with an IPR-equivalent expected at the next meeting, and a Clinical Reference Group has been established.
- Financial forecasting is being reviewed to align running costs with updated commissioning needs and discussions are to be held with commissioners regarding this matter.
- The main governance challenge discussed during August's LNP Board meeting is clarifying the partnership model, whether it should be a partnership or have a lead organisation, especially given the unique nature of the model and its integration with maternity services. An executive-level decision is pending, with further discussions scheduled.

The Board was advised that an LNP governance meeting is set for 5.9.25, with input from Louse Weaver Lowe. The LNP is developing a new unique model and needs to establish/underpin the patient pathway and address complex hosting discussions, which will serve as a test case. A decision must be reached via board-to-board meetings, particularly concerning neonatal versus maternity focus areas. Further discussions will take place over the next two weeks prior to submitting this matter to the Trust Board.

Resolved:
The Board noted the key LNP updates.

25/26/154 Wellbeing Guardian Dashboard
Resolved:
The Board noted Wellbeing Guardian Dashboard and the progress that has been made.

25/26/155 Thriving Culture Programme: Overview & Progress Report

The Board received an overview of the Thriving Culture programme including progress and areas for development. The report brings together all aspects of the programme under the theme of culture, focusing on empowering leaders, connecting data sources, and supporting teams before issues escalate. There is an emphasis on connecting disparate data (e.g., staff survey, FTSU data, soft

intelligence, patient experience) and ensuring values and behaviours are lived daily across the organisation.

The Chair offered thanks for the update and commended the ongoing work on culture, particularly in relation to the launch of the Trust's new values. The articulation of the concept of connections is appreciated and encourages NEDs to consider how they can contribute actively. However, the Board requires greater clarity regarding the specific teams where red flags have been identified, as this information is not currently known to the Board. Insights into the outcomes of these key discussions would also be beneficial, including whether they have led to measurable changes. Currently, information appears fragmented; if there is a unified overview, it has not yet reached the Board. It is essential that this process runs concurrently with financial matters, as both areas significantly influence one another.

The Board was advised that the thriving Multi-Disciplinary Team (MDT) meeting serves as a forum for discussing teams, and there is also a whole host of people interacting with teams. It was proposed to incorporate additional/relevant aspects into the Employment Relations report that the Board receives on a regular basis, utilising it as a mechanism to enhance understanding and communication.

The Chair felt that the report on the Thriving Culture programme is insightful and offers a comprehensive overview of how the organisation gathers intelligence. Going forward it was felt that it would be valuable to also include information on teams who are flourishing and have an outline of strategies for connecting with staff and engaging senior leadership.

Reference was made to FTSU experience, and it was pointed out that other trusts have collected relevant data in order to address challenges within their teams. Although there are known areas of difficulty within the Trust and methods in place to address them, it was felt that the organisation lacks the necessary discipline in its approach.

The Board reflected on the urgency of improving internal communications and transparency, especially regarding financial and workforce pressures, and suggested more direct engagement with staff to assess awareness of organisational values.

Resolved:
The Board noted the Thriving Culture programme update.

25/26/156 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's nursery officially closed on the 29.8.25, concluding 36 years of service. All children have been successfully transitioned to the new nursery, and staff have moved into their new roles. Thanks were offered to all those involved in managing the transition.
- As of August 2025, the Trust's sickness rate is 6%, with the majority attributed to long-term absences. This figure remains notably above the Trust's target of 4.5%. In response, there has been an increased emphasis on managing sickness, and the HR team has introduced a 90-day

attendance improvement initiative as a targeted intervention to further support the effective management and reduction of sickness absence.

- *Medical Education: Quality Review/GMC Survey Feedback* – Alder Hey recently underwent a scheduled NHSE/GMC quality review of its postgraduate education programme. The overall feedback was positive; however, concerns were identified regarding resident doctors' experiences in general paediatrics, including one patient safety issue that was promptly escalated and investigated. An action plan has been developed to address the broader themes highlighted in the feedback and has been submitted to, and approved by, NHSE.

The Chair queried as to whether there have been any challenges in terms of the expectations of junior doctors. It was confirmed that, after review, no significant outlier issues or unexpected challenges have been identified at Alder Hey, and rota challenges are in the process of being addressed. The Board was advised that there is an emphasis on improving working lives for resident doctors, in line with national discussions, and related actions that the NHS as a whole have been asked to address. These actions will be submitted to the People Committee and the Board in due course.

Resolved:
The Board noted the People Plan strategic update.

25/26/157 EDI Action Plan Update

The Board received an update on the progress that has been made in delivering the six 'High Impact Actions' (HIAs) outlined in the NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan. The report presented to the Board outlined the planned actions to support continued delivery, areas for further improvement, and next steps. Attention was drawn to the following key points:

- The Trust was successfully re-accredited with the Navajo Chartermark. The Head of EDI, Angie Ditchfield, and the team were acknowledged for their contributions toward this outcome.
- Alder Hey celebrated 'Liverpool's Pride' in association with the Youth Forum. It was reported that the event was successful.
- The first gender and Ethnicity Pay Gap report has been produced, providing new data for the Trust.
- It was reported that the Trust has developed an Equality Impact Assessment, which integrates inclusive recruitment strategies and neurodiversity considerations into recruitment practices.
- The ACE network is due to launch a visibility campaign on the 16.9.25. The focus is on inclusion, and the aim is to show CYP with disabilities that they can pursue any job that they are in interested. The campaign will also promote a sense of belonging.

Thanks were offered to everyone who has dedicated their efforts to ensure the successful launch of the Visibility campaign.

Resolved:
The Board noted the EDI progress update.

25/26/158 People Committee

The approved minutes from the meeting held on the 22.5.25 were submitted to the Board for information and assurance purposes.

During July's meeting there was a focus on the new Workforce Strategy for Nursing and Allied Health Professionals, the ongoing work in CAMHS which is addressing staff exposure to violence and aggression, and a review of risk management processes. The Committee acknowledged the efforts of ES and the Governance Manager, Jill Preece, in advancing risk quantification and understanding. It was noted that matters discussed by the People Committee have direct implications for safety and quality, underscoring the importance of continued collaboration with the SQAC.

Resolved:
The Board noted the approved minutes from the meeting held on the 22.5.25.

25/26/159 C&M Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common.

The Board was provided with the updated C&M Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common. It was reported that the main revision involves the inclusion of Community and Mental Health Trusts. The updated agreement outlines how the collaborative will be governed without altering the substantive content of previous arrangements. The revised Terms of Reference and governance structure are being submitted to all relevant boards for approval to ensure a streamlined and clear governance structure for the collaborative going forward.

Resolved:
The Board endorsed the revisions to the CMPC Joint Working Agreement and Committee in Common.

25/26/160 Assessing Provider Capability: Guidance for NHS Trust Boards

The Board received an update on the 'Assessing Provider Capability: Guidance for NHS Trust Boards', noting that NHSE has introduced a new self-assessment requirement with a short turnaround time. An overview of the process was provided, and it was reported that NEDs will have the opportunity to review and provide input, with KB identified as a potential reviewer from a control and risk perspective. The completed assessment will be submitted by the 22.10.25 and shared with the Board during November's meeting for scrutiny purposes. It was acknowledged that the Trust is well-prepared for this process due to its ongoing self-assessment practices.

Resolved:
The Board noted the new requirement by NHS England to undertake an annual self-assessment against the six domains in the Insightful Provider Board, with a deadline of the 22.10.25.

25/26/161 Audit and Risk Committee

The approved minutes from the meeting held on the 19.6.25 were submitted to the Board for information and assurance purposes.

During July's meeting the Committee focussed on risk. It was reported that the Community and Mental Health team successfully piloted the rollout of risk appetite across the Division, with their presentation and subsequent feedback informing the wider implementation process. Additionally, the Committee held a focused session on cyber risks; it was suggested that a similar session may be beneficial for the Board given the increasing complexity of cyber threats.

Resolved:
The Board noted the approved minutes from the meeting held on the 19.6.25

25/26/162 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 30.6.25 were submitted to the Board for information and assurance purposes.

During July's meeting the Committee focussed on all relevant matters and an Extraordinary was scheduled to discuss closing the gap. Strategic financial pressures remain a key concern, with ongoing horizon scanning and cross-functional collaboration planned to address emerging challenges.

Resolved:
The Board noted the approved minutes from the meeting held on the 30.6.25 and the update on the Committee's top key risks in M4.

25/26/163 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 14 principal risks aligned to the Trust's strategic objectives. The following points were highlighted:

- It was reported that there has been an increase in red-rated risks, particularly in relation to workforce and financial pressures. The current status of key workforce risks has been reviewed and updated, with recognition that these may change as circumstances evolve.
- Considerable attention has been dedicated to evaluating system risks, and a meeting has been scheduled to facilitate further discussion on this matter.
- The Board acknowledged the horizon scanning work undertaken by the Audit and Risk Committee, with the Executive team scheduled to review and respond to this in detail.
- The BAF will continue to be closely monitored, with ongoing attention to the interdependencies across strategic risks and the need for responsive action as new challenges arise.

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

25/26/164 Governor Elections
Resolved:
The Board noted the outcome of the summer governor election round.

25/26/165 Any Other Business

The Chair expressed appreciation for the substantial work completed over the summer and acknowledged the need for additional strategy time in forthcoming Board meetings in October and November to address the complexity of ongoing issues.

25/26/166 Review of the Meeting

The Board had a thorough discussion of major issues, including risks and opportunities facing the organisation. There was a collective emphasis on maintaining high-quality, safe services for children, with a reminder to keep children's health and well-being central to all decisions. No further significant issues were raised, and the meeting was concluded.

Date and Time of Next Meeting: Thursday 2.10.25 at 1:00pm, 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 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	
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**
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	Jan-26	**4.9.25** - Guidance is yet to be published. **ACTION TO REMAIN OPEN**
Status							
Overdue							
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
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	Closed	**4.9.25 -** This action has been addressed. **ACTION CLOSED**
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	Closed	**26.8.25** - A report is to be submitted to FTPC in October to advise on how the Trust is going to utilise the unsued space in the ground floor of the building. **ACTION CLOSED**
4.9.25	25/26/142.1	Winter Plan and Board Assurance Statement	Complete the Board Assurance Statement process virtually due to the time limitations (statement needs to be signed and submitted by the end of September 2025).	A. Bateman	Sep-25	Closed	26.9.25 - This action has been addressed. ACTION CLOSED

BOARD OF DIRECTORS

Thursday 2nd October 2025

Paper Title:	**Creating the Future Shape of Alder Hey Progress Update**
Report of:	**John Grinnell – Chief Executive 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 Progress Update – October 2025

1. Purpose of Report

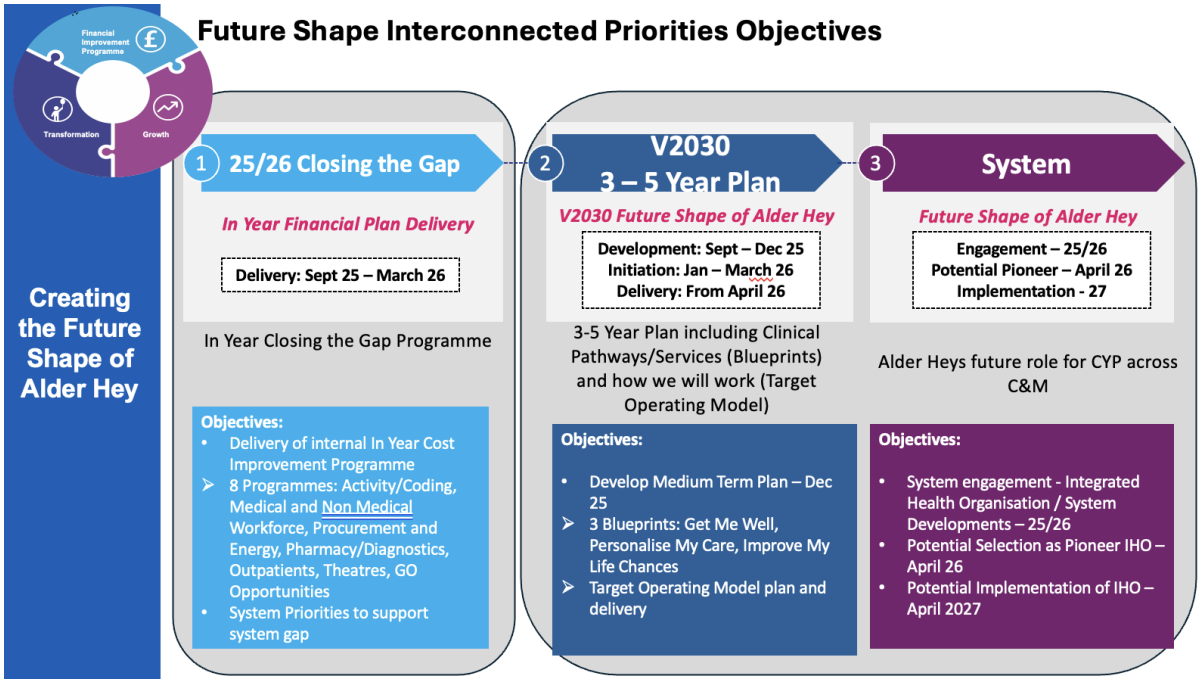
This purpose of this report is to provide a progress update on the key components on creating the future shape of Alder Hey.

2. Creating the Future Shape of Alder Hey

A paper outlining the in year and medium term plans for creating the future shape of Alder Hey was presented to the Board of Directors in September 2025. This plan set out an integrated programme approach across a number of priority areas including:

- In year 'Closing the Gap' programme
- Medium term plan development through the creation of clinical Blueprints and an organisational Target Operating Model
- Integrated Health Organisation System Opportunities

The below shows the interconnected priorities between the key priority areas:



3. Progress Update

3.1 Closing the In Year Gap Programme

The in year gap for 2025/26 is being progressed through a single programme of work, tracked weekly through a strategic command approach using the established Financial Improvement Programme methodology.

In the previous reporting period, this approach has been embedded with a deep dive held at an extraordinary Finance, Transformation and Performance Committee in August.

The current status of this programme indicates an improvement from a £6M to a £2.4m gap (risk adjusted). Further detail will be provided through the Interim Chief Finance Officer report.

With regards to the 3.8M system stretch, work and dialogue with the C&M system is ongoing.

3.2 V2030 – Medium Term Plan

Detailed guidance from NHS England with regards to national expectation for medium term planning is awaited imminently.

Good progress has been made on the Alder Hey plan which had commenced over the summer. This integrated plan will outline the next phase of our journey to Vision 2030.

A weekly planning group has been established to oversee the development of the plan, with oversight of the different component parts, an update for each is provided below.

3.2.1 Clinical Pathways and Services (Blueprints)

Over the summer period, three blueprints have been drafted to shape the future of our clinical pathways and services. These are aligned around three areas of need: Get Me Well, Personalise My Care, Improve My Life Chances.

They identify clear groupings of services and will outline a 3 year implementation and benefits realisation plan.

They identify a number of strategic themes including:

1. **Shift Left -** Enabling a system approach to move activity downstream to community or secondary care providers
2. **Prevention (operational) -** Reduce unnecessary appointments
3. **Prevention (clinical) -** Focus on clinical prevention, integration and neighbourhood models
4. **Digital and Data -** Improving access, safety and productivity through digital and AI solutions
5. **Virtual -** Optimise our virtual care offer enabled by technology
6. **Productivity -** Streamline processes and pathways to increase utilisation and throughput
7. **Consistent and equitable services -** Provide consistency whether care is local, regional, or multiple site. Essential for IHO / chain model
8. **Workforce** – running across all programmes: activity reduction / workforce re-profiling

The blueprints are currently at a first draft stage, for discussion and iteration with the strategy board in October and final draft review by the end of November.

3.2.2 How we will work in the future (Target Operating Model)

The Target Operating Model (TOM) work has commenced at pace since the previous report to the Board of Directors. The TOM will provide a clear picture of how Alder Hey will be organised to deliver V2030 and the clinical services as set out through the work of the clinical blueprints. The TOM will look to align our people, processes, and systems so we can focus on what adds the most value for children, young people, and families.

Self assessments for services are underway, initially to establish a current state analysis, leading to the future shape of Alder Hey. An update will be provided to the strategy board in October with a more detailed discussion scheduled for November 2025.

3.2.3 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.

Engagement with regards to IHO opportunities and system developments for paediatric services are ongoing.

4. Summary and Next Steps

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.

We are on track with the key deliverables as set out to the Board in September, working at pace on a number of integrated programmes of work.

Board of Directors are asked to note the contents of this report.

BOARD OF DIRECTORS

Thursday, 2nd October 2025

Paper Title:	**2025/26 Financial Plan Update**
Report of:	**Interim Chief Financial Officer**
Paper Prepared by:	Interim Chief Financial Officer

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

Does this relate to a risk? Yes ☐ No ☐

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

Risk Number	Risk Description	Score

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

2025/26 Financial Plan
Trust Board
2nd October 2025

Executive Summary

The purpose of this paper is to update the Board on the latest position in relation to the financial plan for 25/26 including the progress against our Cost Improvement Target for the year through the recent Closing the Gap Programme and the deliverability of our financial plan including the forward look of risks and mitigations.

The key points to note from this paper are:

- Significant progress made over the last 4 weeks through Closing the Gap Programme in achieving £19.2m of fully developed and posted savings for the year, against a target of £22.7m, and a further £2m in plans being progressed.
- Some additional pay controls have been approved and implemented to 'close the gap'. This requires oversight and monitoring of the financial, quality and safety impact.
- The remaining CIP gap of c£1.5m which remains a challenge and requires further focus on cost control to ensure delivery of our plan.
- Necessity to deliver on activity plans for the year, working with commissioners on any further opportunity to utilise ERF that may be available to improve access for CYP.
- A proposed approach to managing the system stretch/placeholder currently in our plan of £3.8m has been shared with the ICB, however a plan to achieve this in full is not in place. There is, therefore, a risk to delivering the current plan submitted to NHSE of £7.2m.
- Significant work is still required on the recurrent CIP savings which are currently less than 50% delivered of the target. This will be primarily addressed through the completion of the Target Operating Model, which will define the future shape, size and structure of Alder Hey, by the end of Q3.

The Board is asked to note the contents of this paper and to provide support for the actions and steps set out to focus on delivering the financial plan through Q3 and Q4.

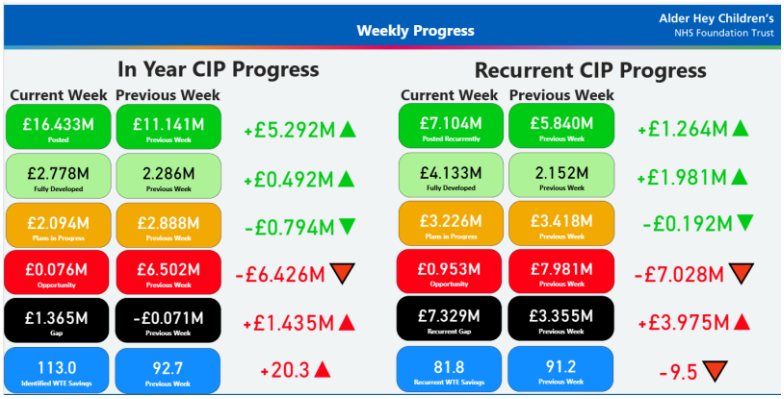
Latest Financial Position

As outlined in the finance report, the Trust reported a £2.5m deficit to the end of August which was £0.2m away from plan although this includes a cost of £0.3m relating to industrial action which was not accounted for in the plan at the start of the year.

CIP is in line with plan in year; however, it includes a number of non-recurrent items resulting in recurrent CIP falling £3.4m behind plan.

Our WTE position at the end of August was also favourable reporting 91 below plan, recognising the significant reduction in temporary spend (c55WTE) and also posts released following the closure of the MARS scheme during May.

Progress has continued through Closing the Gap Programme in identifying and posting CIP savings, with the latest position for the full year now showing £19.2m posted/fully developed and £2m with plans in progress and a gap of £1.5m to the full target of £22.7m.



Whilst this continues to show positive progress, the focus remains on closing the remaining gap and delivering the level of run rate savings required.

The level of recurrent savings continues to remain a concern with only 50% currently in green and a gap of c£8m in plans identified. A key driver of this gap is the lack of transformational benefits delivered through the clinical collaboratives, as whilst some financial savings has been realised, largely linked to the SDEC bed closures in year, productivity through Lyrebird and 10% pay plans, there remains a significant gap. The ongoing work through Q3 on developing the Blueprints and Target Operating Model is set out to identify recurrent savings through new ways of workings and this is critical to ensure financial sustainability for April 2026 onwards.

The latest forecast submitted to the ICB at the end of August based on the agreed methodology adopted, shown a most likely of breakeven and a best case of £3.4m. This includes a risk rated approach to CIP and also assumptions on run rate and income delivery as noted below:

Assumptions included in latest forecast:

- Delivery of activity plans in full for year.
- Payment of prior year income.
- CIP plans as per risk rated approach (100% green, 50% amber, 25% red).

Closing the Gap Programme

During August, a plan was shared with FTPC and PWC on the actions proposed to close the £7m gap at this point, along with oversight of strategic command to move current plans identified in amber and red to green at rapid pace.

A total of 8 areas was included in this programme each with an Executive SRO and a savings target to identify. The latest position by programme area is shown below with £3m posted savings and a further £1m in plans and opportunity.

Ref	Programme Area	SRO	Green	Amber	Red
CTG1	Activity, Coding & Income	AB/KW	Not CIP - but now forecasting to delivery activity plan in full		
CTG2	Workforce - Medical	A.Bass	£nil, but delivering IP & OP		
CTG3	Workforce - Non Medical	MS	£1.8m	£0.1m	
CTG4	Procurement & Energy	NA / RL		£0.05m	
CTG5	Pharmacy & Diagnostics	RL	£0.2m	£0.15m	
CTG6	Planned Care - Inpatient	CL	£0.5m		
CTG7	Planned Care - Outpatient	AB/KW	£0.5m		£0.7m
CTG8	Go Agenda (R&I)	JC	Not CIP - improved year end forecast		
otal			£3m	£0.3m	£0.7m

In order to achieve this level of savings a number of key actions were approved using the governance of the Financial Improvement Programme:

- **Workforce:**
  - Pause recruitment into corporate and managerial non-patient facing roles until the end March 2026 ('break-glass' request can be made, with QIA & EIA to Workforce Establishment Group).
  - Limiting the number of new starters we recruit each month (half of leavers).
  - Reduce temporary staffing in all areas (bank and overtime).
  - No additional annual leave day.
  - MARS scheme re-opened.
- **Outpatients:**
  - Roll our of Ambient Voice Technology at scale to all clinicians increasing capacity and ability to see more CYP during Q4.
  - Maximise utilisation of clinics that regularly have high WNB rate.

Alongside the financial savings, communication briefings have been held with managers and leaders across the organisations to ensure they are fully informed of the decisions being taken and the actions required. Positive feedback has been received from the sessions held and further sessions are planned throughout the rest of the year to keep staff fully informed.

External Position

The C&M position remains significantly challenged and at the end of August, the reported position was £5.9m away from plan. Deficit support funding was not released for Q2 based on the level of risk across the system creating cash challenges for a number of providers.

Following the latest PWC meetings, each provider has been risk rated based on a number of factors including CIP delivery, forecast for year end and confidence in the ability to deliver the plans set. Alder Hey has been rated as medium risk based on the position at the end of Month 4 – key to this rating is the level of CIP delivered at this stage (only 65%).

In terms of the additional stretch and placeholder included in plans back in April, no further redistribution has been agreed and the £3.8m remains in our plan. A proposed approach has been shared with ICB on how this can be delivered collectively albeit a level of risk remains in in year savings given the point in the year.

The Turnaround team at the ICB maintains oversight of financial savings across the system and has issued an additional set of controls for all trusts to review in order to facilitate cost reductions. The controls include:

- Further change to bank rates.
- Implementation of a standard rate card for Resident Doctors.
- Move to a standardised car park tariff for staff and visitors across all providers.
- Cease of overtime and bank in non-clinical areas.
- Reduction in sickness to reduce temporary spend.

Each one of the controls suggested has been assessed by the Executive lead and a paper shared through FIP and strategic command where required and a full response shared with ICB on our position. Where it is safe to implement the controls, we have agreed, however there are a small number that would pose a clinical risk, therefore they will not be implemented at this stage.

Managing the risk to quality & safety from a stretching CIP

Our Financial Improvement Programme approach continues to provide the leadership, processes, and reporting framework to take forward our CIP in a safe and compassionate way. All CIP schemes above £50k require a QIA and EIA.

There is a recognition that additional activities regarding communication and management of risk are required to maintain patient safety and the wellbeing of staff. In September, a number of communication events have taken place to brief managers and leaders, which will be cascaded to teams across the organisation. The Risk Management Forum has agreed to hold an extraordinary session in October focused on the impact and relationship between financial decision making on risk and quality. The session will focus on the cumulative effect of decisions and how risk is dynamically changing over time.

Forward Look and actions

As noted above whilst significant positive progress has been made over the last 2 months, there still remains a level of risk in the Trust not achieving the financial plan for the year end based on the following:

- Gap in run rate CIP savings for Q3 and Q4.
- Risk to activity plans in winter.
- Increased pressure in areas such as drugs and clinical supplies with growing costs.
- No final agreement on the system stretch of £3.8m.

A discussion was held at FTPC on the latest position and remaining risks and it weas agreed that the Closing the Gap programme should remain in place with a continued focus on other areas that can be utilised to meet the gap. A discussion was also held on an approach to managing activity delivery over Q3 and Q4 and ensuring that this is kept as high priority and we maximise the resources we have available.

Conclusion

This report outlines the latest position with regards to the financial plan for the rest of the year and the remaining risks that are being managed. The actions and steps outlined in the report will be progressed at pace to mitigate this risk where possible, however this will require collective action to ensure delivery.

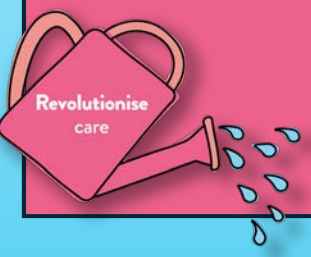
The Board are asked to note the contents of this report.

Flash Report September 2025*

Alder Hey Children's NHS Foundation Trust

Performance is subject to change

1	1	92.4%	6	10
Severe/Fatal Incidents/Never Events	Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections	Patients deteriorating from an inpatient bed



87.5%	259	61.8%	1.61	95%
ED: %Treated within 4 Hours	Number of RTT Patients waiting >52weeks	% Patients waiting within 18 weeks (RTT)	Elective activiy per clinical WTE	Diagnostic Performance

-84	10.5%	73.4%	6.28%
Estimated Workforce Plan	Staff Turnover	%PDRs Completed	% Sickness

Financial Sustainability

TBC	TBC	TBC
I&E position (Actual in month)	I&E year end forecast to plan (Variance)	CIP (Forecast vs full year target)

HIGHLIGHTS

- Sustained performance for time to be seen and treated in ED - 7th consecutive month 80%+.
- Significant reduction in the number of CYP waiting >52 weeks
- High proportion of diagnostic tests completed in six weeks.
- 6th 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

- 6 healthcare associated infections; 3 C.Diff and 3 E.coli
- 1 never event for which PSII is being undertaken

Report was completed during the reporting month (30th Sept), therefore the data does not cover the full period, and financial information is unavailable due to the timing of its release.

VISION 2030

NHS
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NHS Foundation Trust

Integrated Performance Report

Published: September 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	10	n/a	↓
Number of Incidents per 1,000 bed days – No Harm	112	77.4	↑
Number of Incidents per 1,000 bed days – Low Harm and above	22	19.6	↑

Executive Summary

The Trust has achieved several positive outcomes. All complaints were responded to within 25 working days and 93% of PALS contacts within 5 days. Patient feedback remains strong, with the Emergency Department recording its highest Friends and Family Test (FFT) score in over a year at 91%, and 94% of overall responses rating their experience as good or very good. Clinical quality has improved, with 100% of inpatients and 97% of ED patients with suspected sepsis receiving IV antibiotics, alongside a three-month reduction in medication errors causing harm. Awareness of Martha's Rule is increasing, with more parents and carers activating it. Concerns remain, including a reported serious incident that has met statutory requirements and triggered a multi-agency review, and an increase in HDU patients deteriorating and requiring admission to PICU. Looking ahead, the Trust will continue to monitor FFT response levels to understand the impact of changes to survey questions.

Support Our People

	Value	Target	Trend
Workforce Plan	4,327	4,419	↓
Staff Turnover	11.4%	10%	↓
Sickness Absence (Total)	6.3%	4.5%	↑

Executive Summary

The Trust continues to perform strongly in key workforce measures, with mandatory training compliance maintained above 90% and short-term sickness absence remaining below the 2% target. However, challenges remain. The total workforce (WTE) has stayed largely static, while the cost improvement plan (CIP) requires a reduction of over 100 WTE by March 2026. This is being managed through the Workforce Establishment & Vacancy Panel and the Organisation Design collaborative. Long-term sickness absence levels remain high, and while a dedicated HR team and a 90-day improvement programme have been established as part of the Closing the Gap initiative, further progress is needed. In addition, performance development review (PDR) completion rates are still below the 90% target, despite ongoing support from Learning and Development colleagues. Looking forward, the Trust will continue to implement and monitor targeted actions to reduce sickness absence and improve PDR completion rates, while managing workforce plans in line with the CIP requirement.

Revolutionise Care

	Value	Target	Trend
ED % Treated Within 4 Hours	90%	78%	↑
%RTT Patients Waiting >52 Weeks*	2.28%	1.3%	↑
RTT Waiting List Within 18 Weeks*	60.2%	58.7%	↑

Executive Summary

The Trust has demonstrated strong performance, with ED four-hour performance at 90%, RTT improving through waiting list validation and increased activity, and theatre touch-time utilisation consistently above 80%. Elective and outpatient activity remains above plan, and the number of patients waiting over two years for follow-up is decreasing. DM01 performance is sustained above 95%. However, challenges persist with patients waiting over 52 weeks, which is above the 1% target, and WNB rates remain above target. Additionally, cancer performance is declining against the 28-day diagnosis and 31-day decision-to-treat standards, with three breaches in minor operations under the suspected cancer pathway. Looking ahead, weekend clinics for ENT and Dentistry have resumed to support long waiters, and overbooking pilots are in progress for wider rollout in October. An opt-in process for ENT and Dentistry aims to reduce WNB, supported by a new patient demographic system improving contact accuracy. Service teams in the cancer pathway now attend weekly PTL meetings to avoid delays.

Financial Sustainability

	Value	Target	Trend
I&E Year End Forecast	£7.1m	£7.1m	↔
Recurrent Efficiency Plans Delivered	£2.6m	£7.9m	↓
ERF Income (YTD)	£39.9m	£41.1m	↑

Executive Summary

The Trust reported a £1m in-month deficit and £2.5m YTD, £0.2m off plan due to industrial action. It is externally forecasting delivery of the £7.16m planned surplus, subject to CIP and ICB risk share mitigation. The risk-adjusted forecast is £3.4m, while the run-rate forecast indicates breakeven, consistent with last month. CIP is on plan YTD with £15.9m transacted, £1.9m fully developed and £4.9m in progress. Cash is below plan and capital ahead of plan due to budget phasing. Risks remain around CIP delivery and capital funding. Mitigation includes the Financial Improvement Programme (FIP), collaborative workstreams, and Closing the Gap schemes to support delivery of the £22.7m CIP plan. A Capital Prioritisation Workshop approved priority one items, with funding for priority two items to be resolved. Looking ahead, FIP-led cost controls and transformation work aim to support year-end delivery and longer-term sustainability. Closing the Gap actions are progressing to de-risk CIP, with finance escalation and biweekly CIP deep dives in place.

*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:

• 100% of complaints responded to within 25 working days and 93% of PALS responded to within 5 working days • Highest FFT score in ED for more than 12 months – 91%; 94% of FFT responses rated their experience in the Trust as good or very good • 100% of inpatients and 97% of ED patients received IV antibiotics for sepsis concern • Reduction over 3 months in medication errors resulting in harm • Increase in the number of parents / carers activating Martha's rule demonstrating awareness and usability of the tool

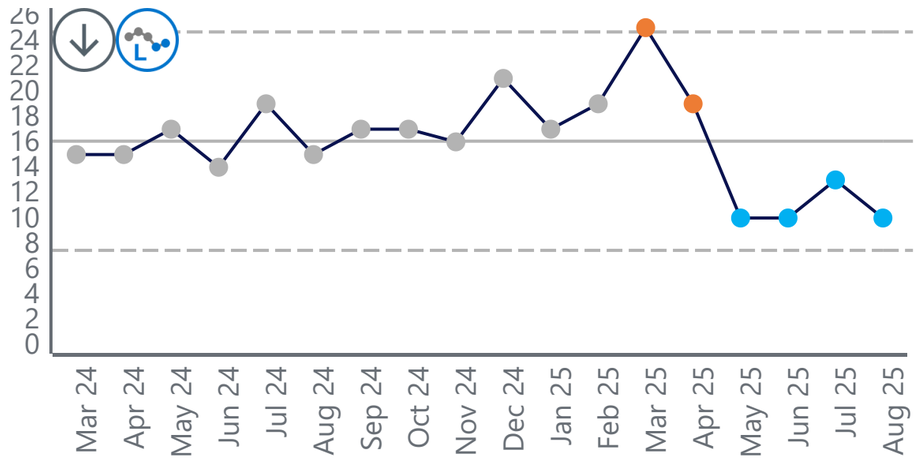
Areas of Concern:

• Serious incident reported; statutory requirements met and multi-agency learning review commissioned • Increase in patients admitted to PICU from HDU due to deterioration

Forward Look (with actions)

Continue to monitor number of FFT responses following changes to the number of questions

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



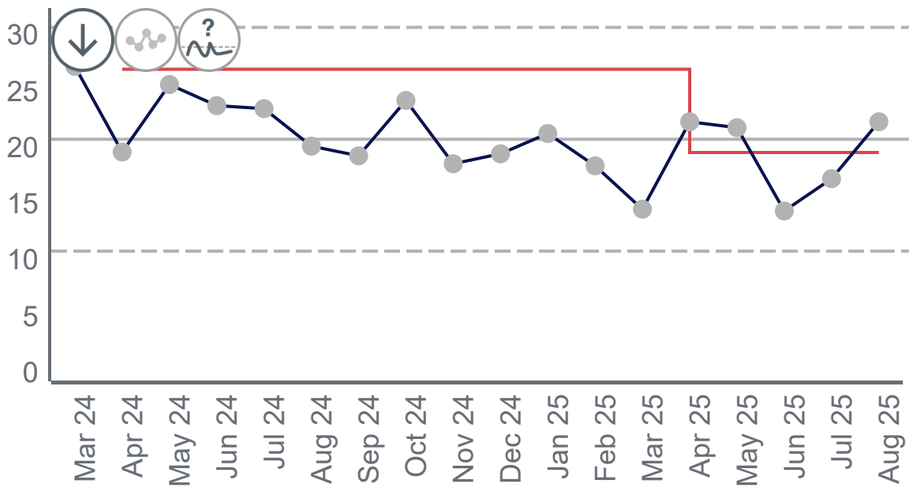
Technical Analysis:

Special cause variation of improving nature with 10 patients deteriorating from an inpatient bed to PICU with an average of 16 a month during the last 18 months. Fourth consecutive month below the average.

Actions:

Reduction over 3 months of patients admitted to PICU from inpatient wards and an increase in the number of parents / carers activating Martha's rule demonstrating awareness and usability of the tool. Continue to inform parents / carers about Marta's Rule when they are welcomed and orientated to the ward

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



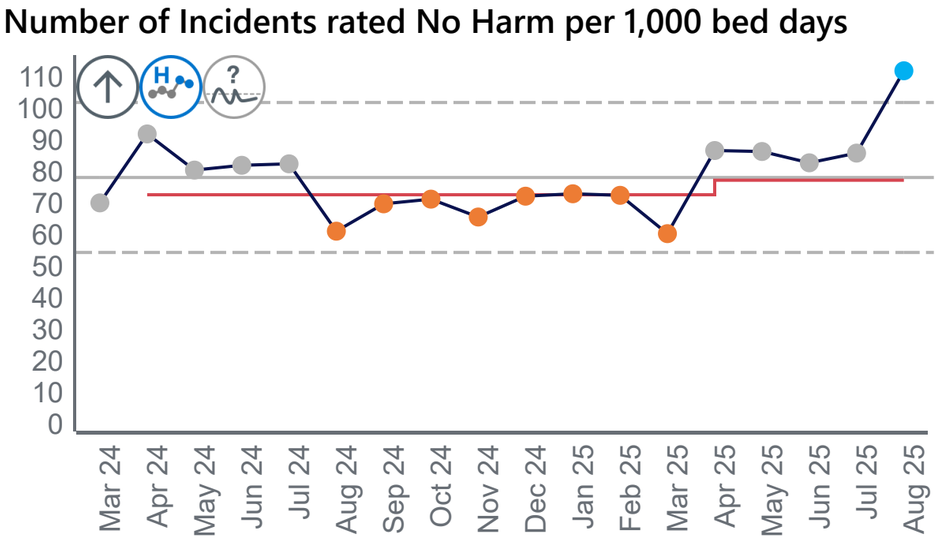
Technical Analysis:

Common cause variation with performance of 17 incidents of harm per 1,000 bed days, with a monthly average of 22 incidents during the period. 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:

Continue to promote a culture of incident reporting

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



Technical Analysis:

Special cause variation of improving nature observed with 112 incidents of no harm per 1000 bed days, with a monthly average of 78. 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. 5th consecutive month above target in 2025/2026.

Actions:

Continue to share examples of Good Catches and near miss incidents at the Patient Safety Meeting and bulletin

Integrated Performance Report | September 2025

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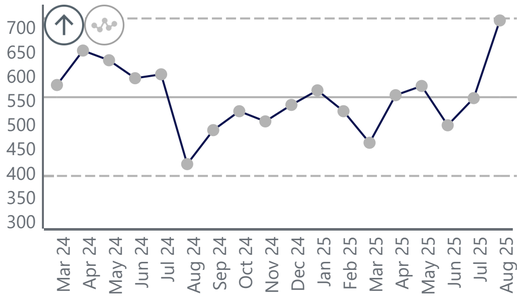
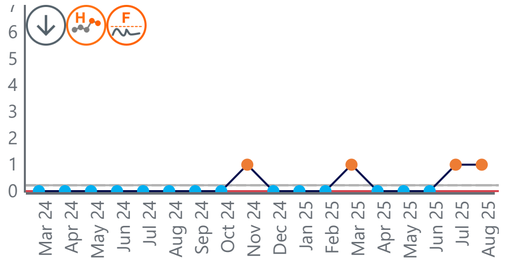
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



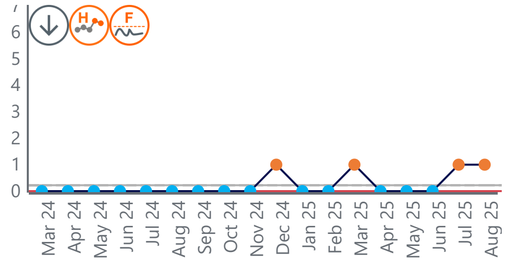
Severe or Fatal Incidents – Physical only

Target: Internal

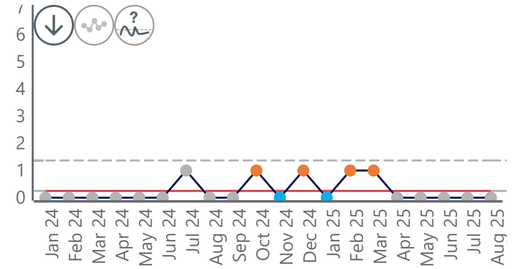


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

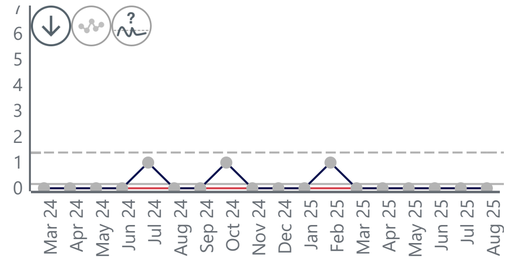


Number of PSIIs (Patient safety incident investigation) undertaken



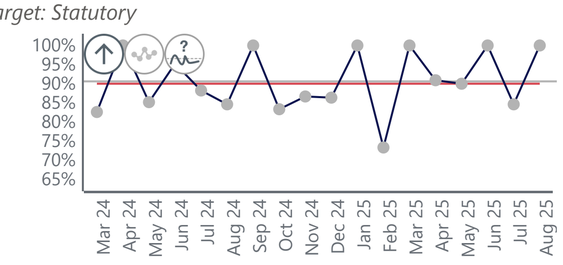
Number of Never Events

Target: Internal



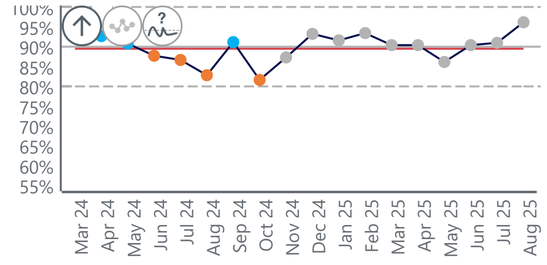
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

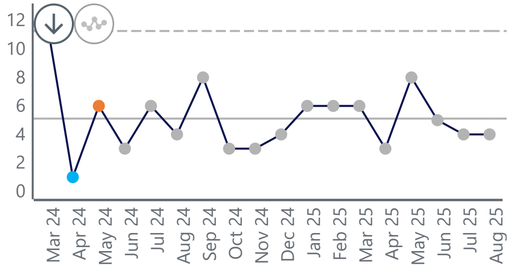


Sepsis % Patients receiving antibiotic within 60 mins for ED

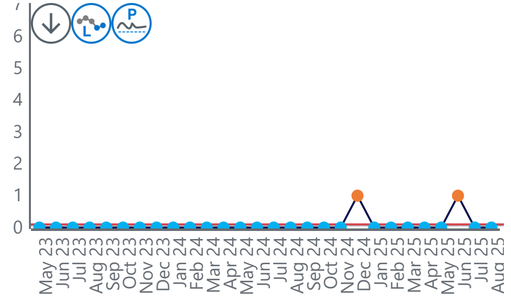
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

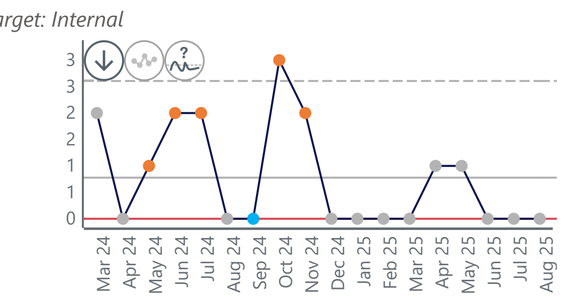


Pressure Ulcers Category 3 and 4

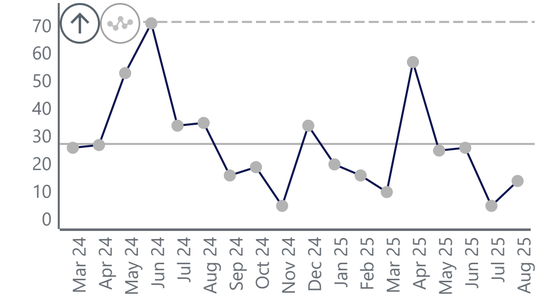


Pressure Ulcers Category 2

Target: Internal

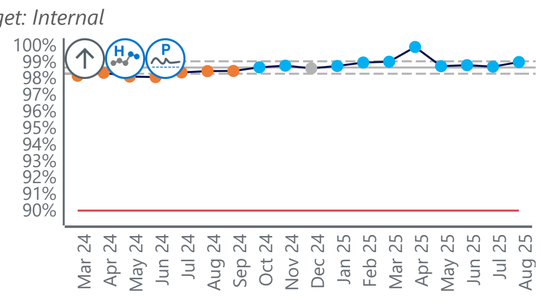


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



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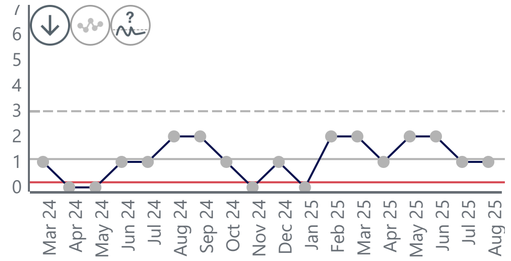
Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

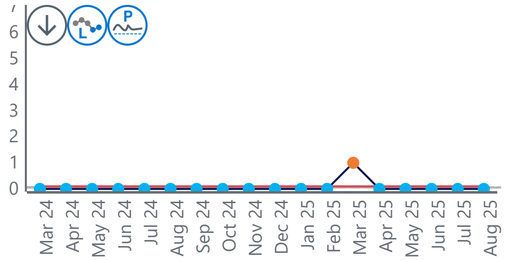
Hospital Acquired Organisms - MSSA

Target: Internal



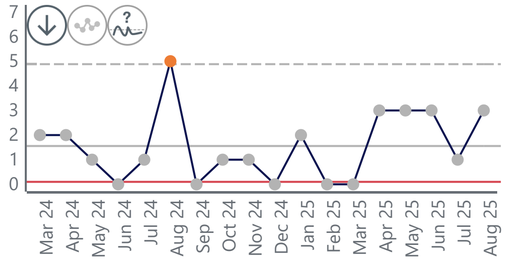
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



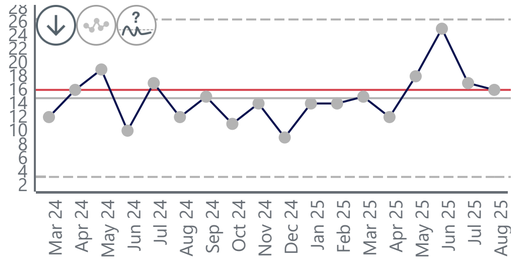
Hospital Acquired Organisms - (C.Difficile)

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

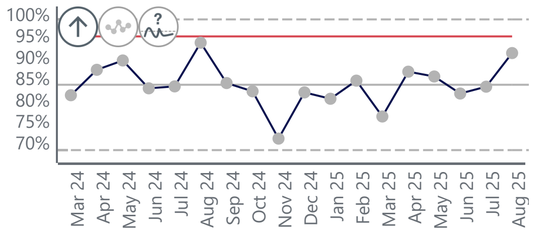
Target: Internal

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

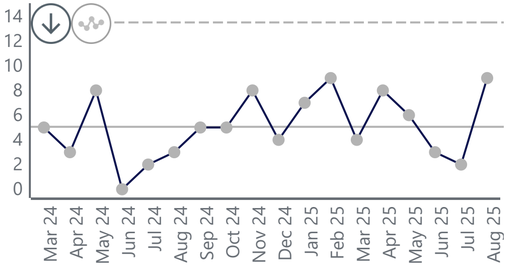
Target: Statutory

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

Target: Internal

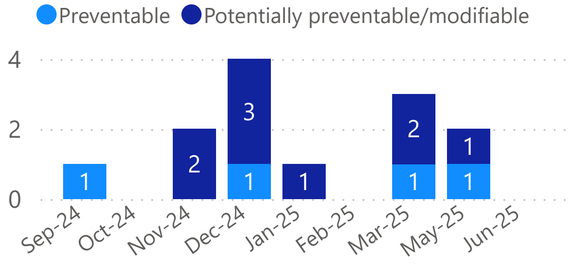


Number of patients deteriorating from HDU admitted to PICU

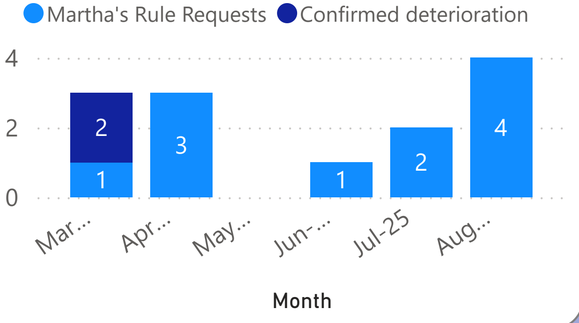


Predictable and preventable deteriorating patients

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 90% • 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:

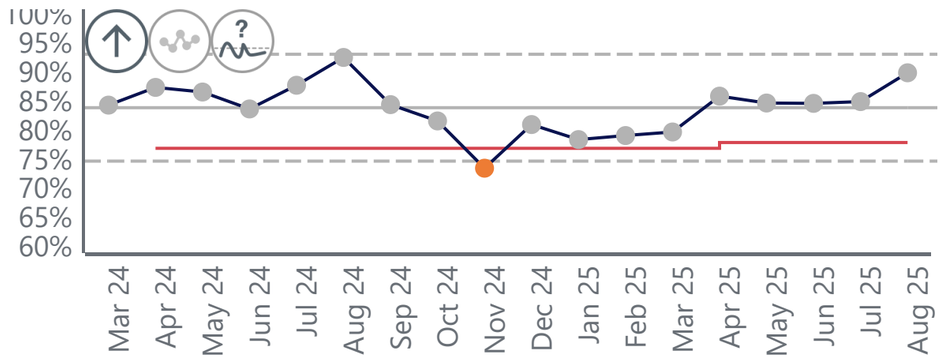
• The number of patients waiting over 52 weeks remains above the 1% target • WNB remains above the trust target • Decline in cancer performance against 28 day diagnosis and 31 day for decision to treat. Three breaches within minor ops under suspected cancer pathway.

Forward Look (with actions)

• Weekend outpatient clinics for ENT and Dentistry have restarted and continue in month, allowing appointments for patients who have been waiting over 52 weeks • Formal overbooking of NEW clinics started in pilot specialities with a view to fully rollout in October • 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 • Service teams performing minor ops under suspected cancer pathway now attending weekly PTL meeting with MDT coordinators to ensure no delays in treatment.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

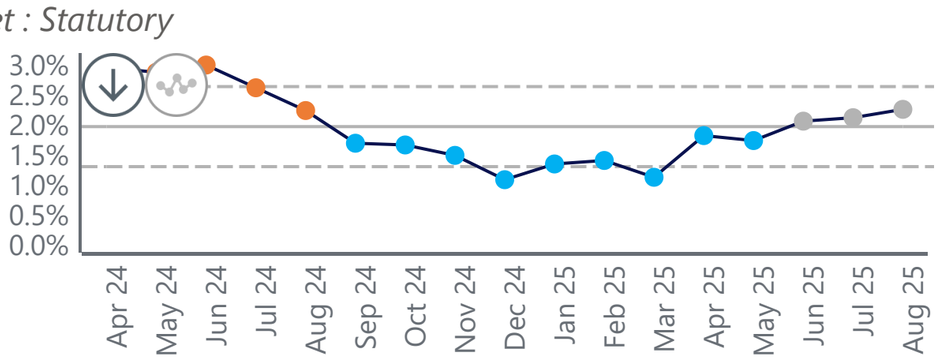
Achieved the national target in August-25. Common cause variation observed with performance of 90%, increase from July-25 (85%). However, this represents a 2.6% decrease compared to August 2024, when performance was 92.6%, although 219 additional attendances occured this year. August 2025 also recorded a 1.65% increase in Resus and Very Urgent patients compared to the same period last year.

Actions:

Clinically ready to proceed working group has now been established to improve interpretation of data and highlight areas of improvement. Handover 45 has been implemented with no true breaches.

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

Target : Statutory



Technical Analysis:

2.28% 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 July-25 position of 2.14% with the total volume at 427. 85% current waits >52 weeks within Dentistry & ENT.

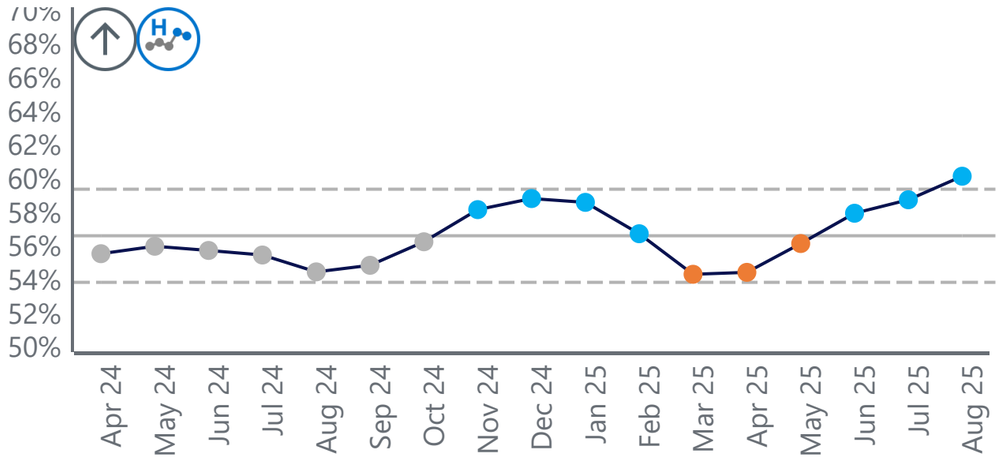
Actions:

The number of patients waiting over 52 weeks remains above the 1% target.

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

RTT waiting list within 18 weeks



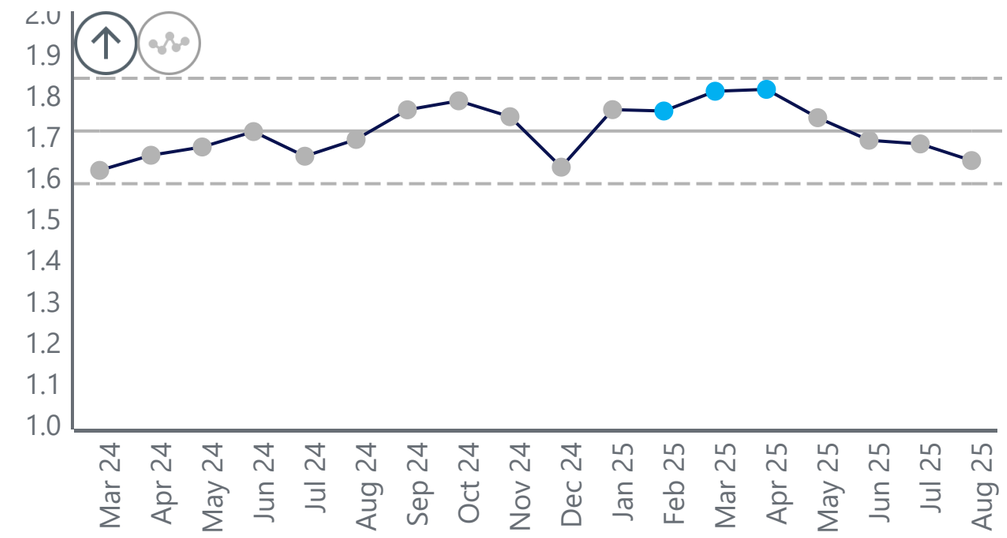
Technical Analysis:

Special cause variation with performance of 60.2% against a year end target of 63.1% by March 2026.
This is improvement from July 2025 position of 58.8%. Oral Surgery and Dentistry lowest performing of services with >100 waiters.

Actions:

Continuous improvement of the % of patients within 18 weeks- Performance of 60.2% in month against a year end target of 63%.

Elective admissions (IP & DC) per clinical WTE



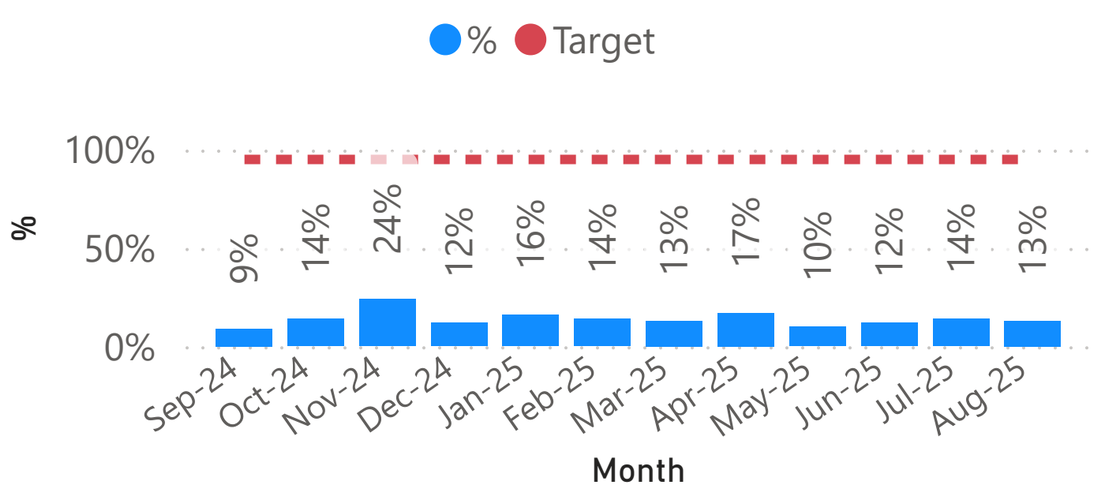
Technical Analysis:

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:

Theatre productivity workstream focused on reducing same day cancellations and by using a data driven approach, increasing the number of patients per session.

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



Technical Analysis:

Performance at the end of August 2025 is 13% against a target of 95% which is a slight decrease from performance of 13% in July 2025.

Actions:

The new integrated assessment pathway for ASD and ADHD assessment has gone live on 1st September which aims to improve coordination and conclusion of neurodevelopmental assessments for children and young people. This is expected to deliver some improvement in access times however demand continues to significant exceed capacity for this service which remains under review with commissioners. Focus remains on the longest waiting children and young people with a reduction in August 2025 of the number of children and young people waiting greater than 104 weeks.

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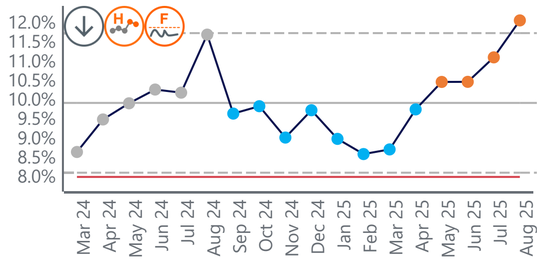
NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

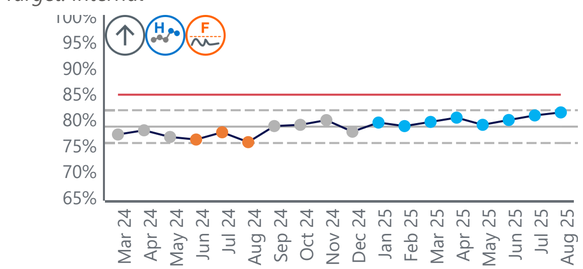
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

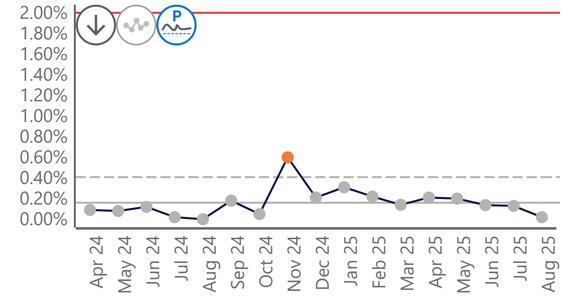


Theatre Utilisation (Capped Touch Time)

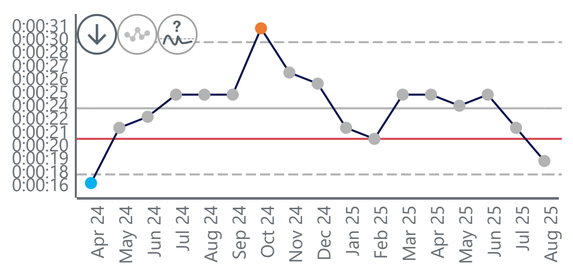
Target: Internal



% of ED attends over 12 hours

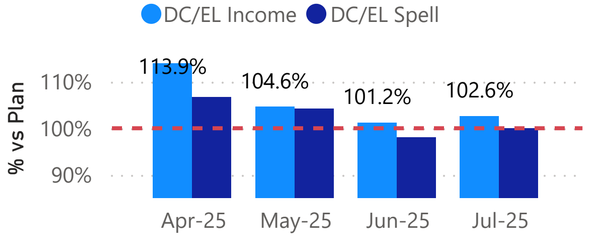


Average Ambulance Vehicle to Handover Time



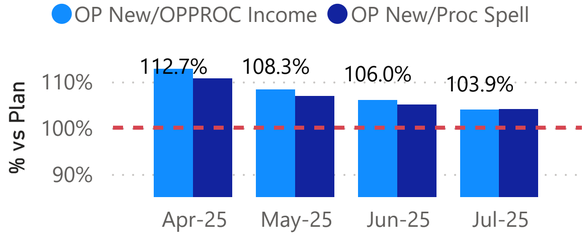
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance



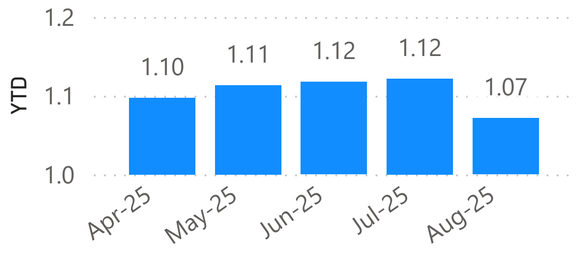
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

SLAM Performance

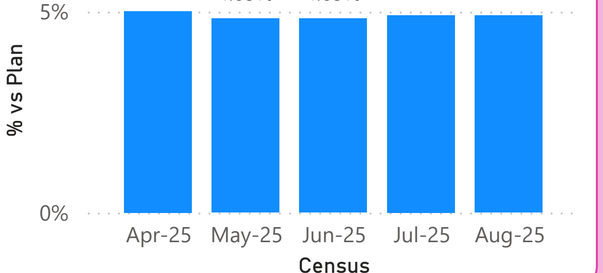


Activity per £1k Operating Expenditure

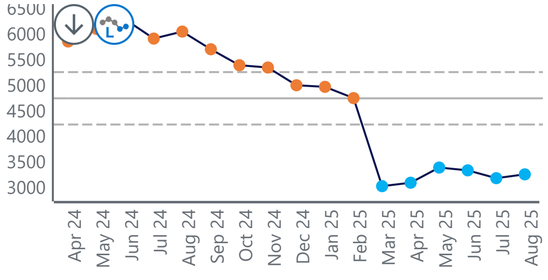
YTD Position



% follow up waiting list on PIFU

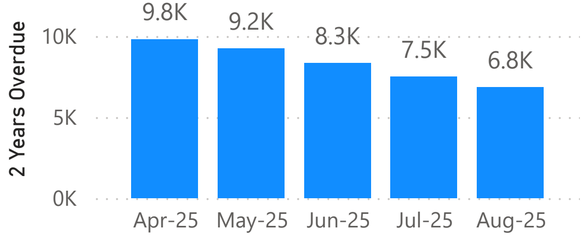


Volume of active outpatient follow up waits - 2 Years & Overdue

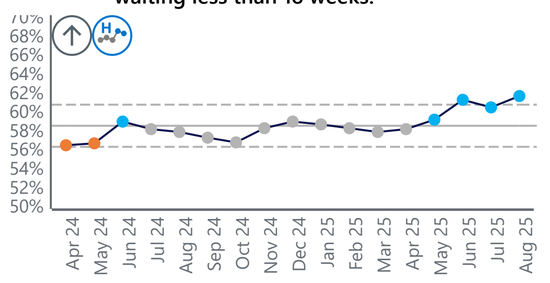


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

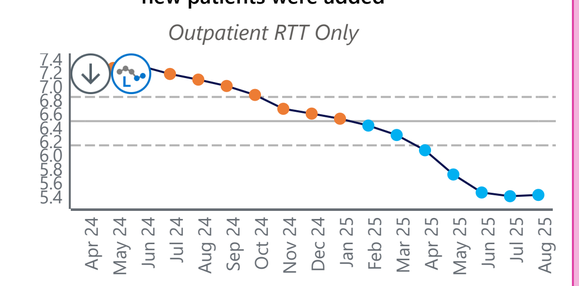


Time to first attendance, waiting for first event and of those waiting less than 18 weeks.



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

Outpatient RTT Only



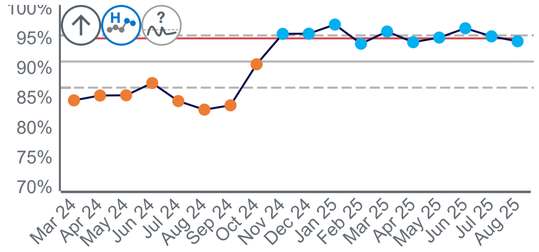
Integrated Performance Report | September 2025

NHS
Alder Hey Children's
NHS Foundation Trust

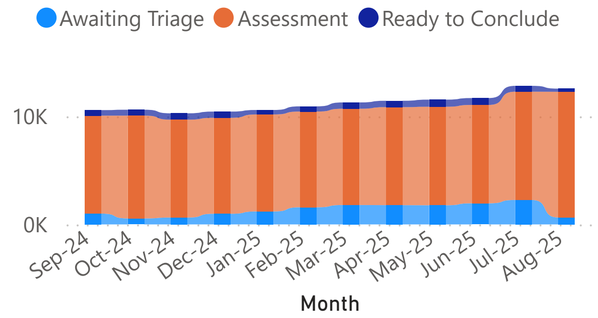
Revolutionise Care - Effective & Responsive - Watch Metrics

Diagnostics: % Completed Within 6 Weeks of referral

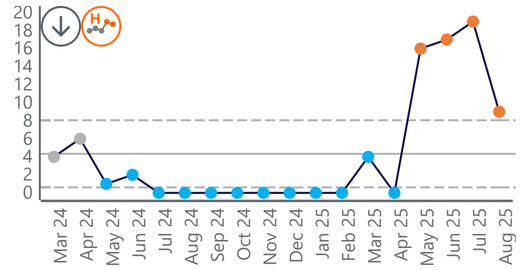
Target: Statutory



Neurodevelopmental Diagnosis Status

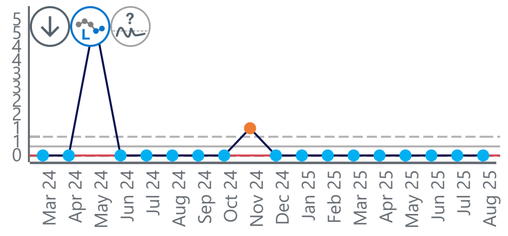


CAMHS: Number of children & young people waiting >52weeks



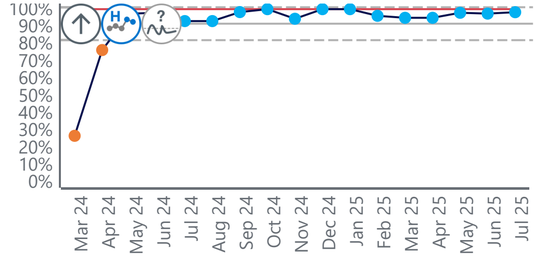
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



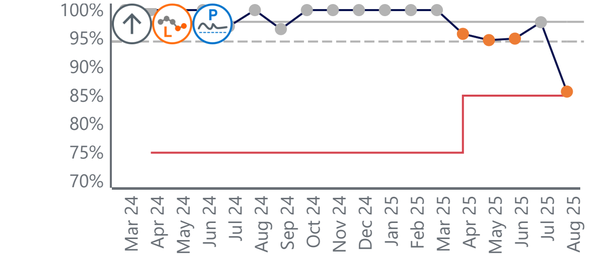
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



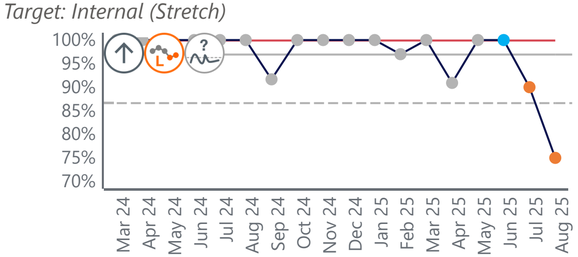
Cancer: Faster Diagnosis within 28 days

Target: Statutory



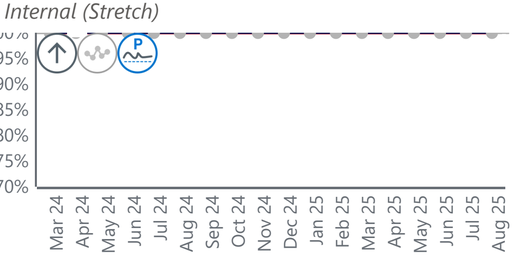
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)

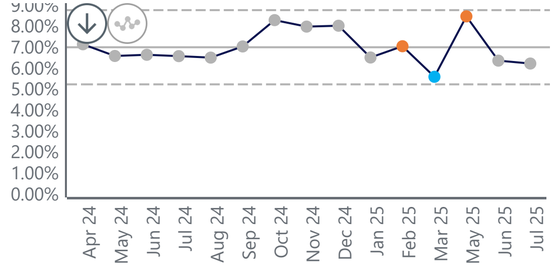


31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

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%
- Short term sickness absence remains below the 2% target

Areas of Concern:

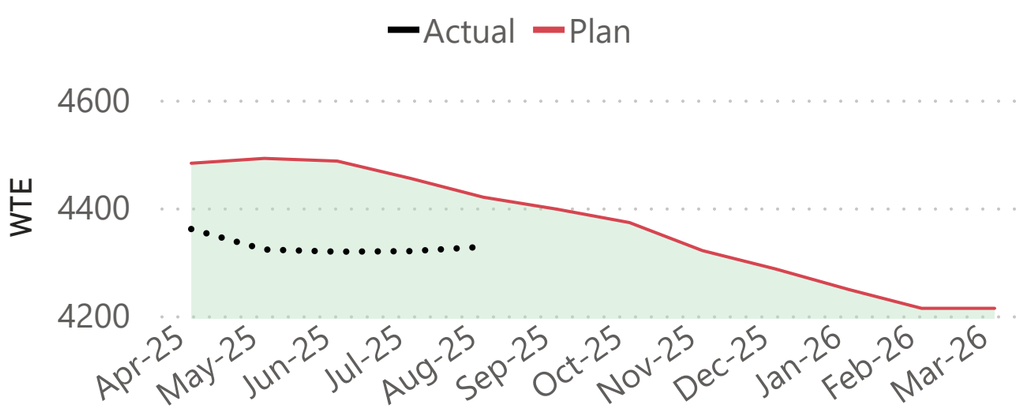
- Total Workforce (WTE): total workforce has remained largely static. The CIP requirement across the year remains significant, with the March 2026 plan over 100 WTE lower than the current position. Additional measures have been agreed and overseen via the Workforce Establishment & Vacancy Panel meeting,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

Forward Look (with actions)

- Long term sickness absence levels are challenging. As a part of the Closing the Gap programme, and target to reduce sickness absence, additional plans, including a team (from within HR) specifically to support sickness absence across the Trust has been created, in addition to the 90-day improvement programme. • PDR Completion: L&D colleagues continue to support managers to achieve PDR completion; a gap between completion levels and the 90% target remain.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

Total workforce for the end of August 2025 was 92 WTE below plan. Actual WTE was 4,327 against a plan of 4,419.

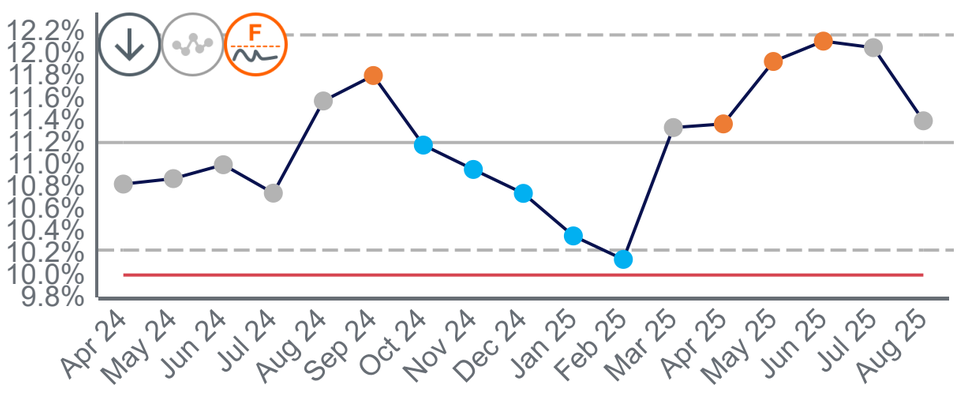
Actions:

WTE in August 2025:
Substantive colleagues (Inc. Trainees): 4326.76 (July: 4318.58)
Bank usage: 88.69 (July: 94.18)
Agency usage: 4.61 (July: 5.76).

In addition, overtime reduced slightly from July (£85,427) to August (£84,005), though higher than May (£82,799), which was the lowest across the previous 12 months.

Staff Turnover

Target: Internal



Technical Analysis:

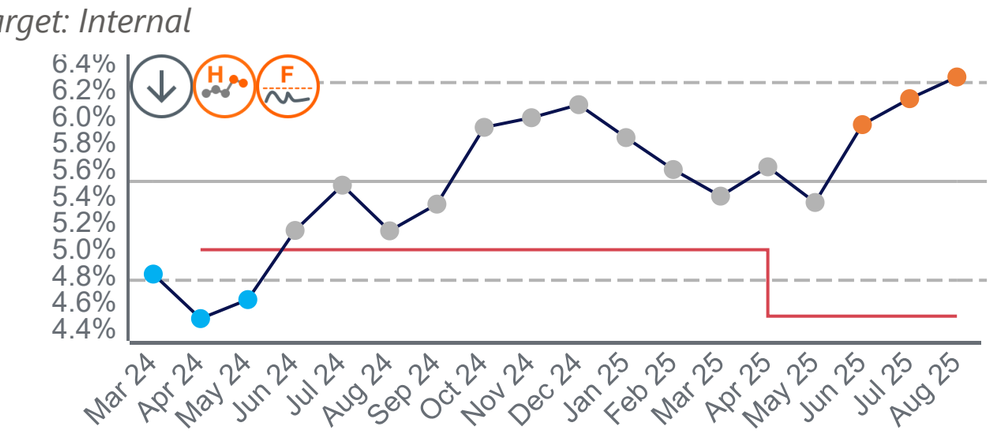
Common cause variation observed with performance of 11.4% in August 2025 against an internal target of 10%. Reduction from July performance of 12.1%. 5th consecutive month against average performance for the 16 months after showing a downward trend Sept 24 to Feb 25.

Actions:

Having seen a steady decline, the recent increase in staff turnover has begun to reduce to just over 11%. The increase was 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:

Special cause variation of concerning nature. Total sickness absence in August 2025 is 6.30% which is above the 5% target and an increase from July 2025 at 6.14%. August 2025 performance comprises STS at 1.60% and LTS at 4.70%. LTS has increased by 1.15% compared to August 2024. Still demonstrating common cause variation, Apr 2024 is last period which would have achieved target which is

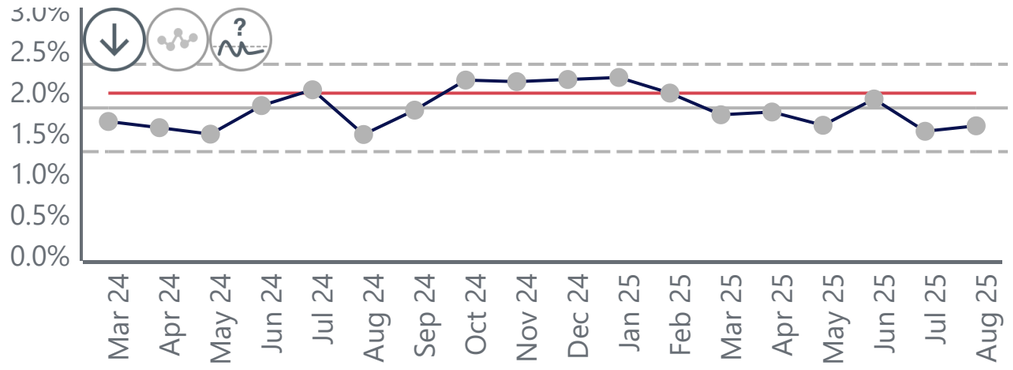
Actions:

Long term sickness absence levels are challenging. As a part of the Closing the Gap programme, and target to reduce sickness absence, additional plans, including a team (from within HR) specifically to support sickness absence across the Trust has been created, in addition to the 90-day improvement programme.

Supporting Our People - Watch Metrics

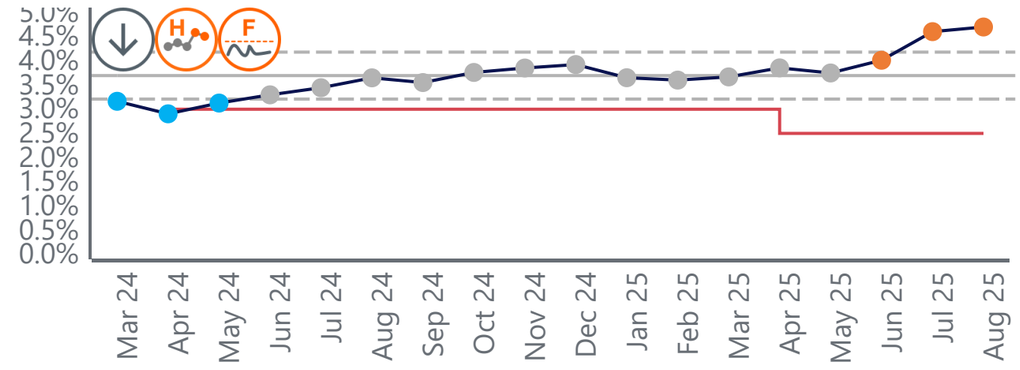
Short Term Sickness

Target: Internal



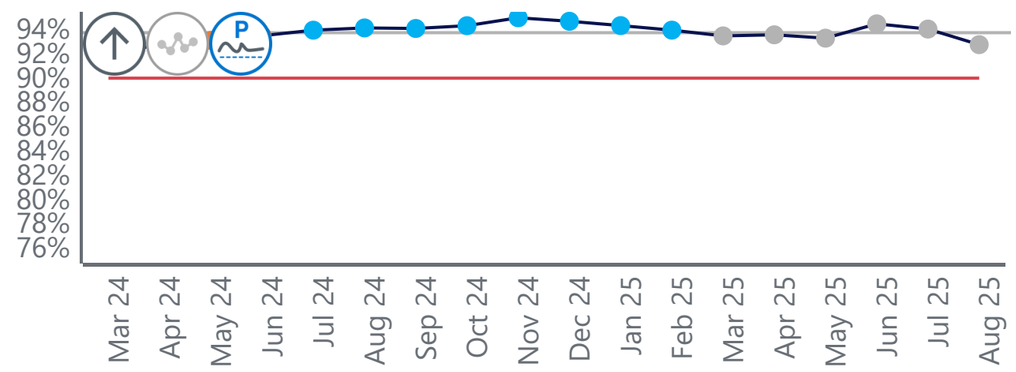
Long Term Sickness

Target: Internal

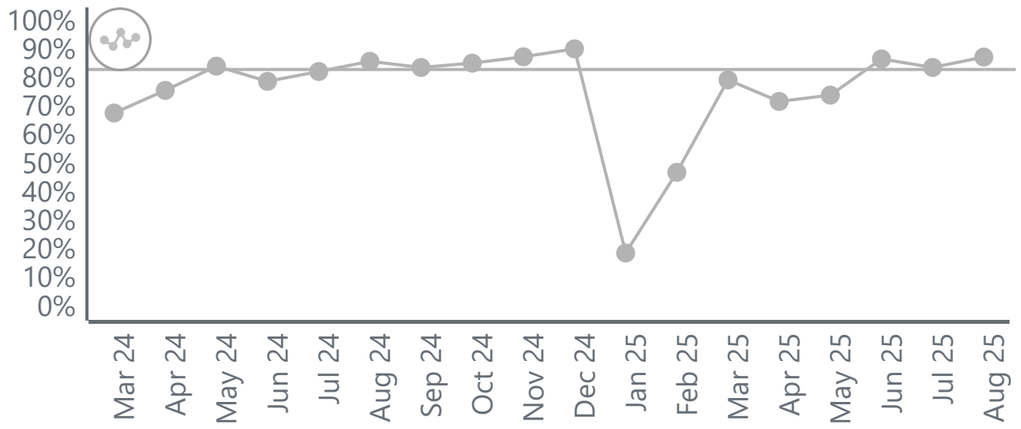


Mandatory Training

Target: Internal

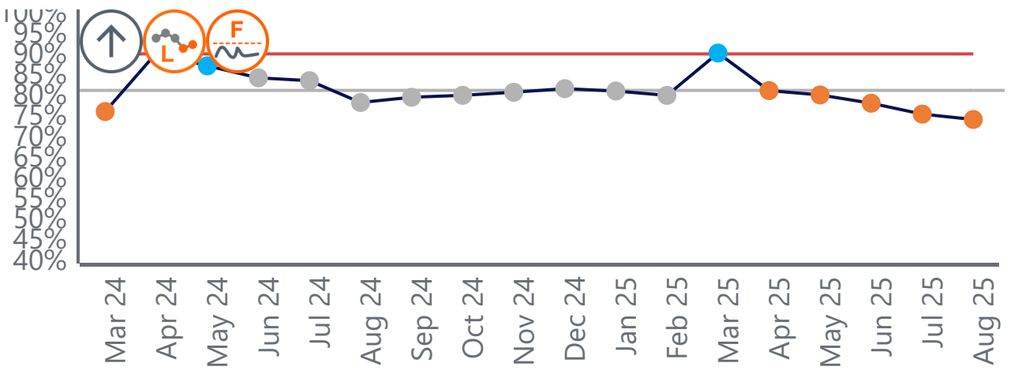


Medical Appraisal

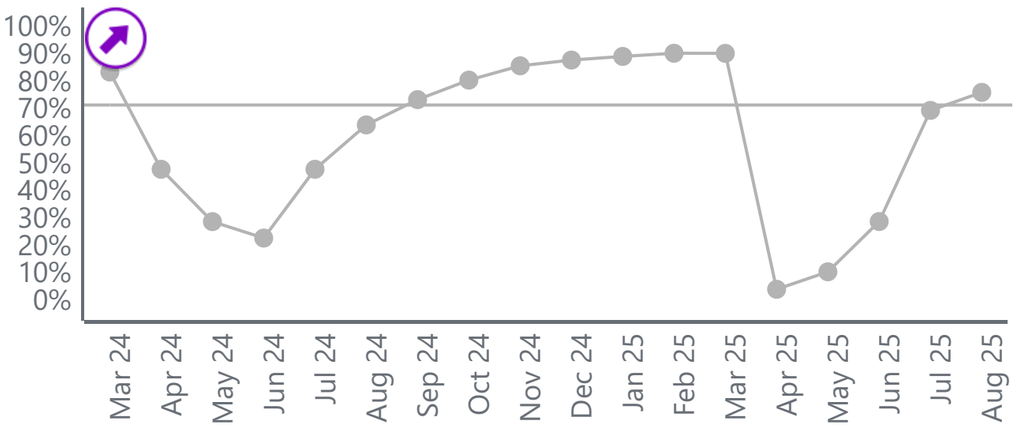


% PDRs Completed (Rolling 12 Months)

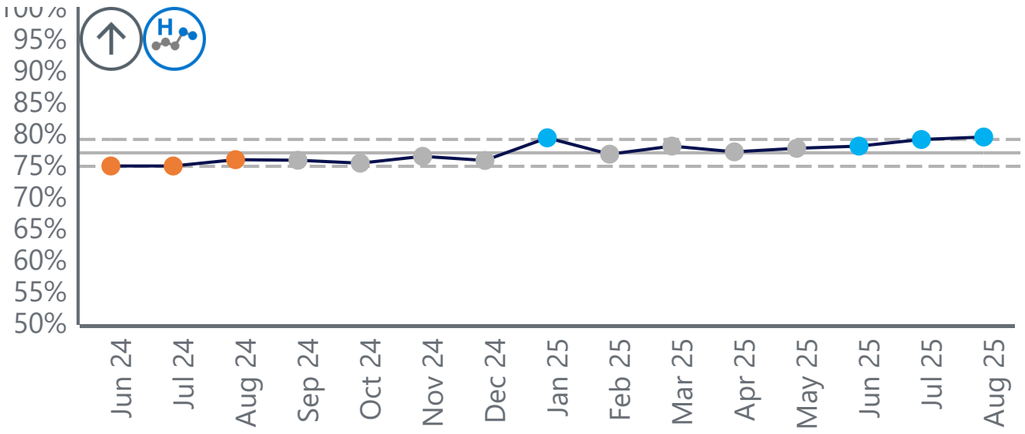
Target: Internal



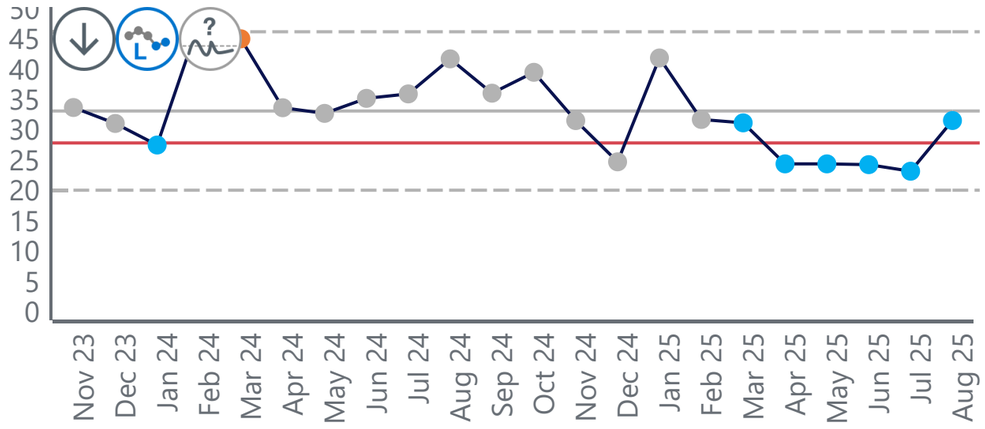
PDR B7+ Completed (Rolling 12 Months)



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:

• Gold accreditation for Clinical Research Facility following latest assessment • Successful ad hoc RPA process to support migration of ASD and ADHD pathways into a single assessment and treatment pathway with around 13,000 records moved • Improvement in July and August in recruitment to time and target % • Proposal to shift start date for Paediatric Open Innovation Zone to July due to delayed sign off of funding agreement under review • Innovation module for thriving operational managers programme underway • All annual statements of expenditure (ASTOX) for NIHR grants hosted by AH submitted • New funding call to support short term grant writing is live (deadline mid-Sept)

Areas of Concern:

• Underachievement to date on both MRI and RPA business cases - decision docs taken to FIP Strategic Command on 28th August with recovery plans to be implemented from Sept onward to achieve break even position • Staffing issues in labs impacting ability to set up new research studies which could impact commercial research income – options for alternative provision under review • Clinical capacity to support research and innovation is limited in some areas (neurology currently under review) • Trustwide recruitment restrictions impacting ability to recruit to externally funded posts in a timely way and therefore posing risks to delivery of external contracts

Forward Look (with actions)

• First report for LCR Combined Authority for the Paediatric Open Innovation Zone in preparation for Sept submission • Futures comms plan underway following new comms and marketing officer starting is post in July – to be completed by end of Sept • Commercial and non-commercial income forecast under review – to be completed by end of Sept

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

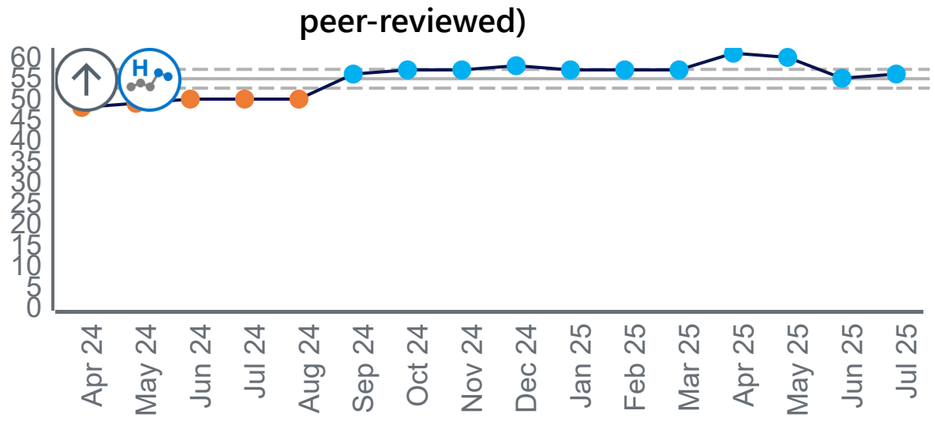
Technical Analysis:

Under Development

Actions:

Under Development

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

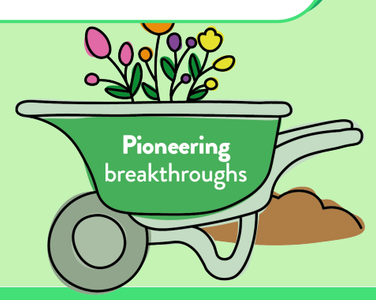


Technical Analysis:

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

Actions:

Number of CIs remains stable – internal funding call live to encourage new CIsto submit external funding applications



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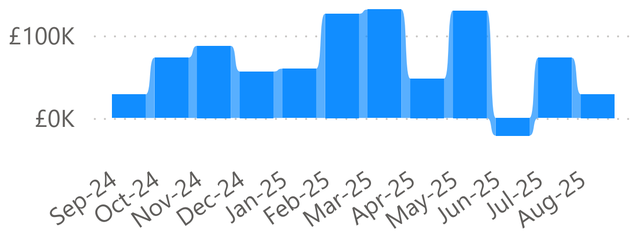
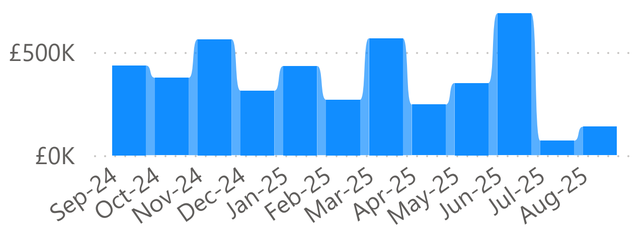
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

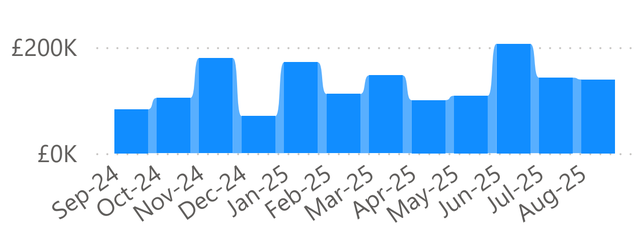
External innovation income received by month (commercial and non-commercial)



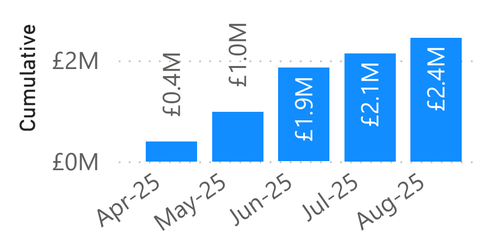
External research income received by month (commercial and non-commercial but excluding NIHR)



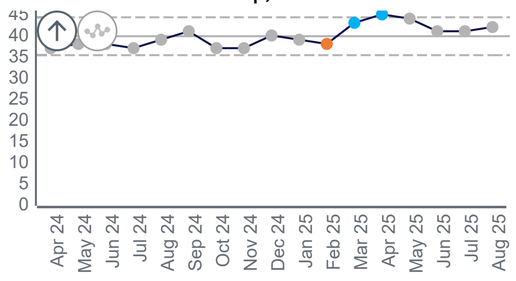
NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)



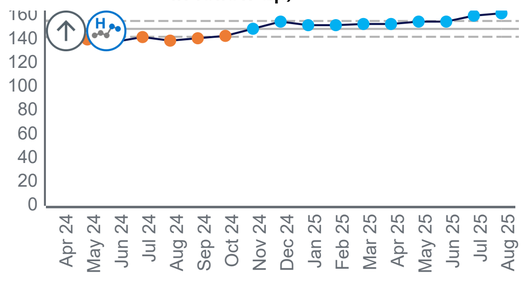
External income received by month across Research and Innovation (YTD Cumulative)



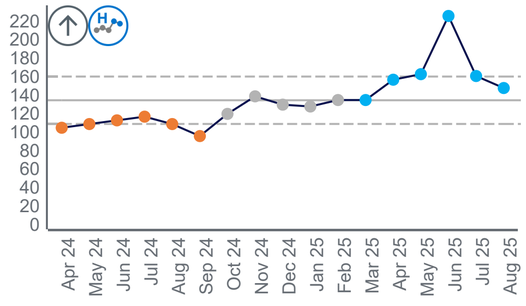
Number of open commercial studies (recruiting and in follow up)



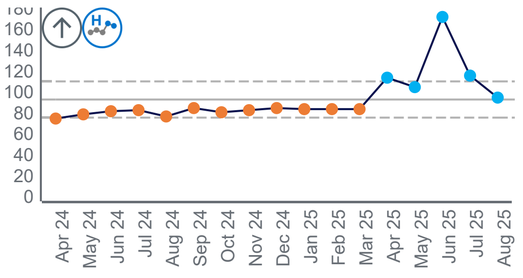
Number of open non-commercial studies (recruiting and in follow up)



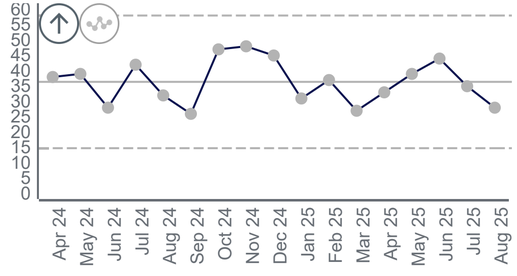
Number of participants recruited to all studies



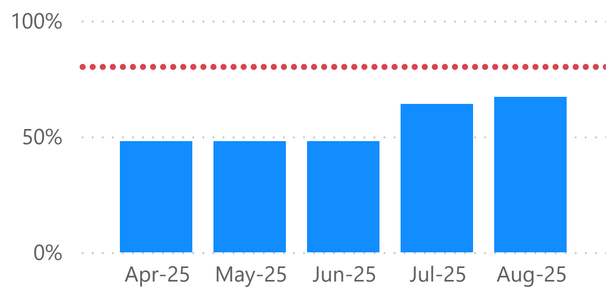
Number of participants recruited to all NIHR portfolio studies



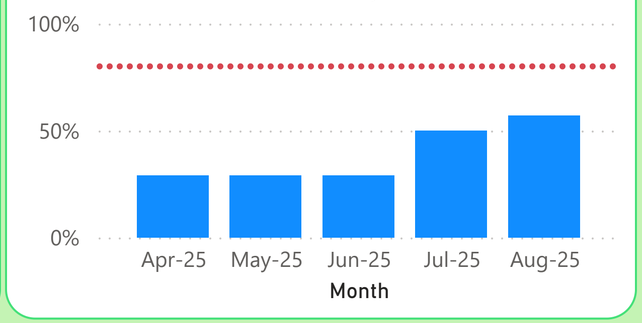
Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



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



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



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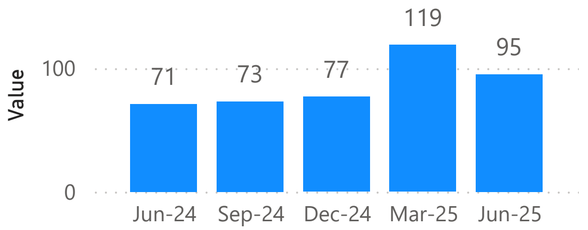
Alder Hey Children's NHS Foundation Trust

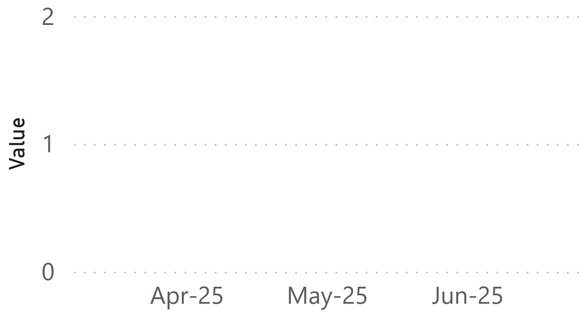
Pioneering Breakthroughs

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

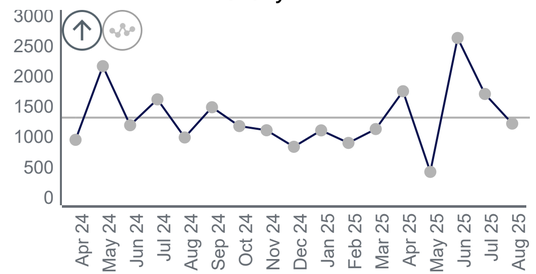
Quarterly



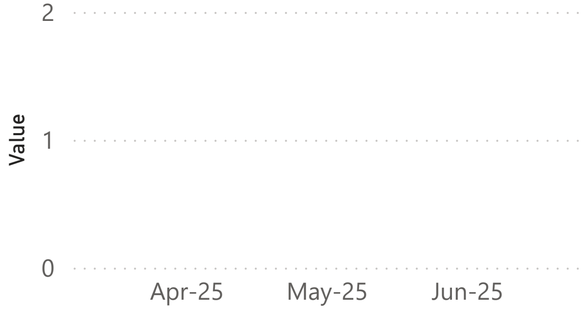
Number of businesses supported by POIZ



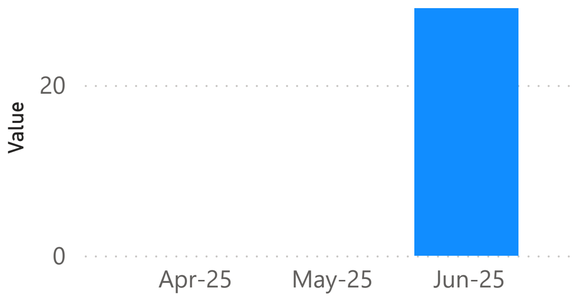
Manual hours released from automation/AI solutions - Monthly



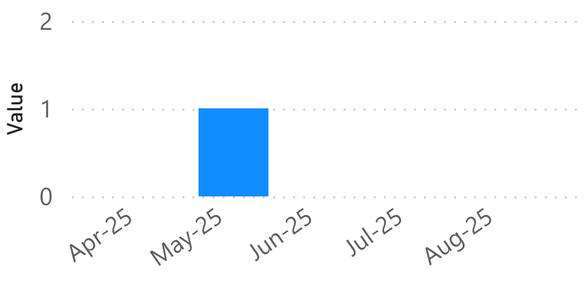
Number of staff trained in innovation methods



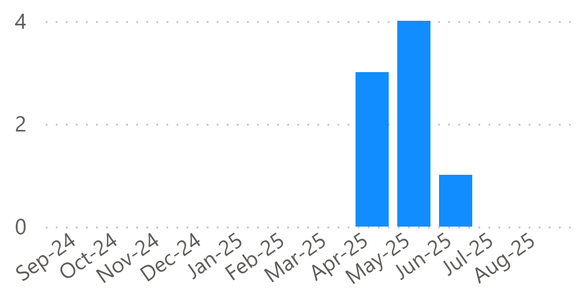
Number of staff trained in research methods



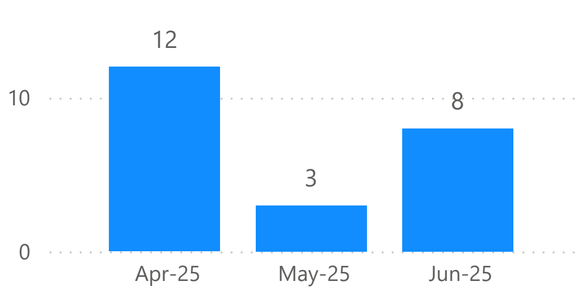
Number of AH-hosted jobs created through new external funding (POIZ metric)



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



Number of primary and secondary schools engaged with Futures activities



Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

Trust reported £1m deficit in month, £2.5m deficit YTD - off plan by £0.2m due to the impact of industrial action. Externally 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. However, extrapolated forecast based on run rate methodology is break even, in line with last month. CIP is on plan YTD. Overall, £15.9m CIP has been transacted in year with £1.9m fully developed and £4.9m in progress/opportunity stage. On track to deliver subject to amber and red schemes. Cash lower than plan and capital ahead of plan due to phasing of budget.

Areas of Concern:

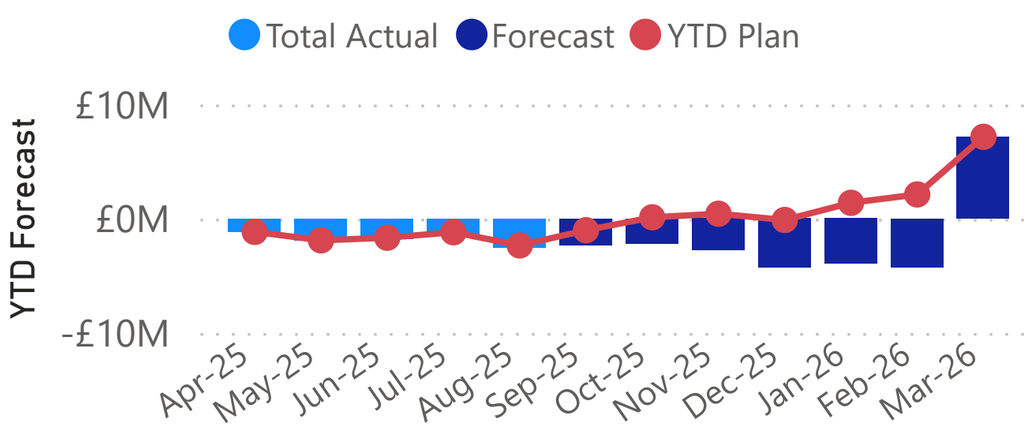
Delivery of CIP programme continues to present a risk. Mitigating actions are being progressed through the Financial Improvement Programme (FIP) and collaborative workstreams. Divisional forecasts have been updated to reflect 'Closing the Gap' schemes to ensure delivery of the £22.7m CIP plan. Capital 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 asap.

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 is in progress 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:

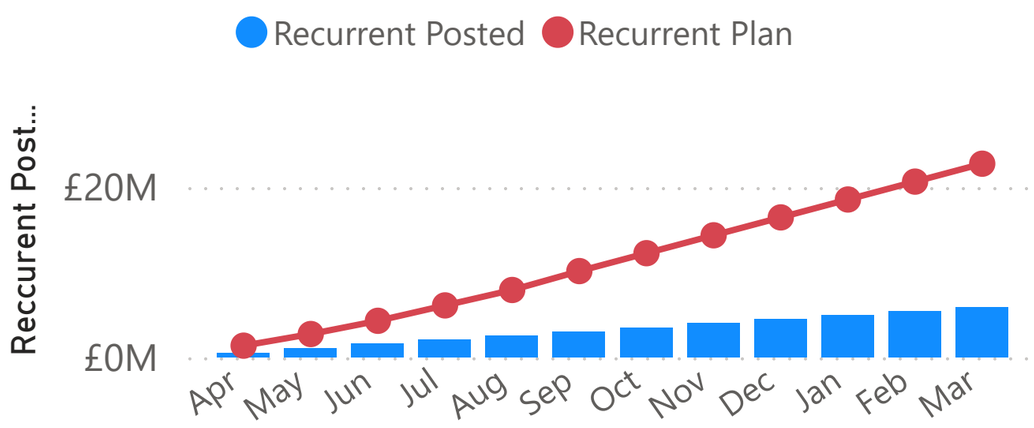
Current plan is £7.160m surplus which we aim to achieve. Risks to delivery of this is linked to achievement of CIP still in progress, identification of system wide schemes to deliver stretch target and management of in year pressures

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



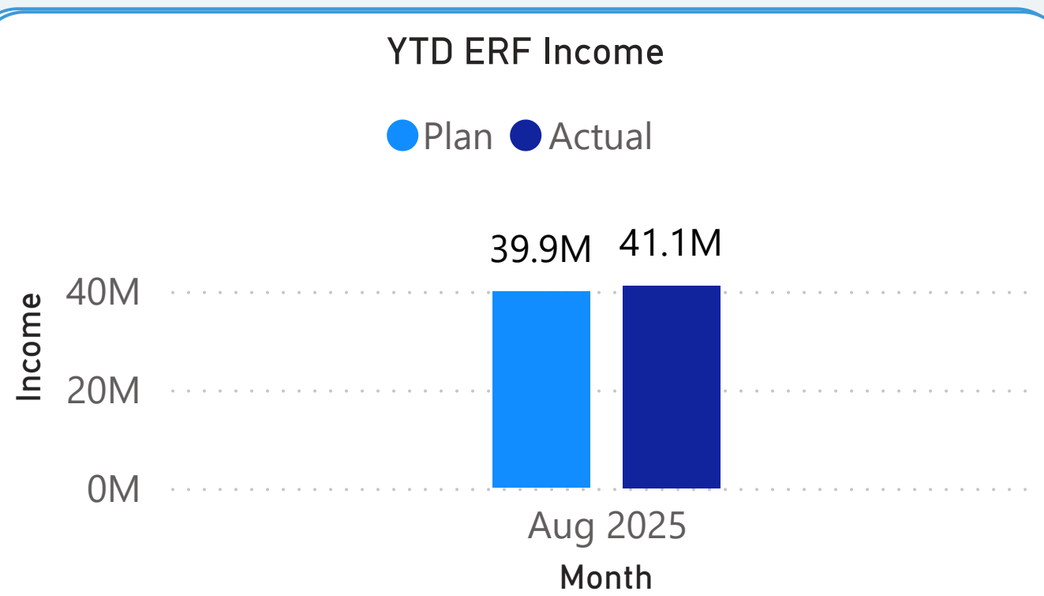
Technical Analysis:

Recurrent CIP identified and in progress is £14.6m.

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:

August performance estimated at 100%. Risk around reduced activity given less WLI due to rate change. Divisions identifying areas to mitigate.

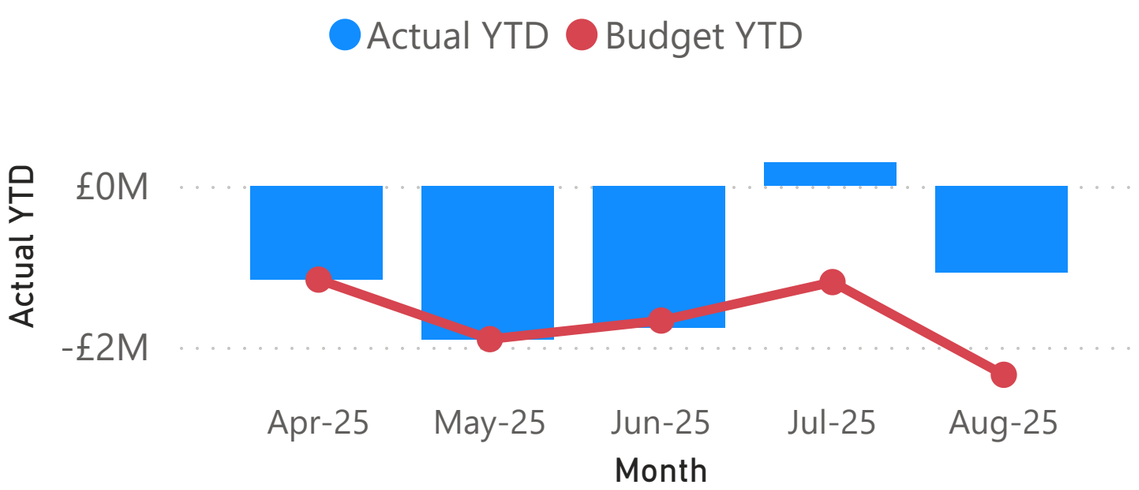
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

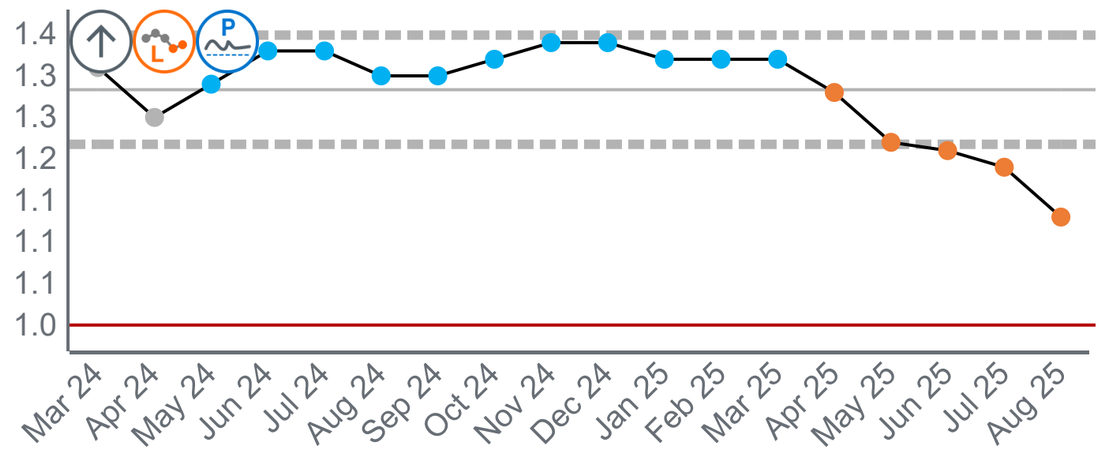
I&E distance from target (cumulative YTD)

Target: Internal

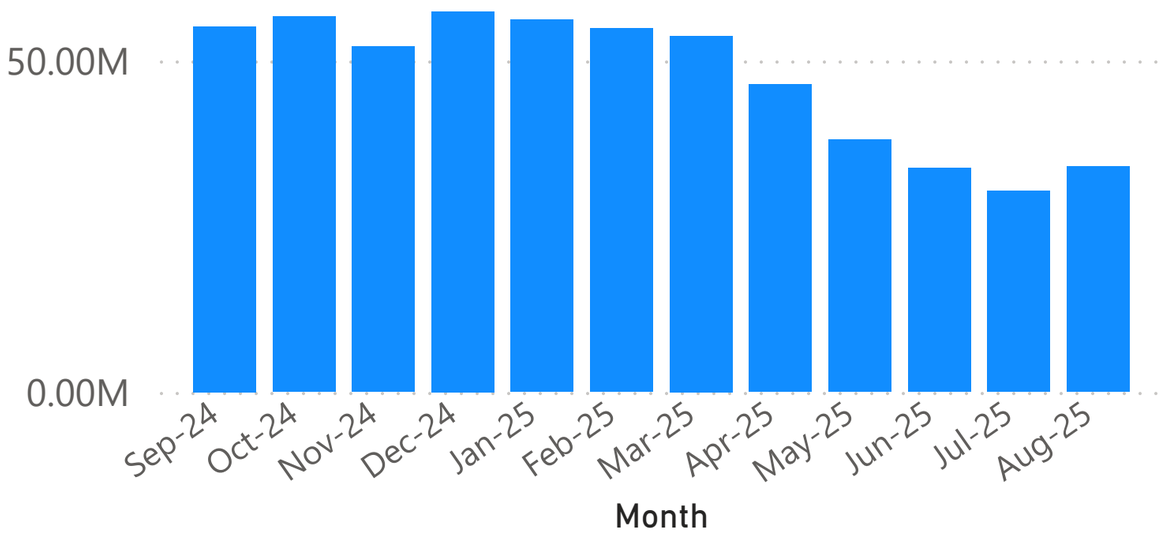


Liquidity

Target: Internal

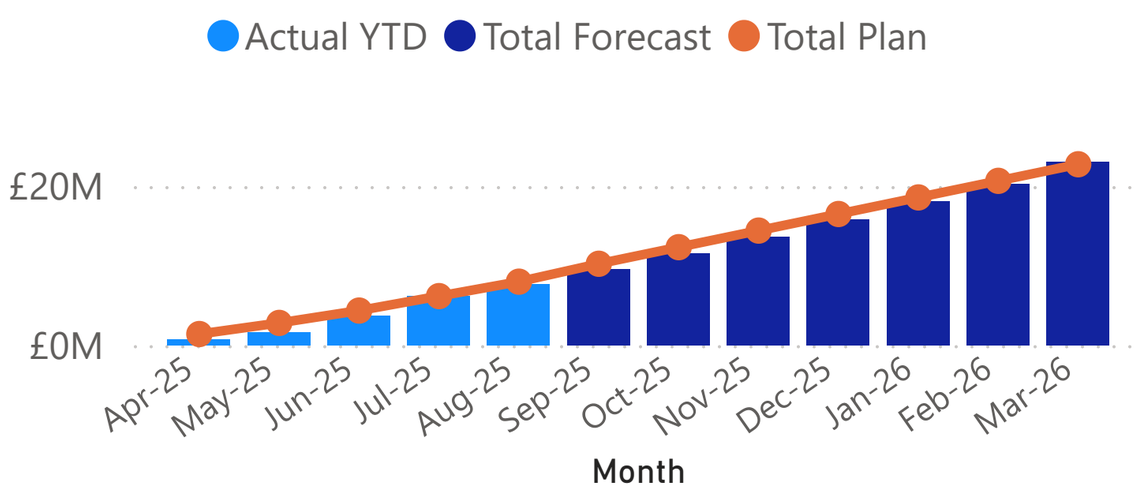


Cash In Bank



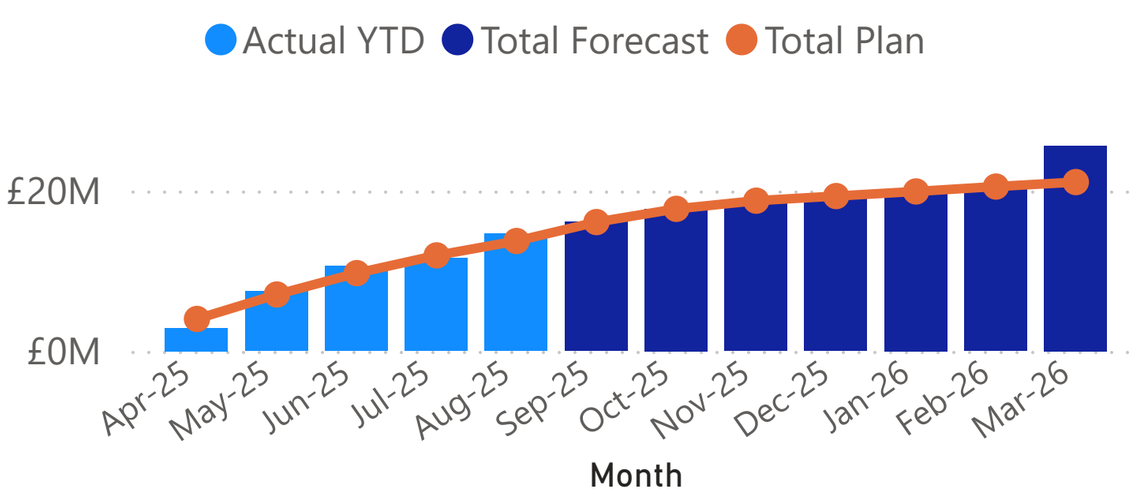
In Year CIP – forecast against plan

Target: Internal



Capital – YTD spend and forecast against plan

Target: Internal



Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

• Positive engagement with all risk owners continues. Delivery of a monthly drop-in risk meeting with all corporate services to support a more robust risk oversight process • Inclusion of risk appetite details now added to Risk Module on InPhase • All Corporate services legacy risks now transcribed onto the updated risk module • Risk review timescales confirmed at RMF

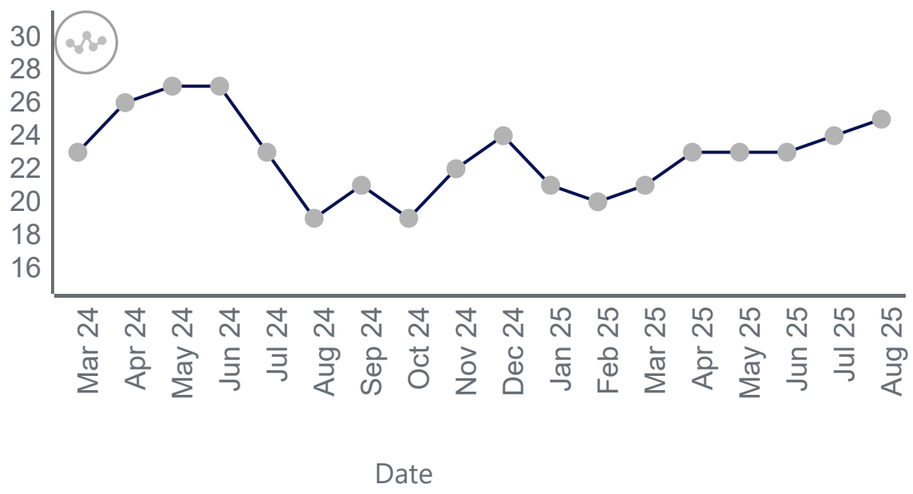
Areas of Concern:

• 32% (8/24) of high risks with actions past expected date of completion • Risk owners have been notified, and risks actioned

Forward Look (with actions)

• Risk appetite process to be rolled out with Medicine Division over the coming months • Discussions regarding delivery of risk management training at ARC • Continued update to risk app continue to ensure improved functionality of InPhase risk module for users.

Number of High Risks (scored 15 and above)



Technical Analysis:

25 high risks on risk register as of the 31st August 2025. Increase of 1 from July 2025.

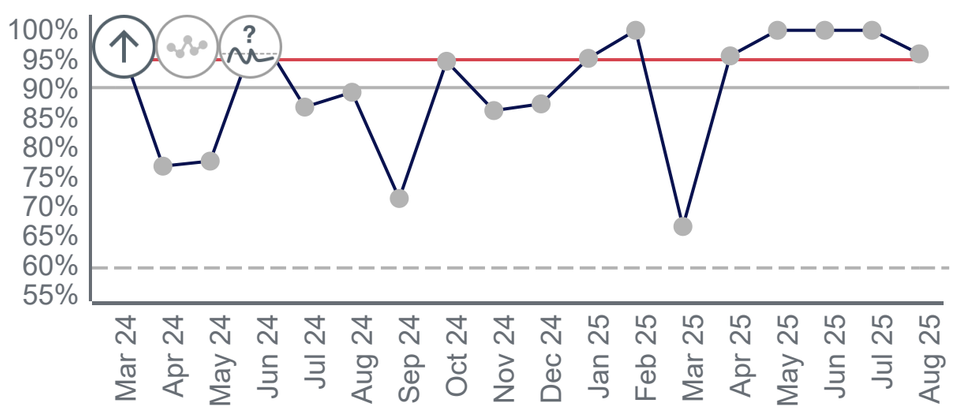
Actions:

Number of high risks = 25 as of end August 2025

The breakdown by category is as follows:
• Quality – Safety = 14 risks • Workforce – Sustainability = 4 risks • Compliance & Regulatory = 3 risks • Financial – Investment = 2 risks • Reputation = 1 risk • Quality – Effectiveness = 1 risk

% of High Risks within review date

Target: Internal



Technical Analysis:

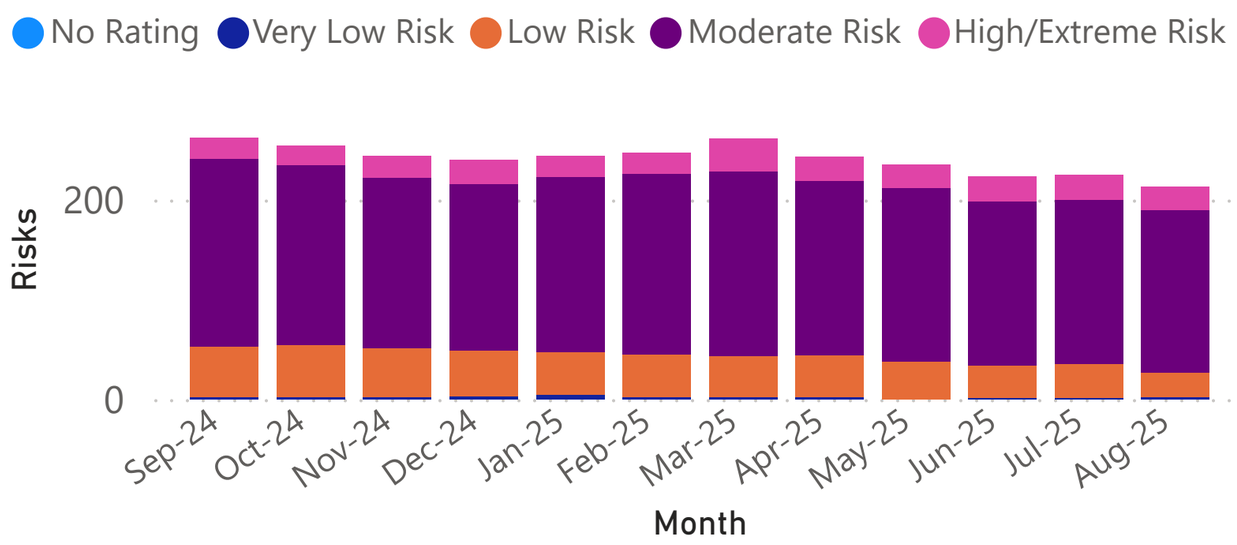
Common cause variation observed with performance of 96%. Slight reduction from performance of 100% in July 2025 however 5th consecutive month above target.

Actions:

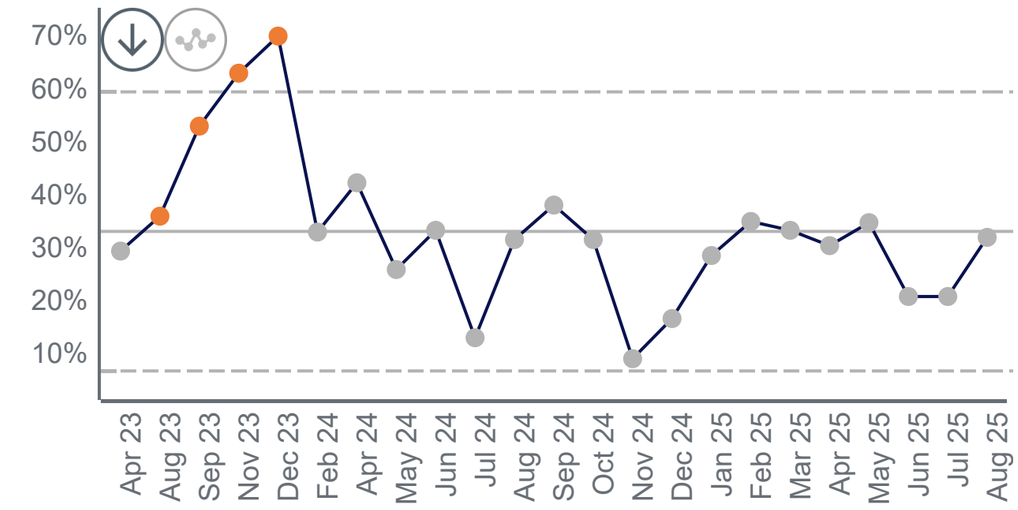
96% of high risks within review date

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

• Sustained improvement in response times to complaints with 100% responded to within 25 working days in August

• Continued improvement in timeliness of Initial Health Assessments completed within 20 days of referral to Alder Hey

• No patient waiting over 52 weeks in Community Paediatrics or Therapies.

• Significant reduction in overdue FU waiting times

• Continued strong financial performance within Division with activity delivered above planned level

• Sensory environments paper published

"It is Noisy, Busy and Smells Weird": Sensory Friendly Environments for Children and Young People Visiting Health Care Settings -

https://www.tandfonline.com/doi/full/10.1080/13575279.2025.2544841

Areas of Concern

• Number of CYP waiting over 52wks in CAMHS reduced at the end of August but remains a priority area of action with improvement plan in pace.

• ASD and ADHD waiting times remain an area of significant challenge however reduction in numbers waiting over 65 weeks for 4th consecutive month

• Sickness absence rates (6%) remain above Trust target

• Was Not Brought rates increased during August (same as August 2024). Improvements in ADHD and Community Paediatrics but worsening position in Specialist Mental Health services

Forward Look (with actions)

• Go live with new ND pathway from start September

• Continued focus on improvement actions for Specialist Mental Health services to support reduction in waiting times and improved Was Not Brought Rates

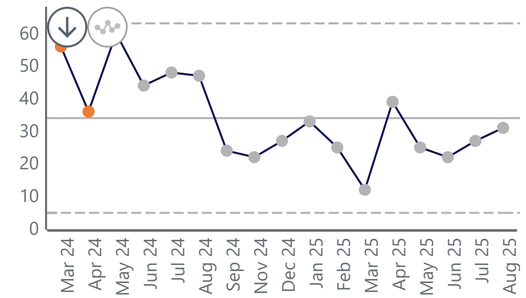
• Roll out of Lyrebird across Division

• Go live of Cleo for ePrescribing between Community Paediatrics/ADHD and community pharmacy

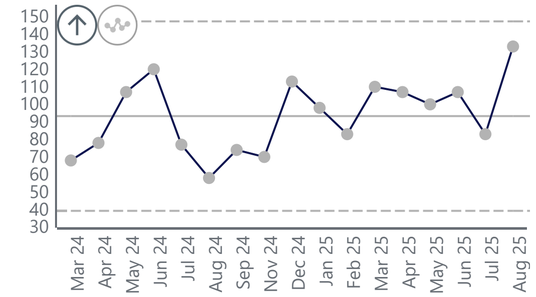
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

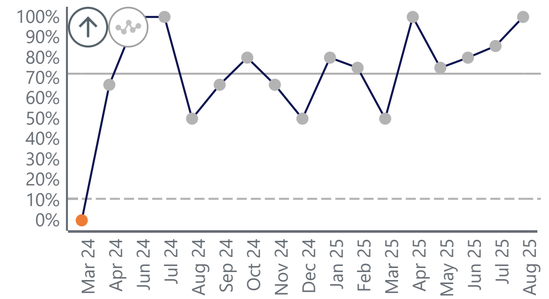
Patient Safety Incidents rated Low Harm & Above



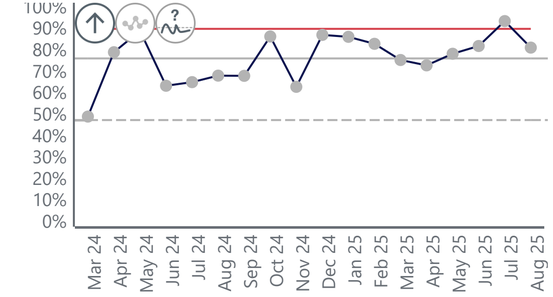
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

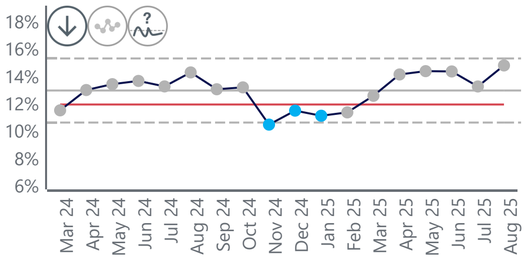


% PALS Resolved within 5 Days

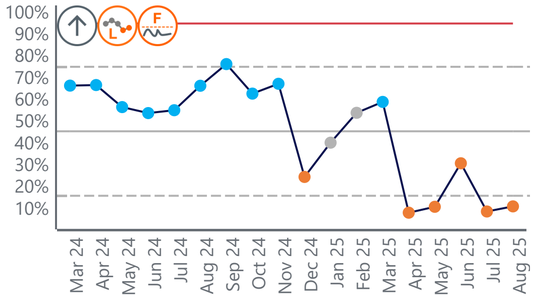


% Was Not Brought Rate (All OP: New and FU)

Target: Internal



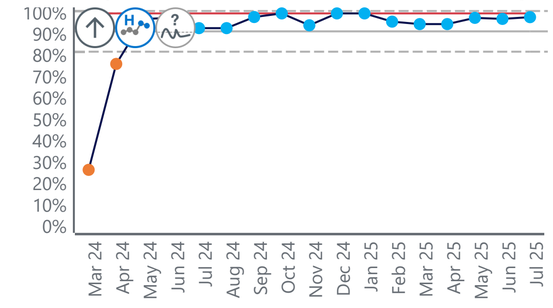
% of Clinical Letters completed within 10 Days



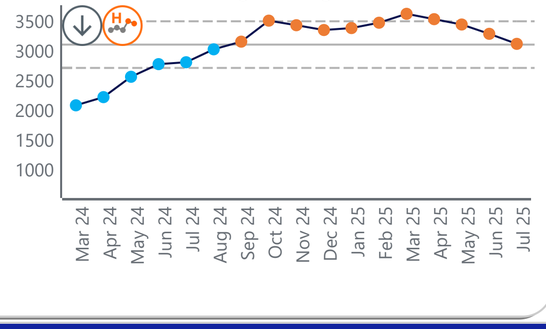
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

SLAM Performance

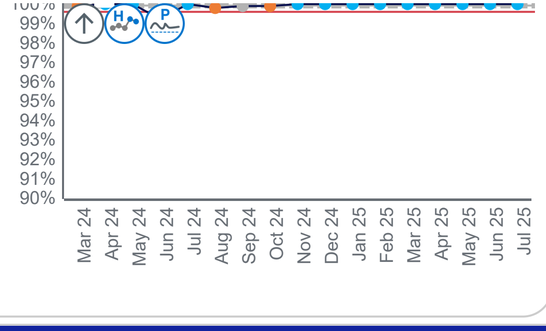
IHA: % complete within 20 days of referral to Alder Hey



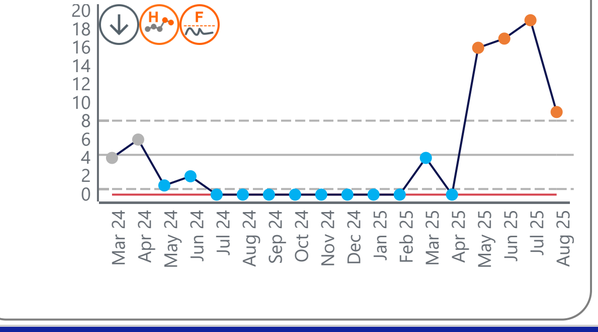
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



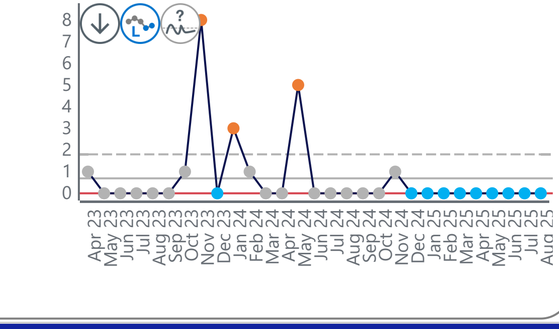
Percentage CYP suspected autism with contact under 13 weeks



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



Number of Paediatric Community Patients waiting >52 weeks



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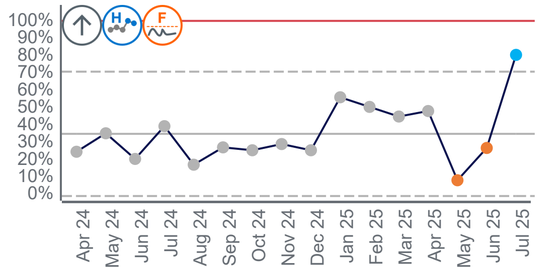
Alder Hey Children's NHS Foundation Trust

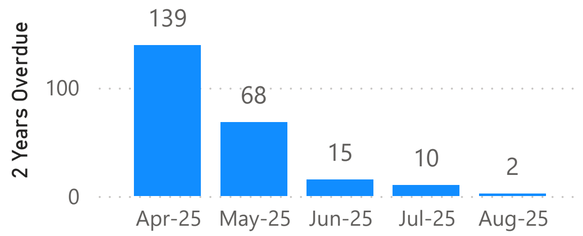
Divisional Performance Summary - Community & Mental Health

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

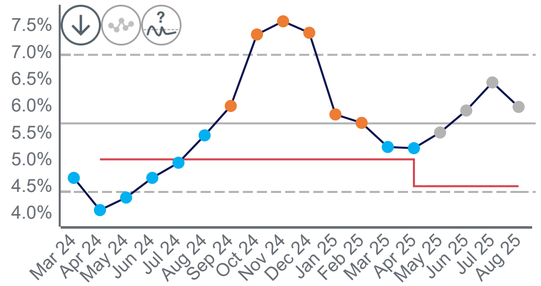


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

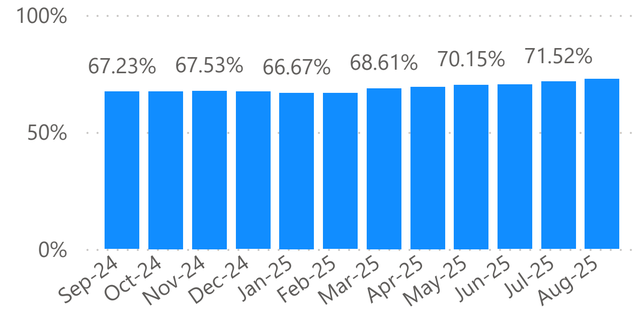
Vol overdue by 31st March 2026



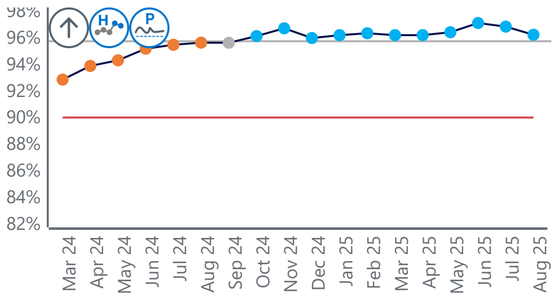
Sickness Absence (Total)



Workforce Stability

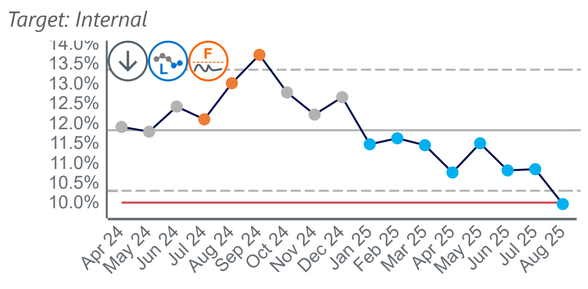


Mandatory Training

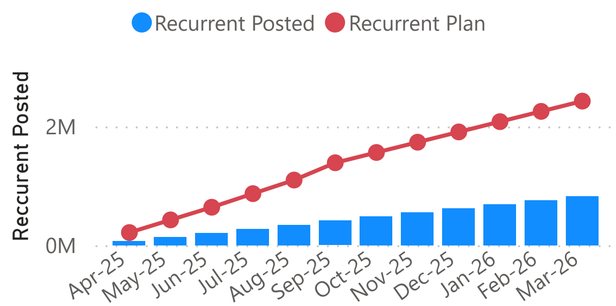


Staff Turnover

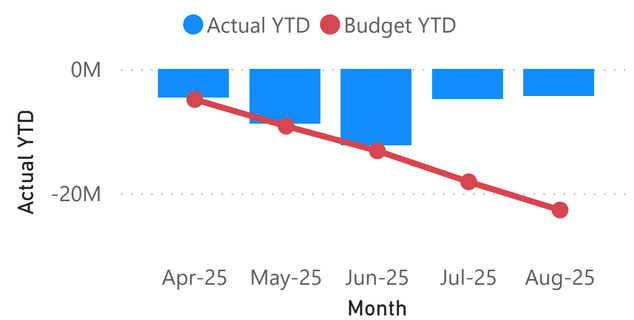
Target: Internal



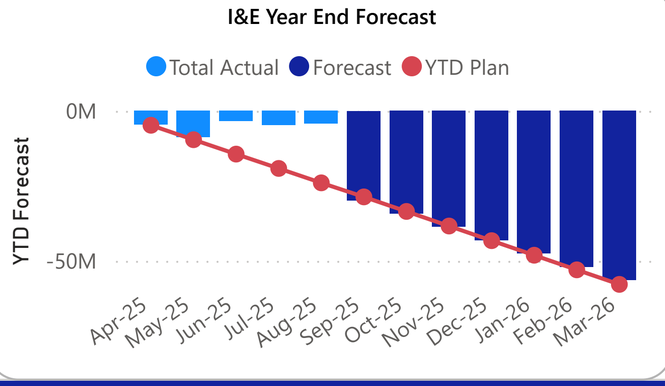
Recurrent Efficiency Plans Delivered (Forecast)



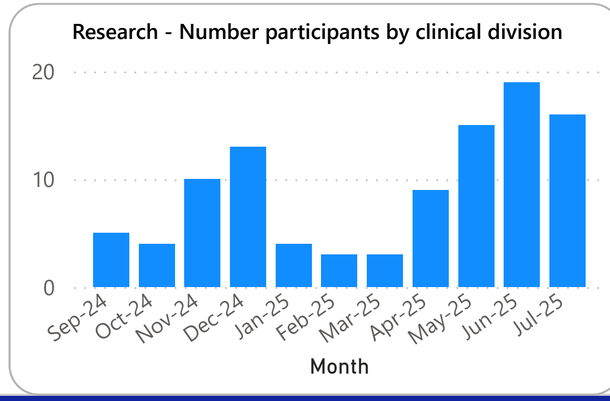
I&E distance from target (cumulative YTD)



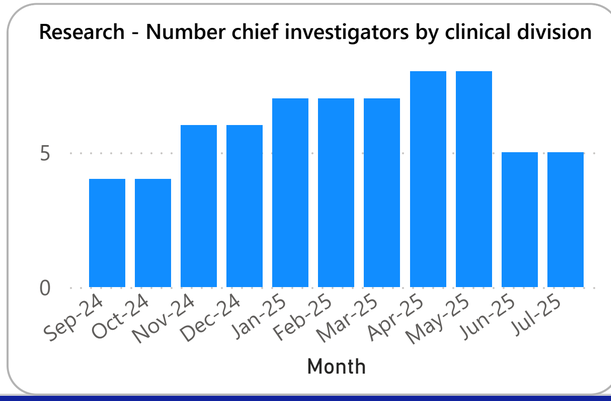
I&E Year End Forecast



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 maintaining low with plans in place to reduce further
- Complaint responses 100% and PALS resolved within 5 days back to 100% in July
- August ED performance - 90%, YTD – 85.9%
- Activity at 100% of plan YTD with a case mix value increase of £455k

Areas of Concern

- Patient safety incidents low harm and above have increase slightly in month
- Mandatory training slipped to 92%

> Medical and Dental is key hot spot area with 82.6% compliance
>Admin and Clerical are also showing at 89.2%

- Increase in staff sickness for the third consecutive month- 6.8%
- Ongoing challenge with delivery of CIP programme

Forward Look (with actions)

- Deep dive focus of mandatory training
- Roll out of Lyrebird
- Starting overbooking clinics with three key specialties identified to start with
- FU validation with ISLA Care ongoing within key areas

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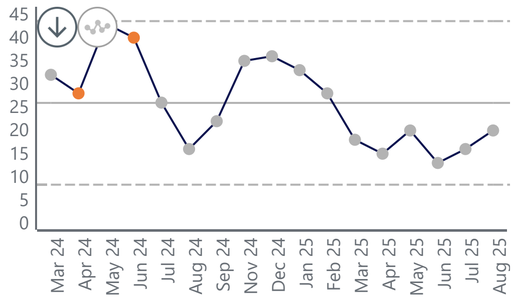
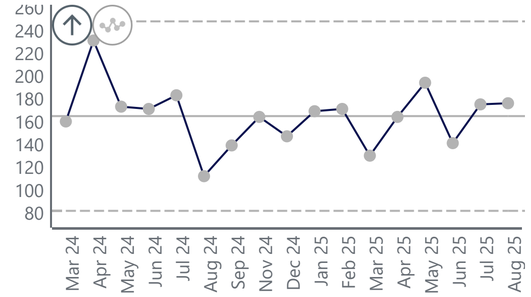
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

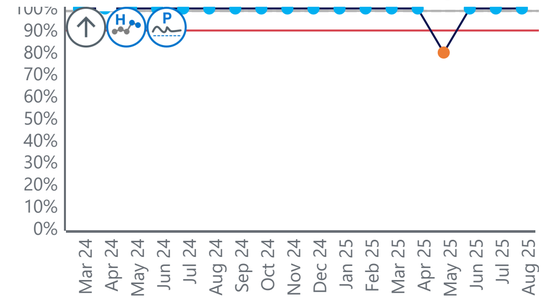
Patient Safety Incidents rated Low Harm & Above



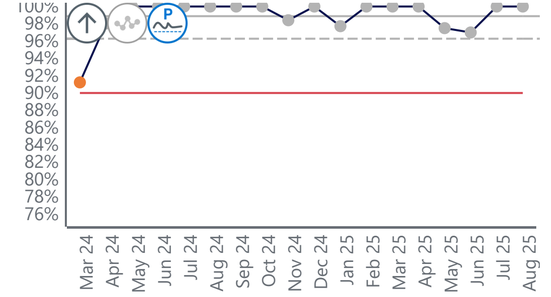
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

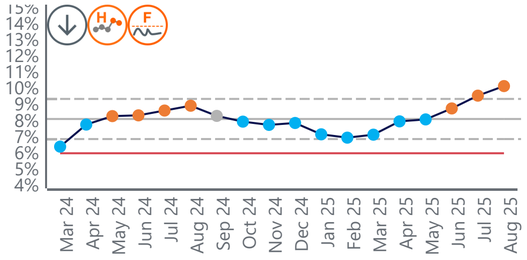


% PALS Resolved within 5 Days

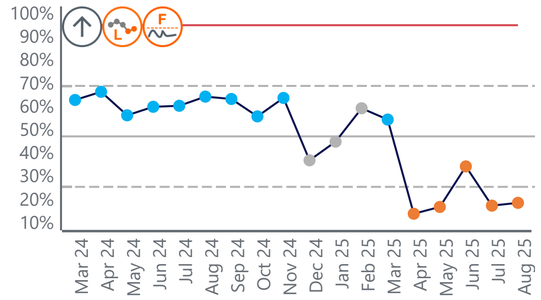


% Was Not Brought Rate (All OP: New and FU)

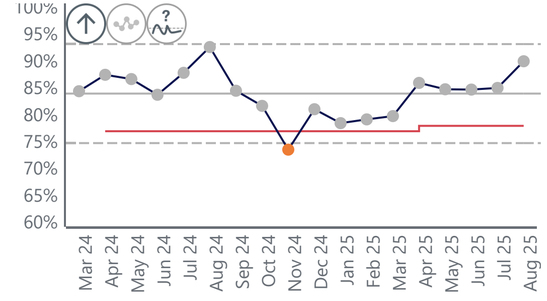
Target: Internal



% of Clinical Letters completed within 10 Days

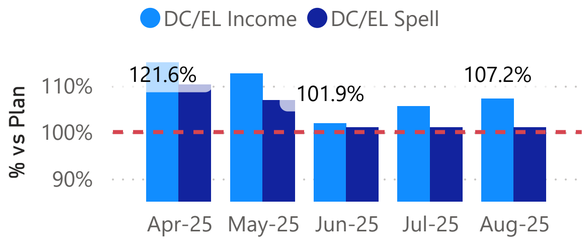


ED: % treated within 4 Hours



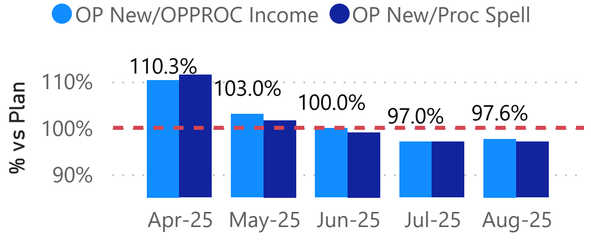
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

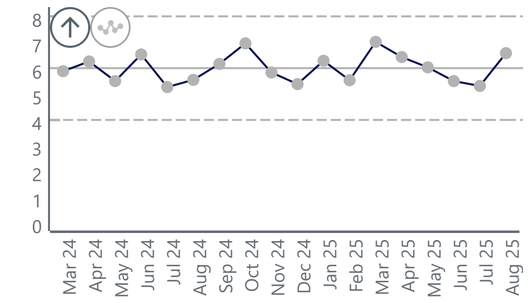


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

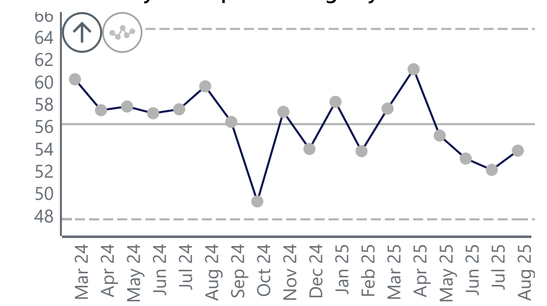
SLAM Performance



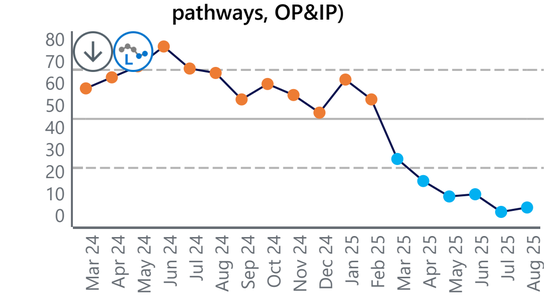
Inpatient Discharges per working day



Day Cases per working day



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



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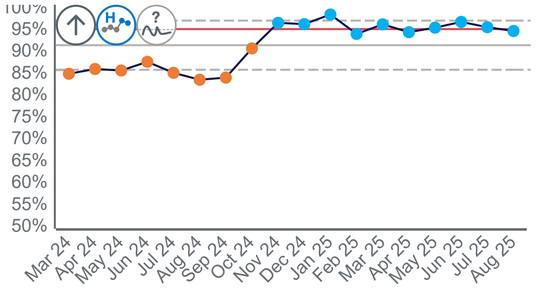
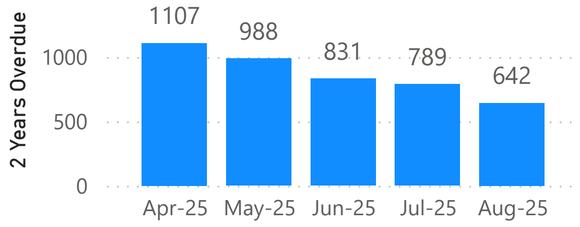
Divisional Performance Summary - Medicine

Diagnostics: % Completed Within 6 Weeks of referral

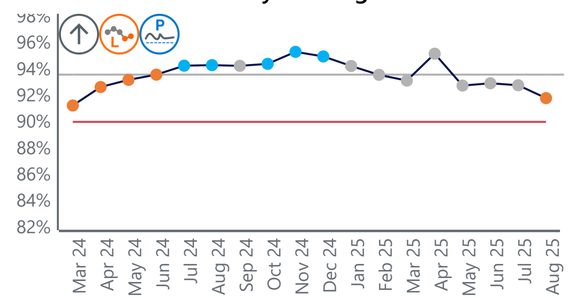


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

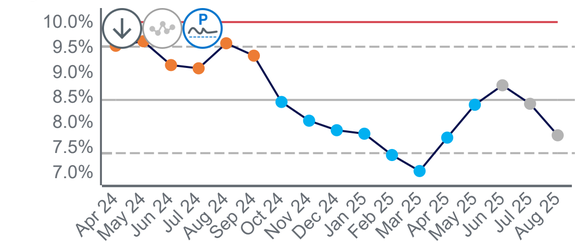


Mandatory Training

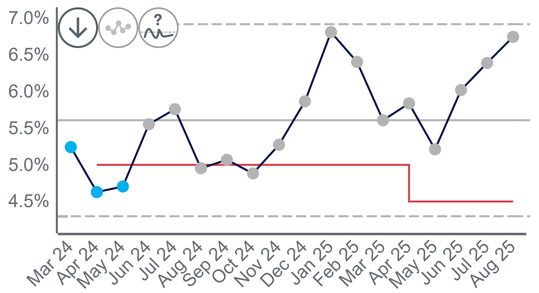


Staff Turnover

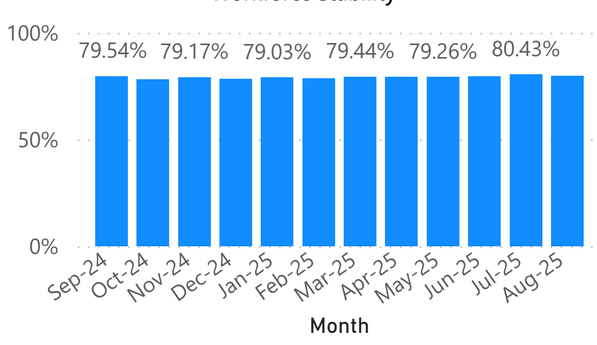
Target: Internal



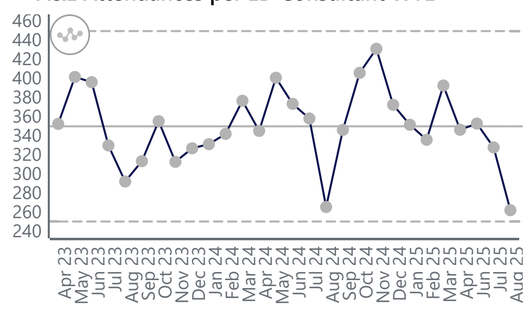
Sickness Absence (Total)



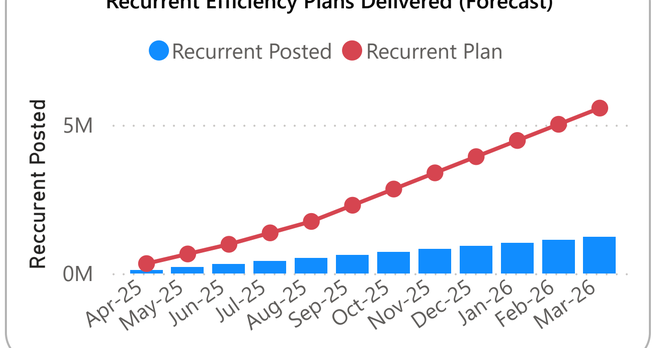
Workforce Stability



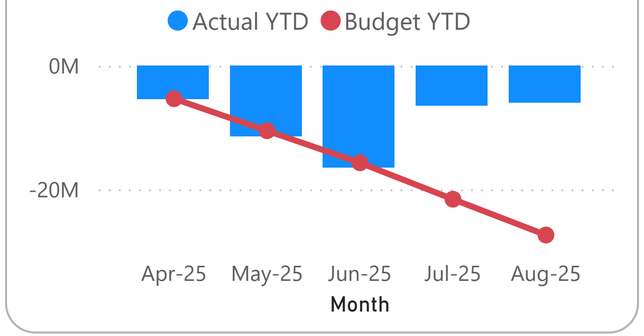
A&E Attendances per ED Consultant WTE



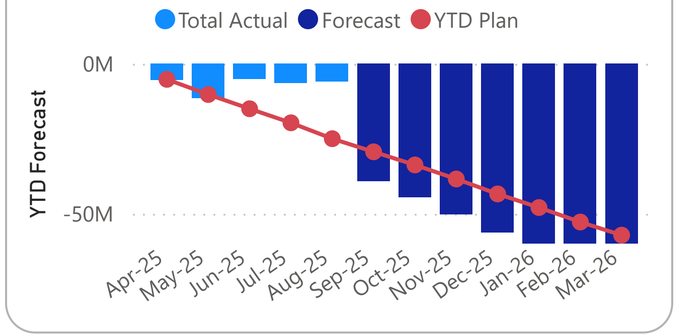
Recurrent Efficiency Plans Delivered (Forecast)



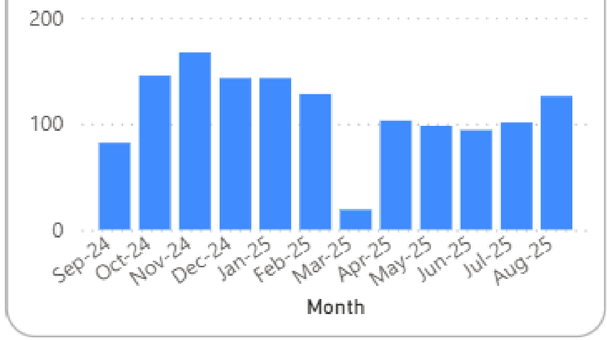
I&E distance from target (cumulative YTD)



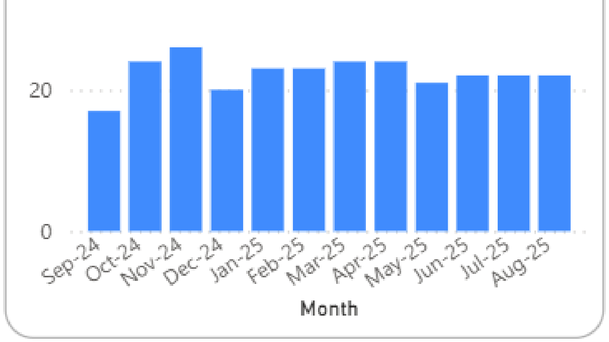
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

- 100% PALS and formal complaints response
- Significant increase in patient safety incidents reporting no harm
- Mandatory training remains above target

Areas of Concern

•WNB rate continues to be above target

•No. of patients waiting over 52 weeks increased slightly in month due to a loss of additional capacity in ENT & Dental over previous months

•Sickness absence increased to 6.4% in month, have seen a rise in short term sickness in month

Forward Look (with actions)

•Restarted insourcing activity in ENT & Dental outpatients which will see an increase in capacity for both income and long waiters

•Conclusion of opt in opt out in ENT & Dental should reduce the volume of long waiters

•Review of hotspots for short term sickness to assess themes, few key hotspots around theatres

•Formal overbooking commenced in Plastics & Dental, to be rolled out at pace across all services

•Planned rollout of Lyrebird at pace

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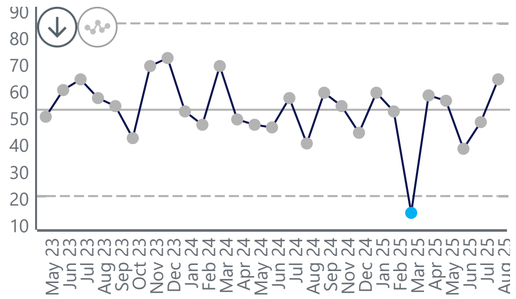
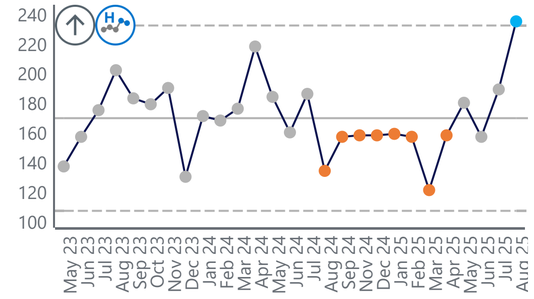
Divisional Performance Summary - Surgery

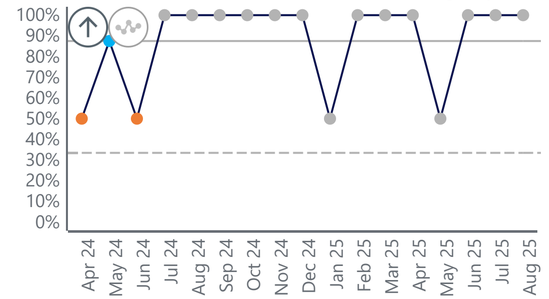
Patient Safety Incidents rated Low Harm & Above



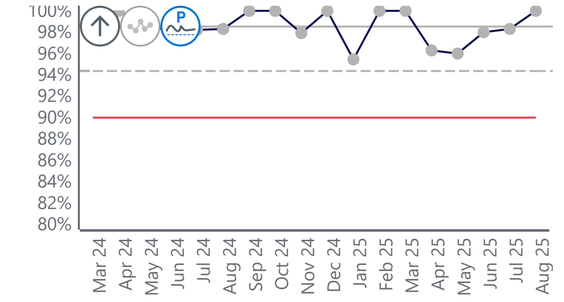
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

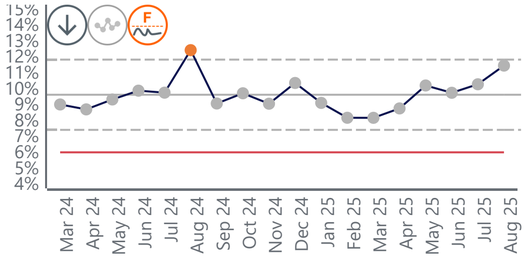


% PALS Resolved within 5 Days

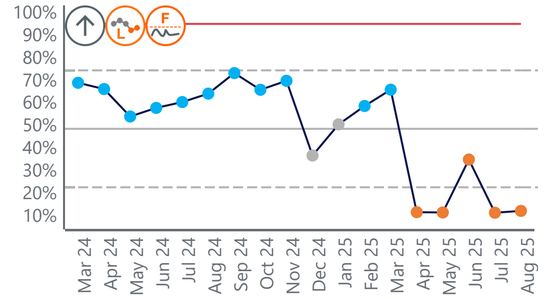


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

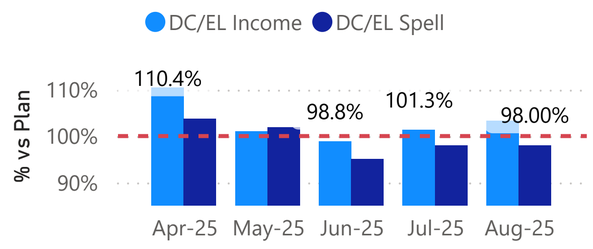


% of Clinical Letters completed within 10 Days



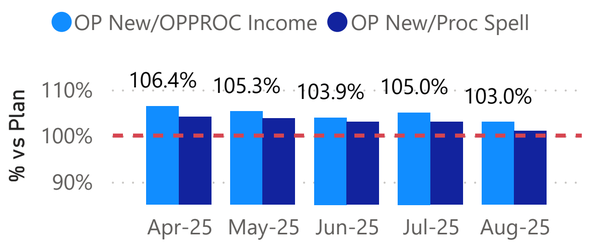
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

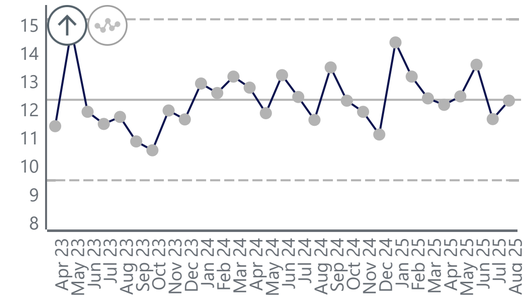


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

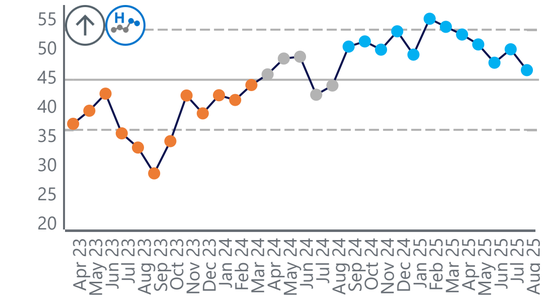
SLAM Performance



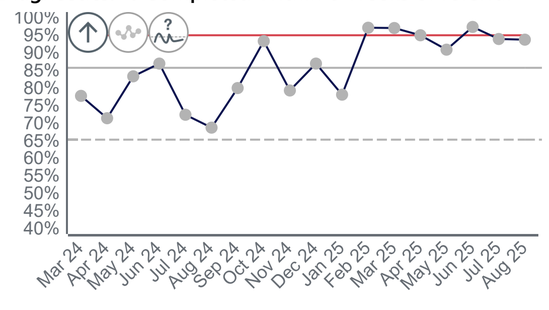
Inpatient Discharges per working day



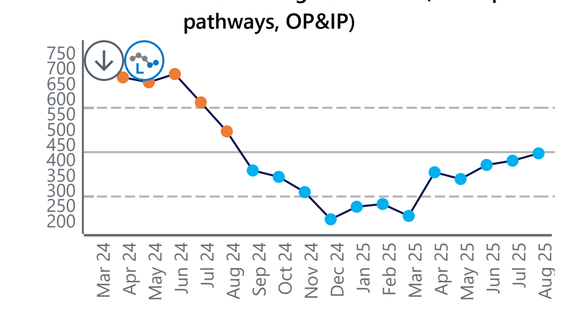
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



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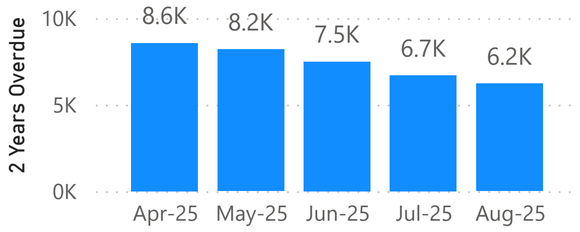
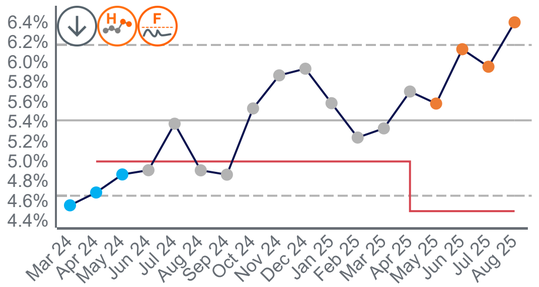
Divisional Performance Summary - Surgery

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

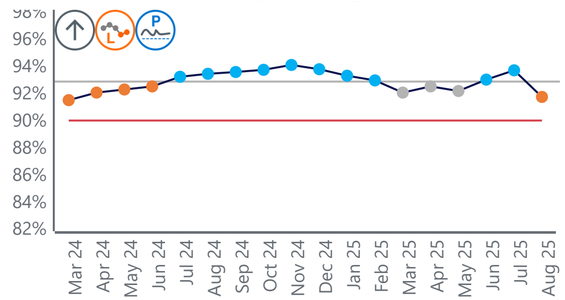
Vol overdue by 31st March 2026



Sickness Absence (Total)

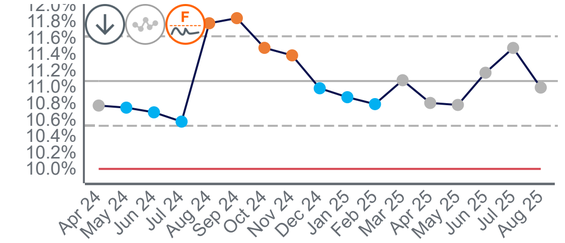


Mandatory Training

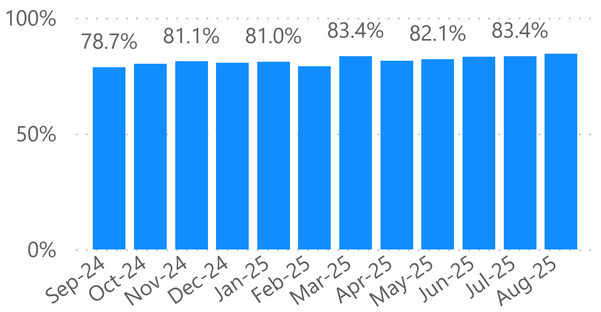


Staff Turnover

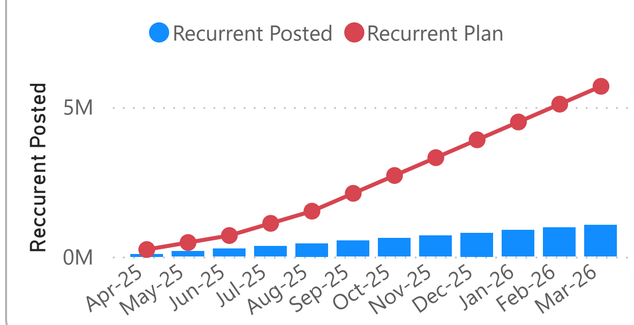
Target: Internal



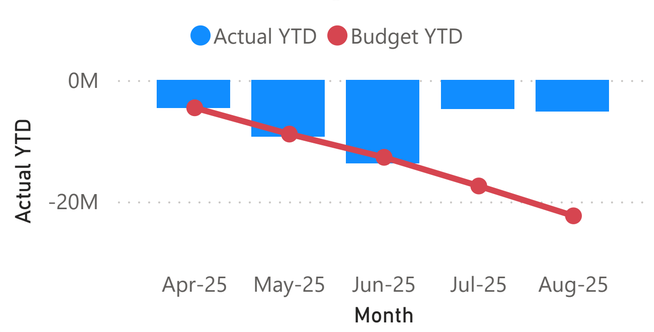
Workforce Stability



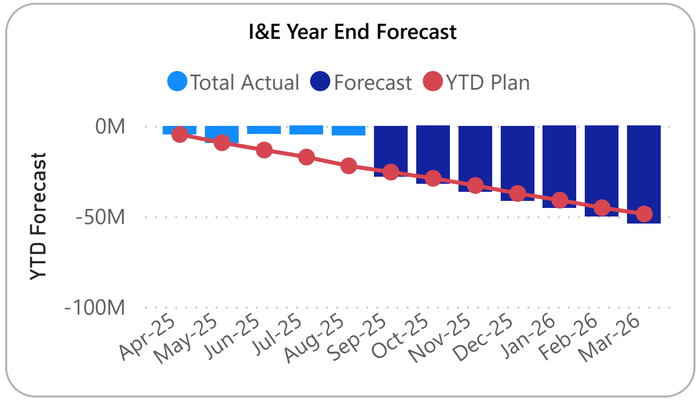
Recurrent Efficiency Plans Delivered (Forecast)



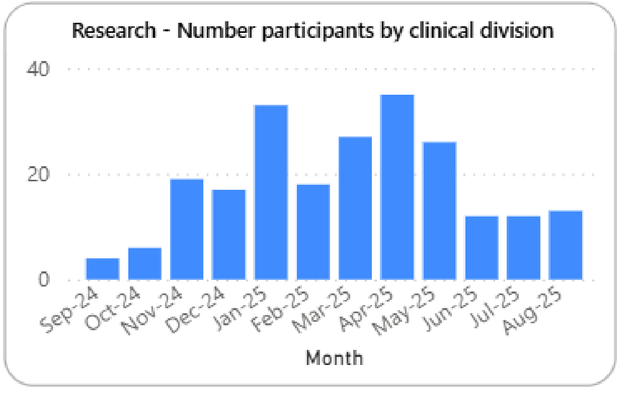
I&E distance from target (cumulative YTD)



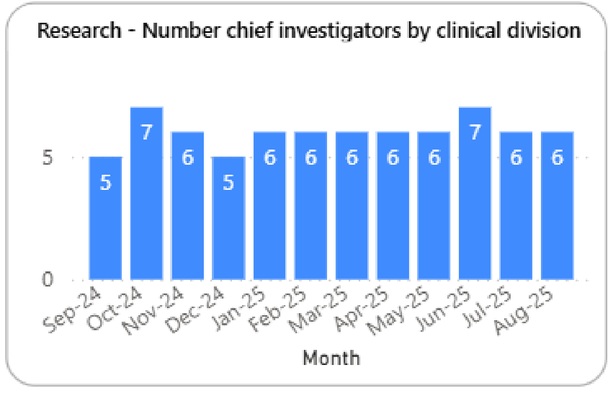
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

- PDRs for band 7+ all completed with exception of recent mat leave returns (dates booked)
- Mandatory training dropped slightly but remains ahead of target
- All other highlights captured under pioneering breakthroughs

Areas of Concern

- Increase in sickness absence in month – however all LTS cases being managed well
- All other areas of concerns captured under pioneering breakthroughs

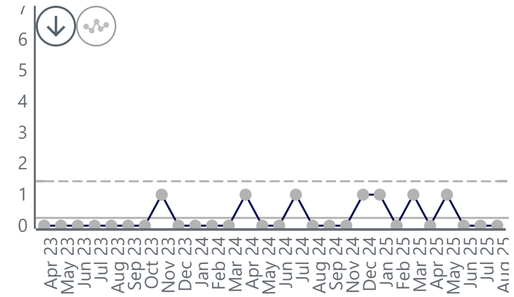
Forward Look (with actions)

- All PDRs to be completed by end of Q2
- Other actions captured under pioneering breakthroughs

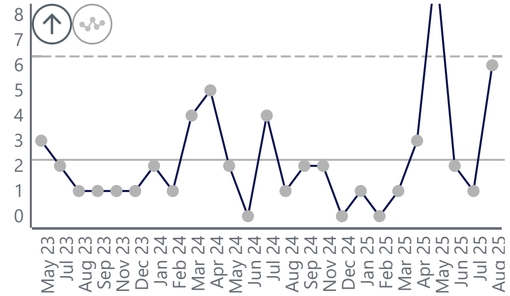
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

Patient Safety Incidents rated Low Harm & Above

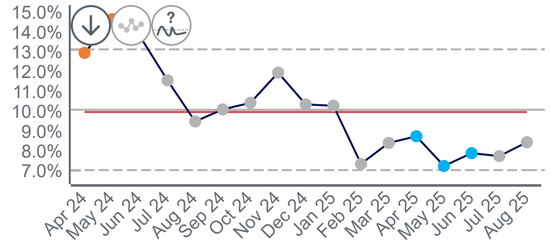


Patient Safety Incidents rated No Harm

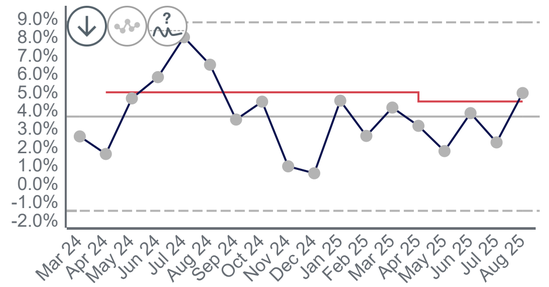


Staff Turnover

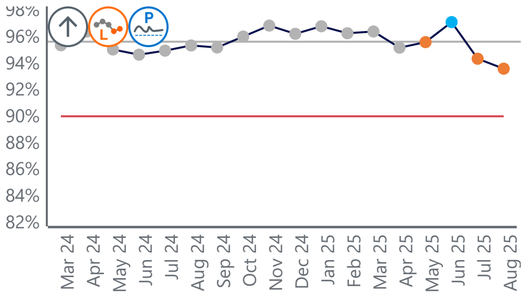
Target: Internal



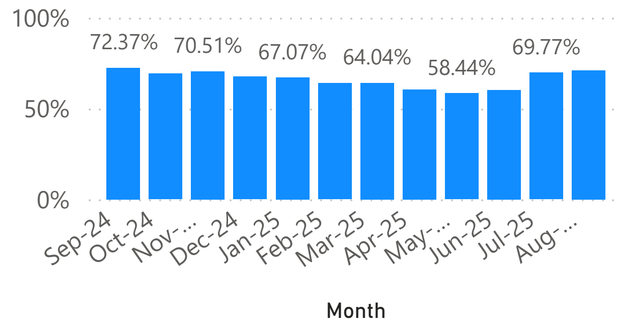
Sickness Absence (Total)



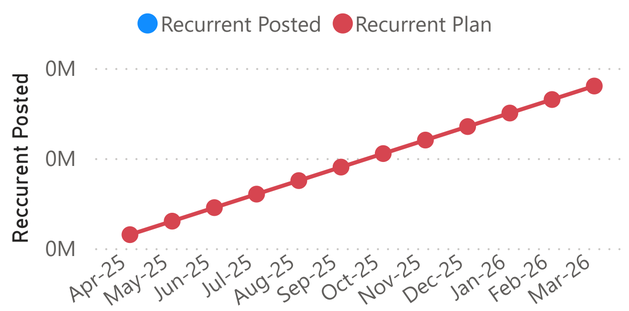
Mandatory Training



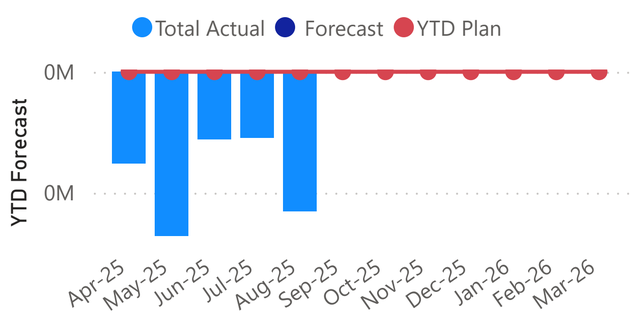
Workforce Stability



Recurrent Efficiency Plans Delivered (Forecast)

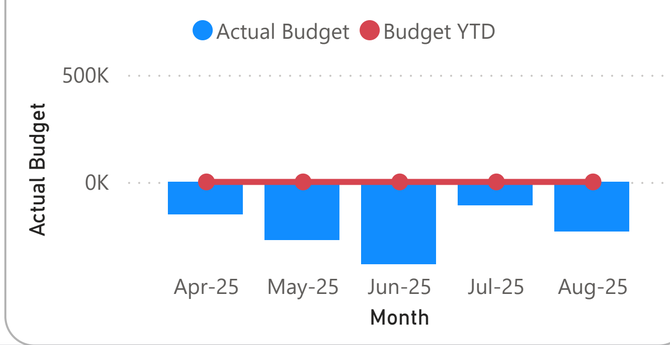


I&E Year End Forecast



Number of Patients Recruited into Research Studies

I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative met on 15th September, highlights from the August data include:

- Mandatory training remains above Trust target at 92%.
- Short term sickness absence currently at 2% which is at Trust target.
- In terms of CIP, the Corporate Collaborative identified plans and/or delivered a total of £4.7m, £3.9m recurrently.
- 100% of risks in date

Areas of Concern

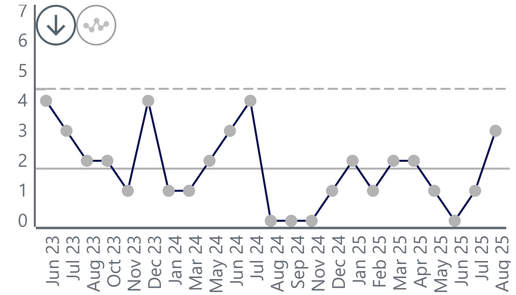
- Overall PDR compliance 63%.
- Overall sickness outside of Trust target at 6.8%
- Return to work compliance increased from previous month to 81% (from 79%) but remains below 100% target.
- There is still a £0.8m gap in recurrent CIP to be identified.

Forward Look (with actions)

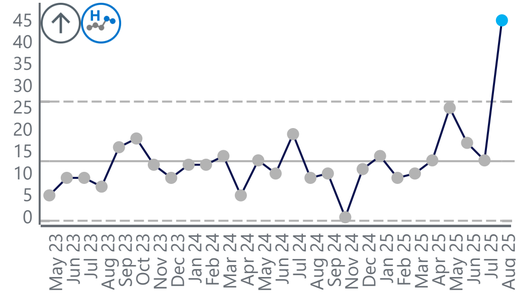
- Continued focus on financial position, system finance and internal controls/opportunities including WTE.
- Ongoing discussion to establish productivity measures for corporate services.

Divisional Performance Summary - Corporate

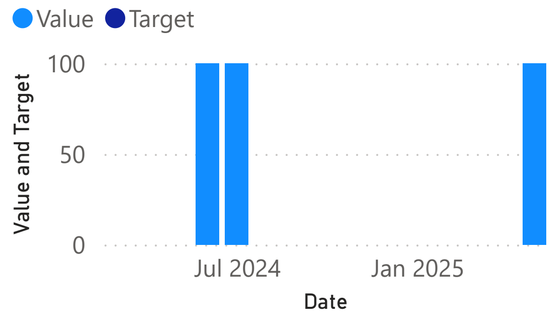
Patient Safety Incidents rated Low Harm & Above



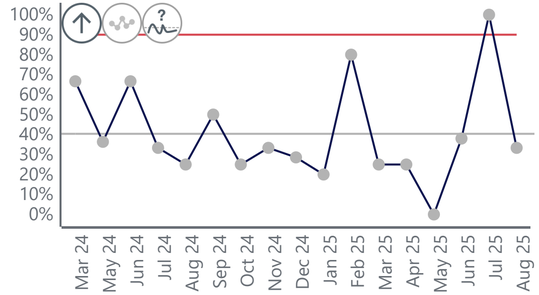
Patient Safety Incidents rated No Harm



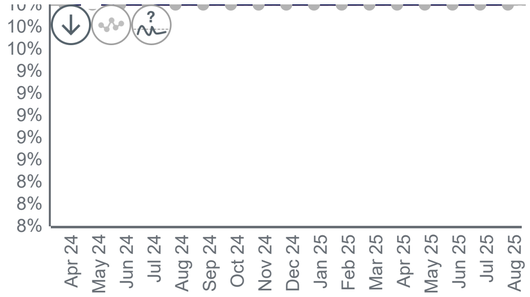
% Complaints Responded to within 25 working days



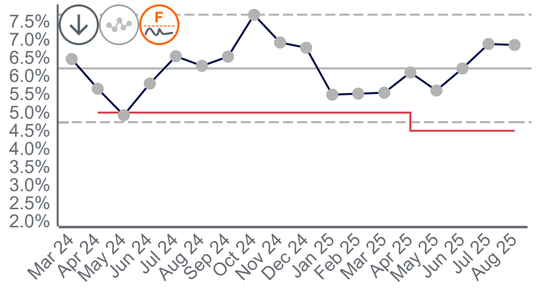
% PALS Resolved within 5 Days



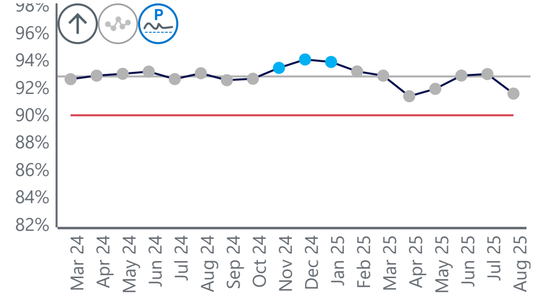
Staff Turnover



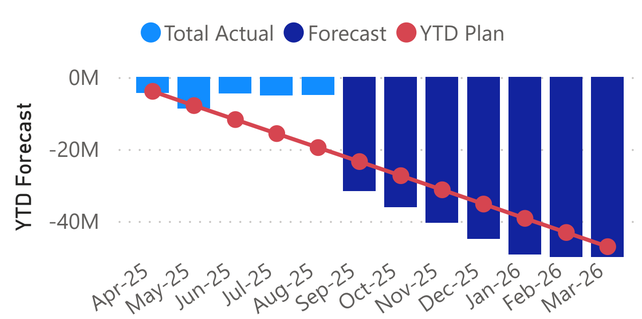
Sickness Absence (Total)



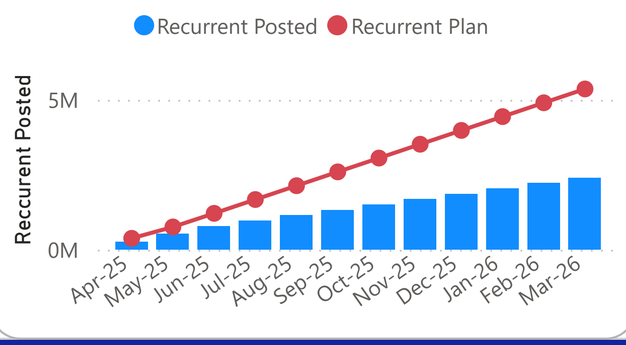
Mandatory Training



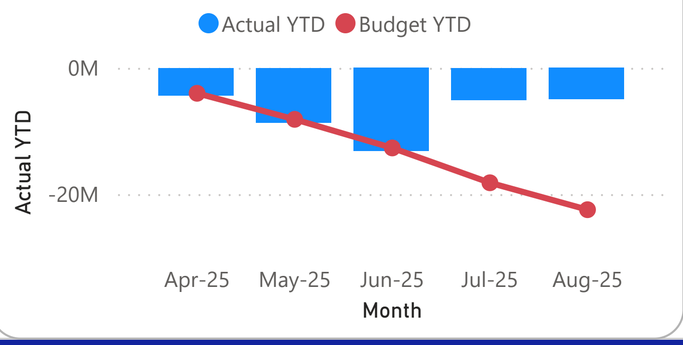
I&E Year End Forecast



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

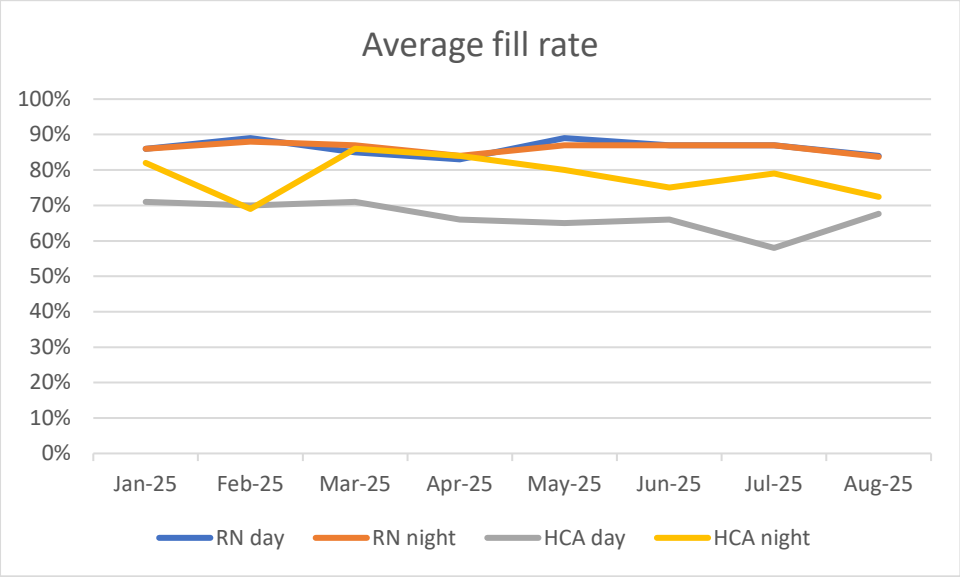
Safe Staffing & Patient Quality Indicator Report August 2025 Staffing, CHPPD and Benchmark

	Day		Night		Patients	CHPPD	National benchmark	Availablity		Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT			
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate	Jan-25	RN - FTE	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	Complaints
Burns Unit	93%		100%		101	18.8	12.28	568.46	31.00	-2.35	-14.40%	0.00		0.00	0.00%	0.00	0.00%	16.00	2.81%	0.00	0.00%	0	8	1	3	7	100%		
HDU	67%	71%	64%	55%	204	34.3	28.46	2,132.39	58.90	1.10	16.00%	3.21	63%	0.53	77.00%	0.00	0.00%	201.91	9.47%	0.00	0.00%	7	55		0	7	100%		
ICU	81%	94%	77%	52%	363	45.0	37.75	4,933.12	124.00	-1.88	-1.20%	0.00		2.00	1.25%	0.00	0.00%	187.06	3.79%	4.00	3.23%	8	83		0	1	100%	1	
Ward 1cC	95%	70%	88%	73%	612	11.9	12.49	1,918.13	155.83	-4.22	-7.30%	0.08	2%	0.00	0.00%	0.00	0.00%	178.44	9.30%	26.03	16.70%	7	45	2	40	14	100.00%	1	
Ward 1cN	94%	36%	107%		237	16.7	19.22	1,104.43	24.80	-0.42	-1.19%	1.63	67%	0.00	0.00%	0.00	0.00%	76.81	6.96%	22.40	90.32%	12	35		0	0			
Ward 3A	89%	63%	87%	89%	683	10.3	10.42	1,631.22	394.07	-6.34	-13.30%	2.62	17%	0.00	0.00%	0.00	0.00%	129.53	7.94%	85.99	21.82%	4	36	1	9	27	100.00%	2	
Ward 3B	87%	108%	86%		343	15.5	16.06	1,296.10	147.64	-0.10	-0.24%	0.65	13%	0.00	0.00%	0.00	0.00%	103.27	7.97%	0.00	0.00%	3	22		1	24	100%	1	
Ward 3C	76%	60%	73%	84%	607	12.4	10.88	1,810.77	397.63	-0.53	-0.90%	1.95	10%	0.00	0.00%	0.00	0.00%	88.25	4.87%	123.80	31.13%	7	94		1	10	90.00%		
Ward 4A	83%	55%	81%	94%	709	11.2	10.65	2,104.56	148.39	-2.32	-3.55%	3.37	41%	0.92	1.35%	0.00	0.00%	218.40	10.38%	38.03	25.63%	3	50		5	22	100%		
Ward 4B	89%	80%	75%	85%	566	14.3	11.84	1,157.50	1,187.91	-8.35	-27.80%	4.23	9%	0.00	0.00%	0.00	0.00%	85.52	7.39%	132.63	11.16%	7	76		8	6	83%		
Ward 4C	75%	39%	83%	47%	541	10.5	10.7	1,816.42	303.61	-7.60	-14.80%	2.00	18%	0.00	0.00%	1.00	10.29%	116.11	6.39%	53.05	17.47%	9	63		1	43	100.00%		1

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

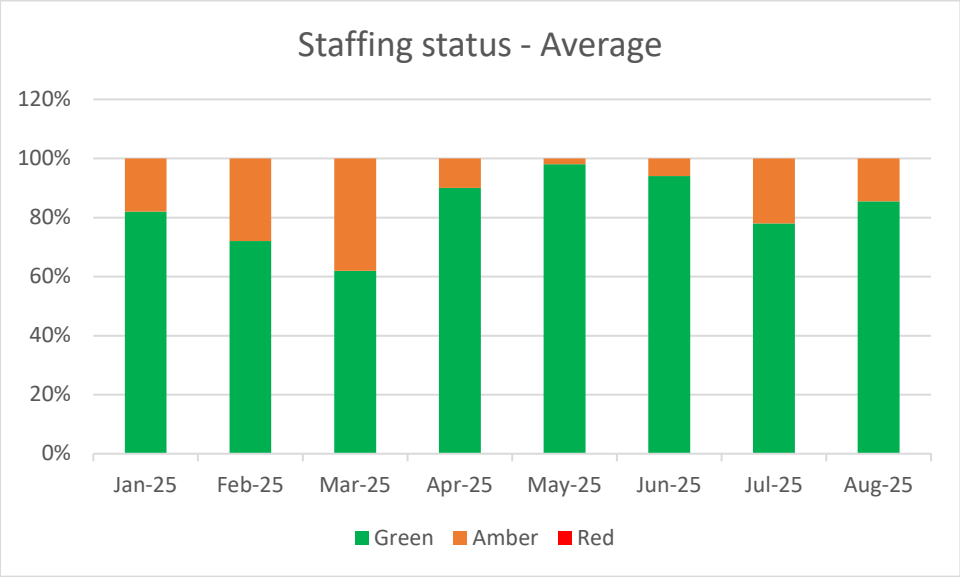
Nursing and care staff average fill rate Aug 2025	
Day and Night average fill rate	
Registered (%)	**Care Staff (%)**
84%	70% ⇧

RN fill rate has reduced slightly since previous month but remains over 80% There is an increase in HCA fill rate which correlates with substantive HCA posts being recruited to.



Summary of Staffing models January – Aug 2025 Registered Nurses

*To Note only red, amber, and green staffing status is now reported via the staffing template***.**



August shows an increase in green staffing status across both day and night shifts and a green staffing model being reported in 86% of shifts. This correlates with a lower bed capacity and acuity of patients. To note this is despite us continuing to see high levels of sickness and a reduction in NHSP spend.

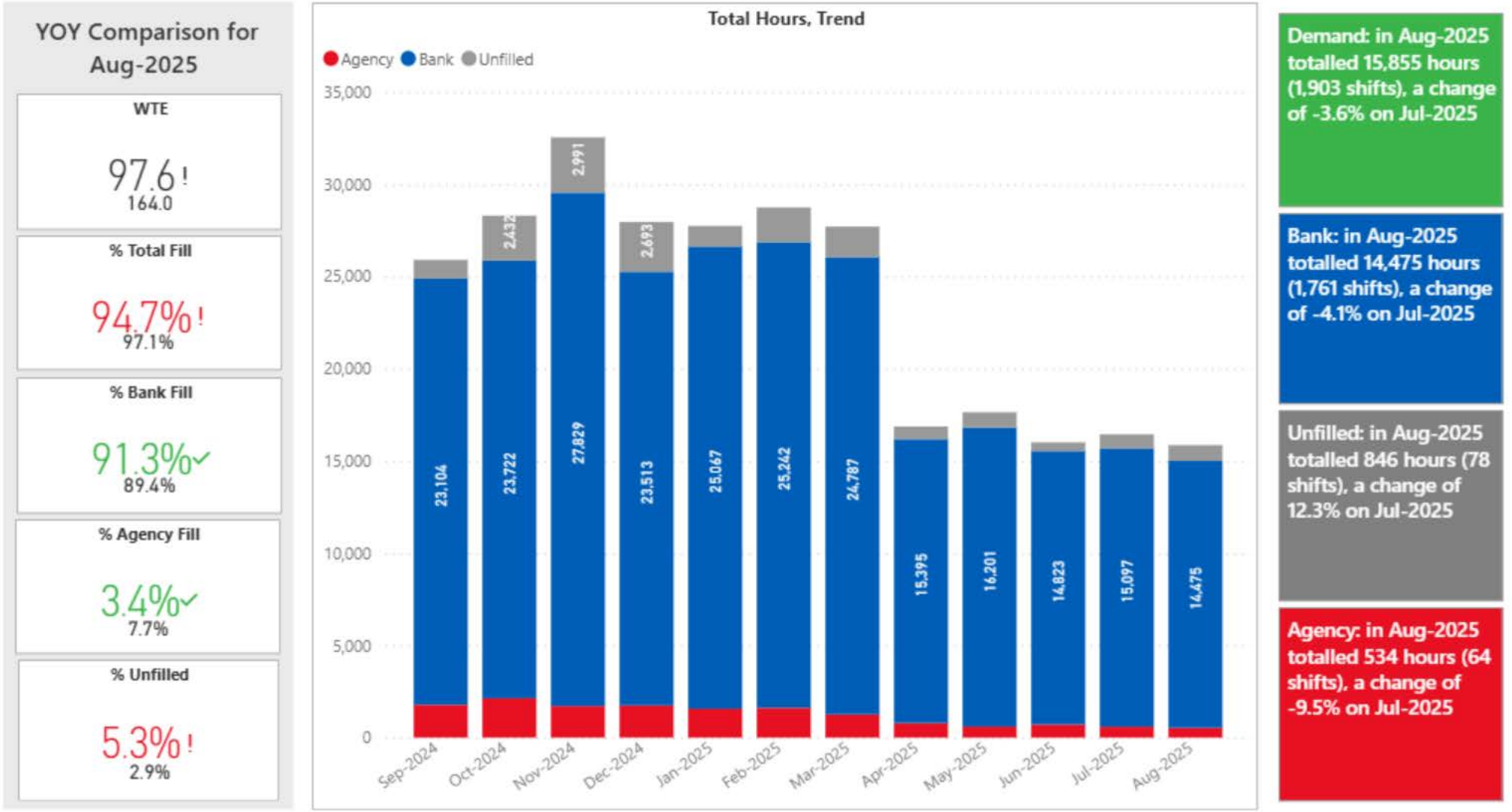
NHSP Bank Spend August 2025

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 with Head of Nursing (Band 8B) approving all NHSP in hours and out of hours Senior Site Clinical Practitioner Overall, in the last 12 months we have seen a significant reduction in bank and agency. Registered Nurse bank spend in August continues to reduce and we have seen the lowest temporary spend within the last 12 months with a decrease of 4.1% from July. 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 Heads of Nursing 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 August which has reduced by 9.5% from July. To note there is no agency within the wards and specialist nursing teams. There continues to be a small amount in theatres, but this has significantly reduced.

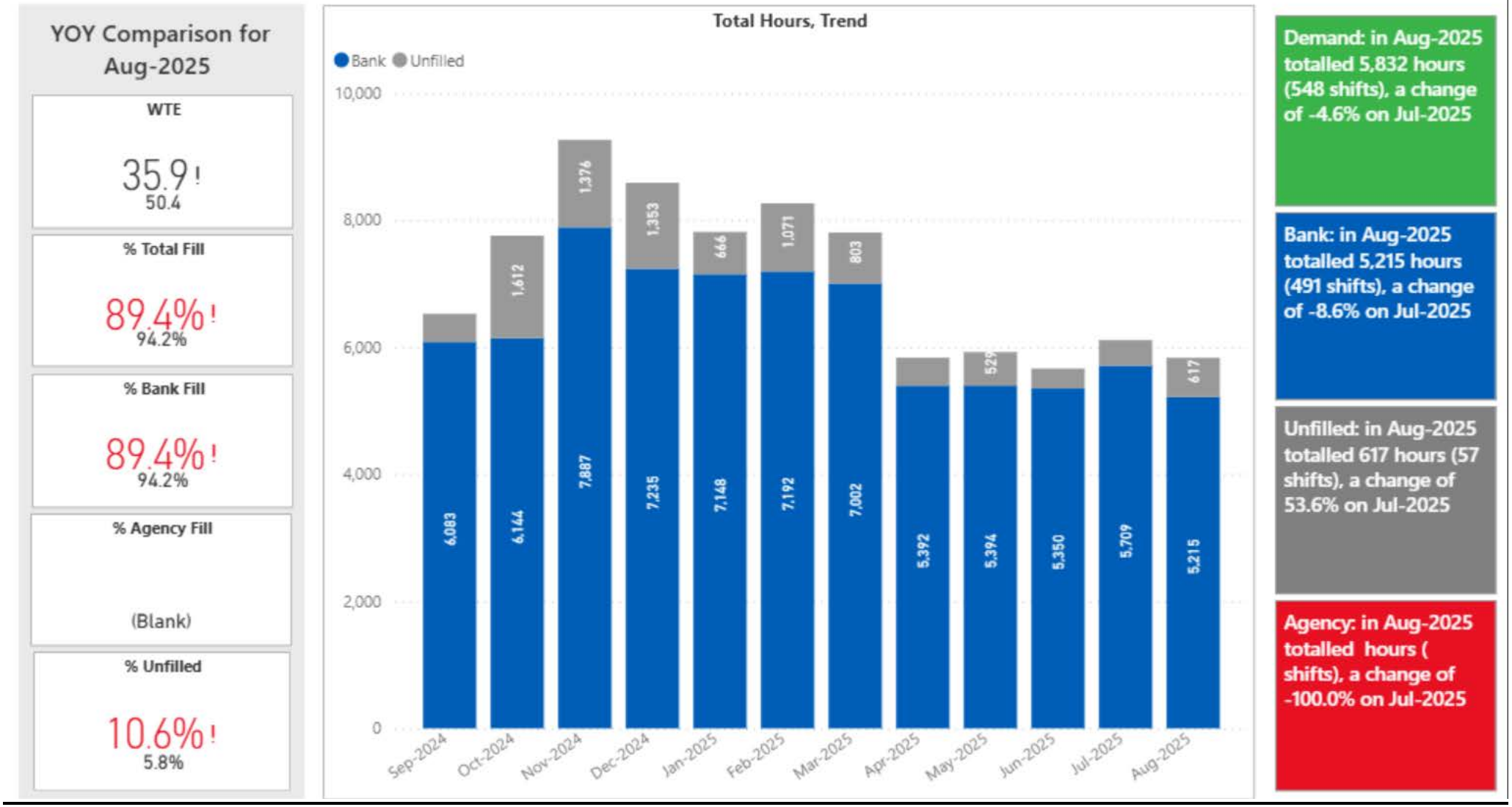
To note within the month of August we have maintained a robust and sustained focus on reducing overtime across all divisions. Each division has conducted a deep dive to identify specific areas and individuals where overtime usage has been used. This has enabled a more targeted and focused approach to reducing overtime and operational efficiency. There is a robust process now in place for any overtime requests related to nursing which ultimately would have to be approved by Chief Nurse.

Unregistered Nurse Bank showed a reduction of 8.6% from the previous month July and is the lowest spend over the last twelve month period which is probably related in part to substantive HCA gaps now being filled. 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 has been ongoing recruitment with further interested candidates who attended. Ward 3C who have had substantive HCA 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 commenced in role in September. It is positive to report that 3C have now filled all vacant HCA posts. As a result of the active recruitment to vacant substantive posts we are seeing a consistent reduction in our HCA temporary spend.

Registered Nurse Bank Spend August 2025



Unregistered Nurse Bank Spend August 2025



KPI E-Roster
Period 21st July-17th August 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%	<4.5%	<7%	<30%
Org.Units/Metrics	Roster Approval (Full) Lead Time Days **(21st July - 17th August 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)	41	37.24%	80.00	-93.53	0.00%	0	0	42.12%	17.16%	8.33%	2.86%	10.94%	0.00%	39.30%
Accident & Emergency - Nursing (912201)	45	17.83%	720.00	124.05	0.12%	11.5	0	21.30%	16.46%	1.66%	0.71%	6.92%	6.70%	32.68%
Burns Unit (915208)	44	26.37%	140.00	-7.68	6.34%	118.5	1	12.32%	15.33%	2.61%	0.00%	2.54%	16.12%	36.61%
Critical Care Ward (913208)	44	14.97%	1200.00	769.12	0.97%	172.5	0	17.46%	16.57%	2.18%	0.19%	3.81%	6.31%	29.07%
High Dependancy Unit (HDU) (913210)	44	23.37%	640.00	292.57	6.17%	425.5	0	34.03%	15.28%	4.35%	1.09%	9.91%	6.45%	37.07%
Medical Daycase Unit (911314)	48	3.13%	50.00	-7.45	3.48%	28.5	0	20.97%	23.50%	0.00%	0.00%	0.00%	0.00%	23.50%
Outpatients (916503)	41	20.32%	420.00	-212.07	0.79%	38	77	29.50%	11.75%	1.14%	0.93%	9.18%	2.34%	26.03%
Sunflower House (912310)	33	42.41%	190.00	-1.27	30.92%	1420.5	74	12.14%	14.54%	3.33%	1.41%	9.12%	2.97%	37.57%
Surgical Daycase Unit (915418)	44	44.37%	85.00	124.42	5.34%	139		32.21%	14.38%	1.11%	4.70%	11.19%	3.92%	35.29%
Theatres - Cardiac & Cardiology (915405)	44	21.20%	130.00	1	0.82%	16		16.78%	14.31%	0.00%	0.15%	8.13%	6.24%	28.82%
Theatres - Emergency (915420)	44	30.40%	230.00	48.7	6.62%	140	4	2.35%	8.58%	1.09%	0.00%	13.41%	0.00%	23.07%
Theatres - IP Anaesthetics (915423)	44	16.85%	82.00	23.92	1.55%	53.5	3	8.98%	13.08%	0.23%	1.74%	7.92%	0.00%	22.97%
Theatres - IP Porters (915435)	44	23.24%	101.00	7.5	8.55%	105.5	1	7.53%	11.26%	0.00%	0.00%	17.11%	0.00%	28.37%
Theatres - IP Recovery (915422)	41	44.05%	103.00	-17.59	9.14%	139.5		6.87%	22.30%	0.54%	6.85%	3.72%	0.00%	33.41%
Theatres - IP Scrub (915424)	44	23.61%	128.00	4	1.46%	25.75		14.24%	13.40%	0.38%	0.69%	11.74%	6.00%	32.21%
Theatres - Ortho & Neuro Scrub (915436)	44	29.54%	37.80	0.5	1.22%	28.5		12.14%	16.77%	1.44%	0.64%	10.54%	7.99%	37.36%
Theatres - SDC Anaesthetics (915429)	44	53.92%	58.40	1.75	31.46%	277.75		20.58%	14.15%	1.27%	4.71%	3.63%	8.26%	32.02%
Theatres - SDC Recovery (915430)	44	34.29%	177.30	-7.1	3.02%	37		12.06%	11.66%	2.31%	0.75%	15.24%	7.62%	37.59%
Theatres - SDC Scrub (915421)	44	27.19%	532.00	-1.75	2.21%	54		14.29%	13.23%	0.59%	1.10%	17.50%	2.23%	34.66%
Ward 1C Cardiac (913307)	44	25.57%	361.00	117.08	3.94%	272	3	10.09%	14.77%	2.68%	0.90%	11.30%	5.02%	34.66%
Ward 1C Neonatal (913310)	38	43.17%	556.00	1215.47	0.00%	0		19.78%	14.22%	4.44%	2.43%	9.65%	7.71%	43.76%
Ward 3A (915309)	44	28.55%	371.00	156.97	10.30%	675.75	9	18.36%	13.05%	0.69%	4.50%	12.82%	9.37%	40.90%
Ward 3B - Oncology (911208)	48	20.84%	555.00	124.05	6.61%	322.5	6	19.36%	18.51%	2.48%	0.17%	11.73%	1.32%	34.68%
Ward 3C (911313)	45	22.81%	607.00	281.82	0.78%	57.5	14	27.55%	12.05%	3.20%	2.10%	10.90%	4.83%	33.36%
Ward 4A (914210)	44	32.44%	634.00	207.12	8.16%	615.25	8	19.87%	15.71%	1.93%	1.34%	10.85%	2.09%	33.84%
Ward 4B (914211)	47	39.56%	533.00	169.38	12.99%	1101	19	21.42%	18.25%	1.98%	1.32%	11.07%	3.91%	36.54%
Ward 4C (912207)	41	18.67%	280.00	124.92	0.64%	34.5	7	25.63%	16.25%	2.99%	3.32%	9.73%	7.80%	41.74%

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 43 days (KPI 42 Days)
- Net hours have decreased from 4772 to 3446 (KPI 9001 to allow for up to a day to owe or be owed)
- Bank/Agency has increased from 6098 to 6310 hours.
- Sickness continues remain high at 9.7%
- Annual leave 15.1% (11%-17%) & other Leave 1.7% (<5%) all within the agreed KPIs
- Study leave 2% (KPI 2%)
- Additional duties have started to decrease from 227 to 226 shifts

BOARD OF DIRECTORS

Thursday, 2nd October 2025

Paper Title:	**2025/26 Capital Plan Update**
Report of:	**Interim Chief Financial Officer**
Paper Prepared by:	Deputy Director of Finance

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 paper is to update the Board on the status of Capital allocation for 25/26 and prioritisation of in year spend.

The Trust had initially anticipated total capital funding of £29.1m for 2025/26, comprised of £23.8m confirmed and £5.3m pending confirmation. £2m further funding has subsequently been brokered with a C&M provider, taking the total expected funding for the year to £31.1m. The £5.3m remains pending confirmation at this stage. Conversations with other providers and the ICB are ongoing, and positive, but with no formal commitment for further funding at this stage.

£31.1m of capital requests have been prioritised through the trust capital prioritisation exercise, including £3m of priority 2 items that have now been progressed following business case approval and confirmation of the brokerage funding secured, leaving £1.9m of priority 2 items outstanding, currently without funding.

In addition to the above, there are also known delays to the neonatal build, elective hub and CT scanner all of which form part of the prioritised capital programme. The impact of delays on overall cost and phasing is being worked through.

It is proposed that the remaining priority 2 items continue through the business case process as required depending on value in parallel to ongoing discussions with the ICB and other providers. If no further funding is secured a further prioritisation exercise will be undertaken to confirm whether any of the remaining priority 2 items should be undertaken at risk. If required, this will be brought back to Board for approval in December.

2. Funding summary

During the annual plan process, the Trust had anticipated total capital (CDEL) of £29.1m for 2025/26, comprised of:

- Confirmed funding: £23.8m (including £2.2m for financial freedoms allocation)
- Pending confirmation: £5.3m (including £2.2m for SDEC, subject to NHSE review)

Since the previous update to Board following has happened;

- A C&M provider has agreed to broker £2m of their CDEL, on the condition we pay this allocation back to them in 26/27.
- Financial freedoms funding has been formally confirmed by the ICB.
- NHSE have responded to SDEC business case with some clarification queries which have been resubmitted and Alder Hey are awaiting a response
- Positive conversations with other providers and the ICB are ongoing in terms of additional brokerage, but no formal confirmation has been given at this stage.

With the above in mind, this takes the current expected capital funding for the year to £31.1m with potential for further funding subject to provider/ICB agreement.

A breakdown of expected funding can be found below;

Funded by	Funding available
CDEL Allocation (TBC)	5,923
2024 UEC incentive	3,200
24/25 Surplus fuding	2,254
Committed charitable funding (now includes incubators)	5,313
PDC funding	1,560
NIHR funding	1,245
Other	367
2025 UEC Incentive funding	4,000
C&M Provider brokerage	2,000
Total known funding	**25,862**
Other	3,100
National UEC funding 25/26 (subject to bid)	2,119
Total potentail other funding (subject to approval etc)	**5,219**
Total funding	**31,081**

3. Capital prioritisation summary

Against the Trust's anticipated capital funding of £31.1m, total requests of £31.1m have been formally approved;

- £25.1m pre-committed
- £3m priority 1 (statutory/health and safety/completion of existing builds)
- £3m priority 2 now fully approved (Core and EPR data centres).

A full breakdown of currently committed capital plan can be found at appendix A.

This leaves £1.9m priority 2 items outstanding. These items were earmarked as confirmed in year priorities, some of which had stretch targets applied from the initial ask, that would be approved through the normal business case process subject to funding becoming available.

Description	Initial ask	Stetch target prioritised as priority 2
Campus works	694	395
Service Excellence (devices etc)	890	750
Domestic cleaning equipment	110	110
Knee kit	70	70
PFI H&S Variations	100	50
Pharmacy cabinets*	538	510
Smart screen	**6**	6
	2,408	**1,891**

**Confirmation received that this could be deferred to 26/27 but requires firm commitment that funding would be available next year.*

In addition to above, there are known delays to the Neonatal build, CT scanner and Elective hub. Work is ongoing to understand the financial impact of these delays both in terms of overall cost and phasing of spend.

4. Next steps

It is proposed that the November Capital Management Group is reserved to review business cases for all remaining priority 2 business cases that have not yet been tabled.

If sufficient funding becomes available the business cases will follow the usual governance process for approval depending on value.

If funding is not forth coming, a further prioritisation exercise will take place in order to confirm whether any or all of the priority 2 items should be taken forward at risk. This exercise will also take into account any additional cost or phasing issues/opportunities with capital items already approved. Any reprioritisation of spend above existing budget, will be brought back to Board in December for formal approval.

5. Recommendation

The Board are asked to approve the approach outlined in the paper. An update on the outcome of capital position and any reprioritisation required will be brought to December Board.

Appendix A – Committed projects

Category	Summarised detail	Prioritised plan
Campus	Car Park	475
Campus	Demolition	246
Campus	Development Team	650
Campus	EDYS (Alder Park)	1,000
Campus	Elective Hub	250
Campus	Infrastructure	94
Campus	Offices / Garages	202
Campus	Surgical Neonatal Development	9,826
Campus	Surgical Neonatal Development (Donated)	4,000
Campus	SDEC PDC	2,119
Campus	Park	222
Campus	Step Places	375
Campus Total		**19,459**
Digital	Data Warehouse	300
Digital	Digital Staffing	1,000
Digital	Federated Data Platform	300
Digital	EPR Data Centre Refresh	1,027
Digital	Core Data Centre Refresh	1,970
Digital Total		**4,597**
Innovation	Innovation (AI&Tech)	150
Innovation Total		**150**
Medical Equipment	Charity donations - CT Scanner / enabling	950
Medical Equipment	Charity donations - Medical equipment	363
Medical Equipment	Replacement Programme	529
Medical Equipment Total		**1,842**
Other	Capital call (NIHR Donated Asset) 24/25 scheme	1,200
Other	MRI Scanner (NIHR Donated Asset)24/25 scheme	45
Other	CSR Diagnostics 25/26 PDC	120
Other	NHS Solar Energy Projects 25/26 PDC	1,440
Other	Rev to Cap	2,354
Other	Contingency	250
Other	Slippage allowance	- 173
Other Total		**5,236**
Sub-total 1 (CAP0432)	**Gross capital expenditure (excluding lease remeasurements)**	**31,284**
Lease Liability Remeasurement	GIDS (Mandarin Court)	49
Lease Liability Remeasurement	Ainsdale Health Centre	5
Lease Liability Remeasurement	Southport Centre for Health	51
Lease Liability Remeasurement	Netherton	- 238
Lease Liability Remeasurement	Sefton Carers Centre	- 70
Lease Liabilities Total		**- 203**
Total	**Gross capital expenditure (including lease remeasurements)**	**31,081**

BOARD OF DIRECTORS

Thursday, 2nd October 2025

Paper Title:	**Trust Mortality Report Quarter 1 2025-26**
Report of:	**Hospital Mortality Review Group (HMRG)**
Paper Prepared by:	Alfie Bass/Julie Grice

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

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

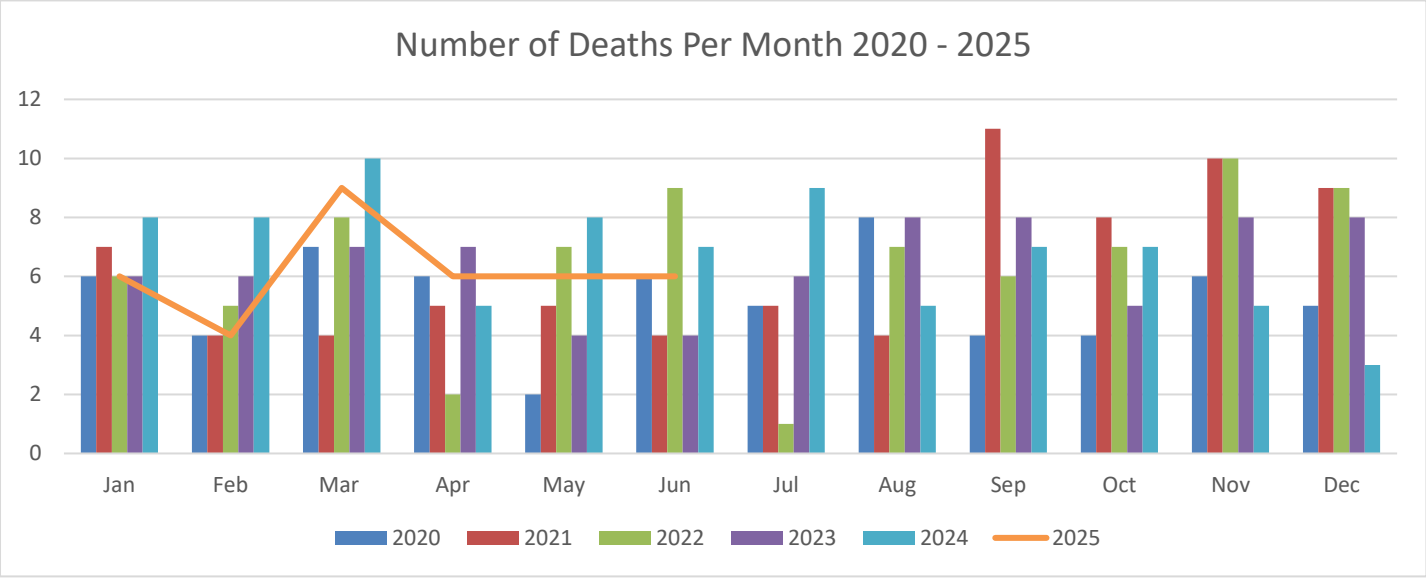
Medical Director's Mortality Report- Quarter 1 2025-26

The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG) including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims.

Section two is the Quarter 1 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

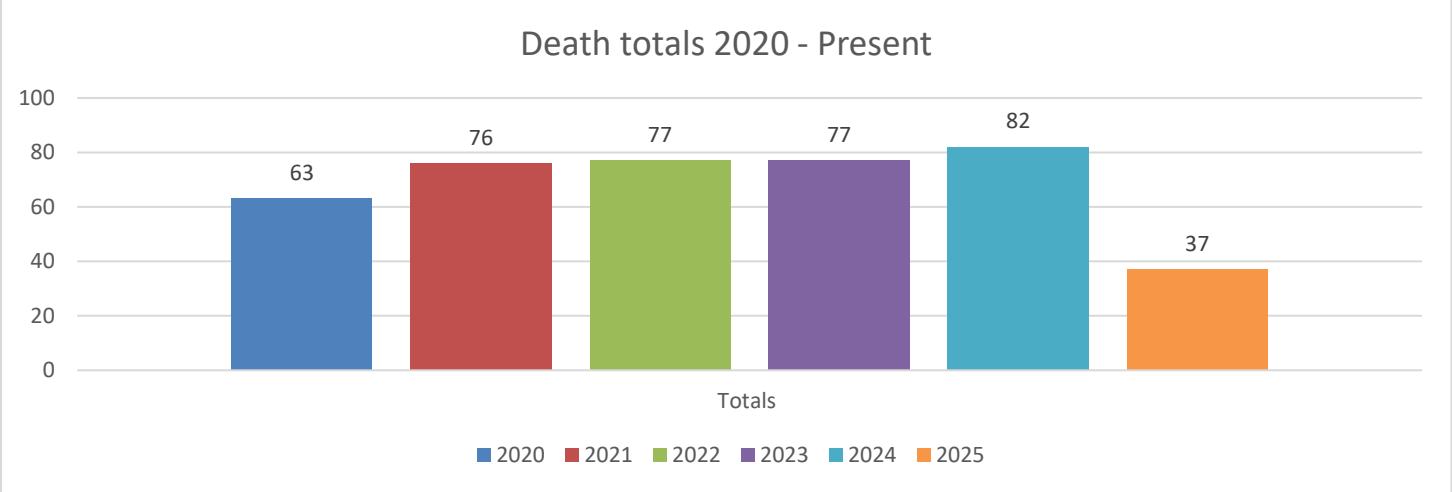
Section 1: Report from the Hospital Mortality Review Group (HMRG)

The graph below illustrates the number of deaths at Alder Hey from 2020 to 2025, with particular focus on the 2025 data line, which indicates that the initially elevated mortality rate earlier in the year subsequently stabilised.



The graph shows monthly death counts from 2020 to 2025, with noticeable fluctuations across years. Peaks commonly occur in March, September, and November, while May often has lower counts. The year 2021 shows the highest single-month death total (11 in September), while 2025 stands out for its

stability—starting with a peak of 9 deaths in March, then maintaining a consistent 6 deaths per month thereafter. Overall, the data suggests varying patterns year to year, with 2025 showing a potential improvement or stabilization in mortality rates.



This graph shows total annual deaths from 2020 to the present. Deaths rose from 63 in 2020 to a peak of 82 in 2024, with 2021–2023 holding steady between 76 and 77. The apparent drop to 37 deaths in 2025 reflects only half a year of data, meaning the total may still align with previous years by year-end. Overall, while deaths fluctuated slightly year to year, they remained relatively high through 2024, and the 2025 total is incomplete and likely to rise.

Previously, deaths occurring in the Emergency Department were excluded from reporting, as they were not classified as inpatient deaths. However, with recent changes to the Child Death Review Process, all such cases are now included in the National Child Mortality Database. This change, alongside an increase in cases brought to Alder Hey where death is inevitable, often related to organ donation or supporting family acceptance, contributes to the slight rise in reported numbers.

The Child Death Review Process in the trust continues to evolve because of issues identified by HMRG members and bereaved families, plus external changes:

1) The AHCH pilot for the Medical Examiner (ME) process began in March 2024 and became a legal requirement in September 2024. ME scrutiny at AHCH is carried out by the Liverpool University Hospitals NHS Foundation Trust Medical Examiner Service, supported by two pediatricians (one actively working and one recently retired from AHCH). To date, approximately 100 paediatric deaths have been reviewed by

the ME team. This quarter, one incident occurred involving duplication of work due to miscommunication, which caused confusion and difficulties for the family registering the death. A process review is underway to prevent this issue from recurring.

2) Over the last few months there has been significant engagement with the GP/DGH's if involved to gain their input enabling a more complete review.

3) There continues to be increasing demand from parents and carers for feedback following the HMRG review. A process is now in place to provide timely responses from the HMRG meetings, with input from psychology to ensure communications are phrased sensitively. It is crucial that, as a Trust, we maintain consistency and timeliness in sharing this information.

4) There have been improvements in the process of coronial feedback during meetings, particularly given some very complex cases over the past six months. This has generated vital learning for the Trust, which has been shared and discussed in detail at subsequent meetings.

5) There is an on-going neonatal audit including cases from the last 5 years. This is a baseline assessment before the new neonatal surgical unit opens so the impact can be measured. The new unit means that some patients will remain at Alder Hey as opposed to transferring back to LWH post-surgery. Hence, figures in both hospitals may be impacted.

6) Complex cases that cross multiple divisions and involve several teams present challenges in ensuring a comprehensive review with all relevant parties before the HMRG meeting. It can be difficult to determine who should lead the review, which sometimes results in delays in the HMRG process.

7) Highlighted this quarter was the theme of lead consultant in complex patients when the main team does not have admitting rights. This can cause a variety of issues especially in communications with families. It has been an issue in previous cases but is very complex to address.

Current Performance of HMRG

Summary of 2025 Deaths

Number of deaths (Jan. 2025 – June 2025)	36 +1 reviewed in LWH
Number of deaths reviewed	18
HMRG Primary Reviews within 4 months (standard)	17/18 (94%)

The percentage of cases reviewed within the 4-month target has remained extremely high. In addition to in-hospital deaths, HMRG also reviews hospice deaths where care was primarily delivered by AHCH. The group demonstrates strong commitment and flexibility, ensuring timely and thorough reviews. Its multidisciplinary membership - including Alder Hey clinicians, NWTS, LWH neonatology, psychology, and the Snowdrop bereavement team - supports a robust and comprehensive review process.

Most cases are complex for a variety of reasons and often require multiple discussions so entailing a considerable amount of time, but this is vital to ensure that the correct conclusions and learning is achieved. The meetings are held monthly on Teams, enabling more people to attend as well as allowing DGH clinicians to be involved if they wish.

Outcomes of the HMRG process 2024

Outcome table:

Month	Number of Inpatient Deaths	HMRG Review Completed	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
					Internal	External		
Jan	6	6	6	6				1
Feb	4	4	4	4				1
Mar	8*1	7	7	7			1	1
April	6							
May	6							
June	6							

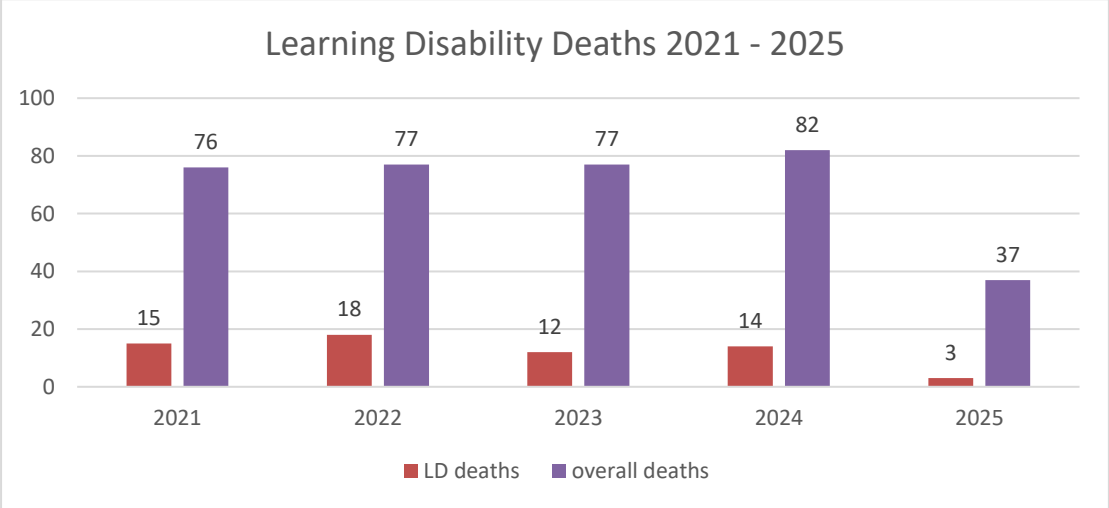
***1 death reviewed in LWH system more appropriate than AHCH but input from clinical teams here**

Potentially Avoidable Deaths

There have been 0 potentially avoidable deaths in the 2025 cases reviewed so far.

Learning disabilities

The number of learning disability cases over the past four years has varied with no clear pattern, as illustrated in the graph below. When compared to the total number of deaths, the percentage has ranged between 16% and 20%. However, in the 2025 cases reviewed so far there is a much lower number of LD cases than usual at 8%. This was the same pattern last year that then balanced out over the whole of 2024.



The LeDeR programme was established to ensure all deaths of patients with learning disabilities are comprehensively reviewed. Since July 2023, the requirement to report deaths of children and young people (CYP) aged 4 and over with a learning disability and/or autism to LeDeR has been removed. These deaths are now reviewed through the standard child death processes. A national thematic report focusing on CYP with learning disabilities and/or autism is still produced, with the most recent issued on 2024

Despite the national change, the Trust has committed to continuing internal reviews of all learning disability/autism-related deaths, including those under 4 years old. This approach supports internal thematic analysis and promotes learning. National discussions are now underway to consider including this younger age group in future LeDeR reporting, as there is currently no clear rationale for their exclusion. Some very young infants in our dataset have

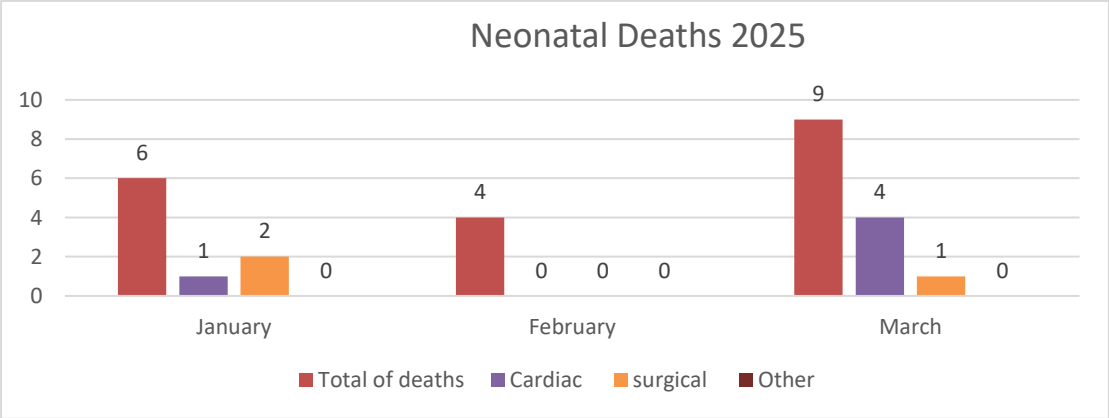
conditions that, had they survived, would likely have resulted in a learning disability diagnosis, hence they are appropriately coded.

No concerning themes or trends have been identified within the LD patient group. Cases will be further reviewed upon completion of any coronial processes to identify any additional learning and adjust coding (e.g. from SUDiC) where necessary. The review group maintains close collaboration with the Learning Disability services to ensure that any findings are shared and acted upon, supporting high-quality care for this complex and often high-contact patient population.

Neonates

The definition of a neonate is a baby less than 28 days old. Of the cases reviewed so far, there have been 8 neonatal deaths which is 44% of the total deaths. Of these cases, 75% had the diagnostic code of congenital, genetic, and chromosomal anomalies. The only other category was neonatal /perinatal causes which was 25%.

The graph below show the breakdown of the caseload into complex congenital cardiac heart defects, surgical and other compared to the total number of neonatal deaths. The surgical cases are predominantly the premature babies with NEC (Necrotising Enterocolitis) which is a recognised complication in premature infants. Of these neonatal cases, it was decided in 75% that after investigations or due to their condition that there were no further treatment options available. They were then changed to palliative pathways after discussion with all relevant teams and with the agreement of the families.



The Perinatal Mortality Review Tool (PMRT) process recommends that reviews are conducted in the trust where the baby dies. However, at AHCH, this is not feasible due to the absence of obstetric services. Instead, the PMRT is

completed by the hospital of birth and then shared with AHCH, allowing HMRG members to review it in advance of their own assessment. To support alignment between the two processes, the HMRG form will be updated to incorporate the PMRT findings and summary, enabling consistent and thorough scrutiny of all neonatal cases.

It is noted that some trusts do not complete a PMRT review if the baby dies outside the hospital of birth. HMRG continues to advocate for the inclusion of obstetric history reviews using PMRT methodology in such cases and will work collaboratively with partner hospitals to promote robust and consistent review processes

Family

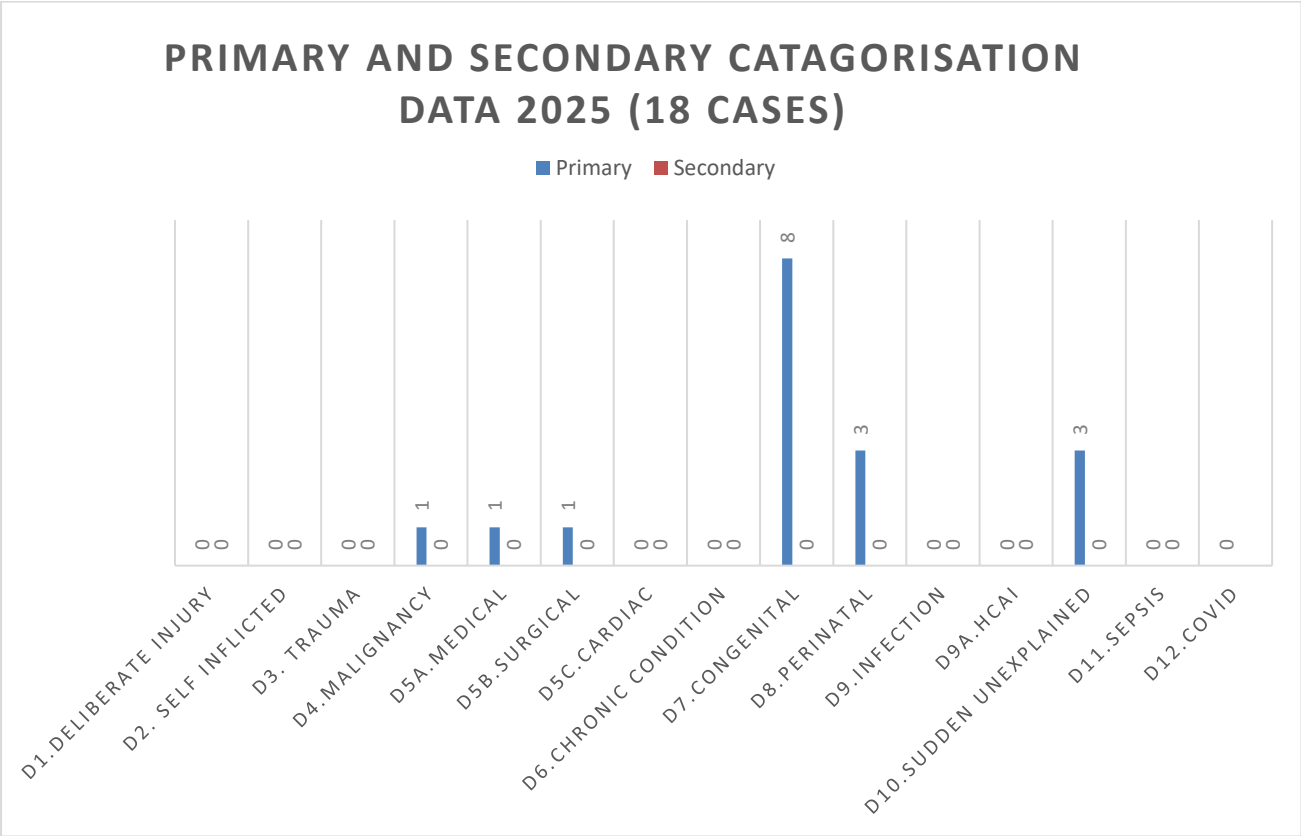
The Snowdrop bereavement team at Alder Hey provides valuable support to families following a patient's death. Ongoing collaboration between HMRG, the palliative care team, and the bereavement team aims to enhance the quality of feedback received from families, helping to inform and guide future improvements in the care we deliver. Named HMRG members have access to a shared inbox which has been created so that families can request feedback after HMRG review, raise any issues and offer feedback both positive and/or negative.

There have been an increasing number of families who are asking for a summary of the HMRG review relating to their CYP. This is provided. We do not send families the HMRG audit tool because in keeping with the child death review guidance, a plain English summary is written to try and prevent additional distress. These summaries are reviewed by palliative care/psychology to ensure they are of a high standard and compassionate. It has been recognised nationally that there is a trend for bereaved families to request written summaries and discussions are ongoing as to how to provide these without causing additional trauma to families.

External Benchmarking

AHCH has engaged with Birmingham Children's Hospital with the view that it is the trust with the closest workload and demographics to us. It has enabled us to compare figures and trends and to work together to improve our processes and learn from each other, and this will continue. There is also engagement with other trusts to create a mortality network. We all face the same issues and therefore it can only be of benefit to learn from each other.

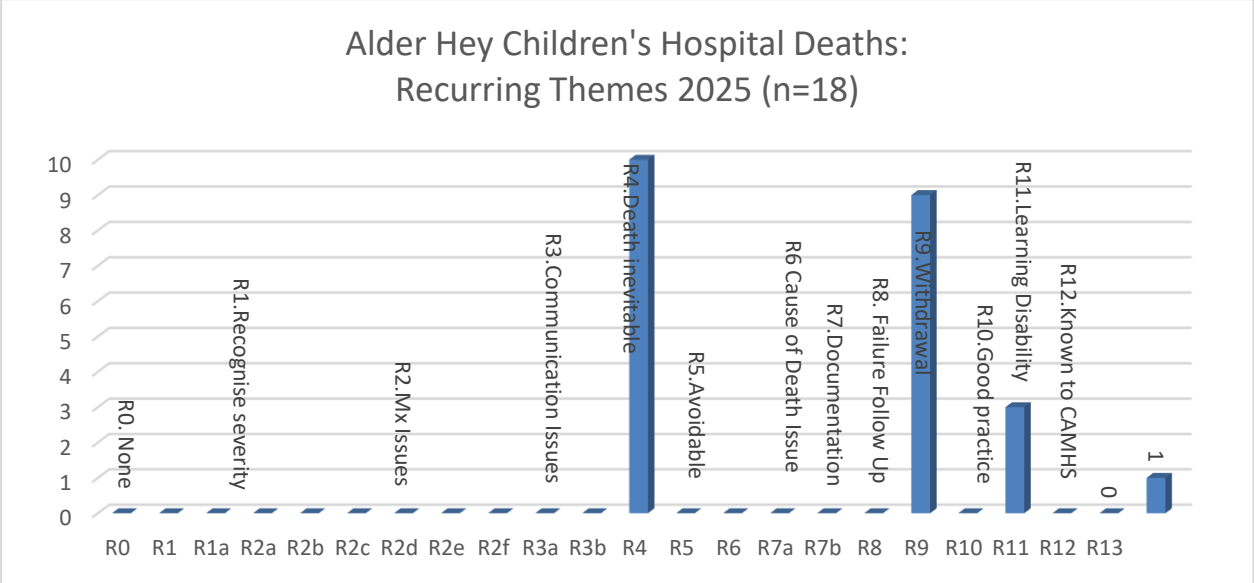
Primary and Secondary Categories



The cases reviewed so far in 2025, show that the highest diagnostic code is 'children with underlying chromosomal, genetic and congenital conditions' (44%). These are often complex and vulnerable patients. These conditions, depending on the case, may be life-limiting or life-threatening and often the care they have received by AHCH, other health professionals and their families have enabled them to live longer than previously anticipated.

Next most frequent, both with 17% are the diagnostic codes Perinatal and 'SUDI – Sudden unexpected death Infant/child. The SUDI cases are those which follow the coronial pathway so the coding will be changed if appropriate following PM or more information. The perinatal cases are those when the cause of death is a complication of prematurity or neonatal causes. These are covered in more detail in the neonatal section.

Recurrent Themes



The main recurrent theme in 2025 to date, is death was concluded to be inevitable in 56%, regardless of the care and expertise that was provided at AHCH. This category also includes the cases where death was inevitable with hindsight. These cases are included to highlight that it is not a reflection on the care AHCH provides as children are transferred for investigations which then indicate conditions which are life-limiting.

The next most common theme was withdrawal of life-sustaining care (50%). This demonstrates that the intensive care team are working with families to ensure that no CYP suffers unnecessarily when available treatment options or continuing treatment are no longer felt to be in the best interests of the CYP.

The LD and avoidable deaths have been discussed earlier in the report.

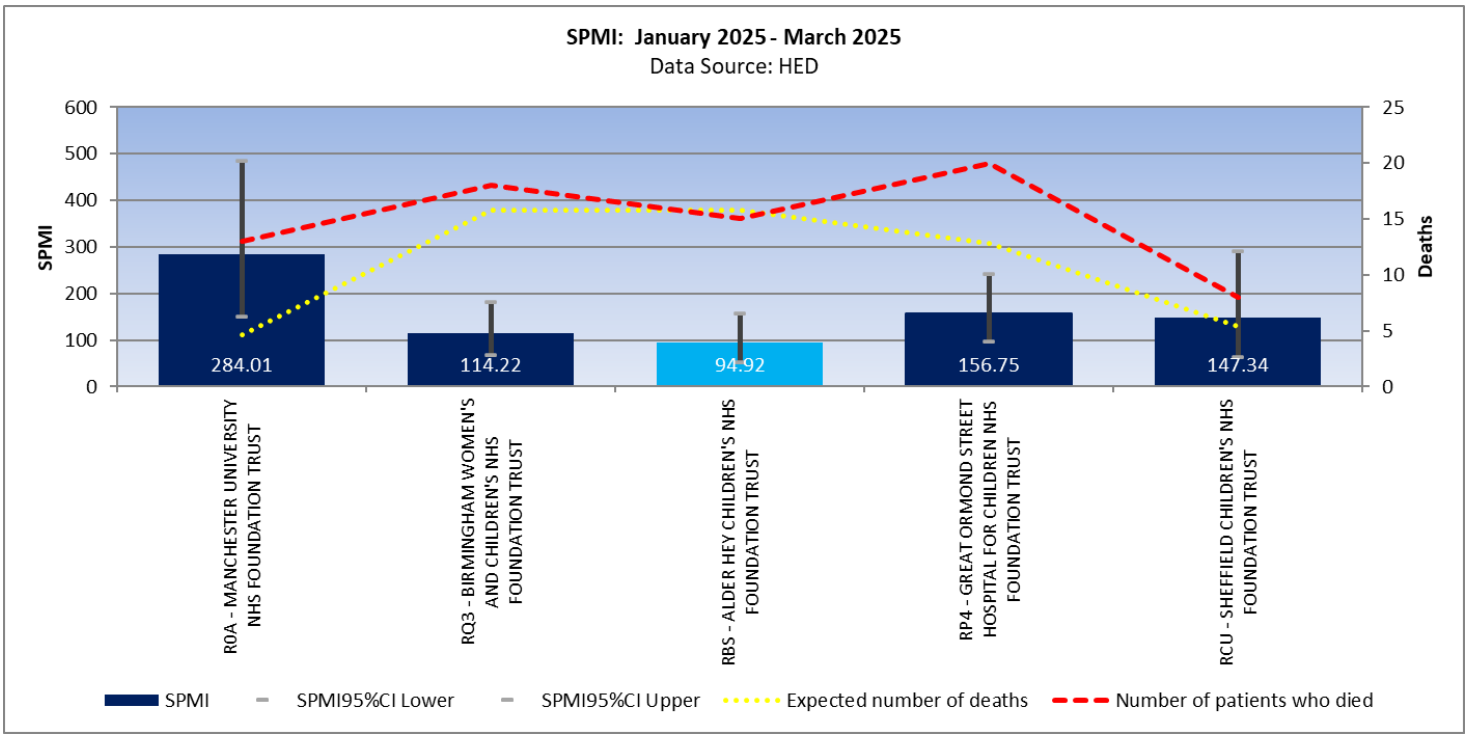
Section 2: Quarter 1 Mortality Report: April 2025 – June 2025

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level

than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the most recent available period covering January 2025 to March 2025.



This chart presents the Standardised Paediatric Mortality Index (SPMI) across five children's NHS trusts for the period January to March 2025. Alder Hey Children's NHS Foundation Trust (RBS) continues to demonstrate strong performance, with the lowest SPMI value of 94.92, well below the national average and expected range. This suggests fewer observed deaths relative to expected mortality. The dotted yellow line reflects the expected number of deaths per trust, while the red dashed line shows actual deaths. Alder Hey's observed mortality closely matches expectations and remains within the 95% confidence interval, reinforcing the trust's consistent and positive mortality outcomes relative to peer institutions.

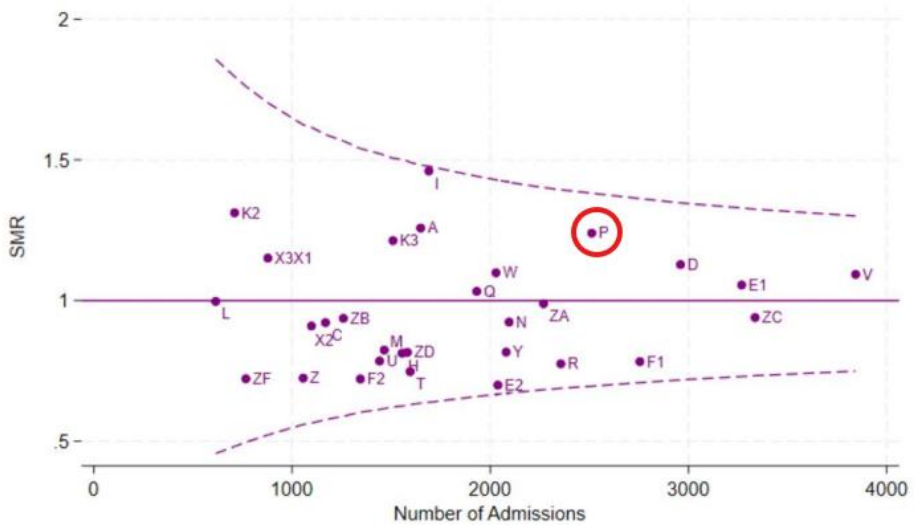
PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other Children's Trusts. In the most recent PICANet report (2024 2021-2023), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.
There was no evidence that any PICU had an excess mortality rate compared to what would be expected based on the level of sickness at the time of admission across the three-year reporting period. This is illustrated in Figure 5

based on inclusion of all SMR estimates being contained within the control chart limits.

Metric 5: Risk adjusted in–PICU mortality

Figure 5: Risk adjusted Standardised Mortality Ratio (SMR) by health organisation, 2021 - 2023

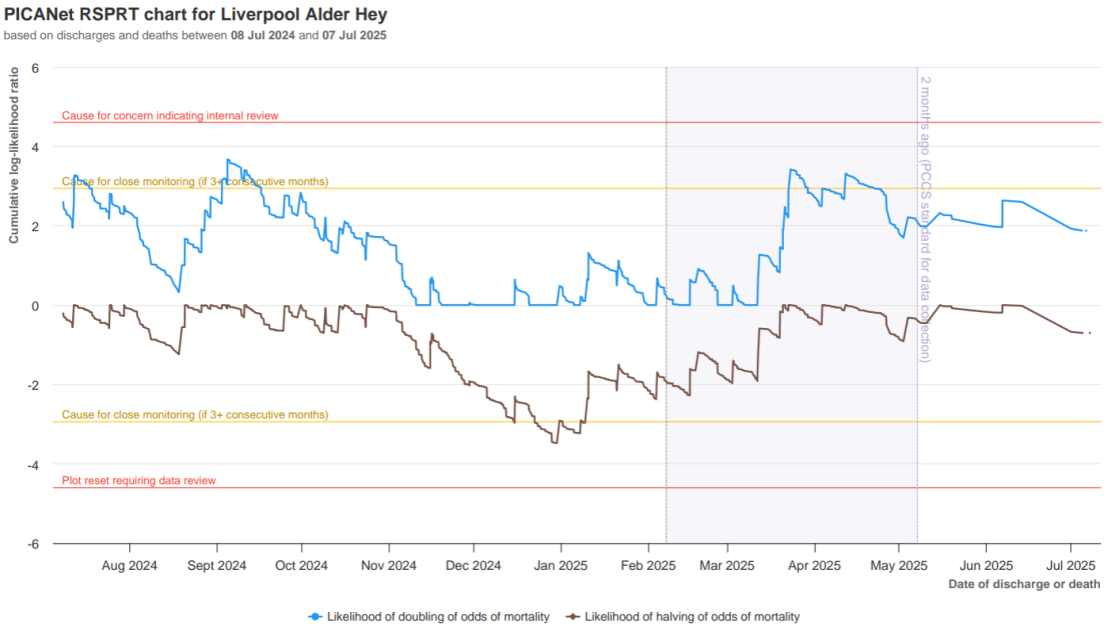


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

a) RSPRT (Risk-adjusted resetting probability ratio test)

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'. Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet.



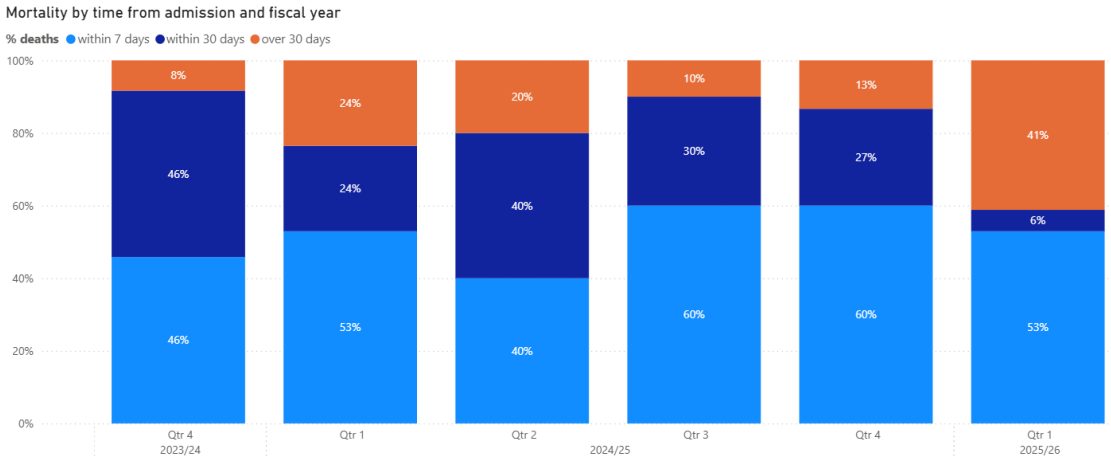
During the last quarter, the mortality rate in PICU has remained stable. Between April and June 2025 there were 199 admissions and 13 deaths, giving a mortality rate of 6.53. Comparatively, the PICU mortality rate in 2024 was 6.93. We continued to monitor the RSPRT which remains in the 'safe zone'.

Of the 13 deaths discussed at out departmental mortality review meeting, the primary death category was noted as multi-organ system failure (MOSF) in 7 (58%), cardiac in 2 (17%), general surgical in 1 (8%), respiratory in 1 (8%) and sepsis in 1 (8%). The maximum length of stay (LOS) was 306 days. Without this outlier, the mean average LOS was 12.2 days (range 0 - 71 days), and median LOS was 2 days. This highlights both the acute severity of the majority of cases as well as the significant complexity / challenges involved in caring for chronic patients in critical care.

Real time monitoring of mortality

Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below the chart shows mortality broken down by the time from admission to death, mortality within 7 days, 30 days and over 30 days from admission.



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, 40-60% of deaths occur within this time frame. In the recent quarter April 2025 – June 2025, 53% of deaths occurred within 7 days of admission, 6% occurred within 8-30 days from admission, and 41% of deaths occurred over 30 days from admission.

Conclusion

The HMRG continues to deliver effective, timely, and comprehensive mortality reviews, maintaining performance against the 4-month target despite increasing complexity and workload. The process is maturing, with learning now routinely shared and engagement with stakeholders, including GPs, DGHs, and external services being strengthened, enhancing the depth and value of each review.

A broader analysis of mortality data, clinical governance, and thematic findings across Alder Hey Children's NHS Foundation Trust highlights a culture of transparency, learning, and continuous improvement. Mortality rates remain within expected thresholds, with Alder Hey reporting consistently low Standardised Paediatric Mortality Index (SPMI) scores compared to peer trusts reflecting strong clinical outcomes. The implementation of the Medical Examiner (ME) process and further integration of HMRG have enhanced oversight and multidisciplinary input into complex cases.

Efforts to improve coronial feedback, streamline communication with families, and resolve operational challenges, such as electronic record clarity and cross-divisional coordination underscore the Trust's commitment to safe, compassionate, and high-quality care. No emerging concerns or adverse trends have been identified across learning disability, neonatal, or general paediatric deaths. The Trust's proactive stance evident in initiatives like the

neonatal audit and its decision to continue reviewing all relevant deaths beyond national requirements, demonstrates a forward-thinking, robust approach to mortality governance.

References

1. **SPMI -** The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 10**

2. **Benchmarking -** As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html), **Pg 11**

3. **PICU SMR** - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 12**

BOARD OF DIRECTORS

Thursday, 2nd October 2025

Paper Title:	**Chair's Report from the Safety and Quality Assurance Committee meeting held on 24th September 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 Safety Quality Assurance Committee meeting held on 24th September 2025, along with the approved minutes from the 23rd July 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 23.07.25	Minutes Approved
Divisional updates	Reports x4 noted
Liverpool Neonatal Partnership Monthly update	Report noted
Care Quality Commission Inspection: Alder Hey Community Mental Health, ASD & ADHD Service update	Report noted
Patient Safety update	Report noted
Cleaning Standards Report	Report noted
Infection Prevention & Control Report	Report noted
Safeguarding Training needs analysis for level 3 safeguarding training Report	Report noted
Safe Waiting List update	Report noted
EPRR Quarterly update	Report noted
Quality Assurance Rounds -Themes and Risks Bi-annaul Report	Report noted
Board Assurance Framework	Report noted
Deep Dive of Risk 1.2 received	Report noted
Mortality Report	Report noted
Ward/Department Accreditation Bi-annual report 2024/25	Report noted
Self Harm reduction and Suicide Prevention Policy – RM40	Policy ratified
Transition to Adult Services Policy – C62	Policy ratified
Informed Consent Policy	Policy ratified
Management of Inspections and Accreditations Policy	Policy ratified
M49 – Research Policy	Policy ratified
Adverse Weather Plan	Plan Ratified

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

SQAC noted that some divisions, especially the Medicine Division are holding high levels of risk. FB would discuss this further offline with the Director of Medicine and the Chief Associate Nurse for Medicine.

4. Positive highlights of note

- SQAC received a good level of discussion on a number of key items and noted positive improvements across a number of areas, whilst noting a number of ongoing challenges. FB invited observers to share any further comments or questions following the meeting.
- SQAC welcomed the Liverpool Neonatal Partnership monthly update, and noted the likely build delay. SQAC noted that the service is working on a plan to mitigate the impacts of this delay and would report on this in future. It was noted that FTPC would be discussing further the causes of the delay, and that it might be helpful to have a post-implementation review at the end of the project.

- SQAC welcomed the update regarding the Care Quality Commission Inspection: Alder Hey Community Mental Health, ASD & ADHD Service report
- SQAC welcomed the Patient Safety update
- SQAC welcomed the Cleanliness update which provided an overview of the current position.
- SQAC noted the assurance of good work and improvements across the divisions with many action plans and policies in progress. SQAC noted the wide range of policies being discussed, all aimed at improving processes.
- SQAC noted the challenging financial environment and the need to closely monitor areas that are fragile or at risk, particularly with the added pressures of winter
- SQAC welcomed the Safeguarding, Training needs analysis for level 3 Safeguarding training Report
- SQAC welcomed the Safe Waiting list update and noted the current position
- SQAC welcomed the EPRR Quarterly update
- SQAC welcomed the Clinical Effectiveness & Outcomes Board Chairs Highlight report
- SQAC welcomed the Board Assurance Framework and a Deep Dive of Risk 1.2
- SQAC welcomed the Mortality report and noted the current position
- SQAC received, Noted and Ratified the Self-Harm reduction and Suicide prevention Policy – RM40
- SQAC received, Noted and Ratified the Transition to Adult Services Policy – C62
- SQAC received, Noted and Ratified the Informed Consent Policy
- SQAC received, Noted and Ratified the Management of Inspections and Accreditations Policy
- SQAC received, Noted and Ratified M49 – Research Policy
- SQAC received, Noted and Ratified the Adverse Weather plan

5. Issues for other committees

None

6. Recommendations

The Board is asked to note the contents of the report

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 23rd July 2025
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing Officer	NA
	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	AB
	Kerry Byrne	Non-Executive Director	KB
	Gerald Meehan	Non-Executive Director	GM
	Rachael Pennington	Associate Chief Nurse - Surgical Division	RP
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health	JP
	Laura Rad	Head of Nursing – Clinical Research	LR
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Jill Preece	Governance Manager	JP
	Veronica Greenwood	Director of Allied Health Professionals	VG
25-26-88	Susan O'Neil	Head of Neonatal Nursing, Liverpool Neonatal Partnership	SON
25-26-91	Paul Sanderson	Chief Pharmacists	PS
25-26-93	Luke Oldland	Account Director, Mitie	LO
Apologies:	Lisa Cooper	Divisional Director, Community & Mental Health Division	LC
	Jackie Rooney	Associate Director of Nursing & Governance	JR
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Alfie Bass	Chief Medical Officer	ABA
	Pauline Brown	Director of Nursing	PB

25/26/83 **Welcome and Apologies**
The Chair welcomed everyone to the meeting and apologies were noted.

25/26/84 **Declarations of Interest** - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

25/26/85 **Minutes of the Previous Meeting**
The Committee members were content to **APPROVE** the minutes of the meeting held on 25th June 2025.

25/26/86 **Matters Arising/Review of Action log**
The action log was reviewed and updated.

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

25/26/87 **Divisional Updates**
Division of Medicine
CW presented the Medicine Division update and drew attention to a few key points from the report including:
Highlights:-

- The Division achieved the highest referral to treatment (RTT) rate in 12 months, up 10% compared to last year, due to focused efforts on waiting list validation, demand, and capacity review (notably in neurology), and job planning.
- New patient validation had been pivotal, with plans to extend this to follow-up patients, resulting in a consistent downward trend in waiting lists.
- The Division was able to achieve 100% of the complaints responded to within 25 working days, despite an increase in the number and complexity of complaints.

Challenges:-

- There was an increase in the number of complaints received, especially in endocrinology and dermatology, though no clear themes had emerged; a deep dive is underway to investigate further. There are a number of complaints which are linked to a consultant being off sick in the obesity service, but not directly referred.
- There had been an apparent increase in hospital-acquired infections (up to four), review showed three were community-acquired; one C. difficile case within oncology, with no lapses in care identified. National trend of increased C.difficile in complex patients, heavily treated oncology patients.
- Emergency preparedness: The Governance team met with the EPRR lead and agreed on a new template, although training needed to be added. The Division is not yet fully compliant with emergency preparedness requirements; improvements are expected by August 2025.
- Several high-risk services are under detailed mitigation, with some needing system-level solutions, such as the escalated metabolic service in Manchester.
- Risks are being well managed and regularly reviewed; however, these are difficult to resolve due to external dependencies.

CW provided assurance that actions are being taken to address all challenges, with progress expected in the coming months
GM referred to the neurology team and sought clarity whether there was capacity for the team to reflect on changes, communicate effectively, and address cultural and developmental aspects during the management of change, emphasising the importance of not missing these elements in the drive to achieve targets.
GM acknowledged the challenges in neurology and highlighted the importance of supporting staff through change, referencing the need for good communication and opportunities for staff to discuss concerns.
GM also sought assurance that risks in the fragile services were being well managed and asked about the complexities involved, particularly where system-level solutions and collaboration with other trusts were required.
CW confirmed that the neurology team have had opportunities to discuss concerns and reflect on changes, noting that the process had been ongoing for over a year and had included consultant engagement, job planning, and resumed on-call services. CW acknowledged challenges but stated that the team is in a much better position than last year, with support provided both within the division and from executive directors.
CW referred to Fragile Services & Risk Management and explained that the fragile/high-risk services each face different problems, CW confirmed that there is not identical set of issues. CW assured the committee that risks are well managed, with detailed mitigation plans which are reviewed at the Risk Committee. CW referred to a number of challenges which require system-level collaboration (e.g., with Manchester for metabolic services), and while progress is being made, some issues are complex and not easily resolved. CW further emphasised that all risks are being actively managed and none are stagnant.

NA expressed his thanks to the Medicine Division for the significant improvements made in month to improve out of date policies.

Surgery Division
RP presented the Surgery Divisional update and drew attention to a few key points from the report including:
Highlights:-
- The Division had achieved gold accreditation in PICU, HDU, and day case areas; all other areas except one received silver, reflecting high quality of care.
- The Division had introduced VR equipment for dental procedures to reduce the need for general anaesthesia in children.

Challenges:-
- Governance and complaints team faced challenges due to long-term sickness, leaving only two team members, impacting complaint handling.
- Nursing temporary staffing spend remains a challenge, especially in PICU and 3A; deep dives are planned to address drivers and solutions.
- Division have a continued reduction in open incidents over the past six months; 100% compliance with regards to sepsis timeframes.

- Training compliance for medical staff remains below 90%; with ongoing support for Clinical Directors to improve this.
- One grade 3 pressure ulcer occurred leading to updated guidance and prevention measures.
- Progress had been made on Business Continuity Plans (BCPs), with critical care floors completed and ward BCPs being amalgamated for efficiency.
- One complaint was outside the timeframe due to complexity and team sickness.
- Risks are well managed, with no overdue actions.
- NICE guidance compliance is good.
- Patient information leaflet compliance is a challenge; the division are exploring AI solutions and reviewing necessity of leaflets to avoid duplication with national resources.

KB questioned the value of the current complaints statistics, suggesting that with low complaint numbers, broad categories do not provide adequate detail, and queried whether a brief summary of each complaint to enable a better understanding would be beneficial. KB recognised this could increase workload and might duplicate work completed in the Patient Experience Group. KB noted that information on whether complaints are upheld is already available at board level, and that extra detail may not be necessary unless it adds clear value.

NA agreed to consider offline whether information could be exported from Inphase to include meaningful data within future reports. FB highlighted the importance of maintaining confidentiality within reports.

Resolved: NA to review whether required information could be exported from Inphase.

Clinical Research Division
LR presented the Clinical Research Divisional update and drew attention to a few key points from the report including:-
Highlights:-
- A new study amendment checklist had been introduced which had received positive feedback.

Challenges:-
- LR advised of a complex incident where seven patients were recruited to a study that should have been paused; an investigation is ongoing to understand the contributing factors.
- Increased pressure on nursing leads was noted due to lack of standalone governance support and additional workload from new trust meetings and incidents.
- LR advised on plans to review summer staffing to ensure sufficient governance coverage.
- Sepsis training compliance had improved
- A Business Continuity Plan (BCP) tabletop exercise was completed with minor actions outstanding. The division is close to being compliant with BCP requirements, pending database updates
- The Clinical Research Facility (CRF) door issue remains unresolved and is being escalated.
- There had been an increase in protocol deviations, mainly related to inappropriate patient recruitment or interventions outside protocol windows; additional training is planned to address this. LR emphasised the need to address protocol adherence and hopes to report full compliance on BCPs by next month.

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:-
- All business continuity plans are up to date except for the Gender service, which is near to completion; the next focus is on testing these plans through tabletop exercises.
- Recent risk appetite work was presented to the Audit and Risk Committee, leading to upcoming changes in risk categories and closure of some risks; risk tolerance training is being added to divisional risk training modules to ensure ongoing awareness and monitoring.

Challenges:-
- Ongoing challenges exist with infrastructure, particularly coordination between estates, security, health and safety, procurement, and IG; JP plans to work with department leads to clarify processes and create a flowchart to streamline issue resolution and reduce delays.

GM sought assurance that the figures related to restricted interventions had stabilised following a previous spike, noting that the data now appeared unremarkable and sought clarity whether there had been a debrief for staff regarding the incident, including lessons learned and considerations for staff.

JP confirmed that the spike in restricted interventions was reflected in the data, which is always a month in arrears, and advised that the figures were now as expected and trending in the right direction. JP advised that new admissions had a different nature.

JP stated that Sunflower House maintains ongoing debriefs, reflective spaces, and trauma-informed processes for staff, with all incidents reviewed and SBARDs completed

GM acknowledged the ongoing impact of a unit closure in the South and discussed the need for appropriate risk assessments and gatekeeping for new admissions, predicting similar challenges may arise in the future.

JP advised that following the relevant young person's discharge, the leadership team conducted a further review, especially considering the impact of a unit closure in the South, which affects the population at Sunflower House. JP described ongoing work to improve gatekeeping, risk assessments, and understanding challenges for different young people. JP acknowledged GM issue raised regarding predictability of future similar cases.
Resolved: SQAC received and **NOTED** the Divisional Assurance Reports.

25/26/88 Liverpool Neonatal Partnership update

SON presented the Liverpool Neonatal Partnership update and drew attention to a few key points from the report including:-

- Activity and occupancy were below 80% on both sites, with a good reporting culture for incidents.
- There was an increase in sickness rates at the Liverpool Women's site and a smaller increase at Alder Hey; recruitment is on track to fill vacancies by September 2025.
- PDR completion rates are improving; however, they are still below target; turnover is decreasing.
- There is improved high-risk equipment competency tracking and a new deteriorating patient collaborative, especially for low dependency escalation.
- No formal complaints or PALS inquiries in June 2025 with no new risks identified.
- Breast milk at discharge for babies under 34 weeks remains below target, especially at Liverpool Women's, prompting collaborative improvement work which is underway to address this.
- Ongoing risk with infusion pumps at Liverpool Women's due to data not feeding into the Badger system; escalation is in progress but remains unresolved.
- Non-co-location risks, impacting MRI and lab access, are being separated for targeted mitigation; some areas show progress, while others still need attention.
- There has been an increase in moisture-associated skin damage incidents at Liverpool Women's, attributed to less frequent nappy changes in smaller babies; targeted care plans and alternative products are being sourced.
- Three moderate harm incidents occurred, all at Liverpool Women's, with appropriate Duty of Candour and shared learning processes followed.
- NICE guidance compliance for neonatal infection is delayed due to the need for input from maternity teams, particularly for early onset infection guidance.
- SON updated the committee regarding the deteriorating patient collaborative which is a new initiative which builds on previous work at Alder Hey and focuses on low dependency escalation at Liverpool Women's, with support from the improvement team at the Royal.
- Speech and Language Therapy (SALT) recruitment, interviews are scheduled on 6th August 2025, there is one excellent candidate who has applied.

GM inquired about a sepsis-related death at day seventeen; SON confirmed that there had been no lapses in care and that a full review had been completed.

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

25/26/89 Patient Safety Update

NA presented the Patient Safety update and drew attention to a few key points within the report:-

- There is a new paediatric life support course with a focus on decision-making.

- Challenges are noted with the bleep data not being automatically recorded in switchboard for resuscitation bleeps, this issue is being addressed.
- Attendance at the resuscitation huddle had improved to 91% following resolution of data recording issues, though some challenges with resuscitation training compliance remain and will be addressed by the People and Wellbeing Committee.
- There was a noted dip in Sepsis performance, particularly in the Emergency Department, however a reduction in transfers from HDU to ITU was seen as a positive trend.
- The team's implementation of Martha's Rule, with a 10-minute response target which is faster than the national average had been consistently met, and most activations did not indicate patient deterioration, though a few required escalation of care. The committee discussed the need for ongoing refinement in the presentation of Martha's Rule data to better track trends and occupancy. No further questions were raised on this item.

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

25/26/90 Sepsis Quarterly Report

NA presented the Sepsis Quarterly report which included in month data and drew attention to a few key points within the report:-

- Sepsis performance metrics showed a dip, particularly in the Emergency Department.
- Nursing compliance with sepsis training is nearly at target, with only a small gap remaining; medical staff compliance continues to be a challenge with further discussions planned to address this.
- The Power BI dashboard for sepsis data had been delayed due to IT complexities; further escalation and support are planned to move this forward.
- There is an expectation that accessibility and completion of sepsis training would improve, but some groups are still lagging.

KB referred to the status of the Power BI dashboard for Sepsis and sought clarity whether the delays were due to the Sepsis team or IT priorities. CW confirmed that progress is slow due to IT complexity and advised that she plans to support efforts to improve progress. NA suggested linking in with IG who had previously made progress on the Dashboard.

Resolved: SQAC received and **NOTED** the Sepsis Quarterly Report and welcomed an update at the September 2025 meeting.

---- Safe ----

25/26/91 Drugs & Therapeutics Committee Quarterly report

PS presented the Drugs & Therapeutics Committee Quarterly report and drew attention to a few key points within the report:-

- Reporting Structure & Annual Report: PS advised that reports had been used in place of a separate annual report; future consideration would be given to a consolidated Annual Pharmacy report encompassing optimization strategy, DTC, and safety.
- Patient Safety & Risk Register: Patient Safety Strategy Board is now focusing on time-critical medicines, with a new dashboard in development. No risks over twelve remain on the register; one outpatient pharmacy risk was closed, and a new risk regarding fingerprint access to electronic medicine cabinets had been added, however this is expected to be resolved soon.
- Controlled Drugs & Incident Learning: With ongoing work to report learning from a controlled drug diversion incident to the Executive Team.
- Committee Reporting Format: Adoption of an A3 summary reporting format for subcommittees (e.g., Non-Medical Prescribing Committee), improving clarity and milestone tracking.
- Non-Medical Prescribing: Considerable progress has been made; all records are now electronic, replacing previous paper-based systems.
- Controlled Drugs Compliance: Visual reporting now highlights compliance trends; Medicine division shows improvement, and the Surgical division have many Green areas, with focus on addressing remaining Amber/Red areas.
- Medicine Shortages remain stable and are being managed as business as usual, with no critical medicines running out.
- Propofol Incident: An incident involving propofol being taken offsite was addressed; consideration is being given to improved storage solutions in theatres with new electronic cabinets.
- Committee Membership: Recruitment of new doctor members to MMOC is a priority, with plans to engage clinical directors for support.

Next Steps

- Continue refining reporting formats and dashboards.
- Progress actions on risk mitigation and incident learning.

- Develop a comprehensive annual pharmacy report for future cycles.
- Address committee membership gaps and storage solutions for high-risk medicines.

PS expressed his thanks to NA for ongoing support with regards to DTC Committee.
GM inquired about the propofol incident, noting its potential for abuse and requested clarification regarding this incident.
PS advised that propofol, while not a controlled drug, was taken offsite by an individual who had since been supported and dealt with appropriately. PS stated that improved storage - potentially via a dedicated cabinet in theatres with electronic access would be considered to enhance control and traceability of propofol in the future.
FB referred to the recruitment process for new doctor members to the MMOC, emphasising the importance of broad medical representation and inquiring whether divisions are supporting and promoting these opportunities. FB stated that PS should seek support from Clinical Directors to address this

NA expressed his thanks to PS for the ongoing improvements.

SQAC were supportive of receiving a consolidated annual Pharmacy report which would be beneficial for future reporting cycles. PS would liaise with NA offline to agree the format/content of the Annual report.
Resolved: SQAC received and **NOTED** the Drugs & Therapeutics Committee Quarterly Report

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

25/26/92 **Transition to Adulthood Annual Report**

JP presented the Transition to Adulthood Annual Report and drew attention to a few key points within the report:-

- There had been significant progress in mapping transition pathways across all divisions and improved engagement with specialist teams.
- The leadership for transition now lies within the complex care support team, with a focus on collaborative working and data-driven validation of outpatient pathways for patients aged 18+ under multiple specialties.
- The team identified and validated cases with open pathways, leading to improved data accuracy and patient flow, and is seeking additional support for ongoing validation work.
- A thorough review of transition processes, policies, and frameworks was completed, with a shift toward shared responsibility and away from adults remaining in paediatric care.
- The report noted enhanced external collaboration, the creation of a SharePoint resource, and the development of user-friendly materials for young people and families.
- Next steps include a trust-wide communication strategy, further Meditech integration, and ongoing evaluation of patient experience and outcomes post-transition.

FB commended the progress made within the Transition to Adulthood Annual Report, emphasising the importance of embedding cultural change, maintaining external collaboration, and monitoring responsiveness from partner services to sustain improvements. FB congratulated JP and the team for their achievements and highlighted the need to escalate issues if external support is required.

NA acknowledged the significant progress made, noting the challenges JP had faced in organising data, policies, and processes, NA stated that the report has clarity and cohesiveness, recognizing the team's hard work and the report's value in demonstrating progress.

KB acknowledged the substantial improvement in the Transition report, referencing previous challenges and expressing appreciation for the clarity and ease of reading the current report. KB asked whether there had been any increase in experience issues, complaints, PALS, or incidents related to transition. JR advised that a new incident category had been introduced to better capture this data, with plans for more robust evaluation. KB suggested including clear goals, aspirations, and timelines for the transition work to help the committee provide oversight and support, especially given the interdependencies and resource needs. JP agreed to take this forward.

LR highlighted the stark improvement in the Transition report and suggested benchmarking with other centres or conducting a service evaluation to determine if Alder Hey is leading in this area. LR

proposed sharing the findings with CHA members or considering publication if benchmarking reveals Alder Hey is ahead of other trusts.
JP advised that benchmarking had not been extensively undertaken due to the complexity and variability across organisations and expressed a willingness to discuss this further offline with LR to explore potential comparative work.
Resolved: SQAC received and **NOTED** the Transition to Adulthood Annual Report

25/26/93 Update on Mitie: Facilities Management Responsiveness and performance progress update
LO presented performance progress update

- LO advised on the theatre performance improvement workstreams: implementing a new target operating model, increasing visibility of reactive repairs, and enabling local temperature control via ward dashboards.
- There had been a significant investment made in staffing, with most key roles filled and a focus on onboarding and retention through enhanced induction processes.
- Progress on reactive repair visibility is ongoing, with technical challenges in reporting by department; collaboration with the BI team was suggested to improve dashboard access and transparency.
- The ward BMS dashboard for local temperature control is in testing, with plans to pilot in theatres pending IT support for access.
- The target is to close out all improvement items by October 2025, though the timeline for repair visibility remains uncertain.
- A follow-up report to SQAC is scheduled for November 2025 to review progress and data transparency, with support offered from AB for BI integration.

FB sought clarity regarding the timeline for restoring a good service. LO stated that service levels are already high, with further improvements expected from new staff and onboarding processes.
FB requested a follow-up report in November 2025 to review progress.
AB endorsed the November timeline and emphasised the need for greater transparency in repair data by area, suggesting collaboration with the BI team to enhance dashboard access and reporting. AB offered his support for connecting with senior BI colleagues if required. LO welcomed AB suggestion, noting that a main dashboard could be used for BI team extraction and local reporting.
Resolved: SQAC received and **NOTED** the Update on Mitie: Facilities Management Responsiveness and performance progress update and welcomed a further update in November 2025.

---- Caring ---
---- Effective ----

25/26/94 Clinical Effectiveness and Outcomes Board Chairs Highlight report
NA presented the Clinical Effectiveness and Outcomes Board Chairs Highlight report

- There had been significant improvement in audit compliance, with 90% of documents for Medicine, Research, and Corporate areas now compliant. Further work is required within Community & Mental health Division and the Division of Surgery to reach compliance targets.
- A new process is being explored for patient information leaflets, aiming to reduce in-house leaflets by using national resources (such as NHS Choices) as the default, which should improve compliance and reduce the administrative burden. The initiative involves collaboration between governance, divisional teams, and patient experience

Resolved: SQAC received and **NOTED** the Clinical Effectiveness and Outcomes Board Chairs Highlight report

25/26/95 Board Assurance Framework
NA presented the Board Assurance Framework and drew attention to a few key points within the report:-

- The Board Assurance Framework (BAF) had been updated with the usual monthly changes, including work on external financial pressures and their potential impact on quality and safety.
- NA advised that a significant amount of staff time is currently dedicated to the Southport enquiry review and external ICB commitments, which is impacting the organisation.
- NA confirmed that the risk appetite and tolerance work would be brought to the September meeting for further discussion.
- SQAC **NOTED** the closure of Risk 1.5

Resolved: SQAC received and **NOTED** the Board Assurance Framework

25/26/96 Clinical Audit Assurance Report
NA presented the Clinical Audit Assurance Report

- 6% of audits were closed within the month and 62% are currently on trajectory
- Several audits are delayed or have experienced slippage; NA advised on the need for divisional teams to refocus efforts to move these forward.

NA offered to address any questions relating to the report. KB advised that she liaise with JP offline regarding any queries she has.
Resolved: SQAC received and **NOTED** the Clinical Audit Assurance Report

---- Effective ----
---- Well Led ----

25/26/97 **Coroners Statement of Events Guidance and Template**
NA introduced the standardised guidance and templates for statements of events, particularly for coroner's inquests and similar inquiries, to address inconsistencies in support and information provided to staff.
- The materials consolidate national and local best practices to ensure a consistent approach across the organisation.
- The guidance and templates were presented for committee approval, having already been reviewed by the Clinical Risk group.

FB suggested that, after initial use and feedback, the resources could be shared with other organisations facing similar needs. NA confirmed that he would update the team as appropriate.

SQAC received, **NOTED** and RATIFIED the Coroners Statement of Events Guidance and Template

25/26/98 **Incident Communication Plan**
Resolved: SQAC received, **NOTED** and Ratified the Incident Communications Plan

25/26/99 **Business Continuity Plan**
Resolved: SQAC received, **NOTED** and Ratified the Business Continuity Plan

25/26/100 **HazMAT CBRN Plan**
Resolved: SQAC received, **NOTED** and Ratified the HazMAT CBRN Plan

---- Well Led ----
---- Any Other Business ----

25/26/101 Any Other Business
NA advised that the phase two recommendations from the Fuller inquiry had been published. NA confirmed that an action plan is being developed over the summer period, with a meeting planned with key personnel to review requirements and prepare a paper for September or October 2025. NA provided assurance that the organisation is largely compliant due to previous work, with only minor changes needed. SQAC welcomed an update for September/October 2025.
FB reminded the committee that in August, a data pack would be issued instead of a meeting unless something significant arises. FB encouraged SQAC to review the data pack and raise questions or request a meeting if necessary.
FB thanked the committee for their hard work and wished colleagues a good break over the summer period.

---- Board Assurance ----

25/26/102 The key assurances and highlights report was presented to the Board meeting held on 5th June 2025.

Date and Time of Next Meeting: 24th September at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 2nd October 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 August and September 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. Through our work in SALS, OD and across People Services we are continuing to hear reports of lowered morale across the organisation with staff in frontline clinical and administrative roles reporting ongoing and increasing stress and vulnerability related to the NHS financial environment. Referrals to SALS continue to be high with presenting issues increasingly related to the impact of the financial environment. Staff describe how an attitude of scarcity affects how they are managed with notable impacts on reasonable adjustments. The reality and perception of reduced resource directly impacts how well staff feel supported and is contributing to the rise in stress, and sickness, and decline in morale. The risk in this context is that kindness and compassion suffer as peoples' capacity to think about others recedes.

Contributing to our collective emotional state is the rise in racism and division in our communities. This is being felt directly and indirectly amongst our staff and is featuring more prominently in the concerns and struggles that staff bring to SALS and across our People Services, reflecting increased moral distress.

Talking about what is happening and hearing the impacts for our staff continues to be critical in this context. 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 engagement and consultation sessions for the new values programme are proving to be an additional and invaluable source of listening to staff, offering compassion, hearing their concerns and taking intelligent action.

We have held 35 individual team or service conversations (comprising approximately 550 staff) with 17 more planned to date. As well as feeding back their views about the values and how they can be translated into action, staff have taken the opportunity to talk about how they are feeling and what support they might need to cope with the current challenges. For those teams who are struggling, the new values are received with less positivity and for some feel that they jar with their current lived experience of work. We are taking the opportunity to role model the values in action in the delivery of these sessions and the action that we take in response to their feedback.

We need to continue 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. The developing Connected Leadership approach is a key part of this 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 (launched on the 19th September).

3. Education, Learning & Development

Reflective of both the NHS 10-year plan, and our own strategic clinical priorities, work continues to ensure 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 launched 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 on four key themes; project work and group support sets. Project activity and outcomes will be shared with Exec's and project sponsors in November 2025. There is the intention of a second cohort commencing in January 2026 and interest from the wider workforce from an attendance perspective, is visible.
- 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 five masterclasses launch in October 2025, linked to leadership and management, values and associated topics. Reflecting insights arising from both the annual TNA and wider qualitative discussions (see previous section relating to staff morale), commencing October 25.
- As part of 'futures' activity, the L&D team, Innovation team and Alder Hery Charity are working in partnership to create a funding pathway for job roles that are unable to utilise NHSE CPD monies. Due to the funding roles Nursing and Allied Health Professional roles are the only groups who can access CPD funding. A new approach is due to launch in October 2025.

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.

On 29th August 2025, an Improving Resident Doctors Working Lives framework was released in the form of a ten-point plan from NHSE. The Medical Education team are working on ensuring this is adopted within the timescale requirements.

Changes to Apprenticeships

As previously highlighted, 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 September 2025 is 6.5% (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

The HR team have temporarily restructured to enable the release of 3 HR team members, to focus solely on addressing sickness absence. This is currently established and will remain in place until at least December 2025 with the potential to run until the end of the financial year.

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.

4. Establishment Control Measures

Total Workforce WTE (whole time equivalent) has continued to be scrutinised both internally and externally.

The 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 August 2025 (month 5).

Table 5.1

	Actual	Actual	Actual	Actual	Actual	Actual
	M12 24/25	**M01 25/26**	**M02 25/26**	**M03 25/26**	**M04 25/26**	**M05 25/26**
Substantive	4,136.71	4,079.84	4053.46	4051.37	4054.61	4054.49
Trainees	178.20	172.86	165.21	169.41	163.97	178.97
Bank	140.71	101.17	98.54	91.03	94.18	88.69
Agency	8.11	6.49	4.64	5.69	5.76	4.61
Total Workforce	**4,463.73**	**4,360.36**	**4,321.85**	**4,317.50**	**4318.52**	**4326.76**
Plan	4,273.40	4,481.85	4,490.85	4486.16	4454.36	4418.86
Difference	***-26.27***	***92.85***	***169.00***	**168.66**	***135.84***	***92.10***

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.

Several control measures have been put in place to address the gap and reduce both WTE and pay costs which include:

- Reduction of temporary premium spend through tighter controls and executive oversight
- Review of Bank payments to align with Cheshire and Merseyside rates
- Recruitment Pause for all recruitment into corporate and managerial non-patient facing roles paused until March 2026.
- A 50% reduction in new starters until 31st March 2026
- Mutually Agreed Resignation Scheme (MARS) open until 31st October
- Reduction of sickness absence rate by 1%. A dedicated team (from within HR) specifically to support with absence across the Trust has been created to support absent colleagues return to work

The controls are monitored weekly through the workforce establishment group as well as the strategic Financial Improvement Programme.

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, 2nd October 2025

Paper Title:	**Chair's Report from The People Committee meeting held on 25th September 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.

- Internal Communications Update:
- Strategy People Update – Key People Issues
- Trust/Divisional Metrics Update
- Staff Survey Action Plan – Progress:
- Closing the Gap: Workforce Efficiencies
- Equality, Diversity & Inclusion Update
  - WRES/WDES/Ethnicity Pay Gap Reports
  - Equality Objectives
  - New QEIA Process
  - General Update
- Board Assurance Framework: Monitoring of Strategic Workforce Risks
- Terms of Reference – Education Governance Committee
- Policies for Ratification:
  - Medical Appraisal & Revalidation Policy – ***APPROVED (Subject to changes)***
  - Apprenticeship Policy – ***APPRVOVED***

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

- The communications department has identified gaps in how we evaluate and analysis our communications, particularly noting the emphasis on internal comms. Rebecca Murphy is now reviewing internal communications as this has not been done recently and will come to the next committee meeting with a plan as to how we do the evaluation to give assurance that our messages and plans are being heard - and to identify audiences who may not be engaged.
- A forum has been set up to look at the impact of reasonable adjustment provision across the Trusts, bearing in mind the number of requests being brought and the impact this has on particular teams.
- The work going on to look at long-term sickness continues, and we discussed how the focus on the HR processes behind each case should not obstruct a conversation in teams affected about other issues there may be, or about the need to deliver a service in a different way because of high sickness rates.
- The WRES report was discussed, and although a great deal of progress has been made, the increase in reports of discrimination was noted, with an action for the People team to provide anonymised case studies, showing how the Trust takes vigorous action when dealing with cases of racial discrimination, to demonstrate how seriously it is taken.
- The increasing number of long-term sickness cases is challenging our operational capacity and leading to a higher dependence on temporary staffing. To address this HR senior leaders are focusing on sickness management, providing targeted support for managers, and implementing proactive staff vaccination campaigns in preparation of winter.
- Recent changes in immigration laws are posing a threat to the employment of staff on visas, especially within the community and medicine divisions. To address this issue, we are consulting immigration specialists, exploring alternative visa options, and engaging support networks to assist all affected
- To address financial deficits, we must reduce our headcount by 100 whole-time equivalents by March. This decision comes with inherent risks to both service quality and staff morale. To mitigate these risks, we will pause recruitment for non-patient-facing roles, review fixed-

term contracts and reduce temporary staffing. Clear communication with managers will be essential to explain the rationale and process for these reductions.
- Reported cases of discrimination and harassment have risen, significantly affecting minority staff and potentially impacting both retention and overall wellbeing. To address this, we are focusing on anti-racism initiatives, conducting policy reviews, launching communication campaigns, and sharing anonymized outcomes of formal cases to build trust in our reporting processes.
- The recent decline in mandatory training figures appears to be linked to changes in reporting requirements and system notifications. We are currently reviewing the system functionality to enhance reminder accuracy, increase communication efforts, and support staff in maintaining compliance.

4. Positive highlights of note

- Successful staff awards evening with over 500 nominations, strong sponsorship, and plans to share nominee stories throughout the year to maintain recognition and morale.
- Divisions are consistently maintaining high compliance rates for mandatory training. Efforts are ongoing to resolve system issues and enhance reminder processes.
- Notable reduction in agency and temporary staffing spend year-to-date, especially in surgery division, reflecting effective workforce controls.
- Significant improvement in appraisal compliance rates, with a 30% increase compared to the previous year.
- Positive progress in six out of nine WRES indicators and nine out of ten WDES indicators, plus launch of the first ethnicity pay gap report and new leadership programmes for internationally recruited staff.
- Launch of a mutual mentoring programme with 30 members, supporting development and cross-network collaboration.
- Enhanced internal communications strategy, including new trust values, lanyard design, and involvement of children and young people in design processes.
- Approval and publication of new equality objectives and a revised equality impact assessment process to strengthen governance and support staff.

5. Issues for other committees

- **Safety and Quality Committee (SQAC)**: Stress and workforce reductions are beginning to impact divisional safety and quality, particularly in the medical division. SQAC is monitoring these risks and engaging with divisional leads to assess coping strategies and potential impacts on patient safety.
- **Risk Management Forum**: There is a need to aggregate and review the medium- and long-term impacts of workforce reduction decisions, including how these changes affect service sustainability and risk profiles. Plans are in place for an extraordinary session to address this.
- **Audit Committee**: System issues affecting mandatory training notifications and compliance tracking may require review of internal controls and assurance mechanisms.

6. Recommendations

The Board is asked to note the Chair's Highlight report for the People Committee meeting that took place on 25th September 2025.

Alder Hey Children's NHS Foundation Trust

People Committee
Minutes of the meeting held on 24th July 2025
MS Teams

Present:

Jo Revill	Non-Executive Director **(Chair)**	(JR)
Adam Bateman	Deputy Chief Executive & Chief Operating Officer	(AB)
Fiona Beveridge	Non-Executive Director	(FB)
Garth Dallas	Non-Executive Director	(GD)
Chloe Lee	Associate Chief Operating Officer – Surgery	(CL)
Sharon Owen	Deputy Chief People Officer	(SO)
Melissa Swindel	Chief People Officer	(MS)

In attendance:

Kathryn Allsopp	Associate Director of People	(KA)
Katherine Birch	Director, Alder Hey Academy	(KB)
Jade Carr HRBP	Corporate & Research	(JC)
Joe Fitzpatrick	Internal Communications Manager	(JF)
Katie Jones	Head of Operational HR	(KJ)
Jill Preece	Governance Manager	(JP)
Nikita Pritchard	Interim Ass Chief Operating Officer – Medicine	(NP)
Christine Pope	General Manger – Surgery	(CP)
Jo Potier	Associate Director of Organisational Development	(JP)
Neil Thomas	Acting Health & Safety Manager	(NT)
Kerry Turner	FTSU Guardian	(KT)
Sarah Leo	Associate Chief Operating Officer – Research	(SL)
Pauline Brown	Nursing Director	(PB)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Apologies:

Nathan Askew	Chief Nursing, AHP and Experience Officer	(NA)
Darren Shaw	Head of Organisational Development	(DS)
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)
Sian Calderwood	Associate Chief Operating Officer - Medicine	(SC)
Erica Saunders	Chief Corporate Affairs Officer	(ES)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
Alfie Bass	Chief Medical Officer	(AB)

24/25/122 **Declarations of Interest**

No declarations were declared.

24/25/123 **Minutes of the previous meeting held on 22nd May 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.

24/25/124 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

The Committee received and noted the contents of the Board Assurance Framework.

The Committee conducted a review of three updated workforce-related risks within the board assurance framework, concentrating on risk appetite, thresholds, and controls. The discussion was facilitated by JP, with contributions from SO.

JP informed that the group had evaluated the criteria for closing risks with scores below a specified threshold (8-9) on the workforce risk register, reiterating that only higher priority risks should be retained on the board assurance framework (BAF).

There was a request for confirmation that all safety concerns would still be escalated appropriately and for clarity on whether post-mitigation risk scores were being used for decisions. Attention was given to ensuring that safety and quality issues removed from the register are appropriately captured and monitored through other mechanisms.

JR asked for assurance that closing lower-level workforce risks would not result in quality issues being missed and wanted clarity on how such risks would be monitored elsewhere. Assurance was sought regarding the escalation of safety concerns and the continued management of the workforce sustainability risks not directly related to patient safety (sickness and stress) in alternative forums.

The Committee resolved to maintain existing risk thresholds, recognising the evolving financial climate but deeming the current approach suitable. Due to national financial pressures and increased scrutiny, the overall risk score was raised from 12 to 16. Further updates were made to controls and actions, including references to financial improvement initiatives and workforce efficiency programmes. The risk description was expanded to address the impact of financial pressures on organisational stability and prospective losses. Controls now encompass new establishment reviews, a three-year workforce plan, and alignment of actions with the ICB.

It was clarified that the risk pertains specifically to workforce EDI and does not extend to broader organisational EDI matters. The Committee discussed the potential need for a separate organisational EDI risk in the future, particularly to address patient-facing equality issues. Staff networks and effective communication were recognised as key controls, with emphasis on integrating EDI into organisational culture. Controls for each identified risk were comprehensively reviewed and enhanced, with additional measures implemented to address gaps such as improved communication, targeted training, and strengthened monitoring processes.

The Committee concurred with the revised risk scores and updated controls and endorsed the continuation of the current approach to managing the risk register.

Further work will focus on developing the talent and succession planning framework and evaluating the introduction of a broader organisational EDI risk.

The Committee was asked to approve changes to the return-to-work KPI with Non-Executive Directors seeking clarity on the rationale and implications.

Non-Executive Directors requested support would be given providing assurance that the process for resolving overpayments was robust and that accountability was in place for significant errors

Resolved: The Committee noted the contents of the Board Assurance Framework

24/25/136 **Board Assurance Report**

The Committee received and noted the contents of the Board Assurance Report.

Resolved: The committee noted the contents of the Board Assurance Report.

24/25/125 **Internal Communications Update**

The Committee received the Internal Communications update report. JF drew the committee's attention to the following:

The committee reviewed the implementation of the new values process within the Staff Awards. It was noted that feedback received indicated that linking recognition initiatives with organisational values were both effective and well-received by the judging panel. A communications plan is in place for the new values, including engagement sessions and a formal launch.

Award sponsorship was also discussed, emphasizing the importance of ensuring sponsors align with organizational values. JF noted most primary sponsors are internal stakeholders/existing suppliers, it was recommended that the sponsor vetting process be clearly documented to address any potential future concerns.

The Communications plan was evaluated during the financial improvement plan. Weekly updates continue to share decisions and cost-saving efforts. The current focus is to incorporate financial messaging into broader transformation communications, emphasizing that organisational change extends beyond financial matters alone.

The Committee assessed the response to a recent measles outbreak, noting the effectiveness of external communications and media engagement efforts. Internally, information was disseminated through multiple channels. The Communication Team continue encouraging staff to serve as public health champions and advocates for vaccination was recognized. Efforts are being made to provide additional opportunities for staff to ask questions and share concerns, rather than solely receiving information. Plans include organizing further engagement sessions and enhancing the visibility and accessibility of leaders.

The committee acknowledged the challenge of balancing transparency regarding financial pressures with the need to maintain morale and staff engagement. Ongoing efforts remain focused on ensuring that communications are reciprocal and responsive to staff needs.

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.

The committee reviewed plans for upcoming industrial action, including measures to maintain patient safety and limit service disruption. Contingency plans are set in place for the next five days.

Industrial action will commence at 7am Friday, 25th July to 7am Wednesday, 30th July 2025.

NHS England will announce clearer and more cohesive guidance on staff derogations than in previous strikes. The committee emphasized supporting colleagues during this period, with support sessions beginning that afternoon.

A new partnership agreement was reached with trade unions following appropriate consultation to update roles and responsibilities and streamlining processes. The committee observed a more collaborative approach from new union representatives.

Resolved: The Committee noted the contents of the People Plan update.

24/25/127 **Trust Wide Metrics**

The Committee received and noted the contents of the Trust Wide Metrics report (June 2025) data. SO drew the committee's attention to the following:

The trust-wide metrics were reviewed, with mandatory training compliance remaining consistently high. Key challenges identified included workforce efficiency and sickness absence, both of which are addressed in separate reporting. The committee resolved to prioritise divisional updates, allowing for more comprehensive discussions on local progress and areas requiring attention.

Sickness Absence Update:
As of June 2025, sickness absence across the trust stands at 5.8%, remaining above the trust target, which has been reduced for the current year. There has been a shift in the profile and underlying causes of sickness. The team analysed the first quarter data from the current and previous financial years, specifically examining categories with significant changes rather than only those with the highest rates.

Absence due to anxiety, stress, and depression has shown an increase in terms of days lost however, as a proportion of total absence, this category has overall decreased.

Enhancements to Return-to-Work Processes:

- All return-to-work discussions are now required to be documented in the roster system, with manual reconciliation to ensure precise reporting.
- New materials place greater emphasis on health, wellbeing, and reasonable adjustments.
- It was proposed return-to-work conversation compliance move from a monthly to a rolling 12-month measurement to reflect sustained improvement efforts. Implementation is scheduled for September 2025 to allow adequate time for system updates.

A new Occupational Health Provider commenced in May 2025, delivering faster access and receiving positive initial feedback. Non-Executive Directors sought assurance that

the new occupational health providers approach to work related stress referrals would not leave colleagues unsupported and that managers understood their responsibilities. Assurance was given explaining notable differences exist in the approach to managing work-related stress cases compared to the previous provider.

The Committee observed a reduction in bank spend associated with sickness absence. Divisional analysis reported absences correlated with current operational pressures. Further analysis is well underway to determine whether elevated rates primarily relate to stress/anxiety or other factors.

Long-Term Absence Management
Employees unlikely to return to work due to long-term health conditions will be supported by occupational health input guiding those decisions and timelines.

The trust is implementing a 90-day improvement initiative, supported by East Cheshire, aimed at addressing sickness absence. This plan focuses on mental health resources, training, and appreciative inquiry, with the objective of identifying effective practices and areas for enhancement.

Approval was sought from the committee to adopt the proposed change in return-to-work KPI measurement, transitioning from in-month to a rolling 12-month assessment beginning in September 2025.

Resolved: The Committee received Trust Wide Metrics Report.

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (June 2025) data and noted progress to date.

The committee acknowledged receipt of the written report with no additional discussion or questions regarding the divisional update.

Resolved: The Committee received the metrics for the Community and Mental Health Division.

Medicine

The Committee received the Medicine Division metrics report (June 2025) data and noted progress to date. NP drew attention to the following:

- **Sickness absence:** Long-term sickness has decreased improving team performance. Short-term sickness shows a slight increase but remains stable. Action is in place in preparation of ahead of winter planning.
- **Return to work:** Documentation completion repots approx. 60% range, with improvement efforts ongoing to maintain.
- **PDR:** Medical appraisals and overall rates have improved for band 7+ Compliance continues to be targeted and completed by end of July 2025 with regular monitoring.

- **Workforce Efficiencies:** Bank spend reduced from £256k from (June 2024) to £63k in (2025), yet premium costs remain high in hard-to-recruit specialties like microbiology, pharmacy, labs, and radiology. Senior Leaders continue to monitor effectively.
- **Recruitment Challenges:** Technical roles across various departments are facing recruitment difficulties due to national shortages. Pharmacy Leaders are considering a seven-day shift implementation to maintain service provisions.
- **Radiology:** Meetings are taking place to implement changes aimed to enhance workforce stability.
- **Overtime & Local Rates:** Overtime and local rates continue in pharmacy, labs, and radiology departments with steps underway to address all areas of concern.
- **Training & Support:** HR/Operational Leaders are actively collaborating to meet workforce needs to support colleagues across the organisation.

Resolved: The Committee received the metrics for the Medicine Division.

Clinical Research Division

The Committee received the Surgery Division metrics report (June 2025) data. SL highlighted the following:

- Overall people metrics indicate stability, with no major concerns reported. One outstanding PDR is scheduled to carry over into August 2025.
- **Workforce Initiatives:** The integration of internationally recruited nurses into research has led to greater diversity, as the BAME workforce increased from 12% to 23% over a two-year period This initiative is attributed to the head of nursing and is under consideration for wider implementation.
- **Collaboration:** Further work continues to align all data and initiatives between research and innovation sectors.
- **PDR Compliance:** Band 7 and above compliance has improved to 75% to date with remaining appraisals scheduled to be completed by the end of July 2025. Outstanding cases are primarily linked to sickness absence.
- **Sickness Absence:** Sickness absence rose to 6.1%, mainly due to long-term sickness in recovery and theatres department. A detailed review determined that cases are managed with HR support, with themes and actions currently in development.
- **Bank & Overtime:** Bank spend shows an increase, particularly in Theatres due to sickness-related absences. Overtime is being monitored, with 37% attributed to covering sickness.
- **Vacancies & Maternity Leave:** Actions continue to address vacancies, aiming for a 50% reduction by September 2025. There shows a recent increase in maternity leave (under 50 WTE) and a total of 30 WTE vacancies, with ongoing efforts to maintain an appropriate balance.

- **Service Review & Workforce Planning:** Steps are being taken to align the workforce with upcoming service needs, such as extending sessional work and supporting staffing levels according to demand.
- **Staff Survey:** Staff survey completion rates have increased, and divisional commitments are being set based on this feedback.
- **Weekend/Out of Hours Working:** Discussions continue regarding weekend working and service modifications, with recognition that these topics may become significant within the three-year strategic vision and workforce plan.
- **Collaboration on Service Model:** There is a focus on defining optimal service models and addressing service challenges collectively.

Resolved: The Committee received the metrics report for the Clinical Research Division.

Surgery Division

The Committee received the Clinical Research Division metrics report (June 2025) data and noted progress to date. CP highlighted the following:

- **Sickness Absence**: Long-term sickness cases were conducted, showing that they are being managed appropriately with HR assistance identifying areas that could be improved. Further focus is analysing the effects of recent changes in theatre working patterns on staff well-being and sickness rates.
- **Bank & Agency:** Monitoring of bank and overtime usage, especially in theatres, is ongoing to manage sickness cover efficiently.
- **PDR:** Actions are being developed and implemented based on themes identified from the sickness review to support staff and help reduce absence.

Resolved: The Committee received the metrics for the Surgery Division.

Corporate

The Committee received the corporate metrics report (June 2025) data and noted progress to date. MS drew the committee's attention to the following:

- **Mandatory Training:** Mandatory Training compliance remains high Mitigations remain in place to manage effectively across services.
- **Workforce efficiency:** Deep dive into sickness absence remains a key focus.
- **Sickness absence** MS indicated that divisions would provide specifics while the overview stays high-level for committee assurance.

Resolved: Committee received the Corporate Services Metrics Update.

24/25/130 **Values – progress Update**

The Committee received and noted the contents of the Values progress update.

The organisation has established new values and defined at high level. These will be gradually incorporated across the organisation. Alder Hey priorities include developing a communication plan and initiating board engagement and consultation process. Staff participation will be sought in creating a practical framework for implementing these values, including providing toolkits and training.

- A formal announcement of these values took place during the executive session, and the engagement plan has been prepared. The official rollout is planned for the staff awards event in September 2025.
- Colleagues can schedule in sessions with our Values Leads using the provided QR code available on posters across the trust. Several Teams have initiated contact to engage further which show positive feedback.
- An action subgroup focused on values work includes an EDI presentation.

All efforts will concentrate on promoting the values, building the supporting framework, and encouraging broad organisational involvement.

Resolved: The Committee received the Values progress Update.

24/25/128 **Raising Concerns FTSU Update**

The Committee received and noted the content of the Raising Concerns Freedom to Speak Up Update. KT drew he committees' attention to the following:

Concerns raised via the FTUP process route continues to grow, with data up to Q4 - Q1 will be reported in August/September 2025. Data is categorized by staff group and theme, with plans to add division-level breakdowns.

Anonymous cases are rising, which may reflect increasing confidence but complicates resolution due to limited feedback options. Alder Hey remains a leading reporter in the North-West, indicating staff comfort in raising issues, as supported by positive staff survey results.

The FTSU Visibility Programme remains ongoing, and senior leaders participation in ward visits. The Speak Up App has now launched but remains in early stages. Ward Managers and department leads are seeking FTSU support which is casting a positive trend. Efforts are underway to monitor post-case detriment, with integration planned for app-based follow-ups.

The Deputy FTSU guardian role has been advertised with planned date for interviews.

KT highlighted to the committee that managing anonymous cases remains challenging, as national guidance favours anonymity but lacks solutions for practical difficulties. An initial review is being planned to create a framework for handling these concerns and communicating the impact of anonymity. KT remains in connection with HR Leaders with the aim to improve data quality, particularly for cases involving multiple people. The new deputy role will focus on data analysis and advancing the FTSU function.

Resolved: The Committee received the Freedom to Speak Up Update.

24/25/131 **Nursing Workforce Report**

The Committee received and noted the contents of the Nursing Workforce Report. The Nursing Workforce report was shared for information purposes.

A new joint nursing and allied health professions (AHP) workforce and education strategy has been introduced, covering the period until 2030.

Recruitment practices have been adjusted due to low vacancy rates (below 2%). The trust now recruits to actual vacancies as well as a buffer for maternity leave, rather than recruiting all successful candidates.

A recruitment event was held, and applicants will be notified of the outcome.

National evidence-based acuity tools have been implemented where feasible, including in children and young people's wards and emergency departments. The trust is participating in audits for future versions of these tools.

Ongoing work supports newly qualified nurses, focusing on clinical supervision and professional development during their preceptorship.

The new strategy will integrate nursing and AHP workforce planning and development. Feedback was recorded for the March 2025 race quality recruitment event, which resulted in the recruitment of healthcare assistants and was identified as an outreach initiative.

Resolved: The Committee received the Nursing Workforce Report.

24/25/130 **Organizational Design Project Initiation Document (PID)**

The Committee received the organisational design project initiation document Update.

SP described the document as a dynamic base document for the collaborative, intended to develop alongside clinical collaboratives and ongoing transformation work. This document outlines the project team, workstreams, and the approach to supporting transformation and Vision 2030.

Identified workstreams include:

- Culture & Organizational Effectiveness includes values initiatives led by JP.
- Leadership & Workforce Efficiency is focused on workforce efficiencies led by SO, including four major reviews.
- Skills for the Future is led by KB, the workstream addresses learning and development needs arising from clinical transformation and ensures robust staff development processes.
- Governance and Accountability is currently paused due to other priorities.

The collaborative is responsible for identifying efficiencies and savings across all staff groups, including but not limited to administrative or support services, in alignment with national requirements and internal financial considerations.
Progress and next steps:

Data collection for the leadership and management review is ongoing. All areas, including laboratories and pharmacy, are subject to efficiency review.

The collaborative will report progress to this committee, the strategy board, and the board. The pace of work will vary by area based on content and complexity.

It is acknowledged that administrative and support staff may feel notably affected by efficiency initiatives however, the review process encompasses all staff groups.

The project is characterized by a broad scope and emphasizes the importance of evidence-based decision making.

Resolved: The Committee received the Organisational Design Project Initiation.

24/25/133 **Overpayments**

The Committee received and noted the contents of the Overpayments update. KJ drew the committees attention to the following:

There has been an increase in both overpayment volumes and values at the start of 2025 compared to 2024. In recent months, several overpayments have exceeded £5k, with the highest around £25k, primarily resulting from late notifications of change allowances. Over the past three months, there were 53 overpayments; 55% were attributed to late notifications of changes, mainly by managers, with others originating from payroll or data corrections.

In 2024, the trust's overpayment ranking ranged from 5th to 9th among peers; current year data is under review. Overpayments are regularly reviewed in payroll and HR governance meetings, where actions are tracked, and notification letters are issued to the managers responsible.

Process Improvement & Communication:

- The Managers central guide now includes pay processes.
- Payroll deadline reminders and manager responsibilities are communicated through email and team channels.
- Detailed overpayment data is provided to divisional leads for local action.

Training sessions have been conducted, but 21% of overpayments involved resident doctors and consultants, indicating the need for more targeted training.
Resolution & Recovery:

- Guidance for recovering overpayments is available on the intranet.
- Payment plans are arranged for staff facing financial hardship.
- Processes for addressing historic overpayments have been reinforced in collaboration with finance.

Pay for medical staff is complex, leading to some overpayments linked to misunderstandings regarding payslips or contract changes. Induction and support materials are being considered to address these issues.

Further accountability for significant overpayments and additional process improvements, including possible automation, may be required. The team will provide updates following continued assessment of potential solutions.

Resolved: The Committee received the Overpayment Update.

24/25/134 **Workforce Efficiencies**

The Committee received and noted the contents Workforce Efficiencies update.

The Workforce Efficiencies Programme, chaired by SO and reporting to the Improvement Programme Board, is dedicated to minimising whole time equivalent (WTE) premium expenditure—including bank and overtime costs—while maintaining productivity and achieving financial savings.

This initiative oversees the implementation of controls and monitoring mechanisms for WTE, premium spend, and establishment management throughout the Trust.

According to the latest figures, the Trust's current staffing stands at 4,318.5 WTE against a planned figure of 4,486.16, representing a favourable variance of 167.5 WTE. Nonetheless, an additional reduction of 100 WTE is required by year-end to meet established targets.

The Mutually Agreed Resignation Scheme (MARS) has contributed to a reduction of 22 WTE, resulting in considerable cost savings. Robust controls have been put in place to curtail overtime and bank spending, with ongoing oversight and reporting at both internal and external levels.

Achieving the remaining reduction of 100 WTE presents the most significant challenge, as current collaborative and efficiency workstreams may not fully deliver the necessary reductions. There is acknowledgement that further difficult decisions may be needed, such as potentially not approving previously agreed posts.

The vacancy control process is currently on hold for two weeks to allow for the introduction of a new establishment review procedure. This process will incorporate collective decision-making by divisional and executive representatives for all workforce requests, including fixed term and bank positions. The objective is to foster a more holistic approach across divisions and corporate functions, with weekly meetings scheduled to ensure sustained momentum and comprehensive oversight.

SO/MS extended their appreciation to all teams for their dedication in reducing bank spend and managing workforce headcount, highlighting the substantial progress achieved to date.

Resolved: The Committee noted the Workforce Efficiencies Update.

24/25/134 **Annual Health & Safety Report**

The Committee received the Health & Safety Dashboard and noted the contents. NT drew the committee's attention to the following:

Overall, incident numbers have remained stable or decreased across the trust. The primary area identified is incidents involving violence and aggression, particularly within the tier 4 CAMHS unit, which reflects characteristics of the patient population. Staff are encouraged to report all incidents to support governance and monitor pressures.

RIDDOR:
Last year, five RIDDOR reportable incidents occurred: four were seven-day injuries and one involved a visitor slipping on spilled liquid and sustaining a leg fracture.

The Health & Safety Team has updated incident investigation procedures with an improved template, requiring managers to review incidents directly to enhance understanding and prevention of future events. Managers receive regular training, including risk assessment and COSHH ("Control of Substances Hazardous to Health") training, to increase responsibility for their areas and reduce reliance on the central health and safety team.

The estates team has created a suite of procedures aligned with trust policies for use in toolbox training sessions. Collaboration with the facilities team is planned to expand this approach.

Fire Safety:
There has been increased demand for technical fire safety support due to new buildings and rented premises. The trust receives support from a university fire safety officer who visits every two weeks. Fire safety training can be scheduled, while health and safety incidents require a more reactive response.

Future plans:
Recruitment of a fire safety apprentice is being considered to develop in-house expertise over a three-year period, as there has not been a full-time fire safety officer at the trust in recent years.

Violence & Aggression:
The majority of violence and aggression incidents are patient-related (estimated at 95-99%), with very few involving parents or visitors. Some incidents are associated with individual patients exhibiting challenging behaviour, particularly in Sunflower House.
The trust implements a zero-tolerance policy for violence and aggression across all groups but recognises that not all incidents are avoidable, especially those involving patients.

New training is being introduced to provide staff with strategies and techniques for managing difficult situations, particularly verbal challenges.

Resolved: The Committee received the Health & Safety Dashboard.

24/25/135 **Equality, Diversity & Inclusion Plans – Monitoring Process**

The Committee received Equality, Diversity and Inclusion plans Report.

The trust has established a comprehensive EDI action plan, featuring impactful changes that are progressing as scheduled and subject to regular review during improvement meetings.

- There is a strong emphasis on EDI-focused training, which has generated positive feedback, particularly in relation to education and training provided for managers.
- At the beginning of the month, the trust underwent a broader reassessment for its EDI charter mark, a process that will be conducted annually. This involves a series of initiatives and ongoing efforts to sustain and enhance the charter mark status.
- The trust plays an active role in Liverpool City Region EDI initiatives, with KJ and the team making significant contributions. A refugee recruitment programme is planned for September, reflecting the trust's wider commitment to EDI recruitment objectives.
- Progress and actions related to EDI are routinely reported at relevant improvement and governance meetings, facilitating accountability and robust oversight.
- Participation in community events, such as Pride, demonstrates the trust's visible dedication to EDI principles.
- The trust continues to implement its detailed EDI action plan, monitor progress rigorously, and report outcomes consistently.
- Training in EDI, especially for managers, remains a priority and has been well received. Emphasis is placed on ongoing evaluation of training effectiveness.
- Maintenance of EDI charter mark status is ensured through annual reassessment and continuous improvement measures.
- Active involvement in Liverpool City Region EDI activities, community events like Pride, and refugee recruitment programmes highlights the trust's broader engagement and commitment.

Resolved: The Committee noted the contents of the Equality, Diversity & Inclusion Annual Report.

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.

Minimal changes/updates were noted for these policies and the membership approved then as presented.

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**

- 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

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 25th September 2025 at 2pm – Tony Bell Boardroom, Institute Building

BOARD OF DIRECTORS

Thursday, 2nd October 2025

Report of:	FTSU Guardian
Paper Prepared by:	FTSU Guardian
Subject/Title:	Freedom to Speak Up – Progress Update Report
Background Papers:	FTSU Board reports from September 2016 onwards NGO Guidance Staff Survey
Purpose of Paper:	To provide the Board with a summary of progress to date to improve and enhance mechanisms for staff to raise concerns and describe the actions planned for the coming period
Action/Decision Required:	The Board is asked to note the progress made to date and to support the further actions outlined
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Best people doing their Best Work**
Resource Impact:	To be identified

1. Purpose

The purpose of this paper is to provide the Board with a summary of the activities of the FTSU service for the Q1 data and to outline the actions planned for the coming period.

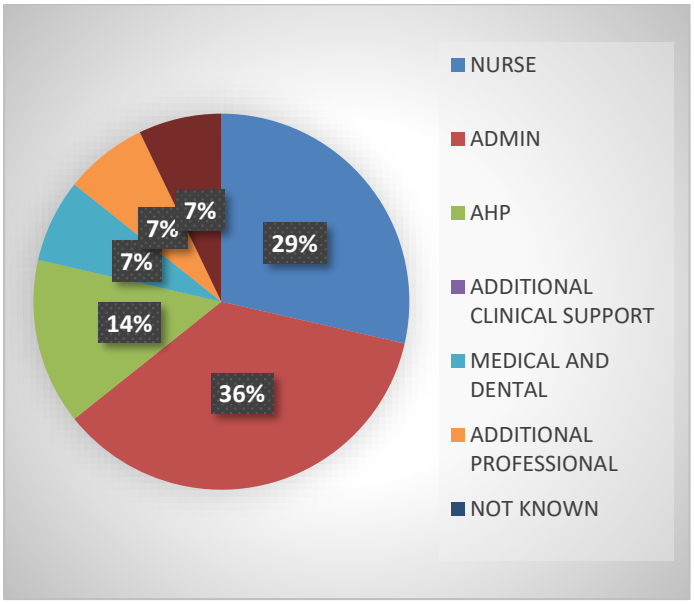
2. Recommendation

The Board is asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed.

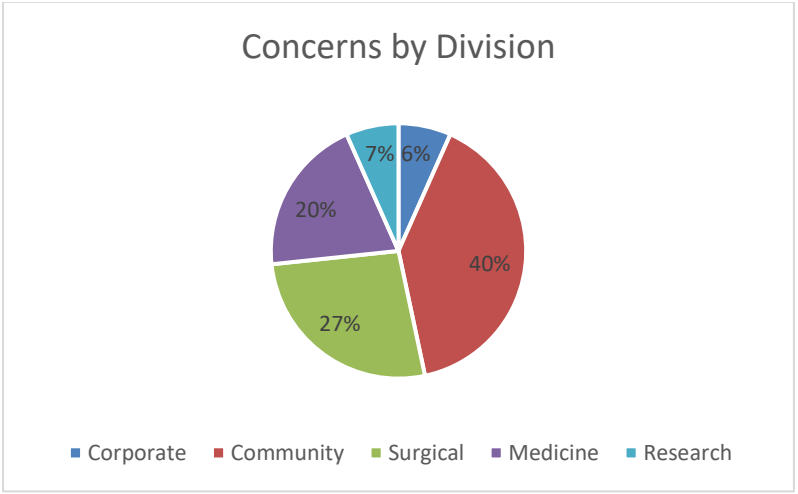
3. FTSU Q1/Q2 Activity

Q1 Data

Staff Group raising concerns



Concerns raised by Division



Themes highlighted in bold are reported as part of the mandated quarterly data collection and returned to the National Guardian's Office.

Theme	Open	Closed	Total
Patent Safety and Quality	0	0	0
Worker Safety and Wellbeing		0	1
Inappropriate Attitudes and Behaviours	2	4	6
Policies, Processes, Procedures, Systems	2	8	10
Infrastructure/Environment	0	0	
Cultural	0	0	0
Leadership	0	0	0
Senior Management Issue	0	0	0
Middle Management Issue	0	0	0
Total	16	0	16

*Speak Up cases often contain multiple themes; therefore, data sets do not always equate together. Issues are recorded under the workers own description. In cases relating to Inappropriate attitudes and Behaviours, it should be consider that there will potentially be an element of staff safety.

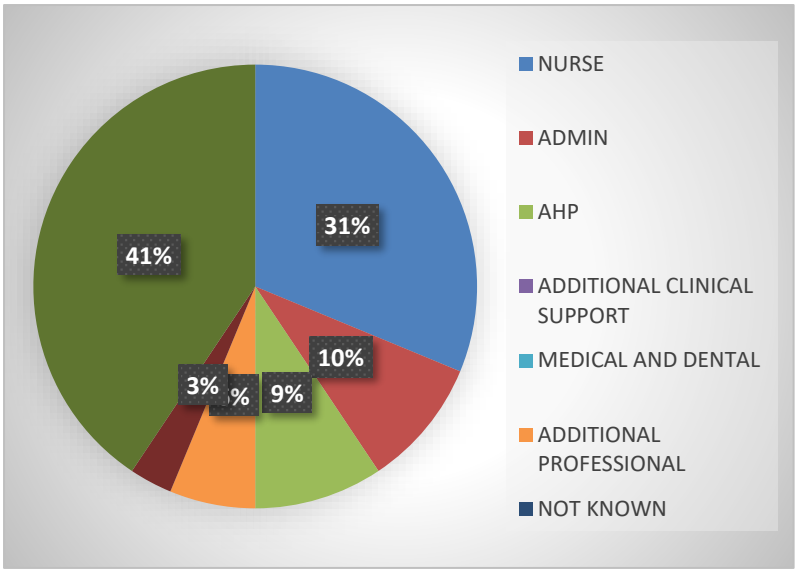
Open Cases Q1

Of the 2 remaining cases open relating to Policies/processes, these are relating to recruitment and retention, there is an approach to these concerns, currently waiting for further discussion with the staff members concerned, to determine if these issues have been addressed.

There are 2 cases relating to behaviours, that remain open, one is currently being managed under a formal process that has not concluded, the other is in relation to lack of support relating to reasonable adjustments, there is an agreed plan regarding this, currently awaiting feedback from the member of staff.

Q2 Data

Staff group raising concerns



Contacts by Professional Groups

There is a wide cross-section of the Trust workforce, that have contacted the FTSU guardian, from a range of worker/professional groups and levels of seniority.
A comprehensive definition for professional groups forms part of the updated guidance.

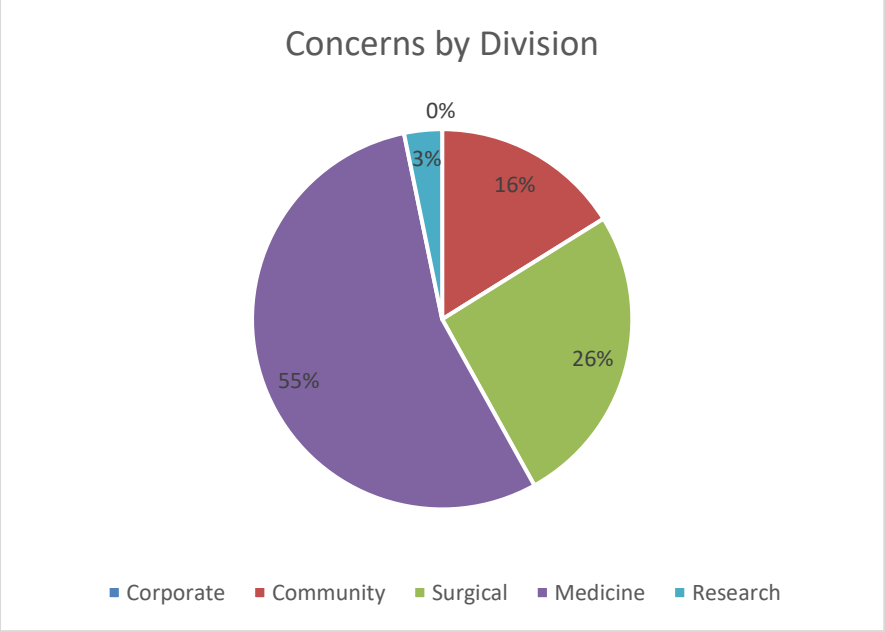
Recording Cases and Reporting Data (nationalguardian.org.uk)

Themes highlighted in bold are reported as part of the mandated quarterly data collection and returned to the National Guardian's Office.

Theme	Open	Closed	Total
Patent Safety and Quality	1	0	1
Worker Safety and Wellbeing	1	0	1
Inappropriate Attitudes and Behaviours	13	0	13
Policies, Processes, Procedures, Systems	8	8	16
Infrastructure/Environment	1	0	1
Cultural	0	0	0
Leadership	0	0	0
Senior Management Issue	0	0	0
Middle Management Issue	0	0	0
Total	24	8	32

*Speak Up cases often contain multiple themes; therefore, data sets do not always equate together. Issues are recorded under the workers own description. In cases relating to Inappropriate attitudes and Behaviours, it should be consider that there will potentially be an element of staff safety.

Concerns raised by Division



<u>Open Cases Q2</u>

There are 11 cases open (in the same dept) relating to behaviours and attitudes, there is a short term and long-term plan for these concerns, as it forms part of a wider departmental issue, which is being supported by the OD team. A meeting is scheduled with those who raised the concerns to understand if the short-term solutions suggested have improved the situation.

There are 8 cases open relating to policy/process, 6 are pending closure awaiting follow up meeting with staff members who raised the concern, 1 remains open as reasonable adjustments were not being supported, currently awaiting follow up meeting to determine if this has moved forward, the final open case is in relation to the vacancy panel process and the impact on the staff member due to this process, FTSUG is scheduled to meet with the director of Finance to understand the process and raise the concerns.

2 cases relating to staff safety, remain open, 1 is in relation to temperature and has been referred to Health and Safety and to the trust site lead, the other remaining case is in regards to staff feeling unsafe due to the infrastructure and this links to last years major incident, discussion has started regarding this and some movement made, however this is slow and staff members are concerned, further discussion to take place.

Finally the concern relating to patient safety was raised by 2 members of staff, it was determined that there was no immediate risk to patients by those raising the concern and that they want to raise this themselves initially, direct with their leads, they wished to have the FTSU service available should this not be listened too

Feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again scoring the process highly in terms of satisfaction.
Staff response to the question '*when people speak up in this organisation, things change'* is indicating, that of those who have raised a concern and responded to the survey, 10.3% of those staff did not believe things changed, this has decreased from 10.7%%. Of the 19 staff responding to the survey,18 shared that they would raise concerns in the future, with 1 indicating that they were not sure.

In recent months there has been a slight increase in those staff raising concerns, feeling unsafe to do so and have a fear that they would suffer a detriment. This slight shift, is of a concern as previous survey results have not indicated this and does require further inquiry so as to understand this situation, consideration will be given to how this will be taken forward

To view results from the questionnaire post closure please click on the link below:
https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=OVmEMfpVb8x8dRhYPVxLZDFdyaHIx6lu&id=G888R1c5sE6Cur6KaqH2Sri2S89zA4NJtHQSSVjh0UBUQktJNk5OWUNCN01YUVNOWjlSTkVQSFBDMC4u

4. Lessons Learnt

A collaborative approach, to a number of concerns, has been undertaken by the FTSUG working with Angie Dichfield EDI lead. These concerns have focused on Reasonable Adjustments and issues around racial abuse, the EDI Lead has provided the below narrative to describe our approach.

We know from our equality data and from listening to our colleagues, some staff experience racism, discrimination, and exclusion in work. This has recently become more apparent to Freedom to Speak Up Guardian and the Head of Equality, Diversity, and Inclusion, and this behaviour does not reflect our Trust Values and our ambition to become an inclusive organisation.
In response to this intelligence, we are piloting dedicated reflective sessions. These will provide safe, facilitated spaces for staff to share experiences, engage in open dialogue, listen to one another, and reflect on behaviours, with the aim of identifying solutions to strengthen a more inclusive culture. These sessions are about learning, understanding, and strengthening our community, so that staff are listened to and feel able to share their experiences. The first pilot will take place on 4C, with a view to roll these out across the organisation. Emerging themes will be collated to inform organisational learning and shape future actions, ensuring accountability and improvement.

Regarding the concern relating to reasonable adjustments, the member of staff contacted the FTSUG last week, thanking them and the EDI lead for their support regarding this concern, stating that this had helped them return to work sooner, having gone off with work related stress and to also stay in employment in Alderhey as they had been successful in securing a post in another trust, but due to the intervention and support now being offered, had declined the position.

In relation to the racial abuse, both the EDI lead and the FTSUG believe that there is requirement to focus on the Zero Tolerance Policy and how it is communicated across the trust.

5. FTSUG Visibility Programme

The FTSU visibility programme, continues, being well received across the organisation and a key component to the FTSU communication plan. As previously indicated, the walkabouts are supported by members of the Executive and Non-executive team, these are well received by staff and demonstrate the commitment of the executive team to the FTSU principles.

There is a requirement for the FTSU visibility to align with the work being undertaken By Jo Potier DOC, so as to avoid duplication, communication has taken place

6. Mandatory training

The Speak Up training module as of the 1st August 2025 was 98.40%compliant. Currently it is not possible to launch the Listen Up, Follow Up training as the ESR system requires adaption to accommodate these training.

7. FTSU App

There is further development required regarding the FTSU App as it is currently in a basic state, a meeting is scheduled for October with the developer to discuss next steps. There is also a requirement to launch the app again as it is currently being underutilized which may be in relation to the original launch, therefore discussion needs to take place with Communications as to the best way for this launch to be delivered.

Kerry Turner
Freedom to Speak Up Guardian
September 2025

BOARD OF DIRECTORS

Thursday, 2nd October 2025

Paper Title:	**Chair's Report from the Audit and Risk Committee Meeting held on the 18th September 2025**
Report of:	**ARC Chair**
Paper Prepared by:	**ARC Chair**

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Minutes from the meeting on 17th July 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

- Verbal update from Divisional Directors on current risks and concerns.
- Presentation on risk management processes within Research, Innovation & Academy.
- Board Assurance Framework (ARC deep dived risks 1.1, 1.2 & 1.4).
- Board Assurance Framework Policy **(Approved).**
- Risk Management Forum Update including Chair's Report and Minutes from most recent meeting
- Corporate Risk Register*.
- Trust Risk Management Report.
- Risk Management Strategy **(Approved).**
- Fraud Risk Assessment Matrix.
- Risk Horizon Scanning Discussion.
- Internal Audit Progress Report, including the outcomes of audits of Asset Management Processes (Substantial) and Data Security & Protection Toolkit (High Risk).
- Internal Audit Follow Up Report.
- Anti-Fraud Services Progress Report including the outcome of reviews of Contract Management and Agency & Bank Staff Identification and Vetting and briefing papers on:
  - Failure to Prevent Fraud Offence which came into effect on 1st September 2025
  - Benchmarking of fraud statistics NHS-wide from 20/21 to 24/25 (fraud identified, prevented, recovered and sanctions applied).
- Analysis of journals posted in 24/25 (value add information provided by E&Y).
- Update on issues in providing Clinical and Non-Clinical Claims information to ARC.
- InPhase Phase 2 Programme Update.
- Update on Action Log from effectiveness reviews of ARC, Internal Audit, External Audit and the Anti-Fraud Service.
- Update on the position against the implementation of additional financial controls requested by C&M ICB as a result of system intervention.
- A report on Lessons Learned from the iDigital Partnership ("Part 2" discussion).

* The Corporate Risk Register was included within the papers but detailed discussion of individual risks was unable to take place as a representative of the Corporate Governance Team was unable to attend the meeting. A paper recommending the approach to risk management training across the Trust was deferred to the December meeting for the same reason.

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

As a result of the Risk Horizon Scanning discussion, the following risks have been referred to the Executives to consider the need to update existing risks or create new risks in relation to:

- The impact of "Closing the Gap" and further workforce reductions in terms of compromising quality and safety and introducing clinical risk.
- Changes to skilled worker visas which could affect divisional stability within Community & Mental Health.
- Discrimination in resource allocation such as prioritising recruitment of clinical roles over admin roles and the need to ensure that this does not lead to any discrimination in the services provided to our children and young people.
- A potential increase in the number of fragile services due to losing highly skilled staff in niche specialties, which could quickly destabilise services and be difficult to recover in the long term.
- Inadequate governance and recording of the reasons for decisions made in the current environment resulting in the Trust being unable to defend the decision in the future (perhaps as a result of an incident arising or a delay in the realisation of a risk such as at an older age of a patient).
- Future service development: funding is now largely dependent upon performance (need to focus on maintaining Segment 1 status).
- Levels of payments for medicines and the potential impact on drug availability / quality / innovation
- Financial risk: cumulative effect of financial decisions on service quality and safety.

4. Positive highlights of note

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

- The BAF has undergone significant update since it was last presented to Board reflecting the current external challenges.
- Divisional Directors are now invited to ARC to provide real-time updates on risks and concerns arising given the extent of change underway in support of the C&M region turnaround.
- An internal audit of the governance of the workforce reduction programme was approved.
- The Finance Team presented a paper detailing the additional controls for pay and non-pay requested by the ICB as part of the C&M region turnaround process. Analysis demonstrated which controls were already in place, which were in progress and those for which discussions are required with the ICB as they may be unworkable or not applicable for the Trust or which to implement may result in an unacceptable level of risk.
- The Chief Nursing Information Officer presented the current implementation status for the phase 2 rollout of InPhase (which introduces additional modules to the Incidents and Risk Management modules implemented in phase 1) and advised that the programme has moved into business as usual.

5. Issues for other committees

FTPC is requested to:

- Undertake a deep dive of BAF risks 3.2 and 4.2 (for which the current level of update and detail does not match the other BAF risks).
- Provide oversight of completion of the Cyber Improvement Action Plan.

6. Recommendations

The Board is asked to **note** the Committee's report.

Appendix 2 – 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 Management Processes	Substantial	FTPC
Financial Measures (Grip & Control)		FTPC
Governance of Workforce Reduction Programme		People Committee
Clinical Audit (fieldwork ongoing)		SQAC
Theatre Management		SQAC
Data Security & Protection Toolkit		FTPC
Cyber review (audit area to be determined)		FTPC
Balance Sheet Controls		FTPC
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 (draft report prep)		SQAC

The following National and Local Proactive Exercises have been undertaken by the Anti-Fraud Specialist:

Proactive Exercise	Recommendations	May be of interest to…
Contract Management (National)	1 Medium 7 Low	FTPC
Agency / Bank Staff - ID Validation & Vetting (Local)	2 Medium 2 Low	People Committee

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 17th July 2025**
via Teams

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mrs. R. Lea	Interim Chief Financial Officer	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRo)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
Observing	Mr G. Dallas	Non-Executive Director	(GD)
	Mr. M. Jennings	Non-Executive Director	(MJ)
Item 25/26/61	Ms. J. Pointon Assoc.	Chief Nurse, Community and MH Services	(JP)
Item 25/26/61	Ms. S. Stephenson	Risk, Governance and Compliance Lead - Community and MH Services	(SS)
Item 25/26/68	Ms. M. Perrigo	Clinical Legal Services Manager	(MP)
Item 25/26/69	Ms. M. Perrigo	Clinical Legal Services Manager	(MP)
Apologies:	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Mr A Bateman	Chief Operating Officer/Deputy CEO	(AB)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Mrs. E. Kirkpatrick	Assoc. Director of Finance - Commercial, Control and Assurance	(EK)

25/26/57 Introductions and Apologies

The Chair welcomed everyone to the meeting and acknowledged the apologies received. An outline of the meeting's agenda was presented to the Committee, and the Chair informed members of the people scheduled to attend during the course of the meeting.
Attention was drawn to the lack of governor attendance at meetings and a discussion took place on alternative engagement methods, with RL suggesting quarterly briefings mirroring the approach used by the Finance, Transformation and Performance Committee (FTPC). The Chair agreed to make contact with the respective governors to determine their preferred method of engagement.

25/26/57.1 Action: KB

25/26/58 Declarations of Interest

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

25/26/59 Minutes from the Meeting held on 19th June 2025
Resolved:
The minutes from the meeting held on the 19.6.25 were agreed as an accurate record of the meeting.

25/26/60 Matters Arising and Action Log

Matters Arising

There were none to discuss.

Action Log

For noting
The Chair circulated an e-mail prior to the meeting outlining the actions that do not require discussion during the meeting.

Action 23/24/97.1: *Risk Tolerance and Appetite (meetings to be widened to develop a risk appetite and tolerances for advocacy)* – A discussion needs to take place with the Charity and the Chief Strategy and Partnerships Officer, Dani Jones, as the position is evolving in terms of the NHS 10-Year Plan and changes across the system. Certain aspects are related to system risk and system governance, which needs to be articulated. It was agreed that a piece of work will be undertaken that incorporates advocacy, but with a wider scope. It was agreed that the action would be revised to reflect this update.
ACTION TO REMAIN OPEN

Action 24/25/10.1: *2023/24 Annual Report on Risk Management (Conversation to take place with the CPO and Director of the Academy to escalate the Committee's request for the Risk Management Training Programme to be included on the list of mandatory training)* – An update was provided on the outcome of this action, as per the narrative in the action log. It was confirmed that meetings are underway with the Development Team to map out what is expected of staff in specific roles in terms of knowledge and how it can be achieved thus becoming a requirement for certain roles. It was confirmed that an options paper will be submitted to the Committee in September for discussion purposes.
ACTION TO REMAIN OPEN

Action 24/25/43.1: *Update on the Risk Appetite and Tolerances for Futures* – It was agreed to schedule a meeting with Mark Jennings to review and reshape ongoing discussions and revisit the Terms of Reference for the Growth and Opportunities Committee.
ACTION TO REMAIN OPEN

Action 24/25/108.1: *RMF Update and Minutes CRR Report (CRR - Include narrative in the report to indicate as to whether the mitigations are within or outside the Trust's control)* – Narrative will be included in the CRR report from July onwards. **ACTION TO REMAIN OPEN**

Action 24/25/115.1: *Briefing on the issue relating to a member of staff being in possession of a lease vehicle nine months after leaving the organisation (Liaise with James Wilcox to see if the action relating to a recommendation made in respect to recruitment by AFS has been addressed ('if it becomes apparent that somebody has worked at the Trust before, whether they have declared it or not, then include that within the checks made via Finance to see if there are any outstanding debts'). If so, include lease cars as part of the recruitment check)* – A procedure has been established to review new starters/individuals re-joining the organisation for any outstanding debt or issues related to lease vehicles. This step has now been formally included in the process. **ACTION CLOSED**

Action 24/25/122.3: *ARC Effectiveness (request that a Third-Party Assurance report from HPL be provided to ARC going forward)* – The last Procurement Board was cancelled therefore the HPL Annual Report that Katie Toothill is compiling will be presented at the next scheduled meeting. Subsequently, the report will be shared with ARC to assess whether it fulfils the Committee's requirements and to identify any potential gaps.
ACTION TO REMAIN OPEN

Action 25/26/06.1: *Conduct a thorough review of the Workplan, Terms of Reference, and supporting papers for ARC to ensure the Committee maintains an appropriate focus and to assess whether documents could be presented using alternative approaches (such as the Brilliant Basics method on IPR data for DPA and FoIA).* Discussions have taken place about whether certain reports submitted to the Audit and Risk Committee (ARC) should also go to other Assurance Committees. This will be reviewed over the next two to four weeks to agree a position, with an update expected in September. It was recommended that the same principles be applied to Clinical Audit reporting. **ACTION TO REMAIN OPEN**

Action 25/26/13.1 to Action 25/26/13.6: *Board Assurance Framework* – These actions will be closed following receipt of the next iteration of the BAF. **ACTION TO REMAIN OPEN**

Action 25/26/14.1: *Risk Management Forum Update (RMF to undertake a deep dive with CAMHS and Corporate Services with a view to understanding why they are outliers for "risks with overdue actions" with the aim to significantly reduce them)* – Both deep dives are to be re-scheduled as key staff members were not in attendance at the last RMF.
ACTION TO REMAIN OPEN

Action 25/26/31.2: *Annual Assurance Report for 2024/25 and Forward Plan for 2025/26 – Data Protection/ Annual Assurance Report for 2024/25 and Forward Plan for 2025/26 - FoI (Review the 2025/26 Forward Plan for Data Protection and FoI to see if the goals are ambitious enough)* – This action is in progress. **ACTION TO REMAIN OPEN**

Action 25/26/31.3: *Data Protection Annual Report, 2024/25 (CAMHS have significantly higher volumes of incidents compared to other teams. Liaise with Lisa Cooper to discuss this matter further)* – This action is in progress **ACTION TO REMAIN OPEN**

Action 25/26/31.4: Annual Assurance Report for 2024/25 and Forward Plan for 2025/26 for DQ, Cyber Security, DP, FoI (Chair to provide observations on the presentation of the suite of reports in preparation for next year's submission) – The Chair has provided observations on the presentation of the suite of reports in preparation for next . **ACTION CLOSED**

Action 25/26/44.1: *E&Y External Audit Year End Report on the Trust's Accounts (Schedule a meeting with E&Y/Finance to discuss the additional audit fees in further detail)* - A meeting will be scheduled in the coming weeks and a virtual update will follow.
ACTION TO REMAIN OPEN

25/26/61 Roll Out of Risk Appetite Across the Community and Mental Health Division; including an Update on the Risk Management Process within the Community and Mental Health Division.

The Committee received an overview of the risk management process within the Community and Mental Health Division. A number of slides were shared with the Committee that provided information on the following areas:

- Good governance meeting structure;
  - Local governance meeting – This provides assurance to the monthly Integrated Governance meeting.
  - Monthly Community and Mental Health Division Integrated Governance meeting – This provides assurance to the Divisional Board and Trust Board sub-groups.
- Divisional risk review meeting process.
- Update on the actions that have been taken to address the priorities for 2024/25.
- Priorities for 2025/26;
  - Substantial Assurance provided following MIAA Risk Review.
    - *Action area:* Ensure all legacy risks and controls are moved to the main InPhase page.
  - Ensure the Divisional Governance SharePoint page/Risk Register Training is updated following conclusion of the risk tolerance work.
  - Work with teams to ensure understanding of risk tolerance.
  - Close any risks agreed as part of the risk tolerance pilot.

The governance meeting structure was discussed, and it was suggested that the Risk Management Forum (RMF) be incorporated into this structure, as the Division regularly attends to provide updates on high risks and the RMF reports to the ARC.

The Committee noted from the Trust Risk Management Report that CAMHS has a higher number of risks with overdue actions compared to other Divisions. It was suggested that this matter be addressed and that efforts be made to reduce the number of overdue actions through ongoing meetings. It was reported that this piece of work is currently underway and nearing completion. Efforts have concentrated on actions not only the risk module of InPhase, but also the incident and complaints feedback module, resulting in a significant reduction in overdue actions. It was confirmed that the respective staff members have been given one month to resolve any outstanding items.

A question was raised about whether the training provided addresses a specific need or constitutes routine practice. The Committee was advised that governance training, which includes topics such as incidents, risks, PALS, and complaints, is offered to all members of the Division. Additionally, master classes are available for Clinical Leads, Service Managers, and individuals responsible for managing risks and incidents. A range of training sessions are held monthly and cover various subjects.

Reference was made to the closure of the Gender Service risk on the Board Assurance Framework (BAF) and it was queried as to whether the actions have been allocated for monitoring. It was reported that when closing a risk, the Division ensures the activity is monitored within the relevant group so it can be reported appropriately. This process guarantees ongoing oversight and provides a built-in escalation route if the risk changes.

Risk Tolerance

The Chair thanked the team for their methodical rollout of the Risk Appetite Pilot across the service. It was felt that the presentation highlighted valuable lessons, insightful questions, and positive discussions on risk from various perspectives.

A number of slides were presented to the Committee to summarise the outcome of the Risk Appetite Pilot. The slides offered information on the following areas:

- Current risk position.

- Risks identified for closure.
- How closed risks will be monitored.
- Risks that were queried;
  - It was reported that of the 14 query risks, the main query relates to clarifying whether the risk category needs to change.
  - Following review of the 14 query risks, 9 were identified as 'Workforce Sustainability' risks, where it was felt that they may need to have their category amended (or closed and a new risk added), for example due to workforce issues reducing, but waiting times/patient safety still being a concern.
- Clarification on risk scoring required.
- Next steps.

The Chair felt that the presentation was really comprehensive and offered some comments:

- The Chair highlighted the positive outcomes from the pilot, such as having the workforce group monitor closed actions related to sustainability and adopting a three-month follow-up period after risk closure. It was suggested that these practices be included in the roll out of risk appetite across other teams.
- It was reported that during the pilot the team requested clarification regarding the management of quality and safety risks with a consequence score of 4-5. The Chair pointed out that these risks are within the scope of SQAC, and the Committee has submitted a proposal describing its approach to handling them. It was confirmed that the proposal will be shared with the team during a detailed meeting scheduled to take place following the completion of the pilot.
- If a new risk is proposed that is already within tolerance, it will be rejected. The Chair felt that it may be beneficial to implement a process similar to the one used at closure, which involves reviewing the entire risk category to identify other risks.

There was a query regarding whether the SEND risk marked for closure includes the risks identified during the recent Liverpool inspection. It was reported that the risk scheduled for closure concerned SEND not being able to log information onto the Meditech system, which has now been resolved, and reporting via Meditech is operational. It is proposed that this risk be closed; however, an additional risk has been entered into the system to correspond with the outcome of the Liverpool SEND inspection.

Members of the Committee agreed that the outcome of the pilot was presented in a clear and well-structured way and demonstrated a strong and logical thought process.

It was noted that the governance team will be developing risk appetite principles, and a request was made for the Division's participation in this process, of which, it was confirmed.

Resolved:
The Committee noted:

- The update on the Risk Management Process within the Community and Mental Health Division.
- The roll out of Risk Appetite across the Community and Mental Health Division,

25/26/62 Board Assurance Framework (BAF)

The Committee received the BAF for May 2025. It was reported that the current review cycle is focused on outstanding workforce risks, which are being addressed through ongoing discussions and will be escalated to the People Committee. It was noted that the BAF is experiencing increased volatility, particularly in relation to workforce and financial pressures, and that these areas will require continued attention. Adjustments are also being made to the risks associated with the new Growth and Opportunities Committee, as well as revisions to external facing risks. The Chair highlighted the need for more up-to-date information to support effective risk horizon scanning, and it was agreed to explore options for providing a current summary of the BAF at future ARC meetings.

25/26/62.1 Action: ES/JP

The Chair of the People Committee, Jo Revill offered thanks to ES and JP for the work that has been undertaken on the workforce risks and the progress that has been made in this area. MIAA also noted a marked increase in attention to people related risks across the trust.

Review of BAF Risks (FTPC)

The Committee conducted a deep dive into the FTPC risks, with the Chair providing a summary analysis and observations suggesting potential impacts if risk tolerances were applied.

ES highlighted the need to formally review risks at FTPC against risk appetite and tolerances, noting that while the FTPC reviews it's top 5 risks on a monthly basis, alignment with BAF risks could be improved. It was felt that a piece of work is required to ensure that the top risks presented at FTPC are aligned with the strategic risks captured in the BAF.

25/26/62.2 Action: ES/RL

The Chair noted that some risks, such as building and infrastructure defects, may lack sufficient controls and asked that these risks be reviewed and updated for the next cycle of the BAF.

25/26/62.3 Action: RL/JP

Resolved:
ARC noted the BAF report for May 2025 and the review of BAF risks allocated to FTPC.

25/26/63 Risk Management Forum Update; including Chair's Highlight Report and Corporate Risk Register

The Committee received an update on the Risk Management Forum (RMF) that took place on the 4.7.25, noting its continued importance as a source of assurance and oversight for Divisional and Corporate risks. Recent meetings have experienced attendance challenges, particularly from the Division of Surgery, while the Division of Medicine has re-engaged positively. The Committee discussed the need to review the meeting scheduling to improve participation and agreed that RMF provides valuable in-depth risk discussions and supports escalation to ARC. During July's meeting deep dive discussions took place regarding Cyber Security and CAMHS and Corporate risks were reviewed.

It was reported that a monthly face to face meeting with the full Digital Team has resulted in significant progress with only one IM&T risk without an action plan at the time of reporting. Consideration is being given to progress with risk appetite.

Corporate Risk Register

The Committee received and reviewed the corporate risk register for the reporting period 1.5.25 to the 31.5.25. It was pointed out that while some risks are complex and subject to change, there were no significant concerns at the time of reporting. The Chair drew attention to risk 297 *(Transcription delay and increase of turnaround times),* specifically the decision to pause further onboarding of clinicians onto Lyrebird until the beginning of 2026 in order to reduce the impact of the organisation's manual transcription workload. It was noted that while this action may be appropriate for the immediate risk, it could conflict with the Trust's wider objective to drive efficiencies through Lyrebird. The importance of monitoring decisions for possible cross-risk impacts was emphasised to ensure such matters are recognised and managed in a timely manner.

Resolved:
ARC noted the RMF update and the Corporate Risk Register for the reporting period; 1.5.25 to the 31.5.25.

25/26/64 Trust Risk Management Report

The Trust Risk Management Report was submitted to provide the Committee with the opportunity to scrutinise the effectiveness of risk management in the Trust as at the 31.5.25. It was noted that 20% of risks currently lack action plans and a further 20% have actions that are overdue. However, there has been a notable progress with the number of overdue actions having almost halved since the start of the year.

It was reported that the number of long-standing high and moderate risks has reduced from the high 30s to 17 although there is a slight upward trend as some risks exceed 12 months, indicating the need for renewed attention. Ongoing work includes the re-scheduling of deep dives for CAMHS and Corporate services, which is expected to further improve action completion rates and risk management disciplines. Additionally, there are plans to enhance processes for smaller Corporate teams via regular meetings and drop-in sessions. It was also pointed out that engagement and challenge from teams has improved.

Resolved:
ARC noted the content of the Trust Risk Management Report, and the level of assurance provided in the report.

25/26/65 Horizon Scanning

The Committee discussed current and emerging risks, including the impact of resident doctor strikes and the formal turnaround process in Cheshire and Merseyside (C&M), with PWC intervention meetings noted as a system-level risk. The following points were raised:

- RL highlighted the need to reflect the system turnaround and its implications for finance, access, and operational risks, suggesting that these may require distinct treatment in the BAF.
- KB raised concerns about the effect of system intervention on the Trust's Vision 2030 Strategy and broader strategic aspirations, emphasising that risks should not be viewed solely through a financial lens.

- ES noted increasing cross-referencing of system pressures in strategic risks and suggested more explicit capture of these issues, including consideration of lower-level risk registers.
- The Southport Inquiry was identified as a complex, sensitive risk, with ES explaining the challenges of articulating it in the risk register and the potential for operational, legal, and staff well-being impacts.
- GM expressed concern about the position of Children's Services within the C&M Integrated Care Board (C&M ICB), the risk of being marginalized in a larger system, and the possible split between Cheshire and Warrington and Merseyside.
- JR highlighted public health risks, referencing the recent measles outbreak and low vaccination rates, and the broader challenge of system investment in Public Health and Primary Care.

Resolved:
It was agreed to prepare a summary paper on risk themes for the Executive Team, based on horizon scanning discussions.

25/26/65.1 Action: KB

25/26/66 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the 2025/26 Internal Audit Plan during the period from April 2025 to June 2025. The following points were highlighted:

- There have been two reports finalised in the reporting period:
  - Conflicts of Interest – Substantial Assurance.
  - Cyber Assessment Framework (CAF) Baseline/Gap Analysis Review (Part 2) – Limited Assurance. It was reported that the CAF audit findings reflect sector-wide challenges in adapting to new standards, with further improvements planned.

The Chair pointed out that a placeholder exists in the plan for a people-related audit, with possible overlap between the Grip and Control Review. MIAA confirmed that they will assess whether these are separate audits or a single engagement. It was reported that a placeholder will be retained for emerging issues or IT controls if required. Overall, progress is on track, with several items due by September.

Resolved:
The Committee received and noted the content of the Internal Audit Progress Report.

25/26/67 Internal Audit Follow-Up Report

The Committee reviewed the Internal Audit Follow-Up Report, noting that the majority of audit actions are progressing as planned, with a short extension approved for the Freedom to Speak Up Guardian deputy recommendation due to recruitment timing. The Committee welcomed confirmation that the high-risk medical devices recommendation has been implemented, recognising the substantial work involved. It was further noted that the overall number of outstanding actions is decreasing and that audit work is being delivered by senior staff, providing assurance on the robustness and quality of the audit process.

The Chair asked for clarification on what "annex 21 staff" refers to in the audit plan summary table, specifically regarding the allocation of audit work by staff grade. MIAA advised that annex staff are those training to be accountants and this has been included in the table for information purposes.

Resolved:
The Committee noted the content of the Internal Audit Follow Up Report.

25/26/68 Annual Assurance Report 2024/25 and Forward Plan for 2025/26 – Non-Clinical Claims

The Committee received a number of slides detailing challenges that caused delays in providing annual assurance for non-clinical and clinical claims. Attention was drawn to the following key points:

- The Annual Assurance Report 2024/25 and Forward Plan for 2025/26 on Clinical Claims faced significant data challenges due to NHS Resolution's migration to a new claims management system, which caused missing and incomplete data for clinical claims across all trusts. This affected the ability to provide a full and accurate report. The Trust relies on NHSR data for reporting, as it is the official source and aligns with published figures, but the transition led to discrepancies and missing claims information.
- The Clinical Legal Services team is not yet using the InPhase legal app, so internal data manipulation is currently managed via spreadsheets, which limits the ability to provide detailed analysis by division or specialty. Work is underway to develop and implement the InPhase legal app to improve future reporting and case management.
- The non-clinical claims function was transferred to the Clinical Legal Services Team in February, requiring new processes and additional data handling skills. The team identified the need for additional business intelligence and administrative support to ensure robust data analysis and timely reporting.
- The plan for 2025/26 includes continuing to resolve data issues with NHSR, implementing the InPhase legal app, securing additional resources, and providing regular updates to the Committee until reporting is stabilised.

The Chair offered thanks for the update, noting that the Committee requests assurance reports to support oversight and identify emerging trends. The Chair confirmed that additional time will be required to address the respective issues.

Resolved:
It was noted that the Committee will receive ongoing updates at each meeting until the data and reporting issues are resolved, after which reporting will return to an annual cycle.

25/26/68.1 Action: MP

25/26/69 Annual Assurance Report 2024/25 and Forward Plan for 2025/26 – Clinical Claims
Resoled:
This item was discussed as part of agenda item 25/26/68.

25/26/70 Update on Progress Against Actions from Effectiveness Reviews

The Committee received an update on progress against actions arising from effectiveness reviews of Internal Audit, External Audit and the Anti-Fraud Service. It was noted that a significant number of actions have been completed since the last report, with only four

actions remaining outstanding, all of which have since been implemented and will be reflected as completed in the next update. The Committee was assured that all actions are being addressed in a timely manner, with strong engagement from the relevant teams.

Resolved:
The Committee noted the update.

25/26/71 Any Other Business

There was none to discuss.

25/26/72 Meeting Review

It was agreed to introduce a summary paper for the Executive Team, capturing key risk themes and discussions from ARC to improve communication and oversight. It was also agreed that governors will be kept informed through post-meeting briefings rather than attending full ARC meetings.

Date and Time of the Next Meeting: Thursday 17th September, 2:00pm-5:00pm, via Teams.

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Thursday 21 August 2025 at 1:30pm**
Room 7, Mezz

Present:	Mr J. Kelly	Non-Executive Director (Chair)	(JK)
	Dame. J. Williams	Non-Executive Director	(JW)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	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. M. Swindell	Chief People Officer	(MS)
	Mr. N. Askew	Chief Nursing Officer	(NA)
In Attendance:	Mr. A. McColl	Associate Director of Finance	(AMc)
	Ms. A. Chindiya	Associate Finance Director	(AC)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Ms. N. Palin	Director of Transformation	(NP)
25/26/083	Mr. J. Chester	Chief Scientific Officer	(JC)
25/26/083	Mr. M. Upton	Acting Head of Performance / General Manager	(MU)
25/26/083	Ms. C. Lee	Associate Chief Operating Officer - Surgery	(CL)
25/26/083	Ms. K. Holian	Programme Manager – Community/ MLHD	(KH)
25/26/083	Mr. R. Viner	Project Manager	(RV)
25/26/083	Mr. P. Sanderson	Chief Pharmacist	(PS)
	Mrs. E. Rees	Executive Assistant (Minutes)	(ER)
Apologies:	Ms. E. Kirkpatrick	Associate Director of Finance	(EK)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mr. A. Bateman	Deputy Chief Executive/ Chief Operating Officer	(AB)
	Mr. G. Wadeson	Associate Director of Finance	(GW)

25/26/077	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
25/26/078	**Minutes of the Last Meeting** The minutes of the last meetings held on 22 July 2025 were approved.
2526/079	**Matter Arising and Action Log** The action log was updated. **Re-Imagining appointment scheduling services and reducing rates of WNB** The report sets out a vision to improve appointment booking and scheduling services at Alder Hey, aiming for a more responsive, efficient, and family-friendly experience through new technology. It proposes a Patient Portal via the NHS

	app, AI-supported booking, and a central contact point to address current process inconsistencies, limited family choices, and outdated communication. The report also targets reducing Was Not Brought (WNB) appointment rates, currently at 10.47% for 2025/26, especially in high-activity areas like Mental Health and ADHD. Planned actions include improved demographic searches, adherence to access policy, a WNB communications campaign, and specialty initiatives such as ADHD appointments in schools. The goal is to lower the Trust WNB rate to 8%.
25/26/080	**Declarations of Interest** There were none to declare.
25/26/081	**Top 5 Risks** **Resolved:** The Committee noted the Top 5 Risks.
25/26/082	**Finance Report - M4 Financial Position** **Resolved:** The Committee received and noted the Financial Report.
25/26/083	**Closing the Financial Gap:** **Update from External Meetings** The Committee discussed the outcomes of the recent PwC engagement, focusing on the trust's financial performance, the cost improvement programme (CIP), and the need to demonstrate robust plans and recurrency to external stakeholders ahead of the September review. JK reported that PwC challenged the trust on the percentage of signed-off, robust CIP plans, noting that the trust was at 60-65% with target set at 100%. The team was tasked with achieving the full 100% by the end of August/next meeting. **System Context incl Stretch** The Committee confirmed agreement to the proposed approach to managing the £3.8m stretch target currently included in the Trust plan and clarifying where responsibility for delivery should lie. It was noted the position of the Trust Board in May and risk of delivery shared with ICB at this time. **Latest Forecast Position** RL presented the latest financial forecast, explaining the difference between the national submission (showing a £7.2m surplus including delivery of the stretch) and the current internal run rate forecast (break-even) using the methodology set by NHSE and the ICB. The £6m gap remains the focus for internal delivery and closing the CIP gap, including maintaining income plans and identifying recurrent benefits. RL explained that the FIP strategic command has been reset to meet weekly, with a new focus on overseeing all programmes, including transformation, and implementing RAG ratings and SRO confidence assessments to strengthen accountability.

Theatre – Productivity
The Committee reviewed progress on the theatre productivity workstream, noting £1m as the initial target with £860,000 identified so far, £350,000 implemented, and a remaining gap. Confidence remains high, but agreement is needed on how to record ongoing reductions.

Updates were given on several workstreams: a new contract for spinal services with Northern Ireland could bring in £240,000, though it relies on weekend theatre staffing; reinstating NHS spinal weekend work has similar financial potential; and non-NHS activity streams could add £100,000. The removal of batch admissions for day cases was discussed, offering up to £175,000 in quarter four and £700,000 for a full year, though would need to assess impact on patient experience.

The group agreed to align numbers across programmes and to resolve staffing and process issues before proceeding further.

Outpatient Productivity
The Committee discussed outpatient productivity as a key area for closing the financial gap and meeting targets. Members noted the significance of improving outpatient productivity, such as reducing unnecessary follow-ups and increasing capacity, to help achieve financial objectives. It was emphasised that the benefits of these initiatives must be accurately captured and not double-counted.

Plans were made for the team to consolidate reported productivity gains from various departments, ensuring a comprehensive and coordinated approach. Aligning these improvements with the overarching goal of reducing expenditure and closing the performance gap was highlighted as a priority.

The Committee acknowledged challenges in accurately recording and aligning these benefits and agreed to focus on this alignment in the coming week to guarantee that all improvements are captured and fully contribute to financial recovery efforts.

Non-Medical Workforce/Medical Workforce
The Committee discussed measures to reduce reliance on premium medical workforce expenditure, such as waiting list initiatives (WLIs), locum staff, and insourcing. Several key milestones were highlighted, including the implementation of a recruitment pause on corporate and managerial non-patient facing roles until December 2025, a review of fixed-term contracts, and a reduction in new starter numbers by 50%.

Additional actions included efforts to decrease the use of bank nurses and overtime, the launch of a 90-day sprint aimed at reducing sickness absence, and a plan to revisit the Mars scheme to identify potential quick wins. The team also initiated reviews of management and leadership structures, as well as an assessment of the Allied Health Professional (AHP) workforce.

The overall objective of these initiatives was to achieve savings of £3 m and reduce the equivalent of 100 whole-time staff members.

The Committee discussed the need to develop and align the target operating model, particularly in relation to management and leadership structures, and to

ensure that workforce changes are sustainable and support future operational needs.

Activity and Income
MU described actions to mitigate a £1 million shortfall in the trust income plan, including retracting cardiac surgery, revising forecasts, negotiating with KPI in-source, and planning to restart theatre activity. Risks include staff availability and sustainability of current activity levels, with mutual aid opportunities being explored.

Procurement and Non Pay
NA and RL discussed procurement savings, noting limited large opportunities but ongoing catalogue rationalisation and materials management. Energy savings are being pursued through broker negotiations and moving to the NHS basket, with additional options like site revaluation under review.

Pharmacy and Diagnostics
PS advised that progress is being made with the outsourced outpatient pharmacy project. The goal is to implement this by the fourth quarter, contingent upon securing the required space without incurring capital costs.

Attention has also been given to managing unfunded and non-commissioned drugs, particularly those prescribed by the hospital but ideally funded by primary care. The importance of establishing effective recharge mechanisms with the Integrated Care Board (ICB) was recognised.

The group is making efforts to accurately capture cost avoidance resulting from decisions not to fund certain high-cost drugs. Additionally, there is ongoing monitoring of prescribing trends to identify further savings opportunities, such as reducing spending on omeprazole liquid.

R&I
The Committee discussed the ongoing shortfall in the research and innovation budget, with specific attention given to managing non-pay costs and achieving income targets. Challenges in recruiting sufficient research patients for the MR scanner were noted, resulting in lower-than-anticipated activity. The team is preparing an options appraisal, with potential savings ranging up to £326,000 depending on the chosen approach. Opportunities have been identified to generate further research scan activity, potentially yielding an additional £205,000 across several initiatives.

The financial impact of Robotic Process Automation (RPA) is still being evaluated, as benefits are yet to be fully realised and hinge on redundancy cost assessments. The renewed business case for RPA is in development.
Efforts to increase commercial income continue, building on last year's successes, with additional funding anticipated from the Clinical Research Delivery Centre (NIHR), though these benefits may not be realised within the current year. The team is also working to optimise poised funding by ensuring that staff salaries currently paid by the trust are covered by these resources.
Overall, the Committee emphasised the need for a strategic approach to address budget challenges and endorsed continued exploration of new income opportunities and funding optimisation.

Resolved:
The Committee received and noted the updates from the SRO's.

25/26/084	**Creating Future Shape of Alder Hey** KW advised the paper is positioned as a key input for the upcoming board strategy discussions, with the intention to discuss it in detail at the private board meeting in September and then progress through October and November, aiming for medium-term plan approval in December, aligning with NHS England expectations. It outlines a plan for the board to consider, with a schedule for further discussion and refinement, including integration of feedback from both executives and non-executives. **Resolved:** The Committee noted the report.
25/26/085	**M4 Integrated Performance Report** **Resolved:** The Committee received and noted M3 Integrated Performance Report.
25/26/086	**Board Assurance Framework** **Resolved:** The Committee received and noted the Board Assurance Framework.
25/26/087	**Any Other Business** There was no any other business.
25/26/088	**Review of the Meeting**
	Date and Time of Next Meeting: Friday 26 September at 9.30am, Teams (moved from 29 September)

25/26 FTPC Key Risks – Month 5 Position

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M5
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 5 position reported £1m deficit in month and £2.5m deficit YTD which is off plan by £0.2m ytd, due the impact of industrial action. PBR/ERF in month performance was higher than plan (£0.4m), added to a backdated gain from M3 & M4 (£0.2m). YTD PBR overperformance (£1.2m) sits within divisional positions. This position is being closely monitored as commissioner expectation is that we perform in line with plan. CIP delivery is on plan in month 5 and YTD. Total savings of £16m have been transacted (green) , forecasting externally to deliver £19.7m (100% green, 75% fully developed, 50% amber and 25% red schemes). 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	The ICB position remains challenged. Month 5 performance was £5.9m adverse ytd (excluding deficit support funding (DSF)). If the system to not achieve plan for the year DSF will not be forthcoming, which would take the ytd position to £35.6m adverse ytd. Aside from DSF the majority of the reported adverse position relates to industrial action (circa £5.9m ytd). M5 forecast for the ICB was a £380.5m deficit (£202.3m adverse to plan). A significant emphasis in reducing the run rate on a recurrent basis is now the focus for ICB turnaround.	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 – M5 capital spend is £1m above plan (£0.9m 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. Following confirmation that £2m brokerage funding from Merseycare (to be repaid in 26/27) has now agreed, the two Data Centre business cases (originally priority 2) have now also been approved to progress. Discussions ongoing with other providers across the system and the ICB re further capital brokerage options –with the hope of resolving funding for the year by early October. All priority 2 cases asked to bring business cases to next Capital Management Group in order to finalise prioritisation. 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.detailed plan will be developed—	High

BOARD OF DIRECTORS

Thursday, 2nd October 2025

Paper Title:	**Board Assurance Framework Report (August 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 August 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 August 2025 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk has been reviewed. The gaps in assurance and actions remain in place with monitoring through SQAC. The increased financial pressure is reflected in the risk, consideration is being given to any impact on quality and safety of the external financial environment. The board have oversight of the financial challenges.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  All actions completed, controls are in place to manage the shortages. Medication supply is monitored by the pharmacy team and published for information to those who prescribe. It is likely that this is an ongoing situation which means we will need to keep the controls in place to remain vigilant and to continue to communicate with all stakeholders via the communication routes that we have established. We have restarted commencing children and young people on medication but are keeping a cautious and gradual pace to this in order not to overwhelm the available stocks. We are training additional nurses to undertake prescribing to increase capacity and meet demand. This work is also now part of the wider ND service transformation programme and the piloting of "Cleo" electronic prescribing all of which aims to streamline the process which will help toward minimising the impact of shortages and any consequent necessary additional reviews and/or changes to individual prescriptions. This work is now considered to be business as usual, and we aim to close this risk and continue to monitor it via the divisional medicine safety group and the Trust wide pharmacy forums as appropriate. Final meeting to agree this step will be held before closure of risk.

- ***Children and young people have timely and safe access to elective, urgent and follow up care (AB).***
  August performance against 2025/26 targets
  - Acute (78%) - ED performance remained above target at 85%
  - RTT (63% by March 2026) - Improvement compared to previous month (60.3% in month)
  - Pts >52 weeks (1% by March 2026) - remains at approx 2% however the number is increasing. The trust has a plan to reduce from approx. 410 to 250 in September
  - DMO1 (95%) - Performance achieved 94%

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***
  The Trust are awaiting further details from Project Co directors on the next steps now that a settlement has been approved. This was discussed at the last liaison committee held on the 14th August.

  Water safety group meetings held alongside operational groups to monitor progress of out-of-range temps and an independent paper has been provided. by Project Co directors. Trust reps have requested a project plan to be provided from P Co directors based on this paper.

  Notification on tap filters has been issued to Project Co.

  Green roofs are performing as expected.

  Chillers are now facing further issues and temporary ones have been put in place.

CHP has been offline for almost a year and again we await P Co's update on this.

- ***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 review and remains the same due to improvement plan in place for Liverpool locality. CQC report uploaded.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***
  This risk continues to be closely monitored. The weekly workforce establishment and vacancy panel scrutinizes the WTE position closely assessing any impact and plans to mitigate associated 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 and all actions reviewed and updated. Key updates to actions relating to values workstream, data insights and communications. No change to risk rating.

- ***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. In consultation with Liverpool City Council Phase 3 target completion is agreed as March 2026.

- ***Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (KW).***
  There is a risk that the Vision 2030 transformation programme will not deliver the required in-year financial savings to meet Cost Improvement Programme (CIP) targets. While the programme remains strategically aligned and has delivered value across its seven strategic goals, the pace of in-year benefit realisation has not met expectations, leaving a residual financial gap and increasing pressure on operational budgets.

  To mitigate this, targeted actions within programmes are being accelerated to maximise in-year savings. A single, aligned plan with strengthened governance is being established to ensure delivery focus. Monthly oversight through the Transformation Board supports reprioritisation, and enhanced benefit tracking with recurrent savings logic is being applied. Delivery models are being refined to integrate transactional and collaborative approaches for greater efficiency.

  Additionally, a risk is being held on the ability to appoint a Head of Experience, which is impacted by the need to control WTEs. This constraint may affect the programme's ability to deliver experience-led improvements at pace, further influencing the achievement of financial targets.

- ***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 as currently no de-escalation of the risk in year to delivery of plan despite the ongoing controls

and actions being taken.

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. The mitigations put in place last month are still ongoing with the expectation that by the end of September the CIP programme will be fully developed. A check in with the Board is planned mid September and a full update to be provided at the next FTPC and Board.

- ***System working to deliver 2030 Strategy (DJ).***
  We are undertaking a risk review to consider the impact of C&M formal turnaround on the trust aspirations / Vision 2030 and maintaining focus on CYP services in face of broader system challenges – further updates will follow in October 25.

- ***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).***
  Actions reviewed and updated. No change to risk score in month - remains at 9.

- ***Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (KW).***
  Risk reviewed and remains at 16. Work is now progressing to refresh aging infrastructure, and both data centres will be completed in the calendar year. There has been delivery of two significant initiatives in August (integrated Obs and PDS) both contributing to achieving strategic goals. Resource and recruitment constraints currently impacting Transcription and Clinical Coding with mitigations in place. Recruitment is still ongoing for a small number of key posts in the dept, most notably in the technical areas of the service.

5. Corporate risks (15+) linked to BAF Risks (as at 8th September 2025)

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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
2450	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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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
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
199	Insufficient funding to provide a 52-week radiology service to report images with current imaging demand ***(NEW)***	4x4	Medicine	3.4	May 2025	Jul 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
399	Three Anti Barricade doors not opening outwards on patient bedrooms and faulty swipe entry on patients bedrooms ***(NEW)***	4x4	Community		Jun 2025	Aug 2025
297	Transcription delay and increase of turnaround times	4x4	Corporate Services	2.1	Dec 2024	Apr 2025

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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
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	4x4	Medicine	1.2	Feb 2023	Oct 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	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.					
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
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
199	Insufficient funding to provide a 52-week radiology service to report images with current imaging demand ***(NEW)***	4x4	Medicine	1.2	May 2025	Jul 2025
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
	None					
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	P-MIP 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
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	Risk Rating		
			Actual	Target	Assurance Committee
Safe		Nathan Askew	9	4	

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	September 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	

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	September 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	

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?)
Appointment of external expertise to advise Trust	- Reporting of external advisors to DD and Exec lead which informs the action plans and response back to SPV - Regular contact with Lawyers on the contractual status
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations.	-Review of the action plan takes place monthly to ensure all remains on track. - Where applicable, a team from the service provider is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact
Joint oversight by SPV and Trust through formal Liaison meeting	-Defects and action plan standing item on the monthly Liaison meeting attended by both Trust and SPV directors. - Minutes taken and circulated on key actions and risks
Regular oversight of defect issues by Trust committee (FTPC)	- Monthly report to FTPC on progress of remedial works through the PFI report - Escalation meetings when required with FTPC
Trust Board awareness of ongoing status of issues and defects including the actions taken	-Report to Trust Board outlining key risks and actions.

Gaps in Controls / Assurance

Remedial Works not yet completed; lack of confidence in timescales being met.

Action	Description	September 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	

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	September 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	September 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	

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	September 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	

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	September 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	Data sent to Digital lead to begin development of Thriving Teams Index to include measures relating to safety culture, leadership, wellbeing, team work, sickness, stability and FTSU cases. 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	Resource secured via Charity to begin design work and to produce new lanyards for staff. Engagement and consultation sessions with wider organisation underway with 21 team values sessions already complete and a further 20 booked in. Data being gathered from these sessions to inform development of values in action toolkit. 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	September 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	

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 clarity on work required to complete Park and campus	- Information provided to capital prioritisation on areas that require capital spend - Tracking of budget and spend in line with business cases through the development team and finance.
Delivery of Design and Access Statement (included in planning application)	- Compliance reporting from Park Project Team
Development monthly meetings with Divisions	- Monthly meetings held with Development Team and Divisions tracking progress of various schemes and escalation of issues - Outputs reported to FTPC via Project Update
Executive Design group to seek input into plans	- Quartely meeting to take place with key executives to share master plans, schemes and seek input - Feedback into Trust Board - NED sponsor
Implement planning approval for full park development.	- Full planning permission gained in December 2019 for the park development in line with the vision - Tracking of works completed to ensure in line with planning approval - Regular updates and meeting with Liverpool City Council and the planning department to discharge pre-commencement conditions -
Neonatal Programme Board in place to ensure scheme delivers in line with business case and vision of clinical teams.	- monthly meeting in place with relevant teams including project highlight reports and any areas of escalation - Regular reports to LNP board on scheme
Planning permission granted for Neonatal and Urgent Care	- Regular updates on implementation of NICU scheme in line with planning permission granted
Regular updates to CEO, Executive Lead and Communications	Fortnightly Report submitted from DD on all areas of campus and any issues for escalation
Report monitoring progress on all areas of campus	- Monthly report to Board on campus - Campus highlighted as a top 5 risk at FTPC and reported through this mechanism with clear risk and escalation where required. - Stakeholder events / reported to Trust Board and CoG - Weekly tracking through Senior Development Team Meetings
Strategic Estates and Space Allocation Group to approve changes to the campus to ensure alignment to vision	- Monthly meetings from September chaired by exec lead and supported by DD

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	September 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	

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	September 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	Risk Rating		
			Actual	Target	Assurance Committee
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Rachel Lea	20	4	

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 enhanced further with Finance App -@ Finance reports shared with each division/@department monthly and now readily available on Finance App -@ Financial in-month and forecast position reported through SDG, Exec team, FT&P, and trust Board including run rate analysis in detail -@ 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	September 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	

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 Sept 25 update: organisation change at RMCH has delayed NWPPB regrouping. New management is in post Sept 25, and we will now engage and progress this agenda.
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 Sept 25 update: NHSE and ICB structural changes are causing uncertainty on timeframes: we continue to monitor and engage with the system on next steps.
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 Sept 25 update: capacity and capability building will be captured in the forthcoming blueprints and TOM work.
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 Sept 25 update: Stakeholder management: An options paper on professionalising stakeholder management was completed for execs on Aug 25. Due to financial constraints, only no/low cost CRM tool options will be considered this year. The need for effective CRM tools is acknowledged, and the Strategy Board will receive an update in October as part of the broader GO review.
Joint development of new models of care on a wider footprint	Get me well: Lung Health respiratory co-created with partners across Liverpool. Sept 25 update: Recent Lung Health event took place, organised by Tripartite: Alder Hey, Merseycare and LUHG. 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	September 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
▪ Caring ▪ Effective ▪ Safe ▪ Well-Led		John Chester

Risk Rating		
Actual	Target	Assurance Committee
9	4	

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	September 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	

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	September 2025	
		Due Date	Action Update
Cyber Assurance Framework & Strategic review of Cyber Security	This has replaced the action around Cyber Essentials +.	22/09/2025	
Experienced Resources	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce	30/09/2025	
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, 2nd October 2025

Paper Title:	Board Assurance Framework Policy
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	Jill Preece, Governance Manager

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	The Board is asked to RATIFY the Board Assurance Framework Policy following approval by the Audit and Risk Committee at its September 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 ☑
Resource Implications:	N/A

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

Alder Hey Children's
NHS Foundation Trust

RM58 – BOARD ASSURANCE FRAMEWORK POLICY

Version:	~~6~~7
Name of ratifying committee:	Board of Directors
Date ratified:	~~29/09/2022~~ 02/10/2025
Name of originator/author:	~~Director of~~ Chief Corporate Affairs Officer
Name of approval committee:	Audit and Risk Committee
Date approved:	~~15/09/2022~~ 11/09/2025
Executive Sponsor:	~~Director of~~ Chief Corporate Affairs Officer
Key search words:	Assurance, Risk, BAF, RM58
Date issued:	~~September 2022~~October 2025
Review date:	September 2028~~5~~

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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
7	September 2025	Chief Corporate Affairs Officer / Governance Manager	Current	
6	September 2022	Director of Corporate Affairs	Archived	
5	September 2019	Director of Corporate Affairs	Archived	
4	February 2018	Director of Corporate Affairs	Archived	
3	September 2016	Director of Corporate Affairs	Archived	
2	July 2015	Director of Corporate Affairs	Archived	
1	July 2014	Director of Corporate Affairs	Archived	

Record of changes made to Board Assurance Framework Policy – Version 76			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Throughout Throughout Throughout 1.6	12	- All references to Resources and Business Development Committee replaced with Finance, Transformation & Performance Committee - Director of Corporate Affairs title change to Chief Corporate Affairs Officer - NHS Improvement updated to NHS England - Risk profiling descriptions updated to be consistent with Risk Assessment Policy.	
Throughout	Throughout	- All references to Integrated Governance Committee replaced with Risk Management Forum. - All references to Workforce & OD Committee replaced with People and Wellbeing Committee - All references to Clinical Quality Assurance Committee replaced with Safety and Quality Assurance Committee - All references to Audit Committee replaced with Audit and Risk Committee	Updated to reflect new committee structure since v5 of the policy
3.3	5	Updated to reflect new Risk Management Forum arrangements	New reporting structure
Throughout	Throughout	References to Corporate functions replaced with business unit functions	Point of consistency
App A 1.6	11	Updated to reflect risk grading on risk management system	

Contents

1 Introduction

A Board Assurance Framework (hereafter referred to as the BAF) must be driven by the objectives of the organisation. Therefore it follows that clear strategic and operational objectives need to be identified before an effective system of internal control can be established. Without clear objectives, the Trust would be unable to identify and evaluate the risks that threaten the achievement of its goals and design and operate a system of internal control to manage those risks. The corporate objectives for the Trust are determined by the Board of Directors, based on organisational, local and national priorities, stated in the Trust's operational plan and other related documents. The BAF enables the Board to demonstrate that it has been properly informed about the totality of its risks and is able to sign the Annual Governance Statement required annually by NHS ~~Improvement~~ England.

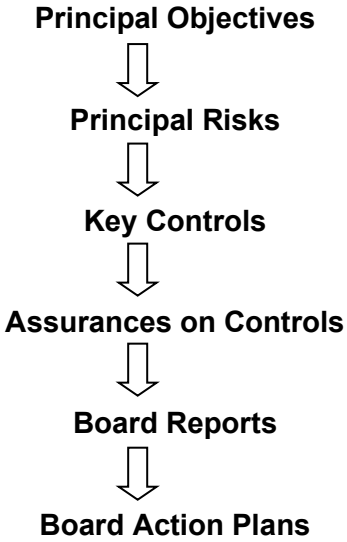
The BAF must be a dynamic tool to enable the Board to assure itself that all significant strategic risks are being managed effectively. The elements involved in this assurance process are:

- The BAF must be reviewed and updated with progress towards closing the identified risks and associated gaps in control and/or assurance at least quarterly.
- Independent scrutiny must take place to ensure that these updates are valid.
- Both of these processes must also consider whether new risks have arisen with the potential to jeopardise the achievement of the Trust's principal strategic objectives.

2 Purpose of Policy

The purpose of this policy is to set out the key structures, systems and processes by which the Board of Directors is assured, via the BAF and the underpinning risk registers that the Trust's strategic and operational objectives are being achieved through the effective management of the strategic and operational risks. See Fig.1 below.

The Board Assurance Framework



3 Duties and Responsibilities

3.1 Board of Directors

- It is the duty of Board members to ensure that they monitor the Trust's significant risks as detailed in the corporate risk register and that those corporate risks link into the high level risks on the BAF, that relate to specific strategic objectives and the associated controls and assurances in line with the work plan. In particular, the Board should focus upon progress by exception of action plans to address gaps in control and assurance.
- The Board should ensure that all systems, processes and procedures required for the BAF function effectively, including where elements have been delegated to Committees.

3.2 Board Committees

- The overall role of the Board's committees is to carry out the detailed work of assurance on behalf of the Board. They report recommendations to the Board. The Board Committee's core role and responsibilities is to:
  - Scrutinise reports on the relevant risks to that Committee's remit from the BAF and the corporate risk register; the delivery of the Annual Plan and compliance with CQC Standards.
  - Contribute to the development of the Annual Planning cycle and ensure that this plan reflects stakeholder requirements.
  - Give the Board confidence that the systems, policies and people they have put in place to deliver the Annual Plan are operating in compliance with CQC Standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.
  - Provide the Board with the evidence required of the effectiveness of controls in order to be able to sign the Annual Governance Statement and maintain unconditional registration with the CQC.
  - Scrutinise reports and evidence of assurances provided by clinicians, managers, Trust committees and independent assurers on the status of the Trust's internal controls.
  - Ensure that unacceptable levels of assurance and risks are reported to the Trust Board for their consideration.

3.3 Risk Management Forum

- The Risk Management Forum oversees the design and effective operation of the risk management process across the Trust including the management of the production of the BAF.
- The Forum provides the Board with assurance that a comprehensive corporate risk register is in place derived from the Executives' view of the major risks to the Trust and the risks being escalated from Divisions and business support functions.
- The Forum oversees the integration of clinical, organisational and financial risk management systems across the Trust with that of corporate business planning.

- It is authorised to take remedial action to resolve weaknesses and incorporate best practice.

3.4 Divisions and Business Unit Functions

- All Divisions and Business Unit Functions should report to the Risk Management Forum on their specific accountabilities and responsibilities as defined in the work plans.

3.5 ~~Director of~~ Chief Corporate Affairs Officer

- The ~~Director of~~ Chief Corporate Affairs Officer will facilitate the process for updating the BAF.
- The ~~Director of~~ Chief Corporate Affairs Officer will ensure the Board of Directors is provided with an updated BAF every month.
- The ~~Director of~~ Chief Corporate Affairs Officer will ensure that timely risk modelling is undertaken for all new identified or emerging risks.

3.6 Executive Directors

- Each risk identified on the BAF will have an Executive Director owner who holds accountability for updating entries in the Assurance Framework against that risk i.e. associated controls, actual assurances (reports etc), action plans and impact/likelihood score.
- Once all updates from risk owners have been received, the Executive Lead will sign off the refreshed BAF.
- The Executive Directors will be accountable for the proactive timely and accurate review and update of all risks owned by their Divisions / business unit function. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them. It is also an opportunity to identify any emerging new risks for assessment and inclusion in the corporate risk register.

3.7 Non-Executive Directors

- It is the role of all Non-Executive Directors to contribute to Board and Committee discussions and make constructive challenges.
- They should identify issues, either through Committee activities or at the Board itself, of which the Audit and Risk Committee will undertake a more detailed review.

3.8 Associate Chief Operating Officers / Heads of Business Unit Functions, Project and Programme Managers

- Associate Chief Operating Officers, business support function Heads of Departments, Project and Programme Managers are accountable for the complete and accurate review and update of all risks owned by their Divisions/ service/ programme. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them.

- They are also accountable for identifying any emerging new risks for assessment and escalation to the corporate risk register.

3.9 All Staff

- To contribute to the identification of risk through active participation in the risk assessment and incident reporting processes by ensuring they comply with their responsibilities identified in the risk assessment and incident reporting policies.
- To follow all relevant safety precautions in line with the Trust's Incident policy.
- Must keep all mandatory training up to date as identified in the Trust's training needs analysis.

4 Process for Maintaining the Board Assurance Framework

4.1 The BAF is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust in achieving its strategic goals.

4.2 The BAF contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.

4.3 Risks are scored using a 5x5 matrix of impact and likelihood. This 5x5 matrix, in which scores for impact or consequence of the risk is multiplied by the score for likelihood of occurrence. The total score generated is known as the risk rating.

4.4 The BAF is maintained by the ~~Director of~~ Chief Corporate Affairs Officer. The information recorded on the Framework includes:

- Description of the risk
- Current risk score
- Control measures in place
- Evidence of current assurances
- Gaps in controls/ assurances
- Target risk rating (as defined by risk appetite)
- Actions required to achieve the target risk rating – the appetite for the specific risk.

4.5 The Board of Directors has delegated responsibility of monitoring risks and assurances to the Risk Management Forum (RMF), which will oversee the design and effective operation of the risk management process across the Trust including the management of the Corporate Risk Register and Board Assurance Framework. The RMF will provide the Audit and Risk Committee with a bi-monthly assurance report on the outcome of the meeting including an updated BAF, a summary of the corporate risk register and any key issues arising from the meeting. The full BAF and corporate risk register will also be produced to inform Board Committees including Safety and Quality Assurance Committee, the ~~Resources and Business~~ Finance, Transformation and

Performance ~~Development~~ Committee, ~~Innovation~~ Futures Committee and People ~~and Wellbeing~~ Committee of the latest position on their related risks.

4.6 The Audit and Risk Committee has delegated responsibility from the Board to oversee this process, ensuring that there is adequate external review and assurance and that this is used to inform the Annual Governance Statement.

5 Process for the Local Management of Risk (which reflects the organisation wide Risk Management Strategy)

- The locally identified risks, derived from completing the risk assessment tool, will be utilised to inform the departmental risk registers. Divisional Associate COOs/Heads of Business Unit Functions are responsible for ensuring that actions are put in place to mitigate identified risks.
- The ways in which risk can be escalated from Ward and department level to Divisions and corporate levels is outlined in the Risk Management Strategy.
- Divisions/ Business Unit Functions will provide exception reports to the Risk Management Forum in line with its work plan.

6 Monitoring Compliance with the Processes

As stipulated within this policy, the Trust will keep the BAF under review via the Risk Management Forum and monthly reports to Board of Directors and its Committees.

- The reports will be presented by the ~~Director of~~ Chief Corporate Affairs Officer to the Board of Directors and its assurance committees.
- An annual audit of the corporate risk register/ Assurance Framework will form part of the internal audit programme, to support the Annual Governance Statement.
- The purpose of this annual audit is to monitor the systems and processes of the approved organisation-wide risk register.
- The Trust's BAF will be monitored to assess compliance with the key performance indicators.
- The audit process will assess whether: -
  - Responsibilities are clearly agreed and recorded and there is evidence to support objectives which are clearly linked to the Trust's operational plan or other strategic documentation.
  - Risks are clearly linked to objectives, their priority (impact/likelihood) has been determined and they have been attributed to a lead.
  - Risks are assessed and new/amended risks are considered and included where appropriate.
  - Controls effectively manage the risk, there is evidence that the controls are in place and that there is adequate management of controls.
  - Controls relied upon are sufficient to manage the risk i.e. expected assurances have been received and provide sufficient information to efficiently manage the risk.
  - Positive assurance evidence is collated and uploaded onto performance accelerator and signed off by the accountable Executive Director.

- Where gaps in control/assurance have been identified, appropriate actions plans have been agreed to address these and are monitored consistently in line with policy standards.
- Board reports, Risk Management Forum minutes, ~~Resources and Business Development~~ Finance, Transformation & Performance Committee minutes, Safety and Quality Assurance Committee minutes, ~~Innovation~~ Futures Committee, People ~~and Wellbeing~~ Committee minutes and Audit Committee minutes provide evidence that the Assurance Framework has been effectively discussed and considered and progress/ action has been taken to address areas raised following the audit.
- The Risk Management Forum and Audit and Risk Committee monitor reports ensuring that recommendations/actions are implemented where monitoring has identified deficiencies. This is to ensure that lessons have been learned and agreed changes in practice made.
- The organisation has a defined risk appetite, which is embedded in the BAF and used by management to make informed decisions.

7 Further Information

Equality Analysis *(hyperlink)*

References

- The Healthy NHS Board
- Taking it on Trust
- Board Assurance Frameworks – A Simple Rules Guide for the NHS
- CQC Standards
- NHS system Oversight Framework
- NHSE~~I~~ Annual Reporting Manual

Associated Documentation

This policy should be read in accordance with the Trust Risk Management Strategy.

Appendix A

1. Definitions

1.1 Assurance

Confidence based on sufficient evidence, that internal controls including policies, procedures, practices and organisational structures are in place and operating effectively ensuring the strategic objectives are being achieved.

1.2 Key Elements Assurance Framework

- An Assurance Framework (BAF) is a simple but comprehensive method for:
  - The management of the principal risks to meeting the organisation's objectives.
  - Providing evidence for the Annual Governance Statement. Guidance on what should be included within the Statement is provided within ~~Monitor's~~ NHSE's Annual Reporting Manual each year.

1.3 Principal Objectives

- Principal Objectives are statements of the crucial measurable results which the organisation must achieve in order to achieve its overall goals in line with its strategic aims.
- Clinical Divisions and business unit functions must align their objectives with the principal objectives in order to ensure that their activities contribute to the achievement of the Trust's principal objectives.
- The BAF must specify the Director who is accountable to the Board for delivering the Principal Objectives of the corporate plan.
- The Principal Objectives must be stated in terms which are:

Specific
Measurable
Achievable
Realistic
Time-based

1.4 Risk Registers

- Risk registers are held at Ward /Departmental level, Divisional level, business support function level, and at Trust Wide level, (Assurance Framework and Corporate Risk Register). The principal risks associated with each strategic objective must be identified on the BAF.
- The risk rating tool (5x5 matrix) enables staff to consider the potential harm that would be caused if a hazard or threat was realised and how likely this is to happen. The two factors of likelihood and impact/consequence are used to establish the level of risk; this will assist staff in deciding which risks take priority and highlight areas which need rapid attention.
- The Divisional/Department/Business Support Function level risk register must reflect the proactive annual risk assessments undertaken and

reactive risks identified through incident reporting etc. including demonstrating action taken against these risks at least monthly.

- Each Division/Department/Business Support function has responsibility to review their own risks and to inform the Risk Management Forum of actions completed to reduce or eliminate the identified risk.
- The Division /Department/Business Support Function risk assessments will contribute to the formulation of the high level Trust Corporate Risk Register along with other forms of risk identification. This will ensure that the risk registers are consistent and that meaningful decisions on the prioritisation and treatment of risks can be made.
- Risk Registers will be kept at Business Support Functions, Divisional and Department/Ward levels within the Trust.
- At Board level the corporate risk register will include risks to the achievement of Principal Objectives together with risks escalated from business support functions, Divisions and Department/Ward levels.

1.5 Principal Risks

- Factors which potentially threaten the achievement of the principal objectives are called principal risks and need to be identified. They should be stated as "If x happens then y will be the consequence".
- Using risk profiling the principal risks to achieving the principal objective are identified and summarised on the BAF together with a score of their likelihood and potential impact.

1.6 Risk Profiling

Risk Profiling is a process that involves the identification and assessment of all risks encountered by an organisation, enabling the identification of high-risk issues, facilitating the management and prioritisation of such risks.

- Risk profiling gives a risk a 'Likelihood score' of:

1 = rare - ~~do not expect this to happen~~ little chance of occurrence.
2 = unlikely - ~~most~~ probably ~~will not happen~~ won't occur.
3 = possible - ~~50:50~~ may occur occasionally / reasonable chance of occurring.
4 = likely - ~~most~~ probably will ~~happen~~ occur.
5 = almost certain - ~~confident that this will happen~~expected to occur frequently.

- Risk profiling gives an impact/consequence score of

1 = Negligible. Almost non - no obvious harm. Insignificant cost increase / schedule slippage
2 = minor - no permanent harm (recovery within month). Less than 5% over local budget / schedule slippage.
3 = moderate - semi-permanent harm (recovery takes longer than 1 month but no more than 1 year) and/or adverse publicity for the Trust. More than 10% over local budget / schedule slippage.
4 = major - permanent harm not resulting in death or severe disability to a person or persons. Start of a national investigation into the Trust.

Disruption of key Trust services which significantly hinder the Trust in meeting its responsibilities. Less than 5% over Trust budget.

5 = catastrophic - death or permanent severe disability to a person or persons and/or significant loss of reputation for the Trust and/or loss of key Trust services which prevent the Trust meeting its responsibilities. More than 10% over Trust budget.

Note: Harm in all the above includes damage to the organisation, its finances, its reputation, its business, its patients, staff or visitors.

1.7 Identification of Risks

Potential principal risks to the achievement of the Trust's objectives are identified in two ways: the 'top down' proactive (risk assessment) identification of risks that directly affect the Trust's achievement of its principal objectives, combined with the 'bottom up' assessment of the most significant risks within the business support, programme and Clinical Risk Registers.

1.8 Controls and Assurance

- Controls are the many different things that are in place to mitigate risk and assist in securing the delivery of objectives; they should make a risk less likely to happen, or reduce its effect if it does happen.
- The Assurance Framework requires the Trust to consider the effectiveness of each control through the process of obtaining assurances that the control is in place and is operating effectively.
- The Assurance Framework summarises how the Board knows that the controls it has in place are effectively managing the principal risks together with references to documentary evidence that the assurances are working effectively.
- There are two groups of assurances on controls:
  - Internal Assurance
  - Independent Assurance
- Internal assurance is provided by the following Committees:
  - Audit and Risk Committee
  - Safety and Quality Assurance Committee
  - ~~Resources and Business Development~~ Finance, Transformation & Performance Committee
  - Risk Management Forum
  - People ~~and Wellbeing~~ Committee
  - Health and Safety Committee
  - Growth and Opportunities Committee
- The purpose of the committees is to carry out an analysis of assurances received, identify any key gaps in the assurance mechanisms and provide an evaluation of the effectiveness of these mechanisms to inform the relevant strategic objectives on the Assurance Framework.
- The Board of Directors then receive summary reports from these committees together with Audit and Risk Committee reports and makes a

final judgement on the level of assurances received and any actions required to ensure delivery of the Trust's objectives and obligations.

- Independent assurance is provided by:
  - Audit and Risk Committee
  - Internal Audit and External Auditors
  - Care Quality Commission
  - Health and Safety Executive
  - NHS ~~Improvement~~ England

1.9 Key Controls

- Key controls are the means by which the risk's impact or likelihood may be reduced together with references to documentary evidence of the existence and effectiveness of that control mechanism. Risk control is achieved by reducing the likelihood of the risk, reducing the impact of the risk and/or transferring the risk. The risk controls are also identified through a risk profiling process and summarised on the Assurance Framework as are any gaps in risk control.

- The Board of Directors and all other Trust staff must use the same grading matrix contained within the risk management system.

- Risk Appetite
  - Risk appetite is the level of risk within which the Trust **aims** to operate. Target risk ratings should be set in accordance with the Trust's Risk Appetite Statement which is set out below:

Category	Risk Appetite Level	Risk Score Threshold
Compliance and Regulatory	LOW-MEDIUM	4-6
Financial – Compliance	LOW-MEDIUM	4-6
Financial - Regulatory	LOW-MEDIUM	4-6
Commercial	MEDIUM-HIGH	10-12
Quality – Safety	LOW	1-3
Quality - Effectiveness	LOW-MEDIUM	4-6
Workforce - Sustainability	MEDIUM	8-9
Workforce – EDI	MEDIUM	8-9
Workforce – Culture	MEDIUM	8-9
Reputation	MEDIUM	8-9
Systems and Partnerships	MEDIUM	8-9
Clinical Innovation	HIGH	15-25
Environment	MEDIUM-HIGH	10-12
Technology - Cyber	LOW-MEDIUM	4-6
Technology – Transformational Change	MEDIUM	8-9

1.10 Gap in control and assurance

- A gap in control is deemed to exist where adequate controls are not in place, or where collectively they are not effective. A failure to put in place

sufficient effective policies, procedures, practices of organisational structures to manage risks and achieve objectives.

- A gap in assurance is deemed to exist where there is a failure to gain evidence that the controls are effective. In other words a failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed is operating effectively.
- Wherever gaps in control or assurance are identified, action plans must be clearly defined, monitored consistently for improvement and allocated to appropriate lead Directors.

1.11 Controls Performance Reports and Associated Action Plans

- Performance reports e.g. audit reports provide strong evidence of the effectiveness of control activities and should identify necessary improvements where controls are lacking. It therefore follows that performance reports generate valuable information for the Assurance Framework and that there is a clear need for performance reporting and the Assurance Framework to be strongly linked.
- Where there is deficits identified in performance action plans must be formulated and consistently monitored to ensure compliance with performance standards (strategic objectives).