BOARD OF DIRECTORS PUBLIC MEETING
Thursday 6th November 2025, commencing at 13:55
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							
1.	**25/26/216**	**13:55 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**25/26/217**	**13:56 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**25/26/218**	**13:57 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **2nd October 2025.**	**D**	Read enclosure
4.	**25/26/219**	**13:59 (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.	**25/26/220**	**14:00 (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.	**25/26/221**	**14:10 (10 mins)**	**2025/26 Financial Plan update; including:** • **C&M financial position update.**	R. Lea	To receive an update on the current position.	**N**	Read report/ Verbal
Performance Against Annual Plan							
7.	**25/26/222**	**14:20 (35 mins)**	**Evidence of Our Performance:** • **Flash Report, M7.** • **Integrated Performance Report for M6, 2025/26:** - **Experience and Safety.**	A. Bateman N. Askew	To receive the Trust's Integrated Performance Report for scrutiny and discussion, highlighting any critical issues. To receive an update on the current position.	**A**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.**	A. Bateman J. Chester M. Swindell D. Jones R. Lea Divisional Directors	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.		
8.	**25/26/223**	**14:55 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell/ J. Halloran	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Presentation
Unrivalled Experience							
9.	**25/26/224**	**15:05 (10 mins)**	**Outpatient Pharmacy Outsourcing Business Case.**	P. Sanderson/ N. Pickard	For ratification.	**D**	Read report
10.	**25/26/225**	**15:15 (5 mins)**	**SARC Accreditation Update.**	L. Cooper	To receive an update on the current position.	**N**	Read report
11.	**25/26/226**	**15:20 (5 mins)**	**Learning from Patient Safety Incidents, Q2.**	N. Askew	To receive the Learning from Patient Safety Incidents report for Q2.	**A**	Read report
12.	**25/26/227**	**15:25 (5 mins)**	**Staff Influenza Vaccination Programme – Update.**	N. Askew	To receive an update on the Staff Influenza Programme.	**A**	Presentation
13.	**25/26/228**	**15:30 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 22.10.25.** - **Approved minutes from the meeting held on the 24.9.25.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 24.9.25.	**A**	Read enclosures
Collaborating in Communities							
14.	**25/26/229**	**15:35**	**LNP Board:** - **Chair's Highlight Report**	A. Bass	To escalate any key risks and receive an	**A**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
		(10 mins)	**from the meeting held on the 6.10.25.** **- Update on governance arrangements.**	A. Bass	update from the meeting held on the 6.10.25. To receive an update on the current position.	**N**	Read report
15.	**25/26/230**	**15:45 (5 mins)**	**Growth and Opportunities Committee:** **- Chair's verbal update from the meeting held on the 7.10.25.** **- Approved minutes from the Futures Committee that took place on the 25.6.25.**	M. Jennings	To escalate any key risks, receive updates and note the approved minutes from the Futures Committee that took place on the 25.6.25.	**A**	Read enclosure
Supporting our People							
16.	**25/26/231**	**15:50 (5 mins)**	**Strategic People Update.**	M. Swindell	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
17.	**25/26/232**	**15:55 (5 mins)**	**NHS England's National Oversight Framework Capability Self-assessment.**	J. Preece/ J. Grinnell	To approve the provider capability self-assessment.	**D**	Read report
18	**25/26/233**	**16:00 (5 mins)**	**Finance, Transformation and Performance Committee:** **- Chair's Highlight Report from the meeting held on the 22.10.25.** **- Approved minutes from the meeting held on the 26.9.25.** **- 2025/26 Top Key Risks, (M6).**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 26.9.25.	**A**	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
19.	**25/26/234**	**16:05 (5 mins)**	**Board Assurance Framework Report.**	N. Askew	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read reports
20.	**25/26/235**	**16:10 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
21.	**25/26/236**	**16:14 (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, 4th December 2025, LT1, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal wasn't used in October 2025

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M6, 2025/26	R. Lea
WRES Report	M. Swindell
WDES Report	M. Swindell
Ethnicity Pay Gap and Equality Objectives Report	M. Swindell

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 2nd October at 11:45am**
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. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer/Deputy CEO	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Dr. B. Owolabi	Non-Executive Director	(BO)
	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)
	Mr. I. Gilbertson	Deputy Chief Digital & Information Officer	(IG)
	Mrs. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Mrs. K. McKeown	Board Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
Item 25/26/187	Ms. M. Ashe	Policy Lead/Advisor to EO	(MA)
Item 25/26/187	Ms. A. Prendergast	Assoc. Director of Strategy and Partnerships	(AP)
Item 25/26/190	Mrs. K. Turner	Freedom To Speak Up Guardian	(KT)
Apologies:	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. R. Lea	Interim Chief Finance Officer	(RL)
	Mr. D. Powell	Development Director	(DP)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)

Patient story

The Chair welcomed Professor Rachel Isba (RI) who was invited to October's Board to share a young person's experience of using Ketamine and her road to recovery. A number of slides were shared to provide background information on non-prescribed Ketamine use in under 16's and the risk factors for dependence associated with use of this drug. The Board was informed of the rapid increase in Ketamine use among young people, particularly in the Northwest, and the emergence of Ketamine-induced bladder damage as a result of taking this drug. RI described the multidisciplinary clinic approach at Alder Hey, the lack of national data, and the urgent need for medical withdrawal support for under-18s, as no NHS inpatient detox exists for this age group.

Board members expressed concern and surprise at the scale and severity of Ketamine use and its complications in young people, noting that most were unaware of the issue before the presentation. Questions were raised about education and prevention efforts in schools, with RI explaining that while awareness of Ketamine is high among students, knowledge of its bladder

complications is low. The fragmented nature of drug education, due to varying local authority approaches was also pointed out.

The Board discussed the importance of peer-led and social media-based harm reduction messaging, suggesting that young people with lived experience could contribute to the development of effective content for digital platforms. RI confirmed that there are plans to engage young people in developing such resources. The discussion also highlighted the necessity of early intervention, potentially beginning at primary school level, as well as the critical role of upstream prevention in mitigating irreversible harm.

The Board asked about engagement with the Youth Forum and other advisory groups. RI advised of the ongoing and planned collaborations to ensure youth voices shape service development and public health messaging.

The Chair expressed appreciation for the contributions of all those involved in this initiative. RI pointed out that young people are asking for help with this issue.

25/26/176 Welcome and Apologies

The Chair welcomed everyone to the meeting and noted the apologies received. The Board extended a formal welcome to Bola Owolabi, who has joined the Trust as a Non-Executive Director.

25/26/177 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.

25/26/178 Minutes of the previous meeting held on 4th September 2025.
Resolved:
The minutes from the meetings held on the 4.9.25 were agreed as an accurate record of the meeting.

25/26/179 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 24/25/46.1: *FTSU (Include data that maps themes in terms of concerns by staff group, in the next quarterly report) – This data will be included in January's FTSU report.* **ACTION TO REMAIN OPEN**

Action 25/26/110.1: *Evidence of Our Performance* (*IPR - Include a graph in the IPR to reflect staff turnover figures) – This action has been addressed.*
ACTION CLOSED

25/26/179 Chair's and CEO's Update

The Chair congratulated Garth Dallas on obtaining his doctorate and recognised Kate Warrener's achievement in being named the leading Chief Information Officer

nationally, which was remarkable given the national scope of the competition. The Chair reflected on the positive atmosphere at recent staff and community events, including the Staff Awards ceremony, and the Onam celebrations organised by nurses from Kerala, highlighting the sense of pride and community within the organisation. The Chair also raised concerns regarding the emergence of discriminatory behaviour, particularly related to race, and emphasised the need for zero tolerance and stronger action to protect both staff and patients.

The CEO, John Grinnell, provided an update on operational and strategic matters. It was reported that the Trust experienced a busy summer but continued to deliver strong operational performance despite ongoing financial and workforce challenges. Key themes are emerging, and discussions remain underway in terms of maintaining activity throughout the winter.

Attention was drawn to the delay in the configuration of NHS England (NHSE) related to legislative and funding issues which are expected to continue. The Board was advised of the publication of a regional blueprint and the ongoing transition of the Integrated Care Board's (ICB's) role as a strategic commissioner, with a further update scheduled for November's Trust Board. It was reported that additional details about the foundational elements of the NHS 10-year plan are expected shortly, and reference was made to the new self-assessment process for NHS Trust Boards and the importance of submitting the Trust's self-assessment within the set deadline.

The Board was provided with an update on local system collaborations, including the relaunch of the Provider Collaborative which will look at the reshaping of clinical services, and ongoing C&M interventions by PWC, with upcoming meetings to clarify roles and delivery for the remainder of the year.

Positive developments from recent external engagements were shared, including the Children's Commissioner's visit to the Trust's Sexual Assault Referral Centre (SARC), and the appointment of the Trust's Clinical Director of Research, Dan Hawcutt, as Chair of the Institute of Child Health and Well-being.

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

25/26/180 Strategy Board Update

A summary was provided of the strategy session that took place on the morning of the 2.10.25, which focused on formulating a blueprint for paediatric services across Cheshire and Merseyside (C&M), as well as considering a proposal to apply for Integrated Health Organisation (IHO) status, initiatives in which Alder Hey is actively assessing potential opportunities. Key progress in both Outpatient and Cardiac services was noted, and it was reported that the Trust has got to develop and submit a comprehensive three-to-five-year plan to the Centre by the year-end with an accompanying document to outline a proposed roadmap

Resolved:
The Board noted October's Strategy Board update.

25/26/181 Creating the Future Shape of Alder Hey – Progress Update

The Boad received an update on the key elements for creating the future shape of Alder Hey. A three-pronged approach was outlined, which includes developing

strategic blueprints, establishing a target operating model (TOM), and aligning the organisation's size with the current financial environment. This approach is intended to guide the Trust's strategic direction and operational planning in the coming months.

Attention was drawn to the ongoing challenges related to closing the financial gap and maintaining productivity, whilst it was noted that achieving the required savings and operational targets remains a priority. The Board discussed the importance of aligning strategic ambitions with operational/financial realities and acknowledged that further proposals and actions to bridge the financial gap are in development.

Resolved:
The Board noted the update provided and the progress that is being made.

25/26/181 2025/26 Financial Plan update; including C&M financial position update

The Board received an update on the latest position of the Financial Plan for 2025/26, including progress towards the Trust's Cost Improvement (CIP) target for the year as reported through the recent Closing the Gap Programme. The Board also reviewed the deliverability of the organisation's Financial Plan, with consideration given to identified risks and proposed mitigations. The following points were noted:

- In the past month, the 'Closing the Gap' programme has delivered £19.2m in confirmed savings towards a £22.7m target, with an additional £2m in progress. The remaining CIP gap of c£1.5m remains a challenge and requires further focus on cost control to ensure delivery of the Trust's plan.
- 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.
- 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 (TOM), which will define the future shape, size and structure of Alder Hey, by the end of Q3.
- The C&M position remains significantly challenged and at the end of August the reported position was £5.9m away from plan. It was reported that deficit support funding was not released because the system continues to be off plan.
- The Trust has been ranked as a medium risk by NHSE, resulting in additional oversight and requests for further financial controls, such as standardising pay rates and reviewing agency usage.
- The Trust is actively seeking additional savings opportunities, although it was noted that the forecast does carry certain risks.

Resolved:
The Board noted the update on the Trust's 2025/26 Financial Plan and the C&M financial position.

25/26/182 Evidence of Our Performance

Flash Report, M6

The Board received the Flash Report for M6. The following points were highlighted:

- The Trust ranks 16th of 134 in Segment 1, which reflects strong financial and operational performance. It was pointed out that maintaining Segment 1 is considered critical for strategic positioning and eligibility for new initiatives.
- Operationally, September was challenging due to high staff absence and equipment issues, but waiting list size has improved, with the number of children waiting over 52 weeks now below 250.
- Despite the Segment 1 position, areas of risk include sickness absence, infection rates (notably C. diff), and elective waiting times, though targeted actions are underway to address each of these matters.
- The Trust has sustained its performance for the seventh consecutive month of 80%+ for time to be seen and treated in ED within 4 hours.
- 95% of diagnostic tests have been completed in six weeks.
- It was reported that the Trust has met the criteria for the Elective Capital Incentive Scheme and is in a strong position to potentially secure funding. Recent improvements in elective treatment times (now at 61.8%,) and reductions in the number of children waiting over 52 weeks strengthen the Trust's case for receiving this funding. The Trust is awaiting confirmation on whether it will be among the ten hospitals to receive this funding.
- The Board was advised of the ongoing focus on closing the financial gap, workforce productivity, and maintaining operational performance throughout the remainder of the year.

An update was provided on the Trust's C. diff status, noting that most cases are concentrated within Oncology, where children are often immuno-suppressed. The Board was informed of the differences in clinical presentation between children and adults, with children potentially being asymptomatic carriers. It was reported that due to current national guidelines the Trust only tests children and young people (CYP) who have symptoms. Ongoing and planned actions were summarised, including collaboration with Oncology to review cleaning protocols, room measurements, and antimicrobial stewardship. It was confirmed that a focused piece of work is being initiated to bring together relevant teams to address this issue. Additionally, SQAC has requested a deep dive into this area of work; however, due to the significance of the concern, it was deemed necessary to submit an interim update to the Board.

Integrated Performance Report (IPR)

Outstanding Care and Experience – Safe and Caring

- There was 1 Never Event reported in September appertaining to a retained swab that is to be investigated. Reference was made to a previous Never Event that had similar circumstances, and it was reported that the Trust has approached the Head of the Association for Perioperative Practice (AFPP) based at the Walton Centre to act as a critical friend as part of the investigation.
- It was confirmed that the investigation relating to a posterior spinal fusion surgery resulting in neurological injury has been concluded and that the report is to be shared with the family.

Pioneering

- The initial report on the Paediatric Open Innovation Zone (POIZ) was well received by the Liverpool Combined Authority (LCR), resulting in a successful introductory visit.

Support our People

- Sickness absence is at 6.3%. Work is being undertaken to reduce this figure.

Community and Mental Health Division

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

Division of Medicine

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

Division of Surgery

It was reported that progress has been made in RTT (*Referral to Treatment*) performance, but ongoing challenges remain, particularly with on-the-day cancellations. A number of initiatives are under consideration to address these matters, such as overbooking theatres, implementing a pre-op/no-op process, and validating clinics. The Board was informed that sickness absence continues to pose a risk, and the Division expects a difficult winter period for theatre operations, which may further impact RTT delivery.

The Board discussed pay rates as a key factor influencing operational delivery and financial sustainability. Recent system-level decisions regarding the standardising of rates for resident doctors and nursing bank staff, were highlighted as a potential risk to service delivery if not carefully managed. The Board asked for further analysis to be undertaken by the ICB and PWC to assess the impact of pay rate changes and ensure any adjustments are evidence-based, to avoid unintended consequences across the system. The discussion also covered the financial balance between saving on pay rates and the potential cost of lost activity, such as decreased weekend work.

Resolved:
The Board:

- Noted the Flash Report for M6.
- Noted the content of the IPR for Month 5.

25/26/184 Capital Plan, 2025/26

The Board received an update on the 2025/26 Capital Plan. It was reported that the Trust initially identified £29.1m in funding, with £23.8m confirmed and £5.3m pending. As a result of successful negotiations with system partners, an additional £2m was secured via brokerage arrangements, bringing the total identified funding to £31.1mn.

£31.1m of capital requests have been prioritised via the Trust's 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. It is proposed that the remaining priority 2 items continue through the business case process. 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.

The Board was advised of the ongoing positive discussions with the ICB and other providers regarding further capital, either through additional brokerage or direct support from the ICB, though no final agreement has been reached. The Capital Programme is being re-forecast due to delays in a number of projects, which may result in some funding being carried forward into the next year. It was confirmed that the Finance team is preparing a list of items that could be brought forward quickly should additional funds become available.

The Board noted the importance of timely decision-making by the ICB to enable capital funds to be spent within the financial year and it was suggested engaging with the Chief Executive of the ICB to expedite approvals.

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

25/26/185 Mortality Report, Q1

Resolved:
The Board noted the content of the Mortality Report for Q1.

25/26/186 Safety and Quality Assurance Committee

The approved minutes from the meeting held on the 23.7.25 were submitted to the Board for information and assurance purposes.

During September's meeting the Committee had an in-depth discussion on safety concerns linked to financial pressures within the Divisions. It was reported that the Chair of SQAC plans to conduct offline meetings to gain a clearer understanding of how these safety concerns are being managed.

The Committee also discussed follow-up actions from the recent CQC inspection of the Trust's Community and Mental Health services, which includes a Trust-wide initiative to have a more robust review of race within patient outcomes across the organisation. A meeting is scheduled to determine the necessary actions required to monitor this area of work.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 23.7.25.

25/26/187 Collaborate for CYP: Partnerships Update

The Board received an update on the Trust's collaborations with partners. A number of slides were shared that provided information on the following areas:

- Integrated Health Organisation for CYP.
  - The Trust's Segment 1 status enables the organisation to be considered for potential wave one delegation. Work continues on capability assessment and stakeholder engagement in preparation for IHO opportunities.
  - A key challenge identified is the lack of visibility in terms of where money is currently spent for each child, which is seen as critical for effective commissioning and service redesign. The IHO aims to

address this by enabling better data, contract management, and joined-up care pathways.

- Tripartite (Alder Hey, Liverpool University Hospital Group, Mersey Care).
  - The partnership is seen as a positive, high-engagement collaboration with plans to involve primary care and define pilot cohorts for targeted interventions.
- Alder Hey (CYP) NHS Neighbourhoods.
- LCR Test and Learn/Public Sector reform;
  - The Trust is involved in the Public Sector Reform "Test, Learn, and Grow" Programme, working with Liverpool City Council (LCC) and the Cabinet Office to pilot transformation in lung health, with mapping and cohort identification underway.

A discussion ensued following the update and a question was raised and responded to regarding the complexity of mapping current and future spending for each child and the availability of external support for this work. The Board also reflected on the importance of proactively organising resources, potentially setting aside a dedicated fund or team for IHO development.

Resolved:
The Board noted the Collaborate for CYP Partnerships update.

25/26/188 People Plan Strategic Update

An update was provided to the Board on the progress that has been made against core workstreams of the People programme. A number of slides were shared that highlighted the multiple factors currently impacting staff morale; including financial pressures, a freeze on recruitment, system-wide challenges, societal changes, and leadership issues. A mix of anecdotal evidence and perception was reported, with increased sickness absence, burnout, presenteeism, and incivility observed. The Board was advised that despite these challenges, the Trust has robust support structures in place, including a new Occupational Health provider, active staff networks, and ongoing leadership development initiatives.

Board members reflected on the importance of effective engagement and communications. The Chair suggested that the Trust's narrative should shift towards optimism and future opportunities, rather than focusing solely on change, and emphasised the need to engage staff who may be uncertain about the impact of organisational changes.

The Board discussed the importance of balancing positive communication with accuracy, recommending that messages be supported by data and actual experience. It was suggested that clinical leaders share examples of successful practice to foster pride and commitment across the organisation.

Further discussion addressed the impact of financial constraints on the Trust's 'yes we can' culture and identity, with Board members cautioning against compromising this ethos, while acknowledging the need to adapt. It was pointed out that it is vital to look at how the Trust demonstrates leadership, which will require streamlining operational processes, addressing internal challenges, and simultaneously advancing strategic growth initiatives. Attention was also drawn to the importance of recognising all staff contributions, not just those in high-profile services, and ensuring that messaging is inclusive and relevant to all roles.

Resolved:
The Board noted the People Plan strategic update.

25/26/189 People Committee

The approved minutes from the meeting held on the 24.7.25 were submitted to the Board for information and assurance purposes.

During September's meeting the Committee noted that the annual staff survey has been launched, and discussions took place about the importance of demonstrating that previous feedback has led to tangible actions. It was reported that the Comms team are undertaking a piece of work to ensure messages are effectively reaching all staff groups and to identify any gaps in understanding or engagement. The need for a unified and simplified internal narrative was highlighted to improve staff morale and clarity.

The Committee discussed recent changes in immigration law and the potential impact of future visa requirements on the organisation, agreeing to further analysis in this area. An increase in reports of discrimination, particularly in the context of the current immigration environment was noted. Updates were received from the Freedom to Speak Up Guardian (FTSUG) and the Equality, Diversity and Inclusion (EDI) Lead, including collaborative work to address racism and reasonable adjustments, and the piloting of reflection sessions on Ward 4C.

Resolved:
The Board noted the approved minutes from the meeting held on the 24.7.25.

25/26/190 Freedom To Speak Up Update

The Board was provided with an update on the activities of the FTSU service in Q1 and Q2 and the actions planned for the coming period. The following points were highlighted:

- The main themes identified in Q1 and Q2 include bullying and harassment, workplace behaviours, relationships, and concerns regarding policies. Data indicated that nursing staff had the highest number of reported cases, consistent with their representation within the workforce.
- There are 4 open cases in Q1 and 24 open cases in Q2.
- An overview was provided of the collaborative efforts between the FTSU Guardian (FTSUG), the EDI Lead and Ward 4C in response to concerns raised regarding behaviours related to racism. These issues were thoroughly discussed, and it was agreed to develop an action plan to address them. Reflection sessions, supported by the Race, Ethnicity, and Cultural Heritage (REACH) network and the Staff Advice Liaison Service (SALS), were recommended to foster trust, provide a safe environment, and discuss the development of an action plan with the team. With consensus reached, reflection sessions were piloted on Ward 4C, leading to interest from additional teams seeking this initiative. A forthcoming decision will determine whether this approach will be extended across other relevant areas, enabling information collection and the formulation of recommendations.
- The FTSU Visibility Programme continues, with Executive walkabouts and collaboration with staff networks.
- Mandatory training compliance for FTSU is 98.40%.

- The FTSU app is live but underutilised therefore a renewed launch is planned.
- It was reported that there has been an increase in concerns related to reasonable adjustments. Work is being undertaken in collaboration with the EDI Lead, staff networks, and union representatives to consider an approach to address these concerns.

A conversation was held about the visibility and communication of the Trust's Zero Tolerance Policy, noting the need for greater awareness and clarity. The Board also discussed the rise in reasonable adjustment requests, acknowledging the importance of addressing these requests for staff wellbeing and inclusion. It was noted that that further efforts are required to reduce barriers and foster greater transparency.

Attention was drawn to three significant data points: the Workforce Race Equality Standard (WRES) findings, the FTSUG report, and statistics verifying the amount of staff employed from ethnic minority backgrounds. It was observed that this data collectively indicates ongoing issues of racism and discrimination within the organisation. To strengthen the Trust's response, it was suggested seeking external support, such as from the NHS Race and Health Observatory, to help address these issues.

Resolved:
The Board noted the FTSU update for Q1 and Q2.

25/26/191 Audit and Risk Committee

The approved minutes from the meeting held on the 17.7.25 were submitted to the Board for information and assurance purposes.

The Board was provided with an update on the Committee's recent work, including a review of lessons learned from the iDigital Partnership which provided oversight of the Cyber Improvement Action Plan that has been completed, and the implementation of real-time verbal updates from Divisional Directors to hear about the rapidly changing risk environment.

During the meeting the Committee received a summary of the additional control requirements for pay and non-pay requested by the ICB, categorising actions by their current status and identifying areas for further discussion. Approval was also given for an internal audit of workforce reduction governance. The Board was informed of the submission of the Horizon Scanning Report to the Executive team following discussion at ARC.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 17.7.25.

25/26/192 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 22.7.25 were submitted to the Board for information and assurance purposes.

During September's meeting the Committee focused mainly on closing the financial gap and the actions relating to the organisation's workforce risks. The Committee discussed the need to reassess risk appetite in light of potential changes associated with the Trust's future direction and agreed to discuss risk appetite and tolerance in greater detail at the next meeting.

Resolved:
The Board noted the update, the approved minutes from the meeting held on the 22.7.25 and the Committee's top key risks in M5.

25/26/193 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.

It was reported that the Trust has experienced radical change recently, making it necessary to revisit and potentially adjust the current risk appetite and tolerances across a number of key categories. It was suggested undertaking a 5x5 calculation and triangulation of top risks, to ensure the BAF accurately reflects the present environment. The process for updating the BAF and risk appetite will continue via the use of the assurance framework, with input from each of the Assurance Committees. The Risk Management Forum will hold an extraordinary meeting to examine the impact of decisions made to date as a result of system controls and the wider financial environment. A detailed Board discussion will follow after this work has been reviewed.

The Chair of the Audit and Risk Committee (ARC) noted that the BAF has been extensively updated, recognising this was a substantial undertaking. Appreciation was expressed to everyone who contributed to the process.

The Board was advised that the Executive team is going to allocate additional time to focus on the items of risk raised as a result of the horizon scanning undertaken by ARC.

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

BAF Policy
Resolved:
The Board received and approved the BAF Policy.

25/26/195 Any Other Business

There was none to discuss.

25/26/196 Review of the Meeting

Non-Executive Director Garth Dallas, presented a comprehensive summary of the key discussions and outcomes from October's Board, addressing financial, operational, and clinical performance, workforce challenges, EDI, quality and safety, and strategic performance. The Chair concluded the meeting by expressing

appreciation to all participants for their preparation and engagement in what was described as an inclusive session. The meeting was regarded as having provided a comprehensive overview of current progress, outlined future directions, and included detailed reporting on present status.

Date and Time of Next Meeting: Thursday 6.11.25 at 2:00pm, LT1, Institute in the Park.

Trust Board (Public)
Action Log
(April 2025 – March 2026)

Date	Ref	Item	Action	By whom?	By when?	Status	Update
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	Dec-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	Feb-24	**Jan-26**	
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**	
Actions for January 2026							
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	**Feb-26**	**2.10.25** - This data will be included in January's FTSU report. **ACTION TO REMAIN OPEN**
Status							
Overdue							
On Track							
Closed							

Trust Board (Public)
Closed Actions
(April 2025 – March 2026)

Date	Ref	Item	Action	By whom?	By when?	Status	Update
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	**Closed**	**2.10.25 –** This action has been addressed. **ACTION CLOSED**
Status							
Overdue							
On Track							
Closed							

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**Managing the 25/26 Financial Year**
Report of:	**Chief Finance Officer**
Paper Prepared by:	Chief Finance 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

Alder Hey Children's NHS
NHS Foundation Trust

Managing the 25/26 Financial Year
Trust Board
6th November 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 and to set out the roadmap on managing the remaining months and what further is required to achieve the financial plan by the end of March 26. This includes both the approved Trust Board plan and the `system stretch`.

The key points to note from this paper are:

- Achievement of financial plan in September and YTD but with several pressures emerging in the month resulting in a gap remaining to the forecast for the year.
- Concerning financial positions across divisions both YTD and forecast.
- Submission of a mid-case forecast of £2.2m surplus and best case of £4.9m against the full £7.2m surplus plan including the £3.8m system stretch.
- Current trajectory implies a gap of between £1m and £3m to the £3.4m surplus.
- A number of actions are being taken to go further in a number of areas including the need for divisions to enact recovery plans and improve their current forecast for both £ and WTE.

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

1. Latest Financial Position to end of September

As detailed in the finance report, the Trust reported a £1.5m surplus in the month of September, taking the year-to-date position to a £1m deficit which is now in line with plan mitigating the industrial action impact of £0.3m.

However, September was a challenging month with areas such as elective income under plan by c£1m, non-pay pressures and overspend in both corporate and clinical areas and clinical areas and an increase in temporary staffing spend.

The divisional position at the end of H1 is significantly challenged reporting c£4.5m adverse to plan which includes £1.5m under delivery of CIP and £2.5m pressure across non pay areas including clinical supplies and drugs.

The overall Trust position is supported by a number of one-off benefits including release of prior year accruals deemed not required, technical benefit from VAT appeals, and also a benefit from prior year income where activity was delivered but not yet paid by commissioners and therefore remains a risk.

Table 1: Financial Position by area YTD and Forecast

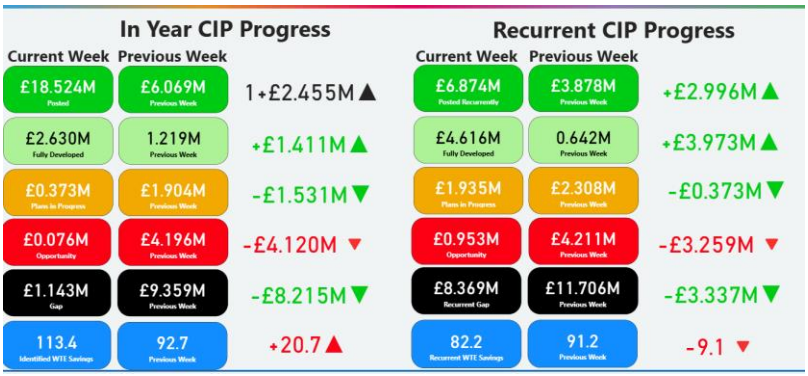
	In Month			Year to Date		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Income	4,716	3,734	(982)	9,247	8,203	(1,045)
Pay Expenditure	(4,979)	(4,226)	752	(29,458)	(27,947)	1,511
Non Pay Expenditure	(577)	(257)	320	(3,346)	(2,423)	923
OMMUNITY & MENTAL HEALTH	**(839)**	**(749)**	**90**	**(23,556)**	**(22,166)**	**1,390**
Income	7,500	7,060	(440)	42,703	41,423	(1,280)
Pay Expenditure	(7,125)	(7,416)	(291)	(43,033)	(43,972)	(939)
Non Pay Expenditure	(5,357)	(5,360)	(3)	(32,049)	(32,148)	(99)
EDICINE	**(4,982)**	**(5,715)**	**(733)**	**(32,379)**	**(34,696)**	**(2,318)**
Income	6,734	6,342	(391)	36,783	37,204	421
Pay Expenditure	(8,318)	(8,321)	(2)	(50,556)	(50,440)	116
Non Pay Expenditure	(2,013)	(2,125)	(112)	(12,197)	(14,516)	(2,320)
URGICAL CARE	**(3,598)**	**(4,103)**	**(506)**	**(25,970)**	**(27,753)**	**(1,782)**
Income	425	511	86	2,718	2,865	147
Pay Expenditure	(2,712)	(2,658)	53	(16,466)	(16,805)	(339)
Non Pay Expenditure	(1,905)	(2,536)	(630)	(12,919)	(14,008)	(1,089)
ORPORATE	**(4,192)**	**(4,683)**	**(491)**	**(26,667)**	**(27,949)**	**(1,282)**
Income	668	719	51	4,011	3,848	(163)
Pay Expenditure	(495)	(581)	(86)	(2,970)	(3,325)	(356)
Non Pay Expenditure	(228)	(254)	(26)	(1,398)	(1,363)	35
OMMERCIAL	**(55)**	**(116)**	**(61)**	**(357)**	**(840)**	**(483)**
Income	18,164	19,790	1,626	125,311	126,769	1,458
Pay Expenditure	(149)	(28)	120	(476)	717	1,193
Non Pay Expenditure	(3,020)	(2,871)	149	(16,925)	(15,102)	1,823
THER	**14,995**	**16,891**	**1,895**	**107,910**	**112,385**	**4,475**
Income	**38,207**	**38,157**	**(50)**	**220,774**	**220,313**	**(461)**
Pay Expenditure	**(23,778)**	**(23,231)**	**547**	**(142,959)**	**(141,772)**	**1,187**
Non Pay Expenditure	**(13,100)**	**(13,403)**	**(302)**	**(78,833)**	**(79,560)**	**(726)**
RAND TOTAL	**1,329**	**1,524**	**195**	**(1,019)**	**(1,019)**	**()**

While the Cost Improvement Programme (CIP) remains on plan in year, it includes several non-recurrent items, with the recurrent CIP £4.8m behind plan YTD.

Our WTE position remains favourable, reporting 82 below plan, however with a trajectory to not achieve the year end forecast. Spend on pay also does not mirror the WTE spend, with a material amount of spend on pay that do not attract WTE (e.g. WLI, additional locum spends, additional PAs etc).

Progress has continued through Closing the Gap Programme in identifying and posting CIP savings, with the latest position for the full year now showing £21.1m posted/fully developed. The remaining £1.2m is showing as black and a gap which remains a concern and is contributing to the overall risk to delivery in year.

Recurrent CIP has remained static since the last update at c£11.5m posted/fully developed and an overall gap of c£10m.



2. Forecast Position

The financial plan of £7.2m surplus is made up of 2 aspects; 1) Trust approved plan £3.4m surplus 2) System Stretch allocation not accepted by Trust Board £3.8m.

At the end of July, a risk to deliver the Trust plan was identified of £6.9m with no identification against the system stretch taking full gap to £10.7m. Since then, through the closing the gap programme c£4.6m opportunities has been identified and progressed alongside £1.2m of the systems stretch also being identified.

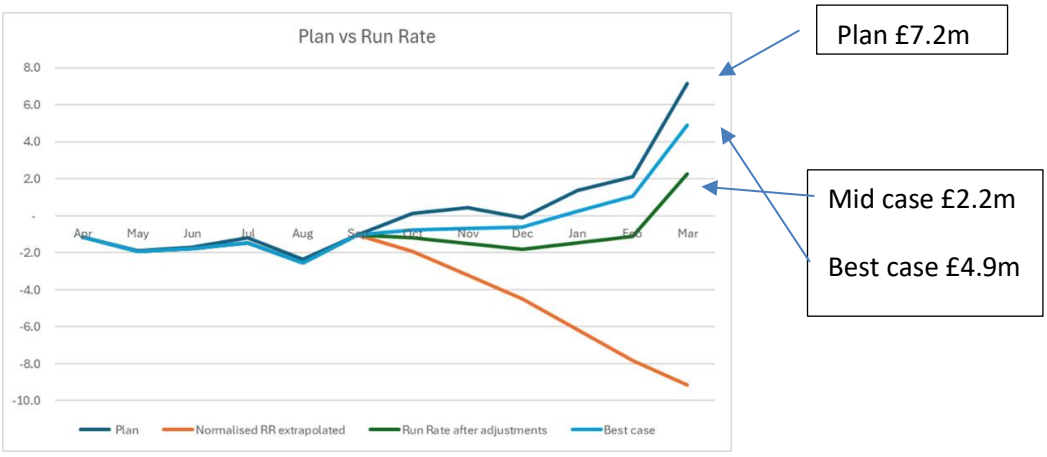
Programme Area	SRO	Green	Amber	Red
Activity, Coding & Income	AB/KW	£1m		
Workforce - Medical	A.Bass			
Workforce - Non Medical	MS	£1.8m		
Procruement & Energy	NA/RL		£0.05m	
Pharamcy & Diagnostics	RL	£0.2m	£0.15m	
Planned Care - Inpatient	CL	£0.4m		
Planned Care - Outpatient	AB/KW	£0.8m		
GO Agenda	JC			
		£4.2m	£0.2m	0

The current mid case submission at the end of October is a £2.3m surplus, gap of £4.9m which is made up from £2.3m gap to Trust plan and £2.6m gap against the systems stretch.

	Alder Hey £m	System Stretch £m	Total £m
Plan	3.4	3.8	7.2
Mid Case as at M4	-3.5	0	-3.5
Gap	**-6.9**	**-3.8**	**-10.7**
Mid case as at M5	0	0	0
Gap	**-3.4**	**-3.8**	**-7.2**
Mid Case as at M6	1.1	1.2	2.3
Gap	**-2.3**	**-2.6**	**-4.9**

A best-case submission has also been submitted that shows a surplus of £4.9m through inclusion of further Alder Hey schemes of £1m and also £1.6m of schemes to support the system stretch. Ongoing discussions with ICB regarding working together on delivery of the stretch through CYP programmes.

	Alder Hey £m	System Stretch £m	Total £m
Plan	3.4	3.8	7.2
Best Case as at M6	2.1	2.8	4.9
Gap	**-1.3**	**-1**	**-2.3**



The mid and best-case scenarios include a number of assumptions which has been discussed through the finance committee in detail but in summary:

- CIP delivery £20.7m (£21.5m best)
- Release legal provision
- Resolution of outstanding income issues with commissioners c£4.7m
- Overperformance on elective income
- Benefit from controls enacted in September in particular workforce c£2m.
- Excludes any cost of MARS this financial year

3. Managing the year End

Whilst positive progress has been made over the recent months, a gap to delivery of plan still remains of between £1.3m and £2.3m depending on delivery of mid or best-case scenario. It is important to lay out further actions and steps that are and need to be taken to improve the current trajectory. NHSE and PWC have also requested that the best-case show delivery of plan and the steps needed to achieve this.

Noting the worsening of forecasts in between months, new pressures that may emerge before year end and also the requirement to fund MARS payments in year that are approved, it would be prudent to aim for min £3m of further improvement.

As part of this further step up a number of additional actions have been agreed by the executive team.

1. Workforce

In September and as outlined in the previous board paper, we agreed to implement several strengthened workforce controls including a cap on the number of new recruitments that we could approve each month to 50% of leavers as a mitigation to achieve the plan.

Whilst the controls have been enacted, over the last 4 weeks a total of 28 posts has been approved which is above the initial cap of c15 per month. The number of requests submitted by the division is well above the cap making the prioritisation by the exec vacancy panel challenging. Each post has been scrutinised and challenged but was deemed essential to replace due to the risks and information provided by the division.

To further enhance this control, each division will be given an allocation of headcount reduction to achieve by March 26 that aligns with the overall reduction required and the cost reduction needed. The divisions be expected to work together to prioritise roles within the cap and alignment to the target operating model work.

In addition, the MARS scheme is due to close on 31st October and an immediate review will take place to understand the requests and opportunity to approve submissions. It is expected posts will be removed in December/January following the approval process.

It is important to note that the current forecast does not include a cost of MARS payments in year. It is essential that the assessment of applications ensures value for money and the minimum payback period to cover the costs and deliver recurrent value going into 26/27. An update will be brought to the Board before decisions are communicated.

2. Closure of Beds

Following a review of occupancy over recent months, a decision has been taken from 27th October to assess bed capacity required on a daily basis and to close beds to manage within the available staff on shift that day. This approach aims to close c16 beds each day and result in a significant reduction in bank spend with 0 bank on acute wards. Staff will be moved as appropriate to cover any gaps on wards.

Operational risk to capacity is mitigated through opening beds if required within the current shift staffing, moving to an amber model, and the booking of bank where required for subsequent shifts.

The financial benefit based on a full month of bank usage on acute wards is estimated at £100k to £150k per month.

Holding band 5 vacancies will help facilitate the above and will give capacity to employ newly qualifying nurses in February 2025. Further assessment of pathway changes and this approach through winter will give an opportunity to review our bed base ready for annual planning.

3. Coding

A coding workstream remains in place as set up through Closing the Gap. There is a regular rhythm established, and key actions have included increasing clinical leadership with an early focus on high value specialties, trust wide engagement and provision of coding intelligence and CXIO hosted lunch and learn sessions. This work is ongoing. The focus of this group is also to improve coding validation and depth of coding to increase average tariff for each episode of care. To date, the group has seen a positive upside of 420K up to month 6 flex date.

The latest depth of coding shows a reduction in the depth of coding this year when compared to 24/25 or 23/24. Actions are ongoing to understand whether the financial impact is material, look to further improve where there are clear financial gains and accurately reflect the work being undertaken whilst also maximising the income received under PBR.

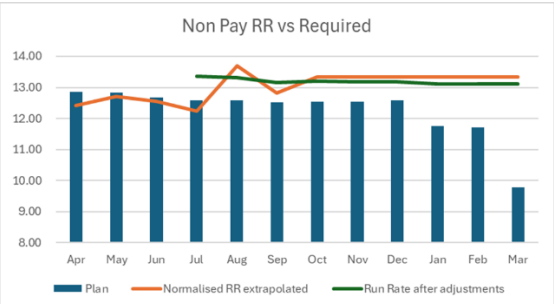
There are challenges with coding workforce, including vacancies in the team which following a decision via FIP are unbale to be covered either with recruitment or via an outsourced parter meaning that prioritisation to ensure stability and steady run rate is needed. Ability to partner with additional capacity in the short term would increase resource in depth of coding and further extensive clinical validation.

AI coding is underway. This workstream has been challenging with the potential partners/suppliers involved. It is expected that a clear decision on the approach will be made imminently. There may be an investment requirement to progress but that will be picked up in the round of progressing.

4. Non-Pay

The run rate within non pay remains a concern for this year and as we head into 26/27, in particular in areas such a clinical supplies, theatre consumables and drugs.

The current forecast for non-pay remains static at current levels and is significantly above the budgeted and planned level. There is an urgent need to use subject matter experts in areas such as Drugs, Labs and Clinical Supplies to assess the opportunity to reduce this in the 2nd half of the year. It is proposed this is agreed in the next 2 weeks with a report to FTPC on actions to be taken and areas of opportunity.



5. Divisional recovery Plans

Whilst a number of cross cutting controls are being enacted, focus is still being put on the individual divisional position and ensuring recovery plans are in place to improve on the current financial forecasts. The Executive team are meeting with each division over the next 2 weeks, chaired by CEO, with the output reporting to FTPC in November.

The divisional position is forecast in total to be close to £10m adverse to plan by the year end which is not acceptable and needs urgent rectification. CIP gap makes up

Each area will be required to set out a trajectory that improves their financial position in year by 25% for those reporting adverse to plan and 15% for those currently on plan or better. This should incorporate the cross-cutting actions detailed in this paper but also necessary steps to be taken to manage and mitigate the current level of overspend.

	Current Forecast £`000	% required	Financial Value £`000
CMH	2,192	15%	329
Medicine	- 5,227	25%	1,307
Surgery	- 3,582	25%	896
Corporate	- 2,523	25%	631
Commercial	- 734	25%	184
Total			**3,345**

6. Decommissioning

A decommissioning review has been initiated but has not yet concluded and therefore it is unlikely this will deliver in year benefit due to the time needed to agree with commissioners and enact plans. However, it is still important to pursue this work and conclude before December, to enable plans to be put in place for delivery form April 26.

The themes of this review include:

- Stop providing services that are not commissioned
- Redefine resource requirements to meet service specifications
- Redefine policies e.g. prescribing drugs that should be within primary care.
- New models of care particularly for loss making services.

An area that is nearing completion is a line-by-line review of the current services contained within the ICB block contract which fall largely within the Community & Mental Health division This was requested as part of the national ask to `deconstruct` the blocks to understand what activity is being delivered for the payments being made. An update on this work will be presented to FTPC in November.

7. Dedicated PMO support team

For the remainder of this year and into next year, a dedicated PMO support team will be required to oversee and govern the delivery of CIP and financial benefit. Resources from across finance, operational, data and DMO have been identified to provide this support, however, starting April 26, this arrangement should be incorporated into the programme structure with defined governance for the reporting and tracking of financial benefit and CIP.

8. Technical

A technical stream is also progressing to provide contingency to any of the actions above or new pressures that may emerge between now and the year end. This includes some aspects that may require further discussion with FTPC and audit.

4. Conclusion

The paper outlines the latest position in relation to the financial forecast for the 25/26 year and the progress that has been made on ensuring the trajectory is to achieve plan. However as noted the gap still remains due to challenges seen in September but also continued worsening of the divisional forecasts resulting in a gap to the delivery of the Trust Board approved plan of £3.4m.

Actions will be taken as set out in the paper to mitigate this gap, but this will require continued focus and clear accountability across all areas.

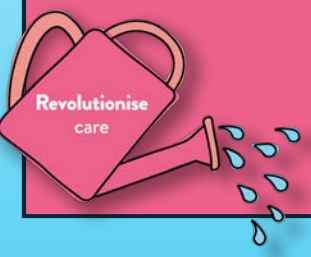
The Board are asked to approve the actions set out in the paper,

Flash Report October 2025

Alder Hey Children's NHS Foundation Trust

Performance is subject to change

0	0	92.4%	2	9
Severe/Fatal Incidents/Never Events	Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections	Patients deteriorating from an inpatient bed



86.7%	267	61.5%	1.65	96%
ED: %Treated within 4 Hours	Number of RTT Patients waiting >52weeks	% Patients waiting within 18 weeks (RTT)	Elective activiy per clinical WTE	Diagnostic Performance

-41	11%	73.9%	TBC
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)

**Financial information is unavailable due to the timing of release*

HIGHLIGHTS

- Sustained performance for time to be seen and treated in ED - 7th consecutive month 80%+.
- High proportion of diagnostic tests completed in six weeks.
- Sustained performance for % patients waiting under 18 weeks for treatment.
- Good patient experience scores.
- Sustained reduced volume of patients deteriorating from an inpatient bed.

CHALLENGES

- 2 healthcare associated infections; 1 C.Diff and 1 MSSA

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: October 2025

Contents

VISION 2030

Our Journey To 2030

BRILLIANT BASICS

VISION 2030

IPR – Executive Summary

NHS
Alder Hey Children's
NHS Foundation Trust

Outstanding Care and Experience

	Value	Target	Trend
Patients deteriorating from an inpatient bed admitted to PICU	11	n/a	↓
Number of Incidents per 1,000 bed days – No Harm	74	77.4	↑
Number of Incidents per 1,000 bed days – Low Harm and above	16	19.6	↓

Executive Summary

Performance remained strong in several key areas, with 92% of informal PALS concerns resolved within five days, no hospital-acquired MRSA, MSSA, or C. diff, and 91% of ED patients with suspected sepsis receiving antibiotics within one hour. However, a new PSII was commissioned following a Never Event (with all reporting duties met), and while increased use of Martha's Rule reflects positive awareness, it may indicate that some families did not feel heard locally. Compliance with formal complaint responses fell to 61%, and 88% of inpatients received timely antibiotics for sepsis. Going forward, the Patient Safety Board, Incident Review Panel, and Experience & Engagement Group continue to function effectively, supported by the successful recruitment to the Experience Manager secondment.

Support Our People

	Value	Target	Trend
Workforce Plan	4,317	4,397	↓
Staff Turnover	11%	10%	↓
Sickness Absence (Total)	6.2%	4.5%	↑

Executive Summary

Mandatory training completion remains strong at over 90%. However, the total workforce (WTE) has stayed largely static, with a significant CIP target requiring a reduction of over 100 WTE by March 2026. Actions are being monitored through the Workforce Establishment & Vacancy Panel. PDR completion remains below the 90% target, with ongoing support from Learning & Development. Medical appraisal compliance has temporarily dropped due to a reporting realignment, and clinicians are being supported to catch up.

Revolutionise Care

	Value	Target	Trend
ED % Treated Within 4 Hours	87.4%	78%	↑
% RTT Patients Waiting >52 Weeks*	1.36%	1.24%	↓
RTT Waiting List Within 18 Weeks*	61.9%	61.7%	↑

Executive Summary

Emergency Department (ED) and elective care performance remain strong, with ED four-hour targets consistently exceeded and RTT performance improving from 60% to 62%, supported by demand reduction, capacity increases, and data quality improvements. Long waits have reduced significantly, with RTT patients waiting over 52 weeks down from 418 to 237, and further reductions expected in CAMHS. Theatre utilisation is consistently above 80%, elective and outpatient income is above plan, DM01 remains above 95%, and ambulance handover times continue to improve. However, patients waiting over 52 weeks still exceed the 1% target, "Did Not Attend" (WNB) rates remain high, and overdue two-year follow-ups are rising. Looking ahead, weekend ENT theatre lists are resuming, formal overbooking is being expanded, and an opt-in process for ENT and Dentistry is being trialled to reduce WNBs. The Safe Follow-Up Lead is implementing failsafe roles in services with the largest overdue follow-up backlogs.

Financial Sustainability

	Value	Target	Trend
I&E Year End Forecast	£7.1m	£7.1m	↔
Recurrent Efficiency Plans Delivered	£3m	£10.1m	↓
ERF Income (YTD)	£49m	£49.3m	↑

Executive Summary

The Trust reported a £1.5m surplus in-month and a £1m year-to-date deficit, both in line with plan. Despite industrial action costs now absorbed, delivery of the planned £7.16m year-end surplus depends on mitigating CIP and ICB risk share pressures. The current run-rate forecast shows a £2.3m surplus—an improvement from month 5. CIP delivery is slightly ahead of plan (£0.1m) due to non-recurrent benefits, with £18.5m transacted to date (£10m recurrent). Cash is below plan, while capital spend is ahead due to budget phasing. CIP delivery and capital funding remain key risks, being addressed through the Financial Improvement Programme (FIP) and "Closing the Gap" schemes. Going forward, the Trust is maintaining tight cost controls, progressing transformation initiatives for long-term sustainability, and prioritising capital projects. Enhanced oversight includes biweekly CIP deep dives and a finance escalation process for divisions off-plan.

*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:

• 92% of informal PALS concerns responded to within 5 working days • No hospital acquired MRSA, MSSA or C-diff • 91% of patients in ED received antibiotics in one hour for sepsis concern

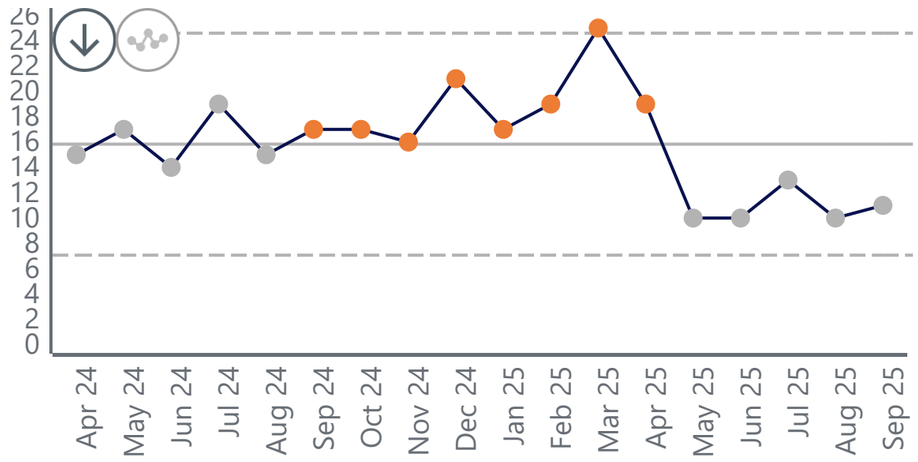
Areas of Concern:

• One new PSII commissioned following a Never Event. Compliant with statutory duties related to reporting • Increase in families using Martha's Rule; it is positive that families know how to use and feel able to use however these families may not have felt heard at local level prompting their use of the rule. One of 7 the requests confirmed deterioration • Decrease in compliance in formal complaint responses (61%) • 88% of inpatients received antibiotics in 60 minutes for sepsis concern

Forward Look (with actions)

• Patient Safety Board, Patient Safety Incident Review Panel, and Patient Experience and Engagement Group all working effectively • Experience Manager secondment successfully recruited to.

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



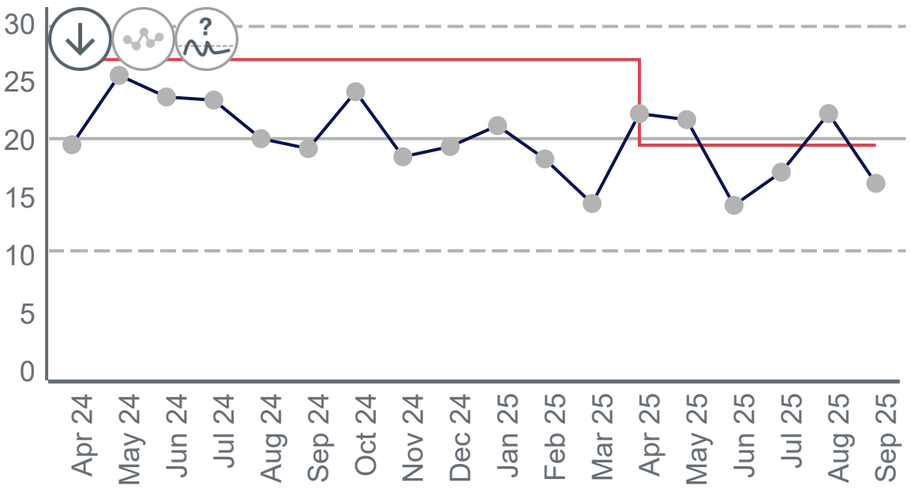
Technical Analysis:

Common cause variation observed with 11 patients deteriorating from an inpatient bed to PICU with an average of 16 a month during the last 18 months. Fifth consecutive month below the average.

Actions:

Sustained decrease over 5 months in the number of patients admitted. Response Team continue to review every case for learning

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



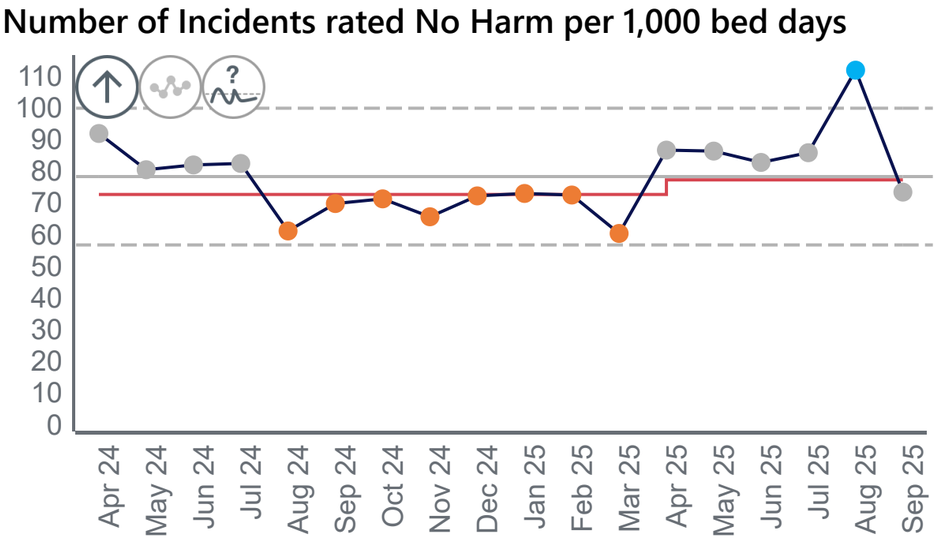
Technical Analysis:

Common cause variation with performance of 16 incidents of harm per 1,000 bed days, with a monthly average of 20 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:

Trust below the adjusted threshold for incidents resulting in harm which is positive. Robust review process in place

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



Technical Analysis:

Common cause variation observed with 74 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. First month in 25/26 below target, although YTD would still be achieving target.

Actions:

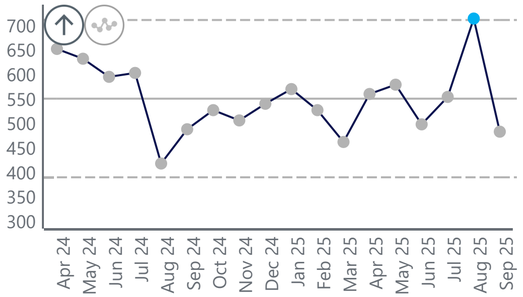
Decreased number reported – the Trust encourages all staff to report no harm and near miss incidents to identify any improvements that can be made

Integrated Performance Report | October 2025

NHS
Alder Hey Children's
NHS Foundation Trust

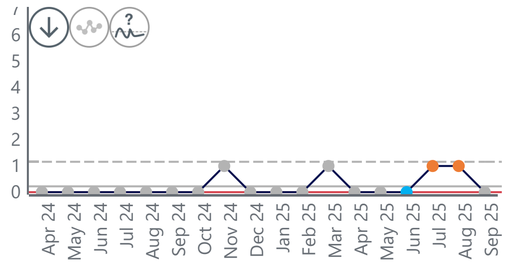
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



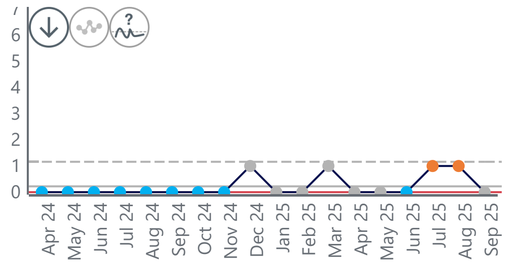
Severe or Fatal Incidents – Physical only

Target: Internal

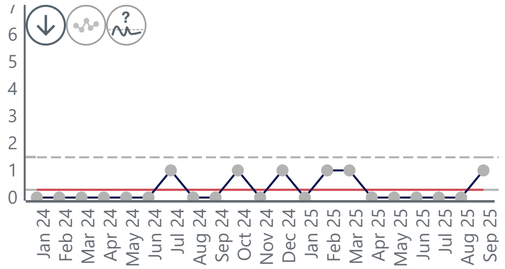


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

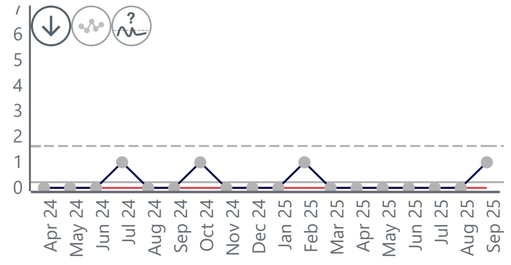


Number of PSIIs (Patient safety incident investigation) undertaken



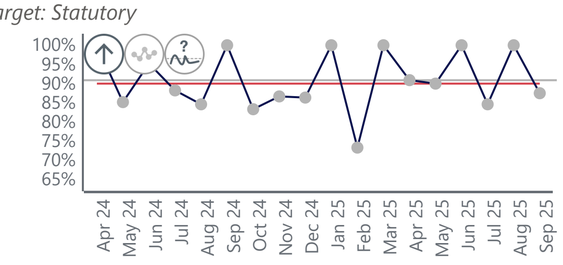
Number of Never Events

Target: Internal



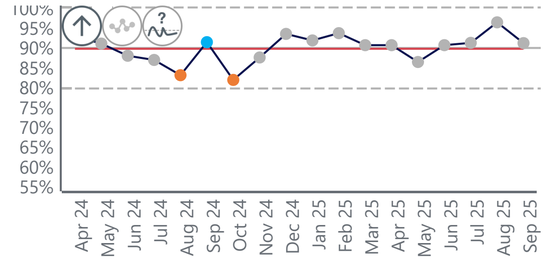
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

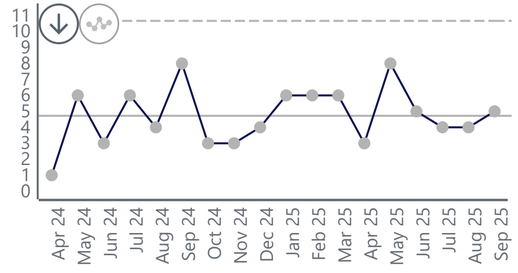


Sepsis % Patients receiving antibiotic within 60 mins for ED

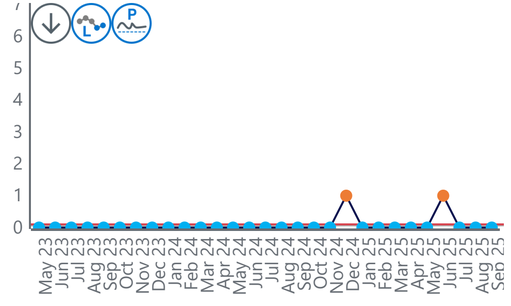
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

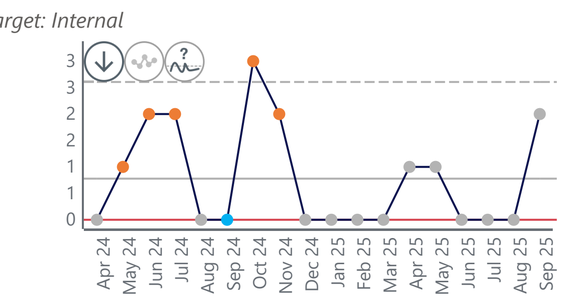


Pressure Ulcers Category 3 and 4

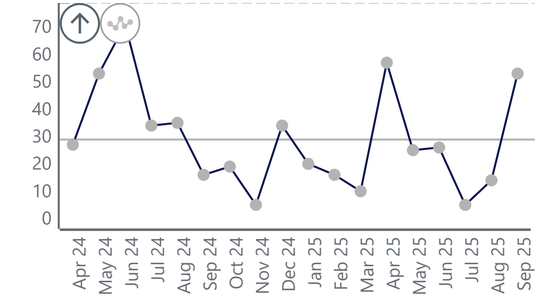


Pressure Ulcers Category 2

Target: Internal

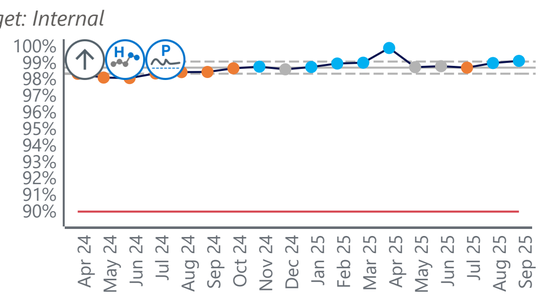


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



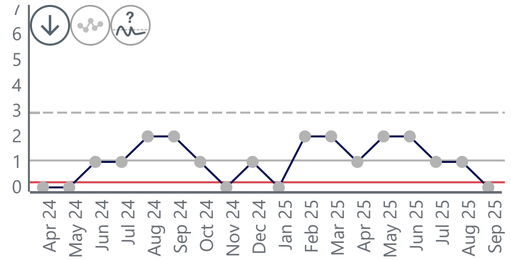
Integrated Performance Report | October 2025

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

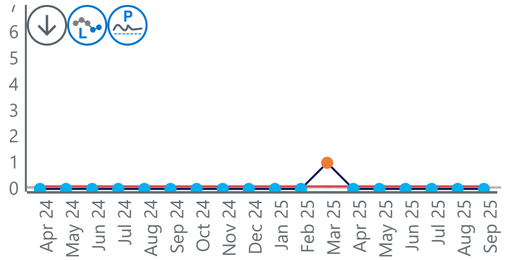
Hospital Acquired Organisms - MSSA

Target: Internal



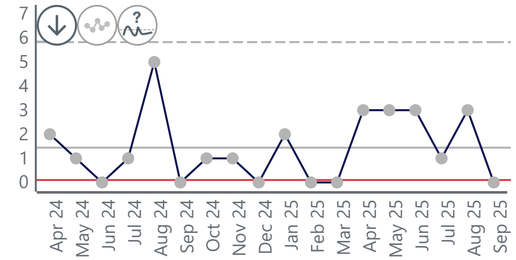
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



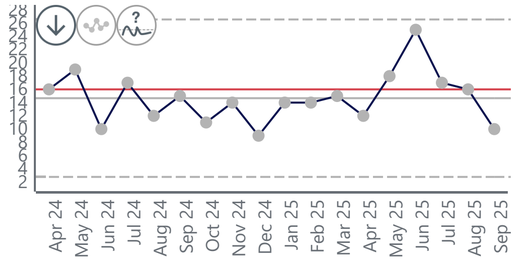
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



Number of formal complaints received

Target: Internal



% PALS Resolved within 5 Days

Target: Internal

Number of PALs contacts

Target: Internal

% Complaints Responded to within 25 working days

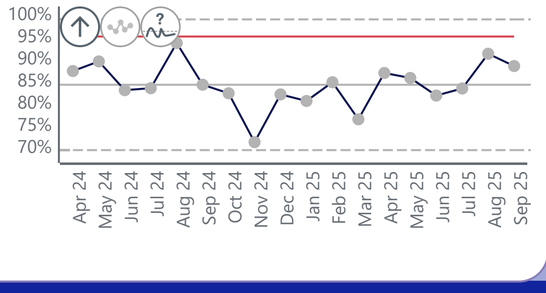
Target: Internal

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

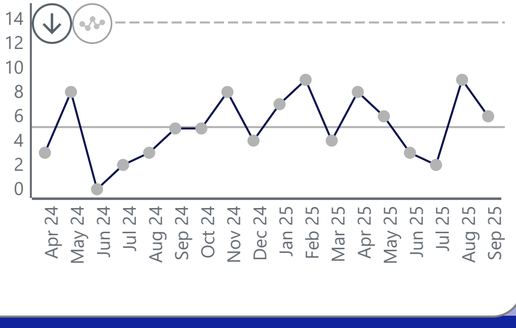
Target: Statutory

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

Target: Internal

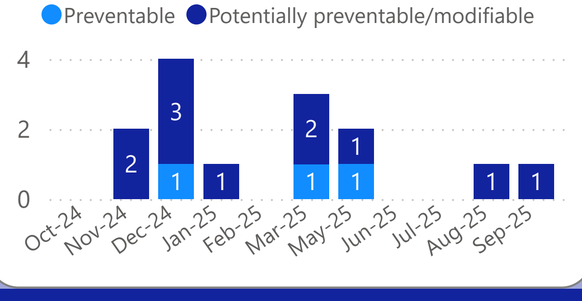


Number of patients deteriorating from HDU admitted to PICU

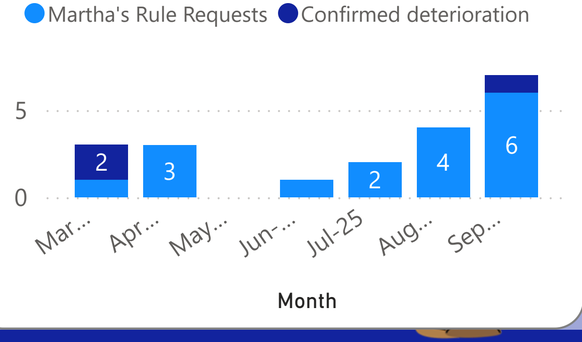


Predictable and preventable deteriorating patients

Not inclusive of all categories



Martha's Rule



Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

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

Highlights:

• ED performance for patients waiting less than 4 hours remains consistently above the national target • RTT performance significantly improved from 60% to 62% in month. This was due to several key projects to reduce demand, increase capacity and cleanse any data quality errors • The number of RTT patients waiting over 52 weeks for treatment has reduced from 418 to 237. Further reduction in CAMHS patients waiting over 52 weeks
• Theatre touchtime utilisation consistently above 80% throughout the year • YTD performance (income) for elective and outpatient activity remains above plan • DM01 performance remains above 95% target • Consistent reduction in ambulance handover times

Areas of Concern:

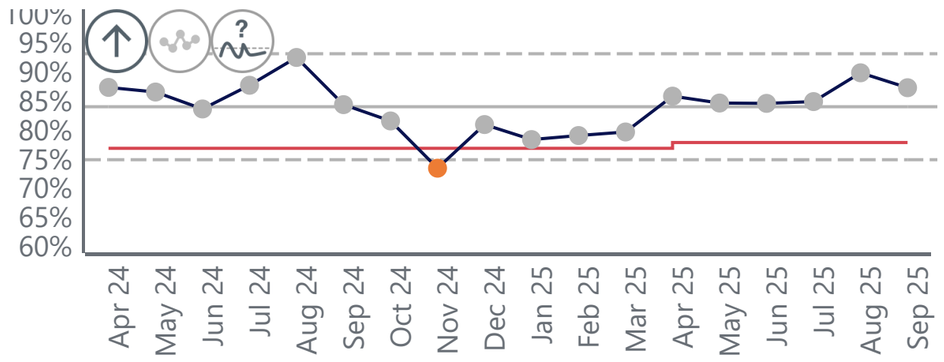
• The number of patients waiting over 52 weeks remains above the 1% target • WNB remains above the trust target • The number of overdue 2 year overdue follow ups is gradually increasing

Forward Look (with actions)

• Weekend theatre lists for ENT are restarting on 18th October • Formal overbooking has commenced and is rolling out to new services each week • A new opt-in process for ENT and Dentistry began in August 25 which means all new patients booked for an appointment in October will have opted in. WNB will be reviewed to determine if this approach reduces current WNB rate. • Safe Follow Up Lead is in the process of rolling out service 'failsafe' roles in the services with the highest overdue follow up waiting list.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

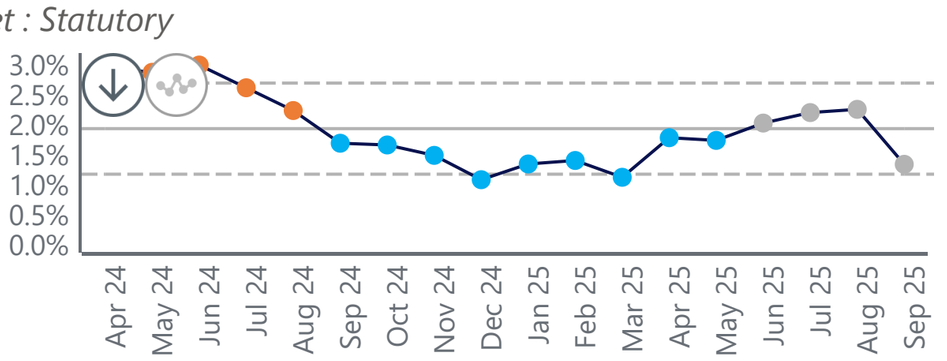
Achieved the national target in September-25. Common cause variation observed with performance of 87.4%, slight decrease from Aug-25 (90%) which is typically the highest performing month. Sept-25 represents a 2.9% increase compared to Sept-24, when performance was 84.5%. Whilst Sept-25 also experienced a 1.1% increase in Resus and Very Urgent patients compared to the same period last year.

Actions:

September performance 87.4%. Median triage and time to seen within target. New escalation plan signed off and dissemination in progress. Targeted review of 12 hour breaches. Expanding streaming potential for winter. Reviewing processes around speciality review.

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

Target : Statutory



Technical Analysis:

1.36% 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 significant decrease from August-25 position of 2.28%. With the total volume now at 237 breaches. 71% current waits >52 weeks within Dentistry.

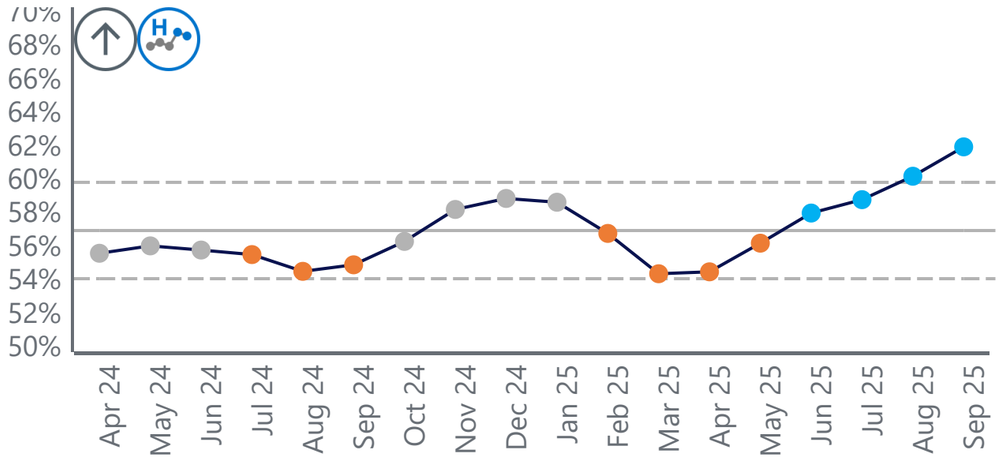
Actions:

An adapted opt-in approach was piloted in ENT and Dentistry during August and September. Out of the patients who were contacted via text message, phone call, and letter, 39% opted in. This resulted in the discharge of 240 new patients. A report on the pilot will be written and presented in October, with recommendations for rolling out this approach to other services.

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

RTT waiting list within 18 weeks



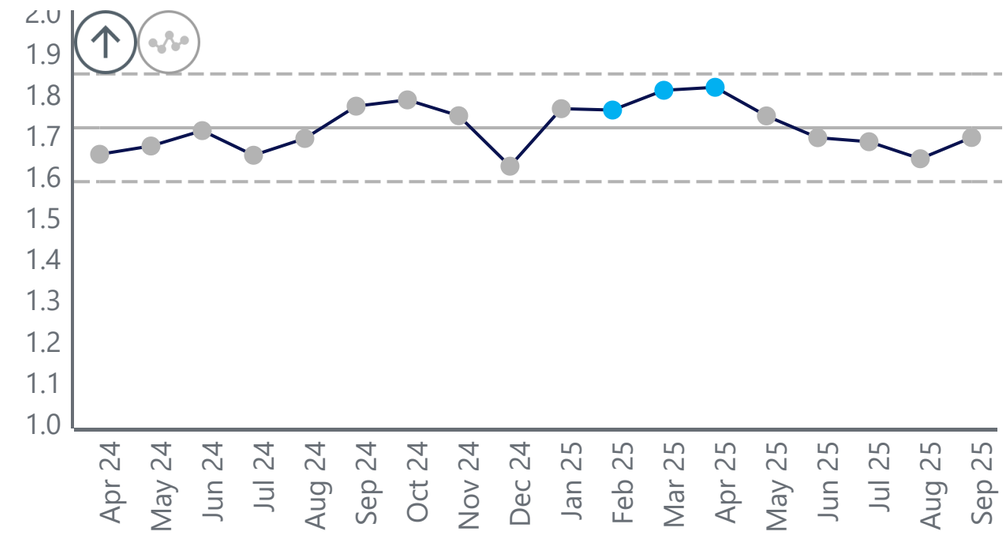
Technical Analysis:

Special cause variation with performance of 61.9% against a year end target of 63.1% by March 2026. This is improvement from August 2025 position of 60.1%. Oral Surgery and Dentistry lowest performing of services with >100 waiters.

Actions:

A data-driven approach to overbook outpatient clinics that are consistently underutilised commenced in September. Additional services are being onboarded each week. This approach books an additional new patient, which will gradually improve RTT.

Elective admissions (IP & DC) per clinical WTE



Technical Analysis:

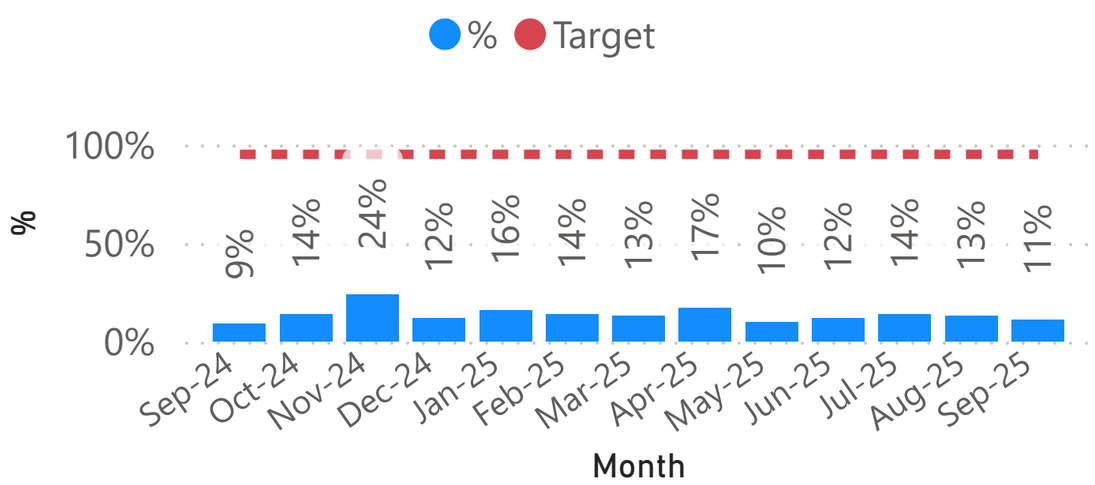
Common cause variation has been observed with performance of 1.70 admissions per Clinical WTE (1606.29). Slight increase from August-25 rate at 1.65. However Sept-25 experienced -5 admissions per working day compared to Sept-25.

Actions:

There are two ongoing working groups focused on increasing the number of patients treated theatre.

1. No Pre-Op, No TCI Date: This group aims to reduce cancellations.
2. Daycase Admission Team (pilot): This pilot will book and backfill theatre slots promptly, ensuring that capacity is utilised efficiently.

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



Technical Analysis:

Performance at the end of September 2025 is 11% against a target of 95% which is a slight decrease from performance of 13% in August 2025.

Actions:

Focus remains on longest waiting children and young people therefore % of young people receiving an outcome within 65 weeks of assessment remains low as expected. The new assessment pathway for the neurodevelopmental service was launched in September 2025 as part of the continuing ND Transformation Programme with the aim of providing an improved streamlined assessment pathway for children and young people. Demand continues to exceed capacity for these services which remains under review with commissioners.

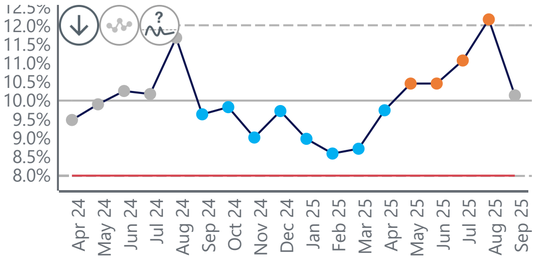
Integrated Performance Report | October 2025

NHS
Alder Hey Children's
NHS Foundation Trust

Revolutionise Care - Effective & Responsive - Watch Metrics

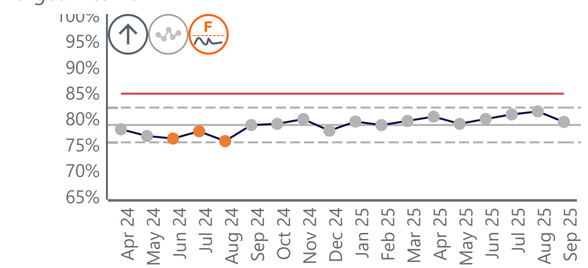
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

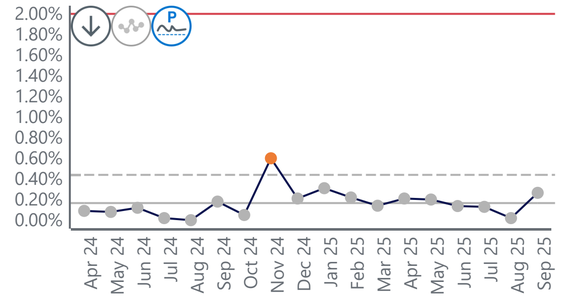


Theatre Utilisation (Capped Touch Time)

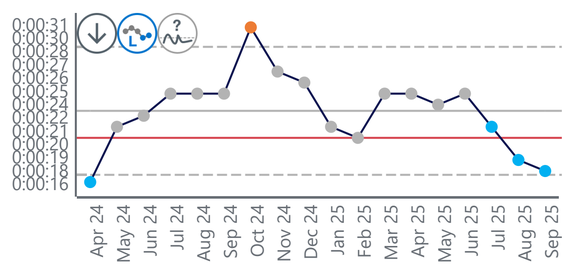
Target: Internal



% of ED attends over 12 hours

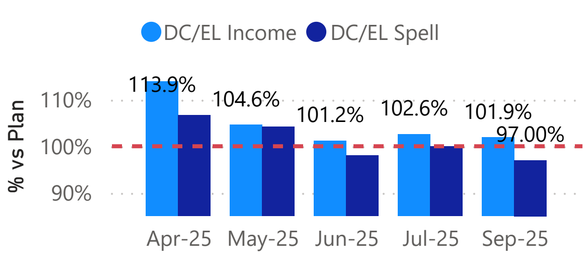


Average Ambulance Vehicle to Handover Time



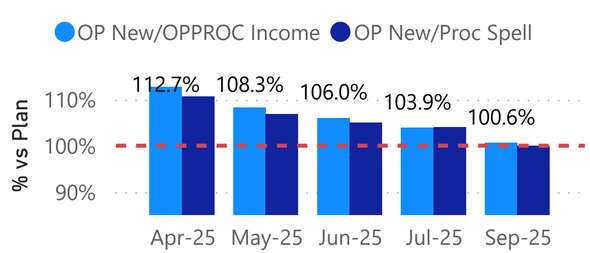
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance



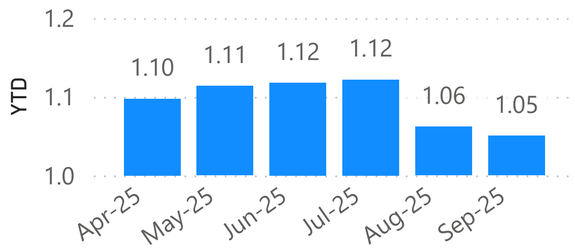
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

SLAM Performance

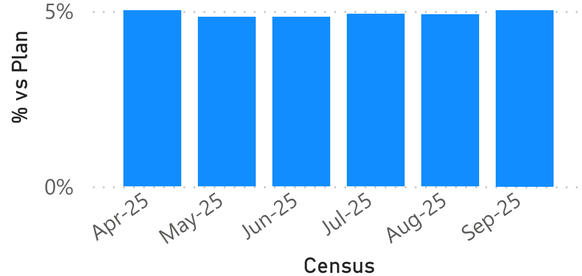


Activity per £1k Operating Expenditure

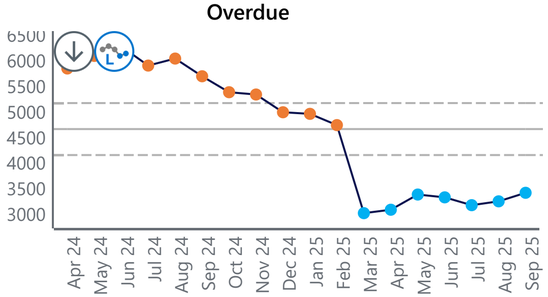
YTD Position



% follow up waiting list on PIFU

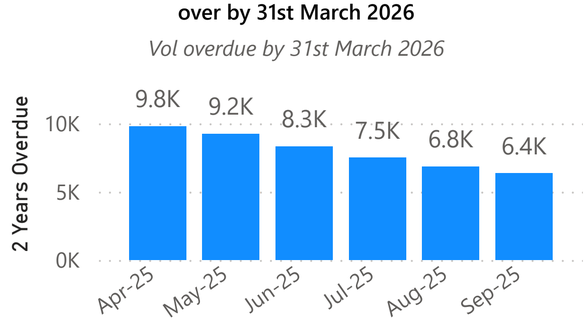


Volume of active outpatient follow up waits - 2 Years & Overdue

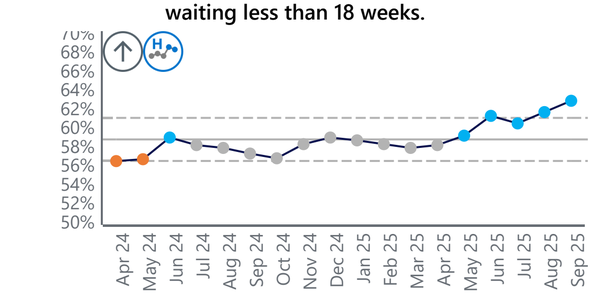


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

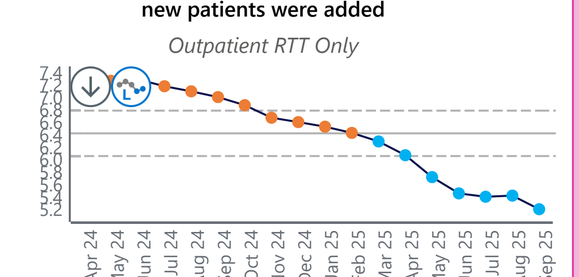


Time to first attendance, waiting for first event and of those waiting less than 18 weeks.



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

Outpatient RTT Only



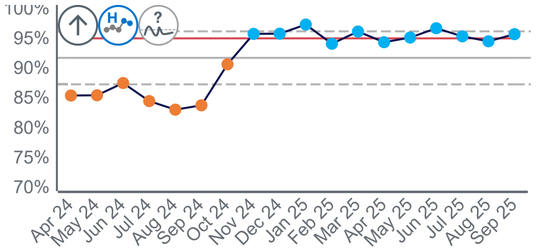
Integrated Performance Report | October 2025

Alder Hey Children's NHS Foundation Trust

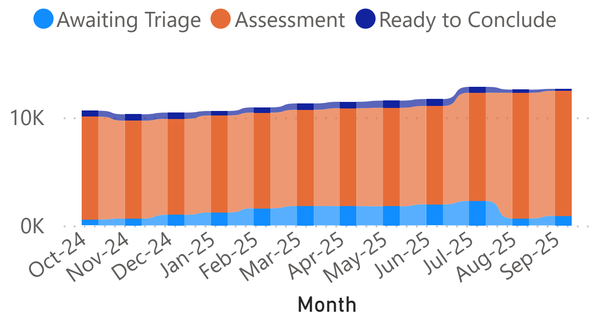
Revolutionise Care - Effective & Responsive - Watch Metrics

Diagnostics: % Completed Within 6 Weeks of referral

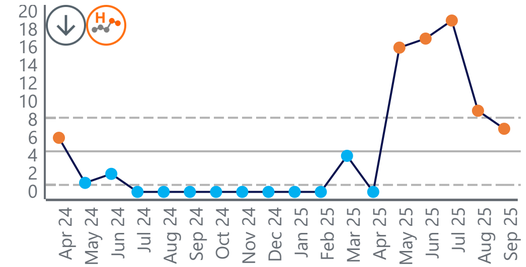
Target: Statutory



Neurodevelopmental Diagnosis Status

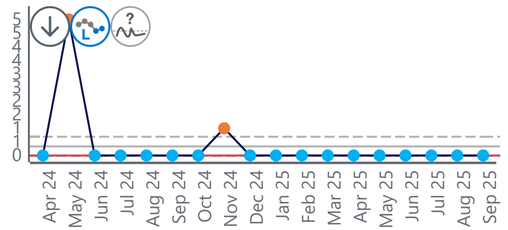


CAMHS: Number of children & young people waiting >52weeks



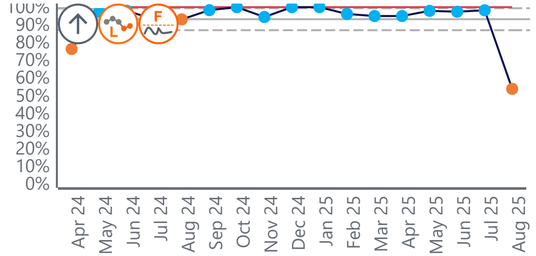
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



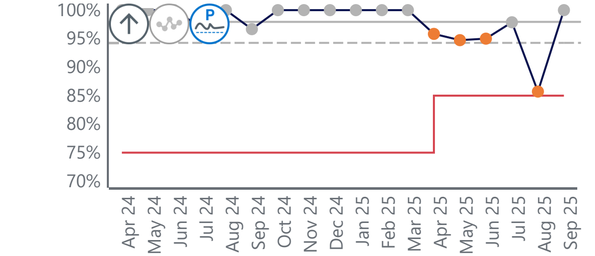
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



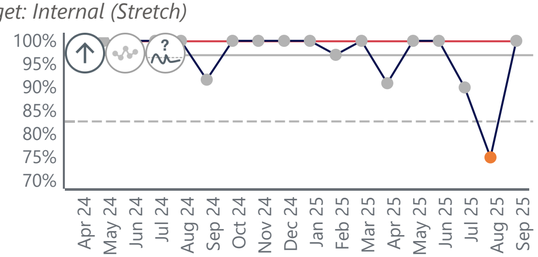
Cancer: Faster Diagnosis within 28 days

Target: Statutory



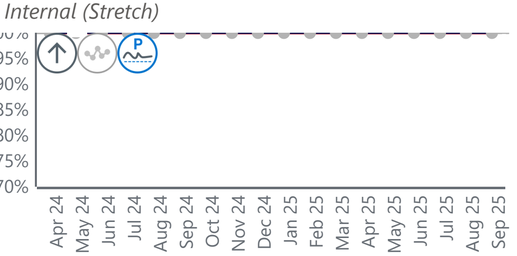
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)

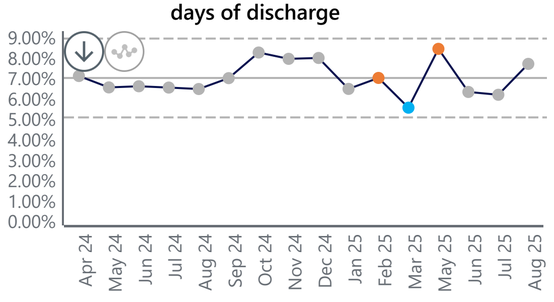


31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

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%

Areas of Concern:

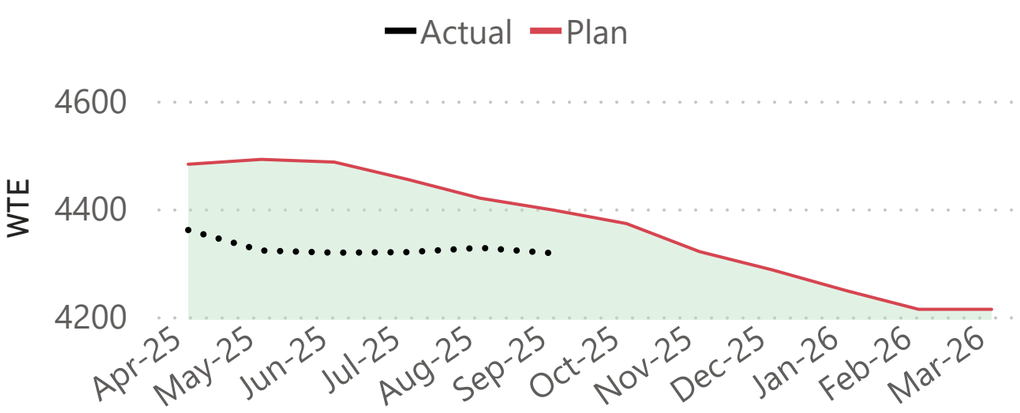
• Total Workforce (WTE): total workforce has remained largely static. The CIP requirement across the year remains significant, with the March 2026 plan over 100 WTE lower than the current position. Additional measures have been agreed and overseen via the Workforce Establishment & Vacancy Panel.

Forward Look (with actions)

• PDR Completion: L&D colleagues continue to support managers to achieve PDR completion; a gap between completion levels and the 90% target remain • The change in medical appraisal compliance is due to a realignment of the reporting window to match the Trust appraisal window (April to March as opposed to birthday to birthday). The team are working with clinicians to get those behind with appraisal back on track.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

Total workforce for the end of September 2025 was 80 WTE below plan. Actual WTE was 4,317 against a plan of 4,397.

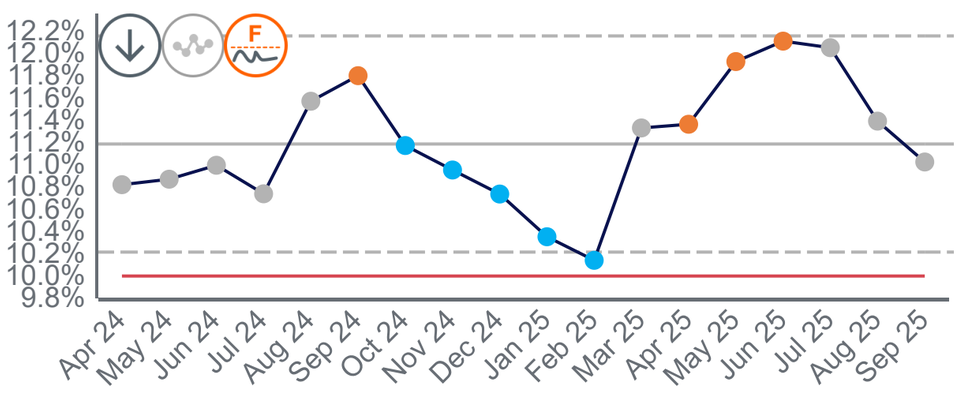
Actions:

WTE in August 2025:

• Substantive colleagues (Inc. Trainees): 4219.31 (August: 4233.46)
• Bank usage: 94.16 (August: 88.69)
• Agency usage: 3.33 (August: 4.61).

Staff Turnover

Target: Internal



Technical Analysis:

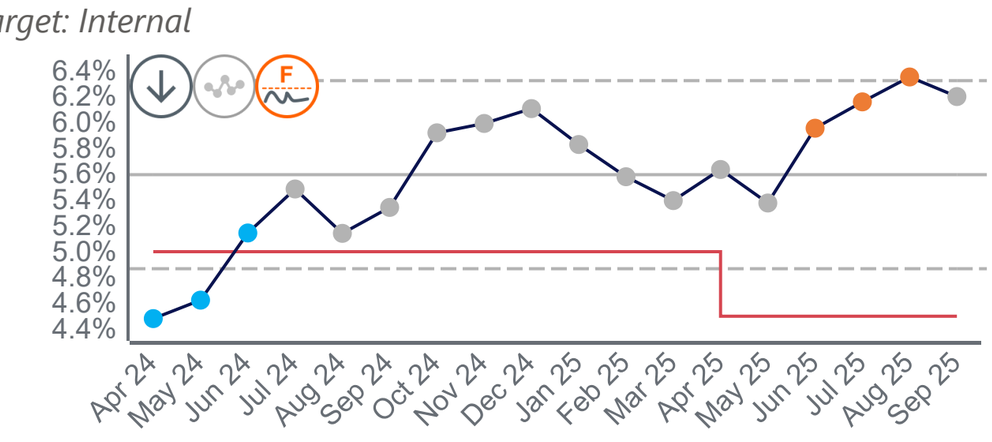
Common cause variation observed with performance of 11% in September 2025 against an internal target of 10%. Reduction from August performance of 11.4%. Consistently failing metric however however 3rd consecutive month with a reduction and lowest since March 2025.

Actions:

Having seen a steady decline, the recent increase in staff turnover has begun to reduce to 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:

Common cause varation observed. Total sickness absence in September 2025 is 6.20% which is above the 5% target, although slight decrease from August 2025 at 6.35%. September 2025 performance comprises STS at 2.01% and LTS at 4.79%. First month STS has been above target since Mar-25. Apr 2024 is last period which would have achieved current target which is now 4.5% in 2025/2026.

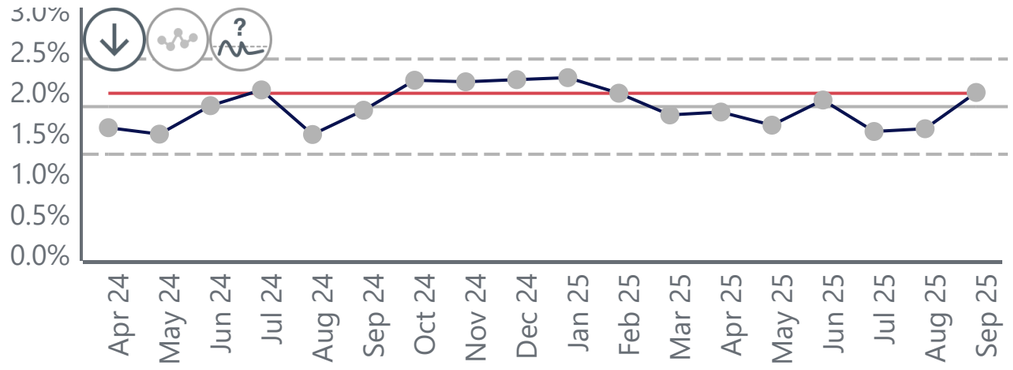
Actions:

Sickness absence levels are challenging. As a part of the Closing the Gap programme, and target to reduce sickness absence, HR resource has been temporarily redistributed to specifically focus on sickness absence management and improvement. Updates are regularly reported to Exec colleagues.

Supporting Our People - Watch Metrics

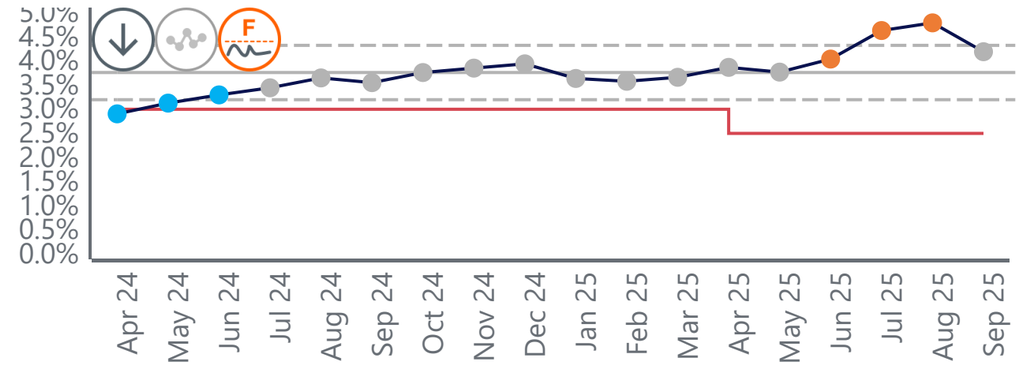
Short Term Sickness

Target: Internal



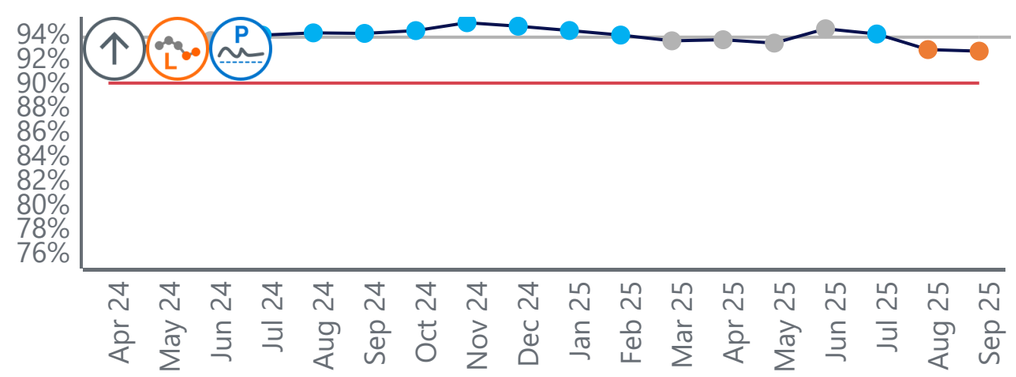
Long Term Sickness

Target: Internal

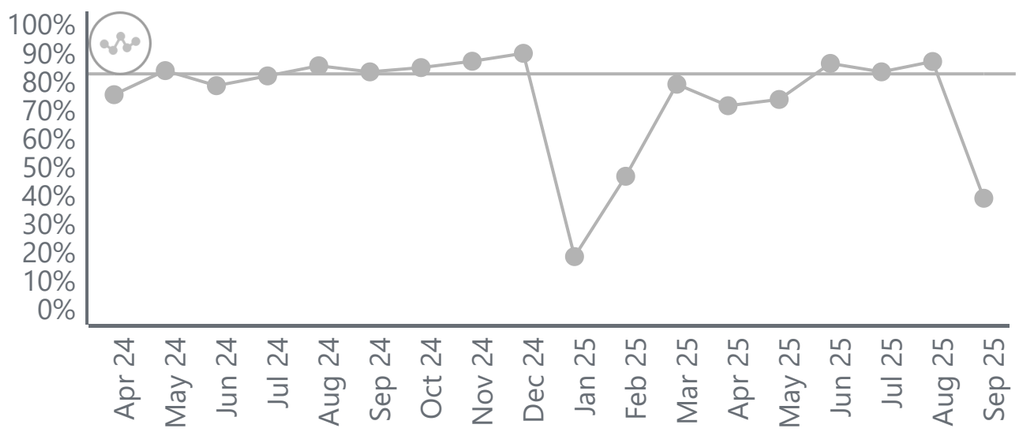


Mandatory Training

Target: Internal

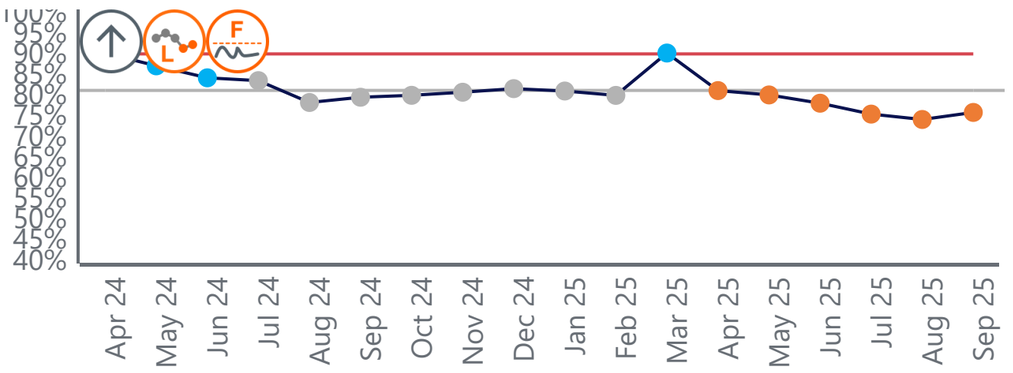


Medical Appraisal

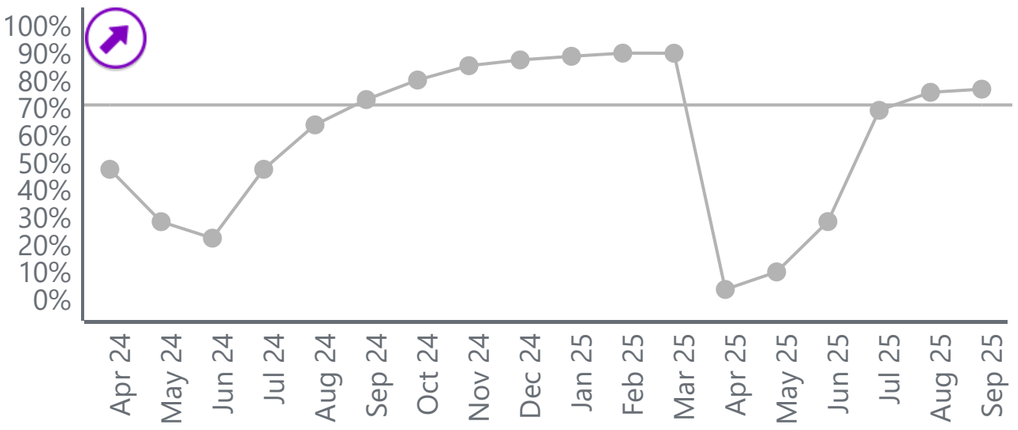


% PDRs Completed (Rolling 12 Months)

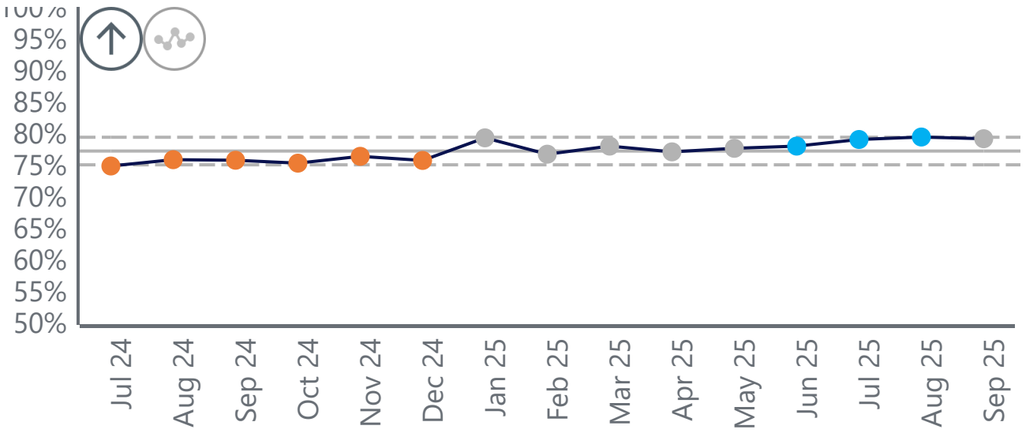
Target: Internal



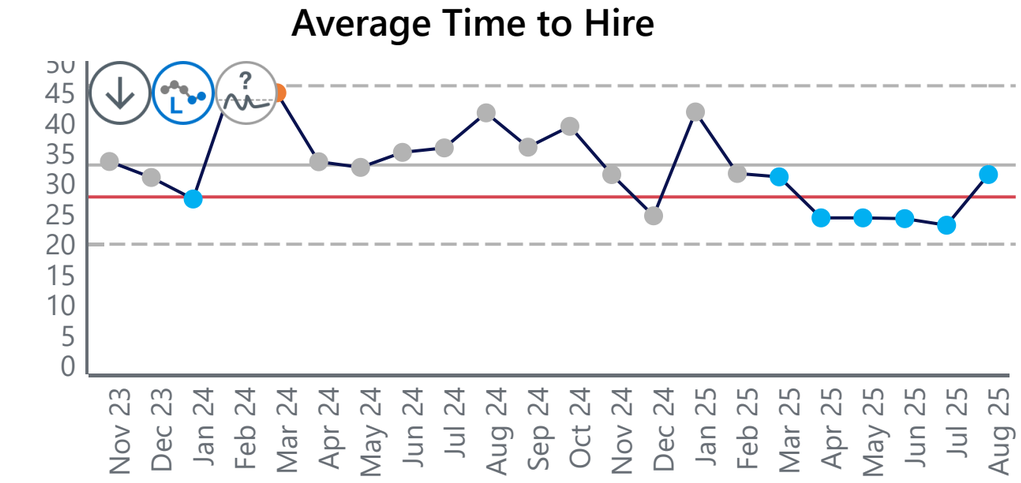
PDR B7+ Completed (Rolling 12 Months)



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:

• Prof Dan Hawcutt confirmed as Director of the Liverpool Institute for Child Health and Wellbeing - period of transition commenced • Futures team developments - acting up appointments for Associate Chief Nurse and Operations and Events Manager and Paediatric Open Innovation Zone Programme Manager • Draft Futures Comms and Marketing plan developed following commencement of dedicated Comms and Marketing Officer in July • Successful introductory meeting for Paediatric Open Innovation Zone (POIZ) with Combined Authority Investment Zone Programme Team took place on 1st Oct and monthly reporting has commenced • Successful collaborative C&M bid for NHSE North West transformation funding to support a pilot to roll out Lyrebird (Ambient Voice Technology) across the region • Successful delivery of one-off automation process linked with the ND pathway involving 14,800 referrals and 7,400 patient accounts which would have taken months of manual administrative work (completed in under 4 weeks) • AH to host first paediatric pharmacogenomics clinic in UK (led by Dan Hawcutt) from September • Positive feedback from the thriving operational managers programme on the innovation training module • Plans in place for launch of innovation competition in primary and secondary schools • Number of Lyrebird users continues to increase ahead of Trust-wide deployment before the end of the financial year • Project board for new patient portal has taken place, and set of workshops in the diary to make out with stakeholders • Co-pilot continues to be well utilised across the current user base, paper drafted to confirm next steps regarding the project • Internal funding awards made for grant writing protected time • Continued improvement in recruitment to time and target for sponsored and hosted research

Areas of Concern:

• Clinical capacity to support Research and Innovation remains a challenge • MRI and RPA business case progress off track and being monitored through FIP • Review of commercial research income forecast underway as currently off track

Forward Look (with actions)

• Mitigation plans being actioned for MRI and RPA • Commercial research activity under review to inform accurate forecast at end on M7 • Transition planning underway for CRD leadership following LICHW Director appointment • Innovation schools competion to be launched

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

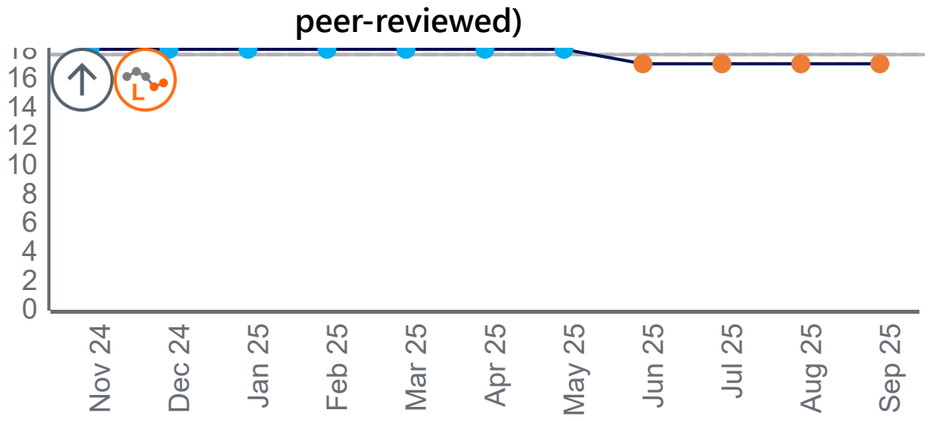
Technical Analysis:

Under Review

Actions:

Under Review

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



Technical Analysis:

Note – this metric has been adjusted to only include externally funded and peer-reviewed research

Actions:

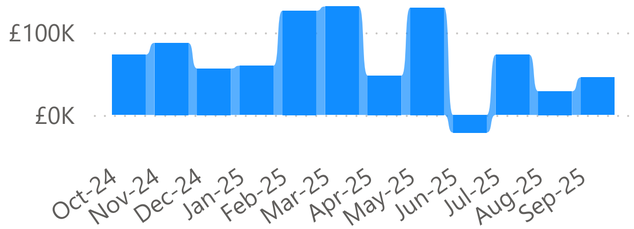
Currently stable – internal strategic funding awards aimed at increasing externally funded AH led research activity

Integrated Performance Report | October 2025

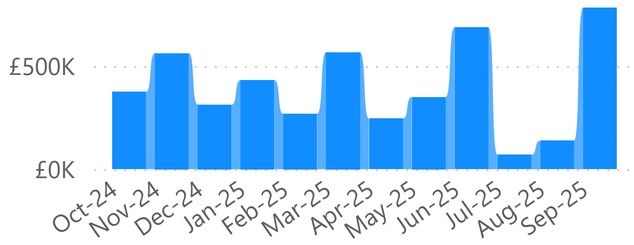
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

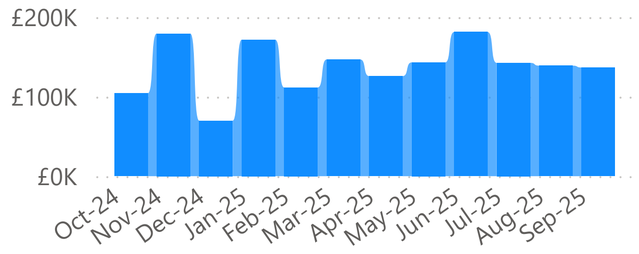
External innovation income received by month (commercial and non-commercial)



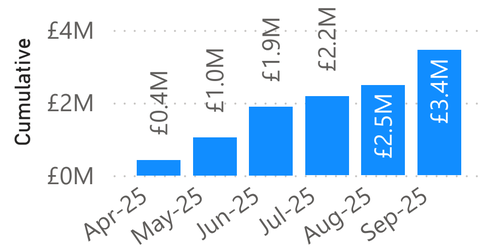
External research income received by month (commercial and non-commercial but excluding NIHR)



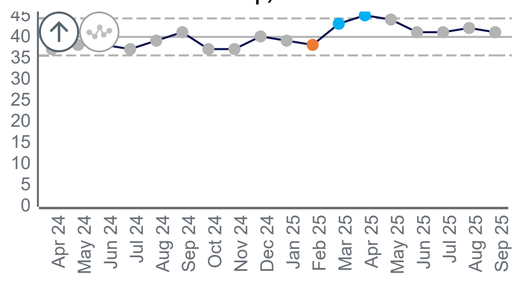
NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)



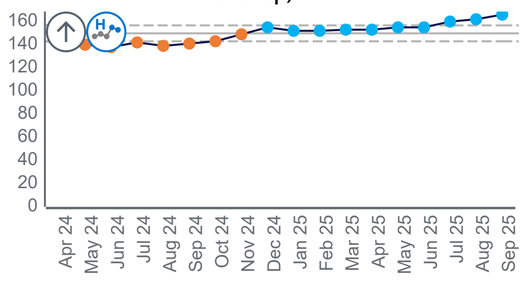
External income received by month across Research and Innovation (YTD Cumulative)



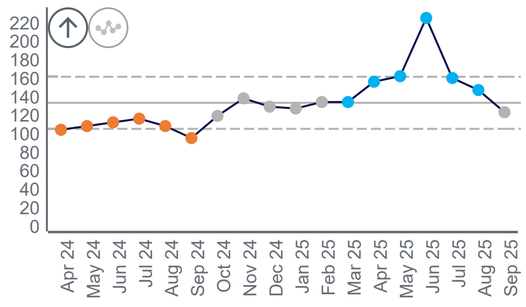
Number of open commercial studies (recruiting and in follow up)



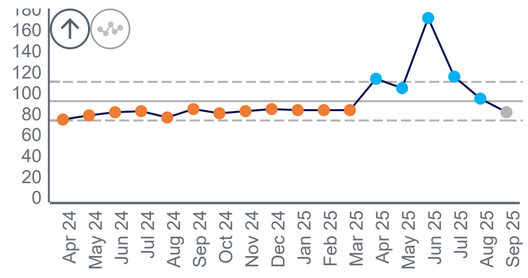
Number of open non-commercial studies (recruiting and in follow up)



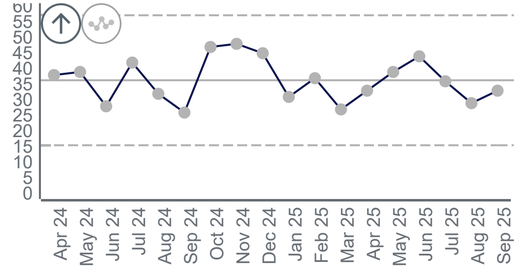
Number of participants recruited to all studies



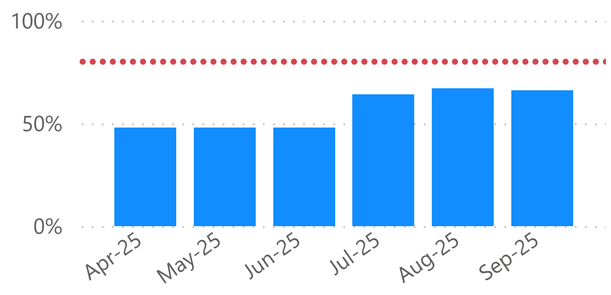
Number of participants recruited to all NIHR portfolio studies



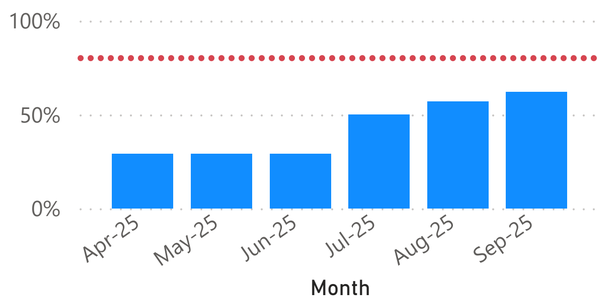
Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



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



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



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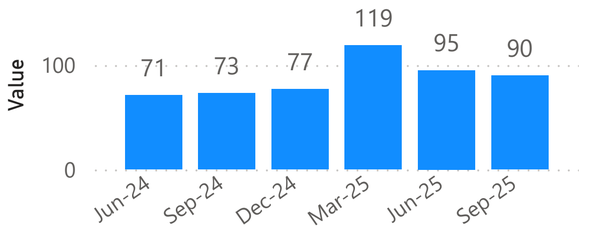
NHS
Alder Hey Children's
NHS Foundation Trust

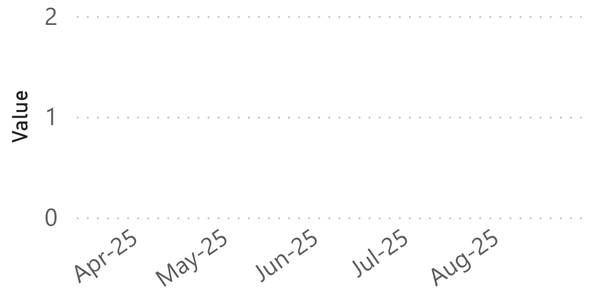
Pioneering Breakthroughs

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

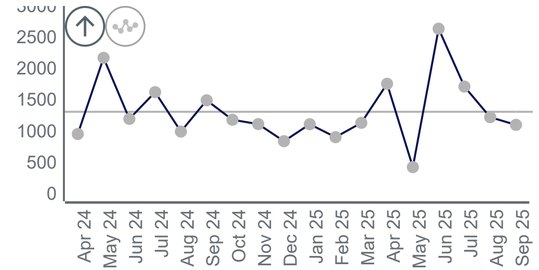
Quarterly



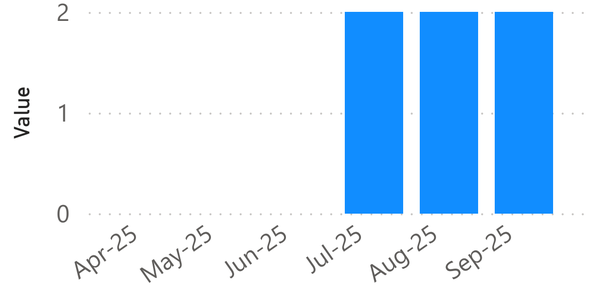
Number of businesses supported by POIZ



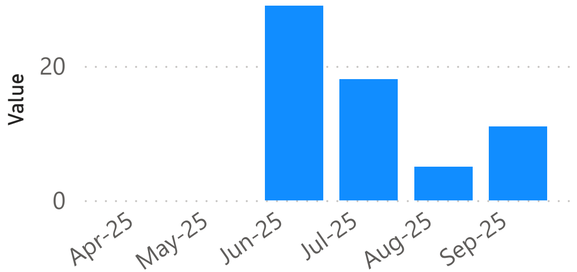
Manual hours released from automation/AI solutions - Monthly



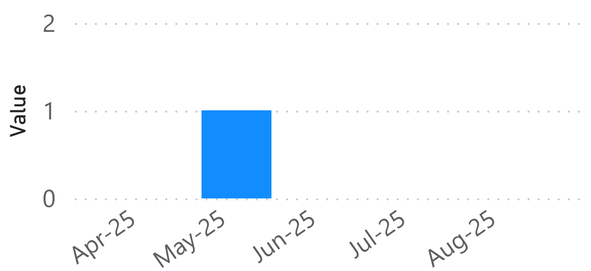
Number of staff trained in innovation methods



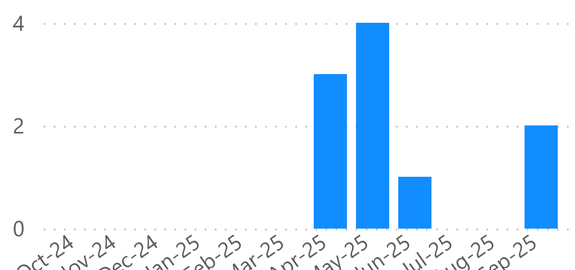
Number of staff trained in research methods



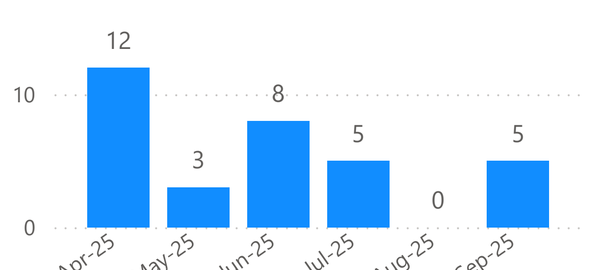
Number of AH-hosted jobs created through new external funding (POIZ metric)



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:

£1.5m surplus in month, £1m deficit YTD in line with plan. Prior months industrial action costs now absorbed. Externally forecasting to achieve £7.160m planned surplus subject to CIP and ICB risk share being mitigated. However, extrapolated forecast based on run rate methodology is £2.3m surplus, an improvement of £2.3m compared to M5. CIP is £0.1m above plan YTD mainly due to non-recurrent benefits. Overall, £18.5m CIP has been transacted (£10m recurrently) with £2.4m fully developed. Cash lower than plan and capital ahead of plan due to phasing of budget.

Areas of Concern:

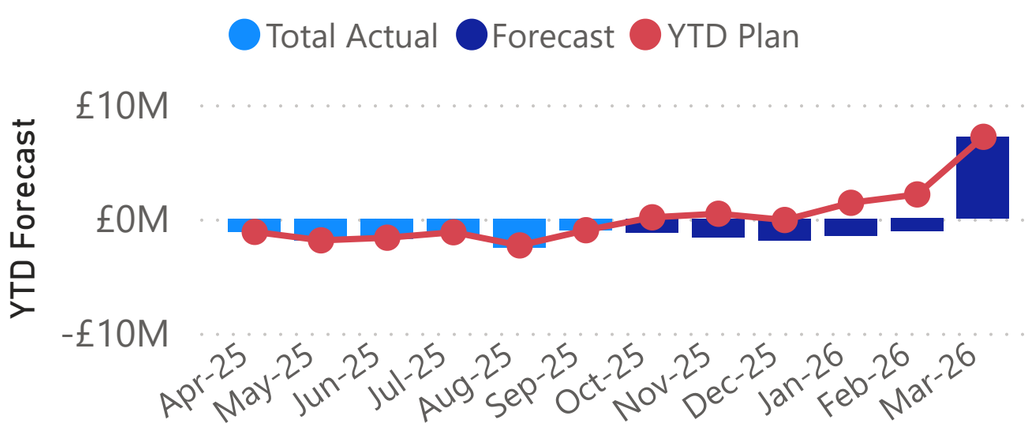
Delivery of CIP programme continues to present a risk. Mitigating actions are being progressed through the Financial Improvement Programme (FIP) and collaborative workstreams. Divisional forecasts have been updated to reflect 'Closing the Gap' schemes to ensure delivery of the £22.7m CIP plan. Capital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

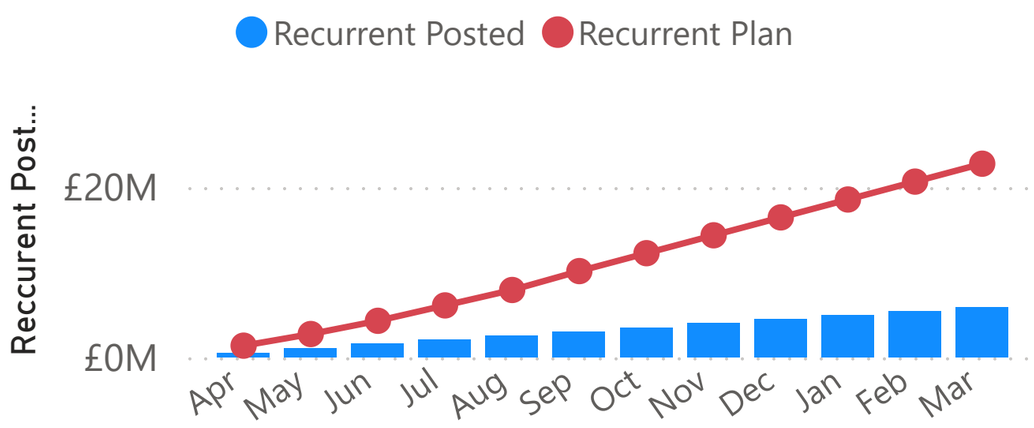
Current plan is £7.160m surplus which we aim to achieve. Risks to delivery of this is linked to achievement of CIP still in progress, identification of system wide schemes to deliver stretch target and management of in year pressures.

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



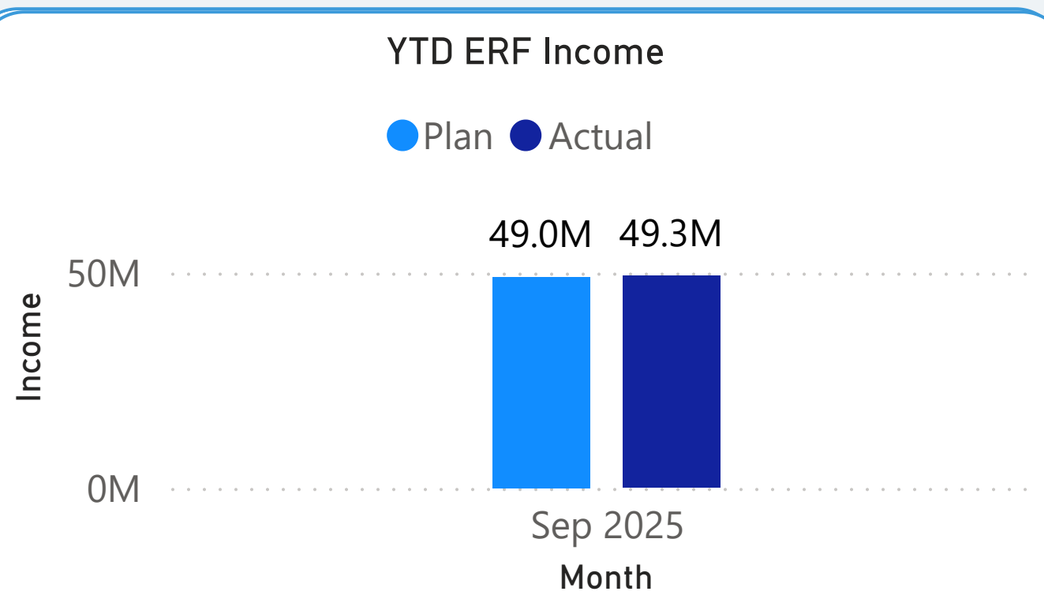
Technical Analysis:

Recurrent CIP identified and in progress is £13.4m.

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:

September performance estimated at 86%.

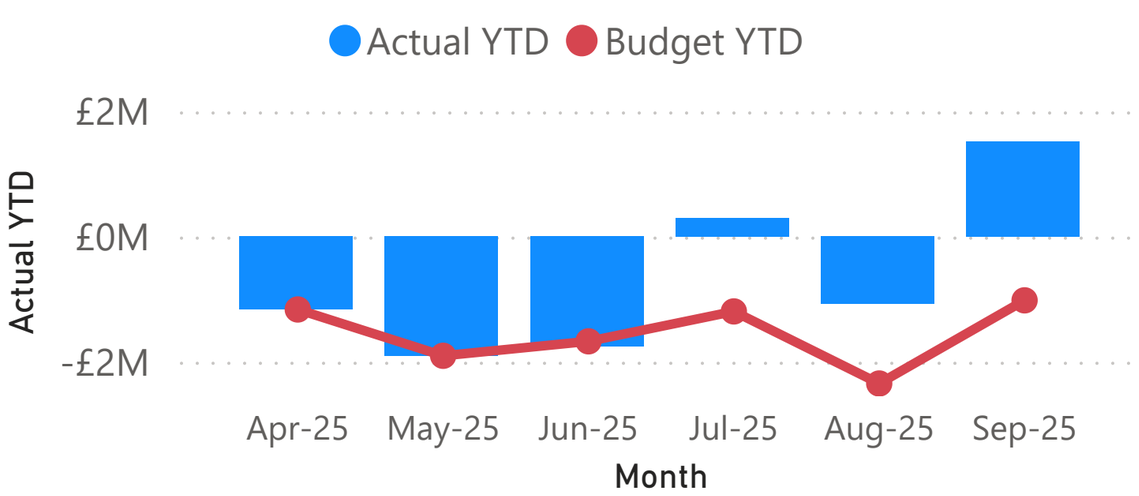
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

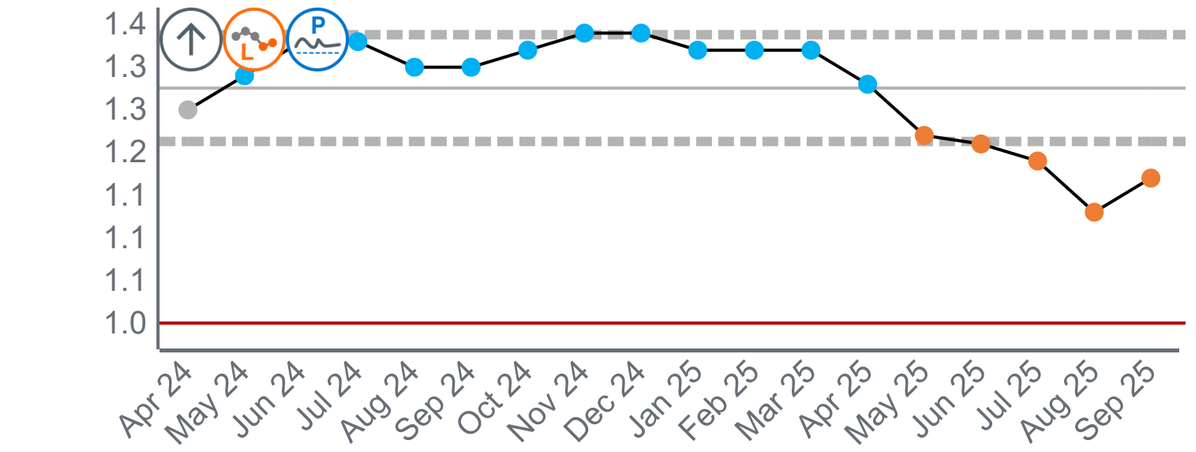
I&E distance from target (cumulative YTD)

Target: Internal

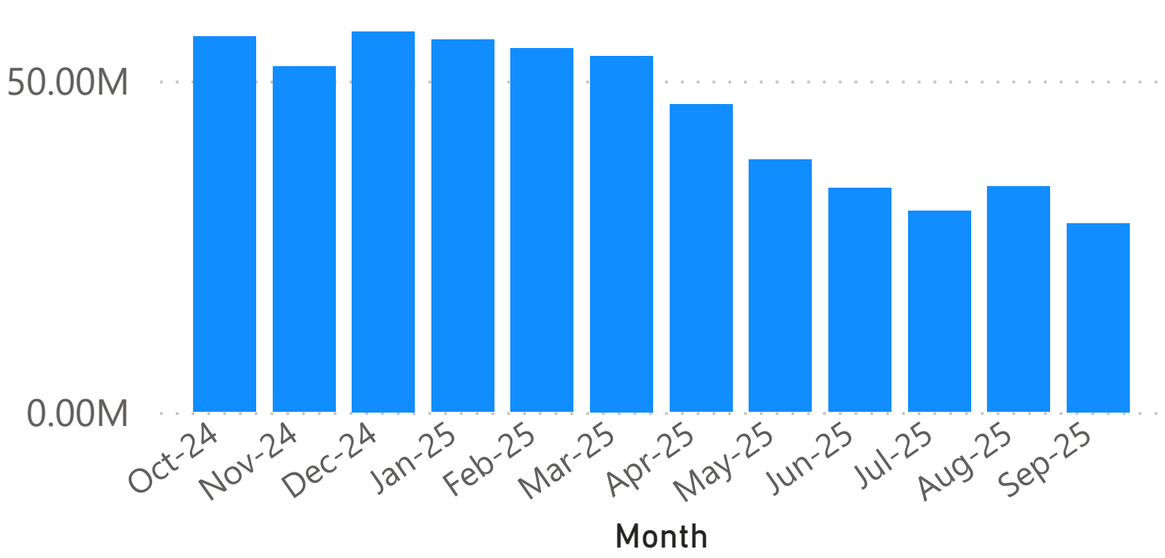


Liquidity

Target: Internal

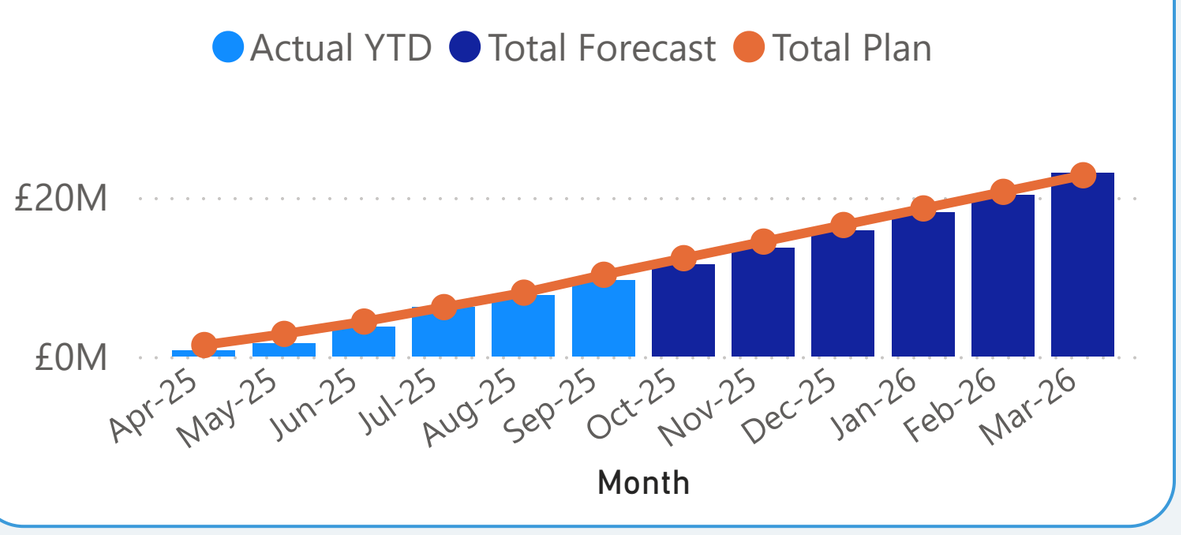


Cash In Bank



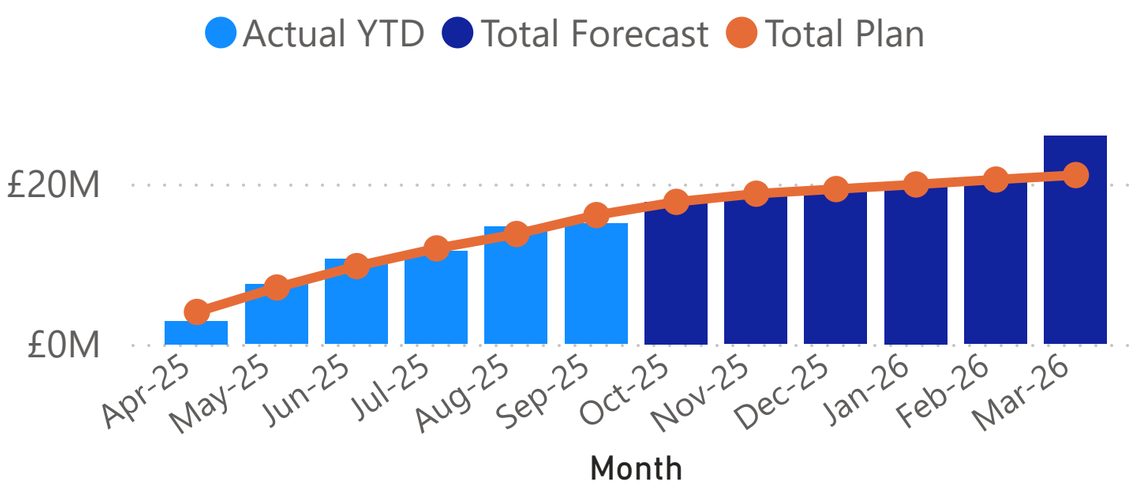
In Year CIP – forecast against plan

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. Work ongoing with divisions to transcribe legacy risks • Communications regarding risk review timescales disseminated across organisation.

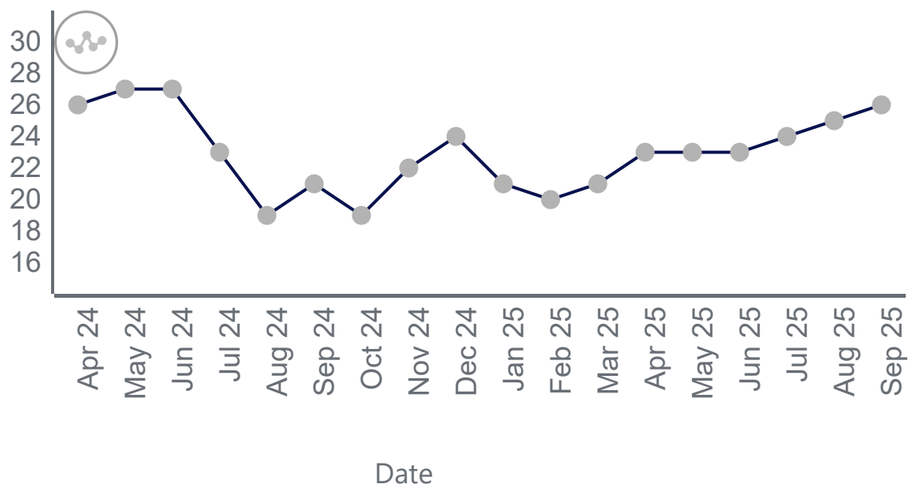
Areas of Concern:

• Risk appetite roll out currently paused pending further discussion at Trust Board re tolerance levels even current financial position • 19.2% (5/26) of high risks with actions past expected date of completion. Risk owners have been notified and risks actioned

Forward Look (with actions)

• Discussions ongoing with Medicine Division regarding risk appetite planned for 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:

Number of high risks is 26 as of the end of September 2025

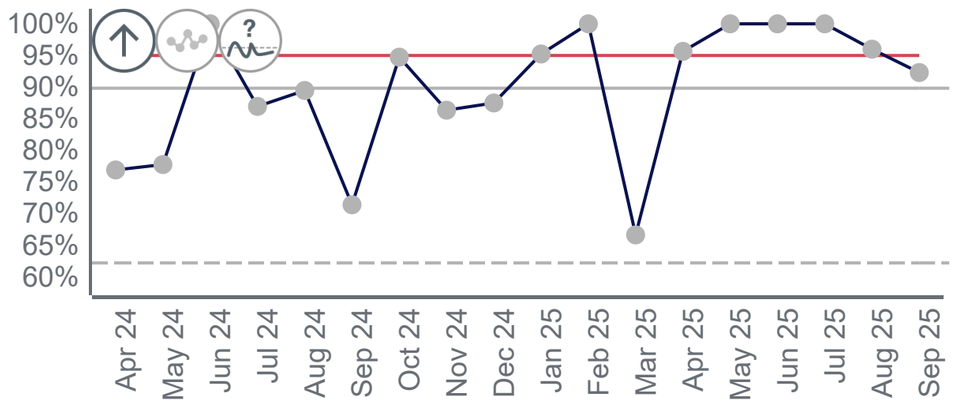
Actions:

The breakdown by category is as follows:

• Quality – Safety = 14 risks • Workforce – Sustainability = 5 risks • Compliance and Regulatory = 3 risks • Financial – Investment = 2 risks • Reputation = 1 risk • Commercial = 1 risk

% of High Risks within review date

Target: Internal



Technical Analysis:

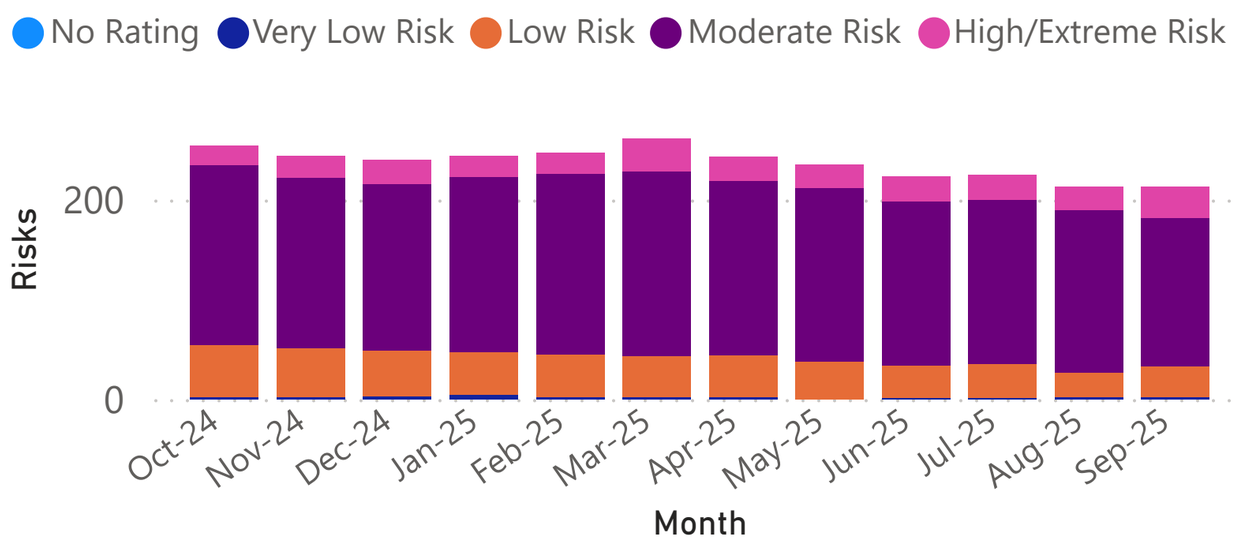
Common cause variation observed with performance of 92%. Slight reduction from performance of 96% in August 2025. First month below target this financial year.

Actions:

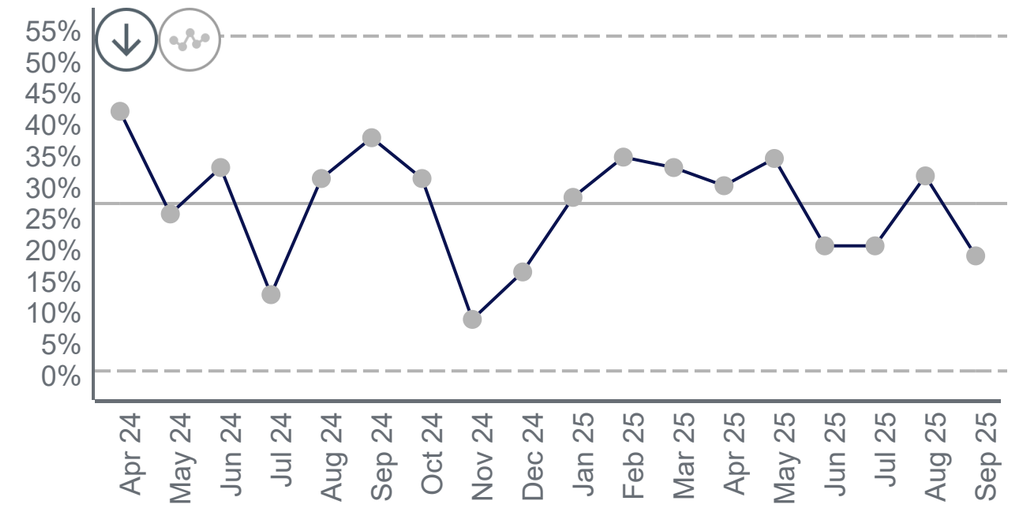
92.3% of high risks within review date

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

- Improvement in number of PALS responded to within 5 days (83%)
- Reduction in WNB rate (13%)
- Reduction in staff turnover – lowest YTD (9.1%)
- Continued improvement in 18 week RTT for Community Paediatrics (63%)
- Improvement in waiting time for first assessment in Community Mental Health Services (73%)
- Mandatory training compliance remains above target (96%)

Areas of Concern

- Reduction in IHA compliance within 20 days of referral (54%) – with expected further reduction in M7
- Increase in sickness absence (6.3%) – increase within short term sickness (1.7%) and reduction in long term sickness (4%)
- Reduction in number of complaints resolved within 25 working days (33%)
- Reduction in number of children & young people waiting over 52 weeks for treatment to start (7) in Community Mental Health Services (Liverpool) - improvement plan in place with 0 x 52+ weeks expected end of October 2025
- Ongoing concerns regarding the number of clinical letters outstanding - slight improvement in number of clinical letters completed within 10 days (14%) due to delays in transcription process
- Ongoing challenges with ADHD medication shortage which is impacting on waiting times for the diagnostic pathway

Forward Look (with actions)

- Deep dive into reduction of IHA KPIs, with demand and capacity work and improvement plan to be developed.
- ASD / ADHD transformation programme gone live September 2025 – work ongoing to streamline and validate data.
- Knowsley ASD Assessment Service commenced September 2025
- EMIS to Meditech Programme Board commenced September 2025
- Referral team improvement plan in place to meet KPI by 31 August 2025 – met and maintained
- Clinic Utilisation review and WNB deep dive continues
- Liverpool CAMHS performance improvement plan in place using A3 brilliant basics methodology – Trajectory for improvement finalised, Choice clinics introduced August 2025, risk and triage calls commenced September 2025.
- Continued work ongoing to improve Mental Health data reporting. Phase 1 completed with 2024/25 annual data re-submitted - awaiting publication (July 2025) expecting 0% data quality errors and significant increase in data flowing. Phase 2 (Crisis Care) work commenced, with Meditech developments prioritised for October 2025.
- No child or young person waiting longer than 2 years for follow up. Work ongoing to address children waiting 1+ year.
- Work ongoing to provide psychological support to children impacted by the Southport critical incident.

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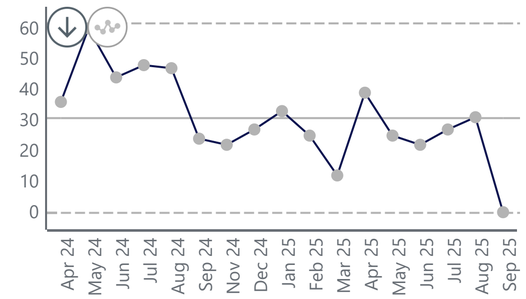
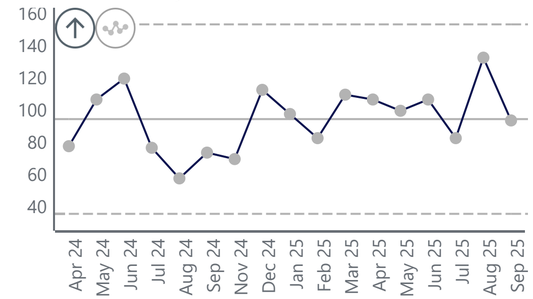
Divisional Performance Summary - Community & Mental Health

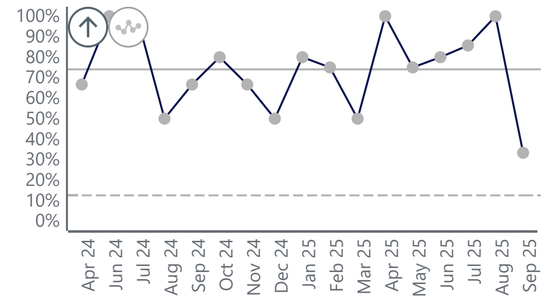
Patient Safety Incidents rated Low Harm & Above



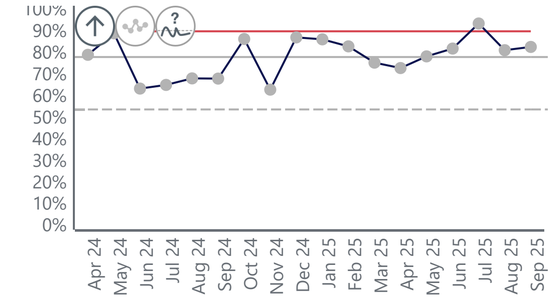
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

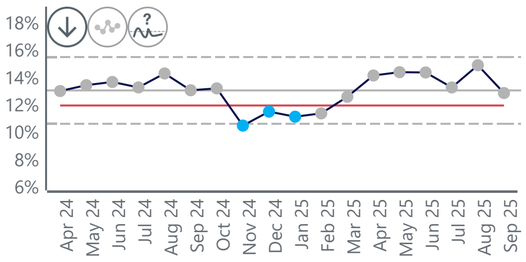


% PALS Resolved within 5 Days

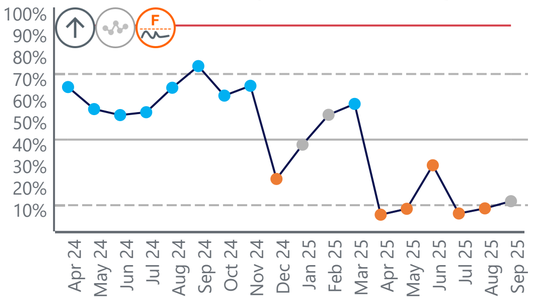


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

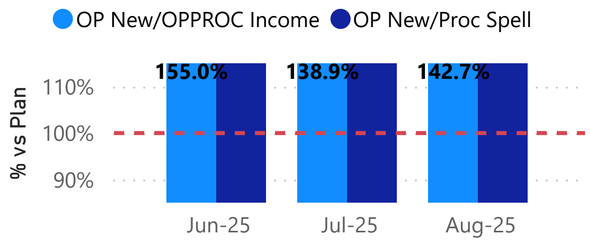


% of Clinical Letters completed within 10 Days

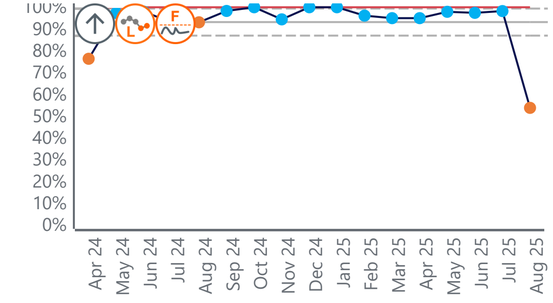


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

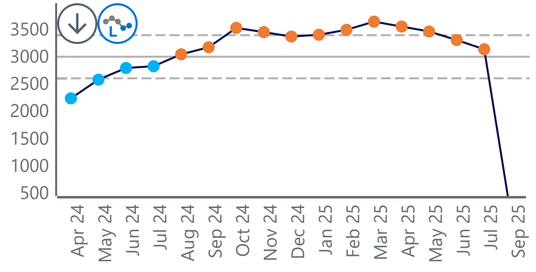
SLAM Performance



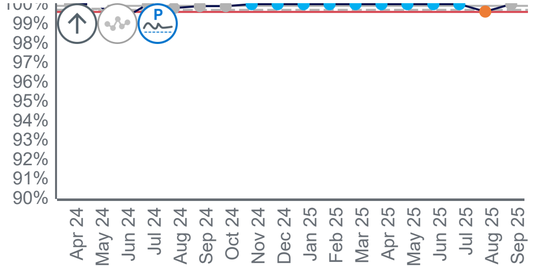
IHA: % complete within 20 days of referral to Alder Hey



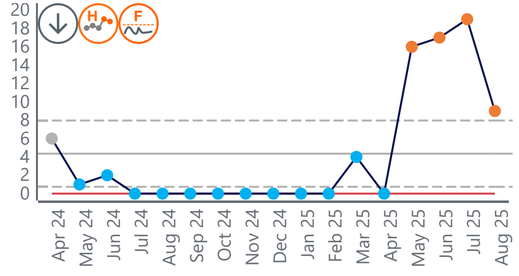
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



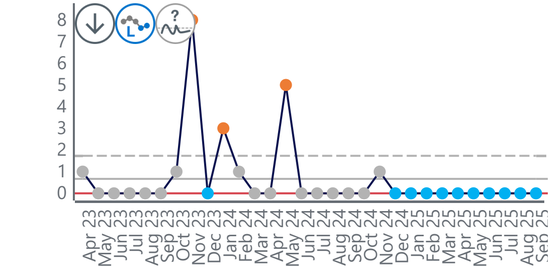
Percentage CYP suspected autism with contact under 13 weeks



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



Number of Paediatric Community Patients waiting >52 weeks



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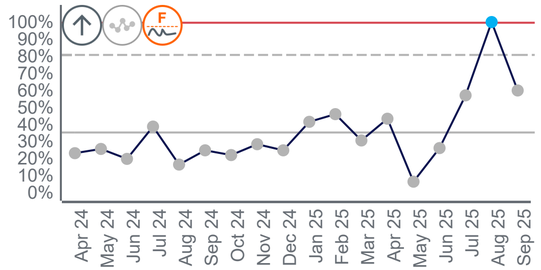
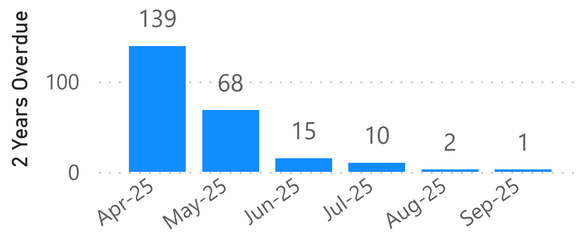
Divisional Performance Summary - Community & Mental Health

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

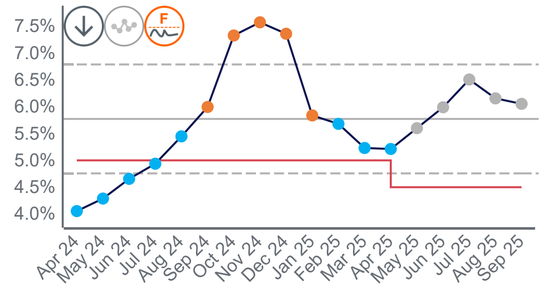


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

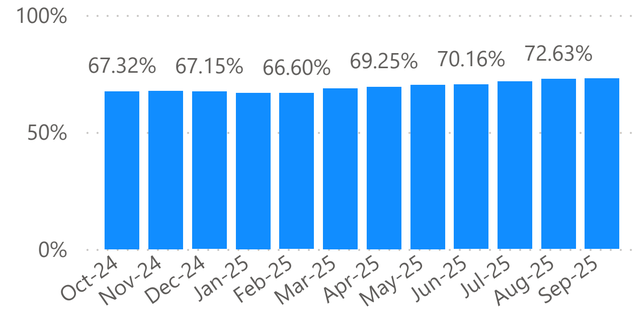
Vol overdue by 31st March 2026



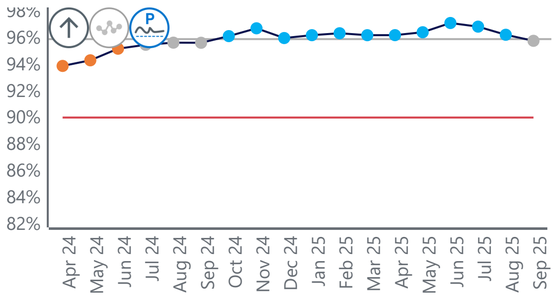
Sickness Absence (Total)



Workforce Stability

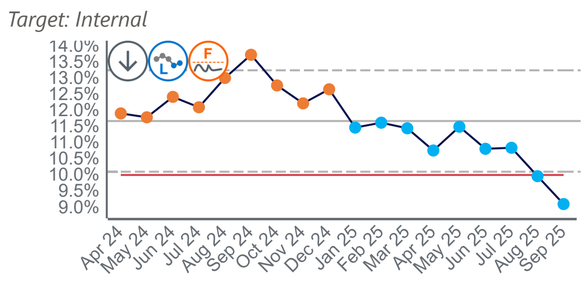


Mandatory Training

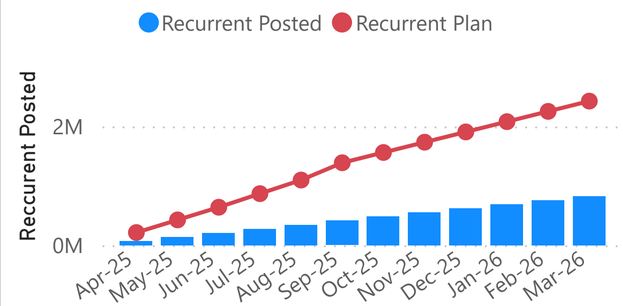


Staff Turnover

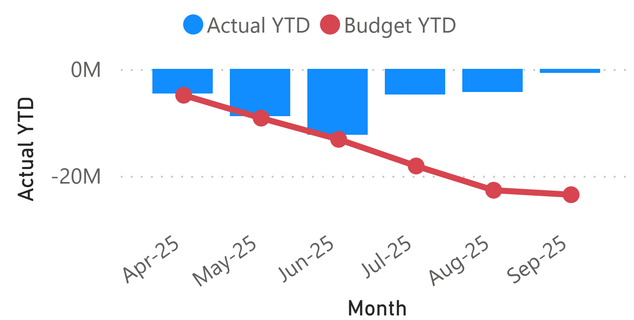
Target: Internal



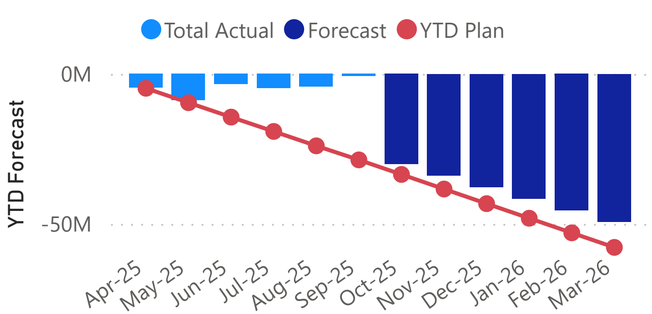
Recurrent Efficiency Plans Delivered (Forecast)



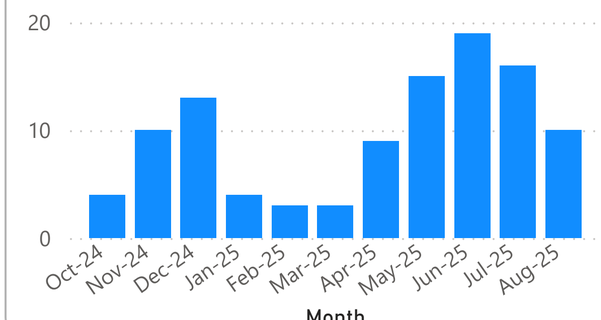
I&E distance from target (cumulative YTD)



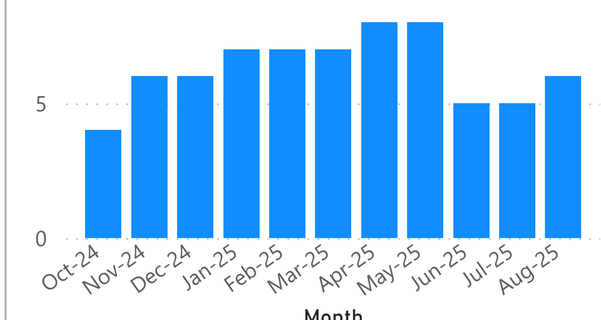
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Zero 52 week waits in Medicine in September

• There has been a reduction in WNB for the first time in six months.

• ED Performance has maintained at 87.4% for September with an increase of 900 attends compared to August. YTD ED performance is 86.3%

• Achieving plan YTD for ERF – activity at 98% but due to case mix income is £239k over

• DM01 maintained position

• Follow ups overdue over two years reduced from 1,107 in April 2025 to 527 in September 2025

Areas of Concern

• Whilst above the 90% target, Mandatory training has declined to 92%

• Sickness has reduced in September for the first time since May but is still in a challenged position at 6.4%

• £1.5m in black for CIP as at M6 (28%)

• Dip in complaints responded to within 28 days to 88% however this equates to 1 complaint which was responded to one day over.

Forward Look (with actions)

• Weekly access meetings to review RTT, DMO1, FU backlogs, utilisation and productivity

• Weekly CIP meetings review potential schemes to close the financial gap

• Rolling out overbooking within medicine to mitigate high WNB rates

• Weekly complaints meeting with escalation process to ACN to manage all PALs and Formal complaints

• All managers engaging with the new sickness management process to support staff and reduce sickness.

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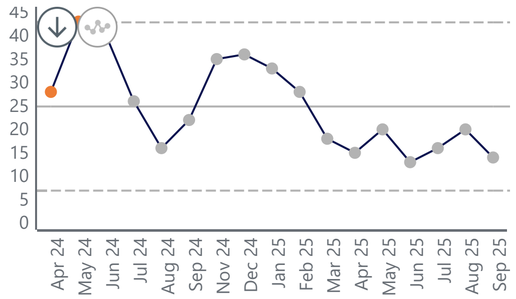
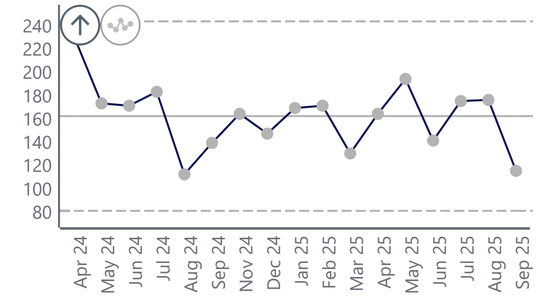
Divisional Performance Summary - Medicine

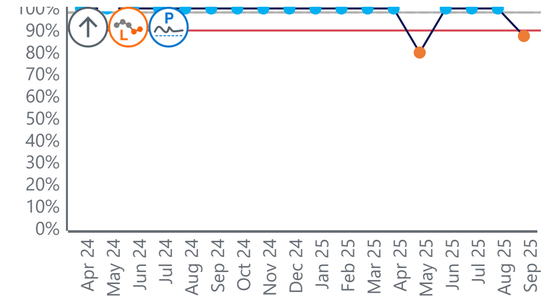
Patient Safety Incidents rated Low Harm & Above



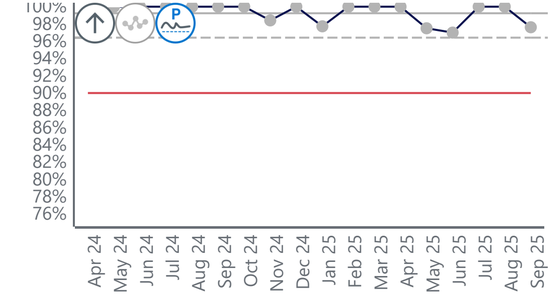
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

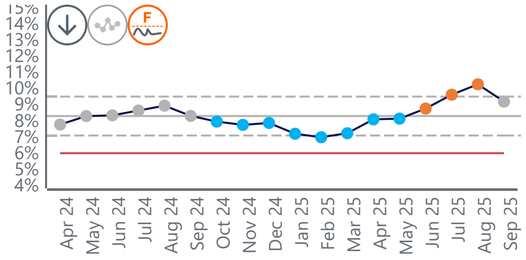


% PALS Resolved within 5 Days

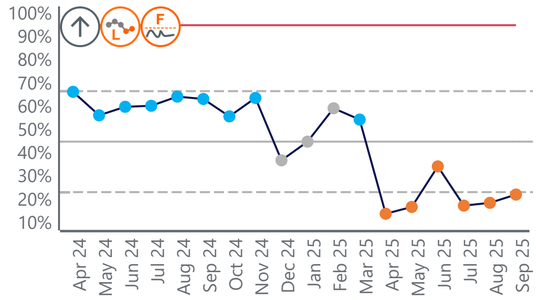


% Was Not Brought Rate (All OP: New and FU)

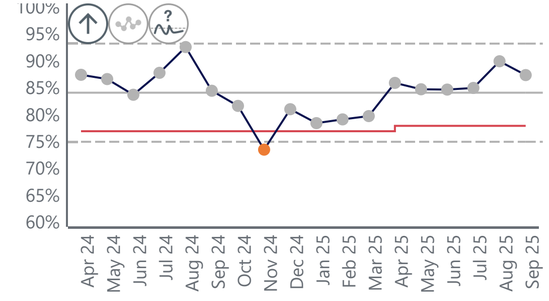
Target: Internal



% of Clinical Letters completed within 10 Days

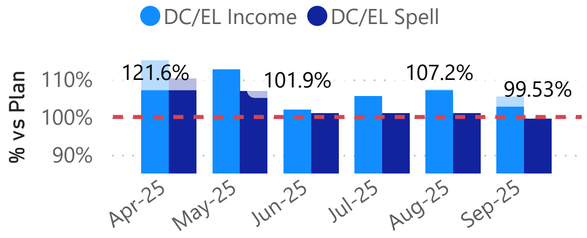


ED: % treated within 4 Hours



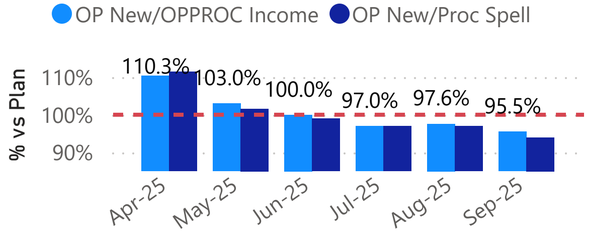
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

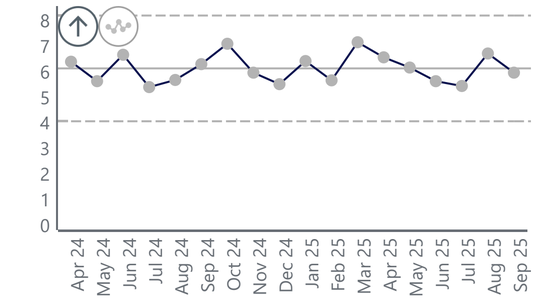


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

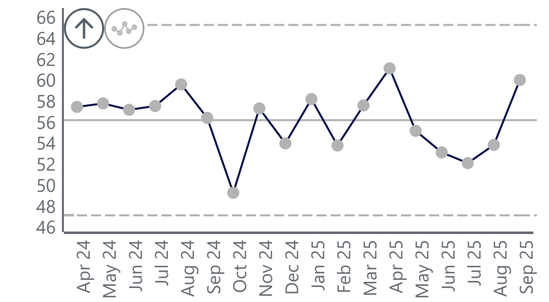
SLAM Performance



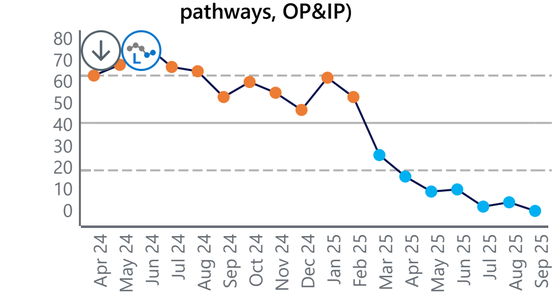
Inpatient Discharges per working day



Day Cases per working day



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



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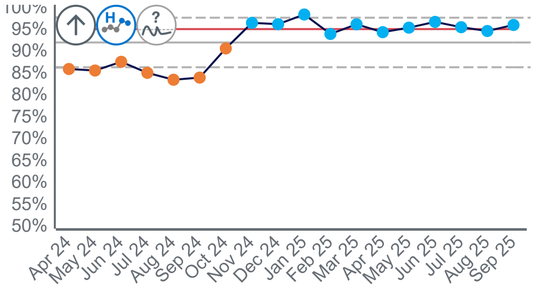
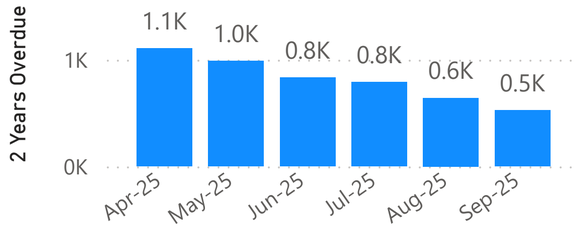
Divisional Performance Summary - Medicine

Diagnostics: % Completed Within 6 Weeks of referral

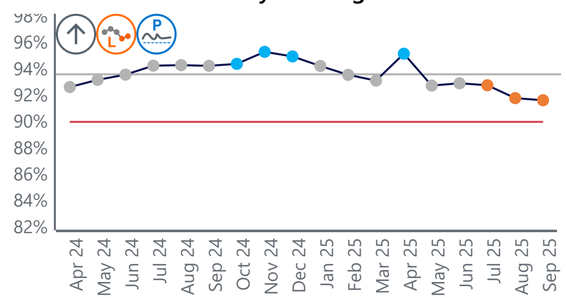


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

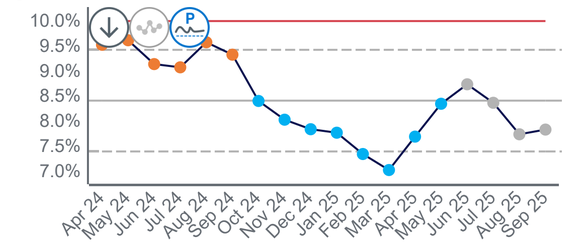


Mandatory Training

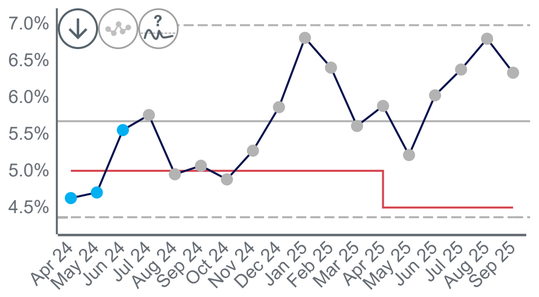


Staff Turnover

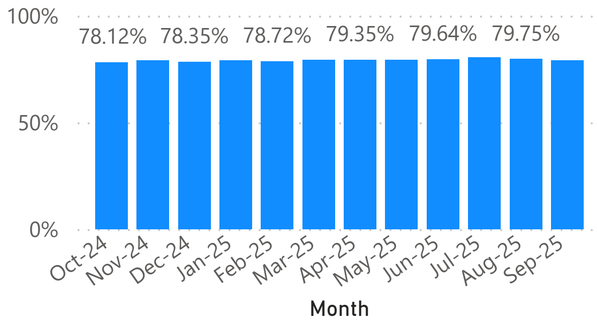
Target: Internal



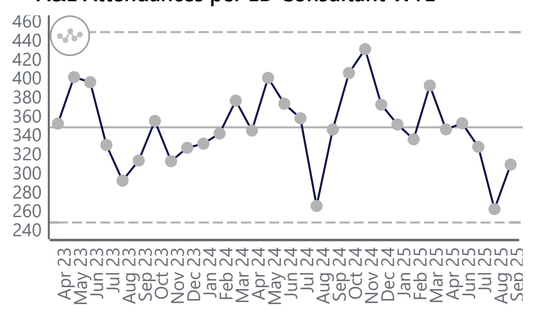
Sickness Absence (Total)



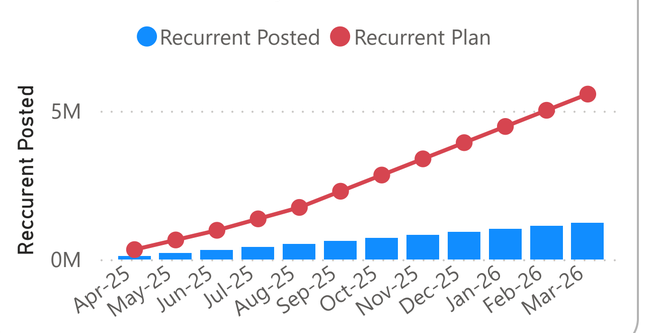
Workforce Stability



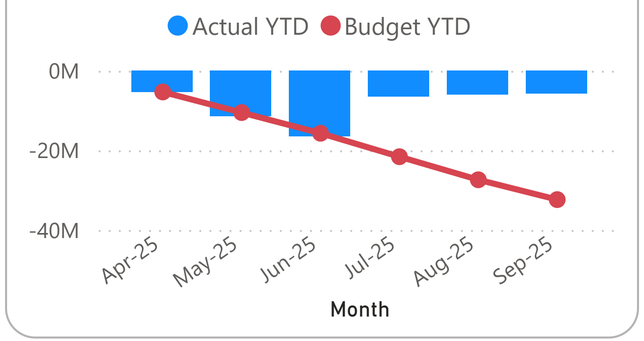
A&E Attendances per ED Consultant WTE



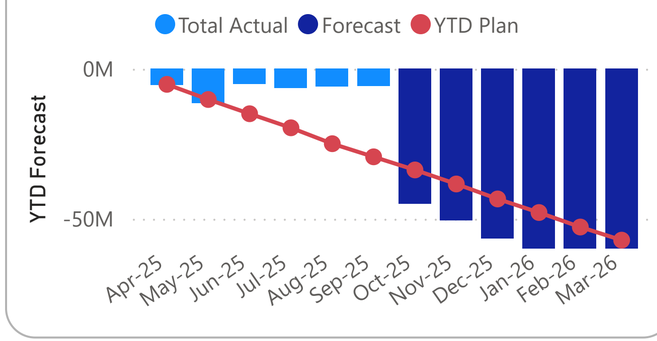
Recurrent Efficiency Plans Delivered (Forecast)



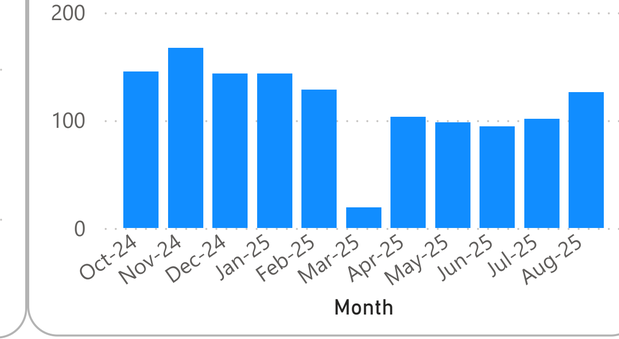
I&E distance from target (cumulative YTD)



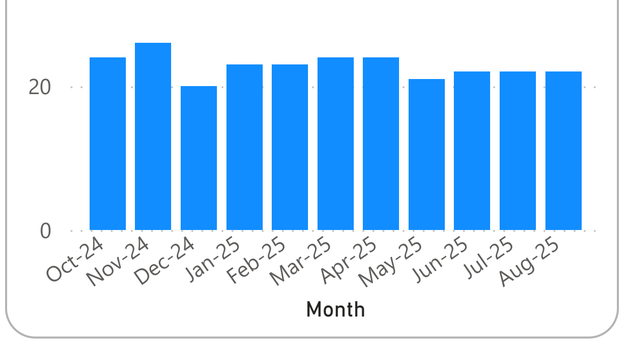
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

•PALS and formal complaints response consistently above 95%

•Mandatory training remains above target

• The number of patients waiting over 52 weeks for treatment has reduced from 418 to 237.

Areas of Concern

• WNB rate continues to be above target

• The number of two year overdue follow ups has increased

• Sickness absence increased to 6.9% in month, have seen a rise in short term sickness in month

Forward Look (with actions)

• Weekend theatre lists for ENT are restarting on 18th October

• Formal overbooking has commenced and is rolling out to new services each week

NHS
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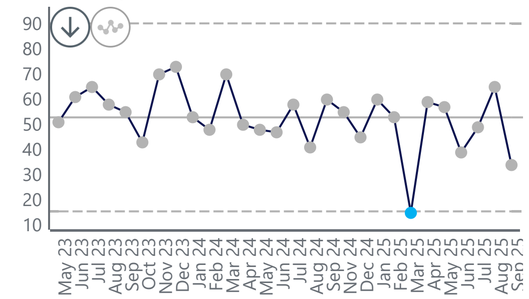
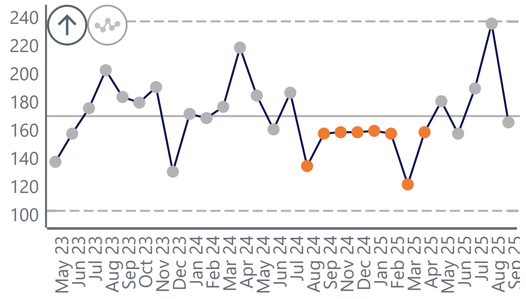
Divisional Performance Summary - Surgery

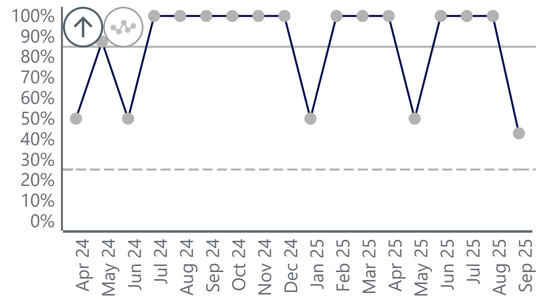
Patient Safety Incidents rated Low Harm & Above



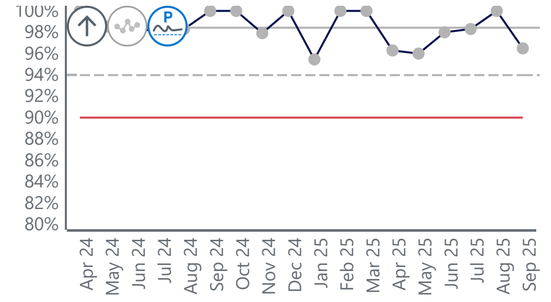
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

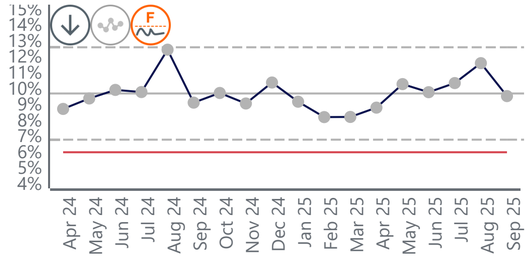


% PALS Resolved within 5 Days

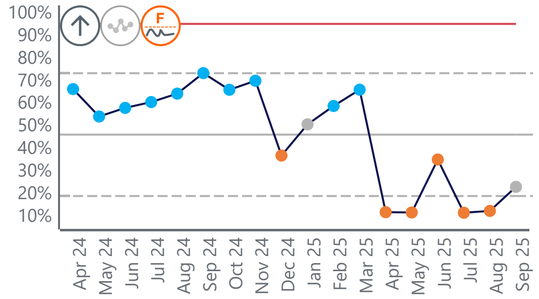


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

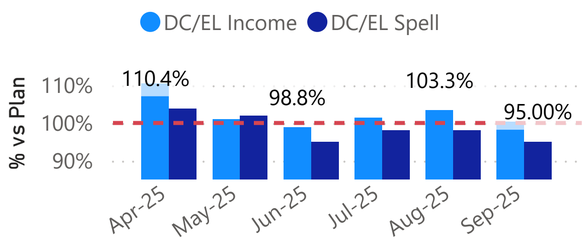


% of Clinical Letters completed within 10 Days



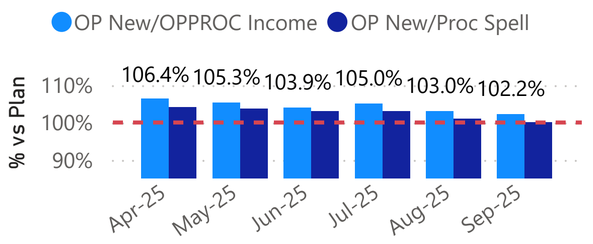
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

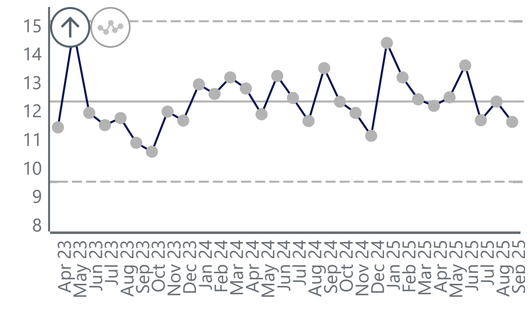


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

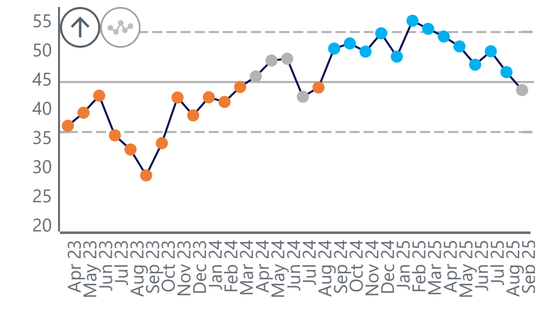
SLAM Performance



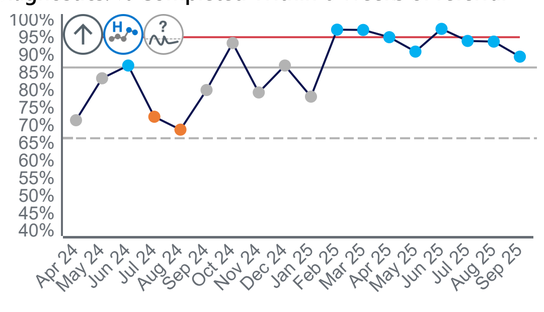
Inpatient Discharges per working day



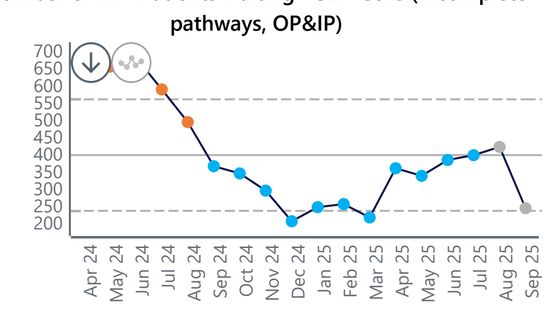
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



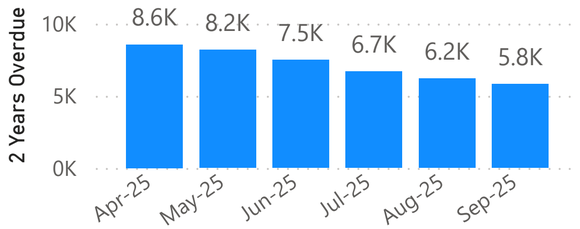
Integrated Performance Report | October 2025

Alder Hey Children's NHS Foundation Trust

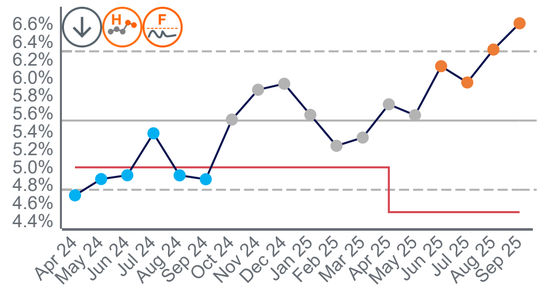
Divisional Performance Summary - Surgery

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

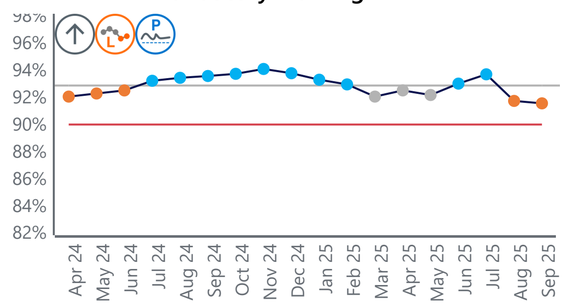
Vol overdue by 31st March 2026



Sickness Absence (Total)

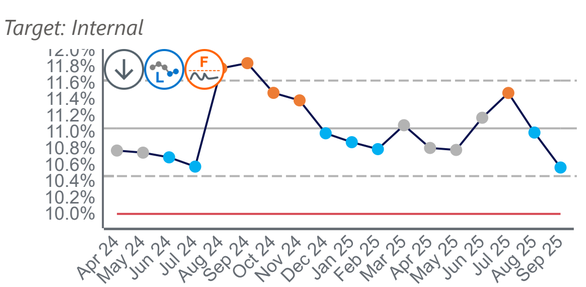


Mandatory Training

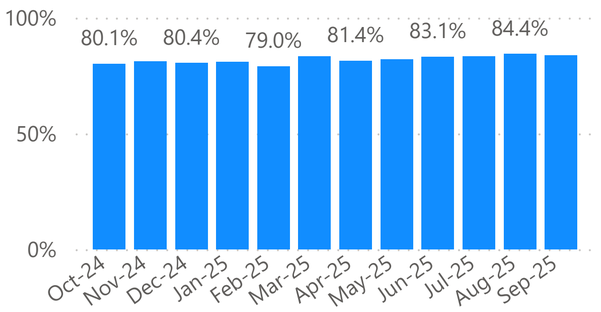


Staff Turnover

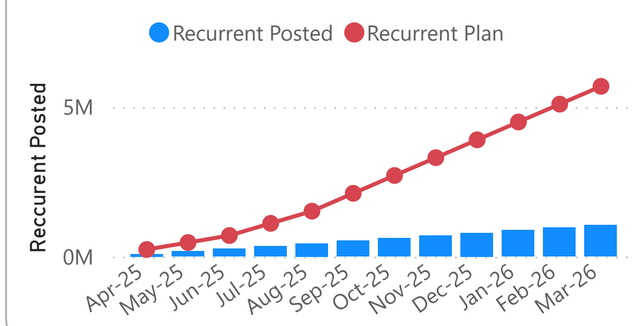
Target: Internal



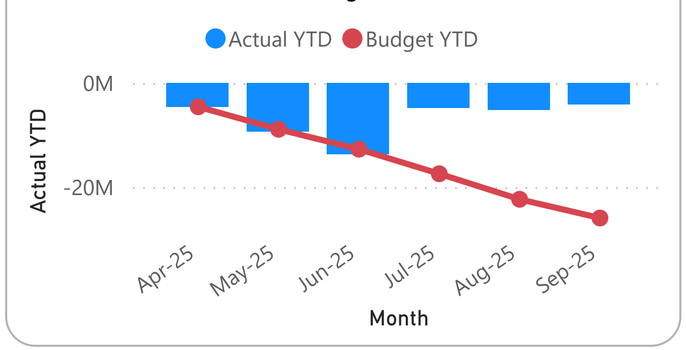
Workforce Stability



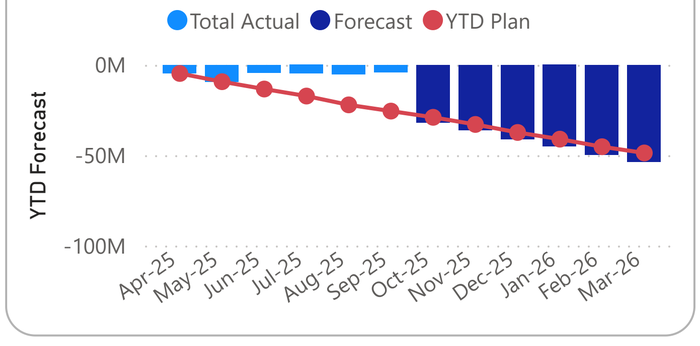
Recurrent Efficiency Plans Delivered (Forecast)



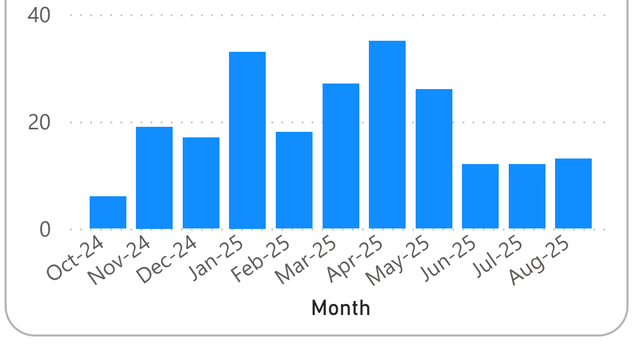
I&E distance from target (cumulative YTD)



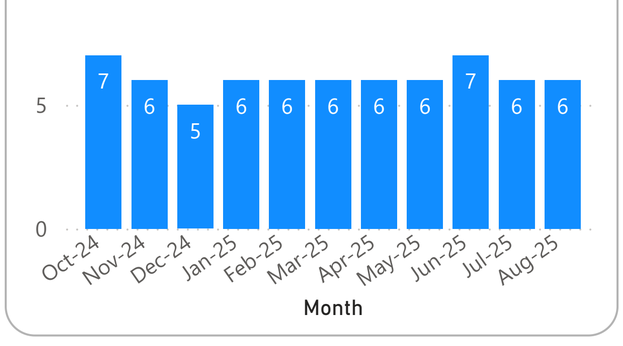
I&E Year End Forecast



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

- No concerns with HR metrics – PDRs and mandatory training are on track and long term sickness is being managed in line with policy
- See pioneering breakthroughs section for research highlights

Areas of Concern

- See pioneering breakthroughs section for research areas of concern

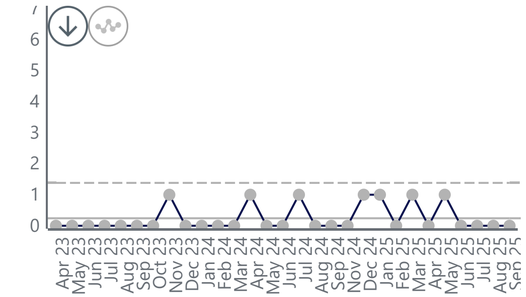
Forward Look (with actions)

- See pioneering breakthroughs section for research forward look

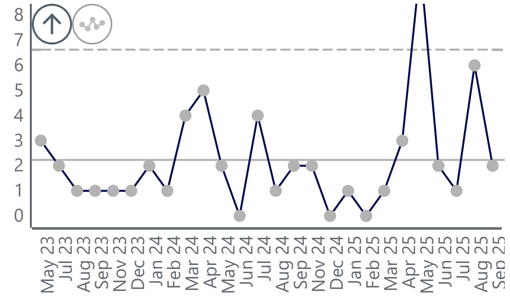
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

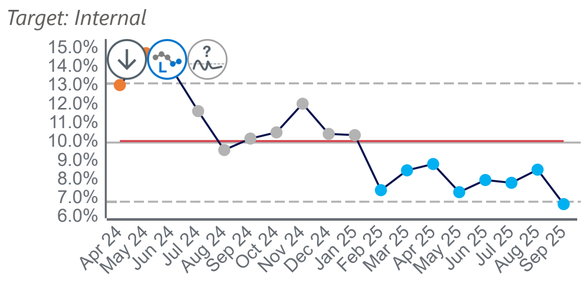
Patient Safety Incidents rated Low Harm & Above



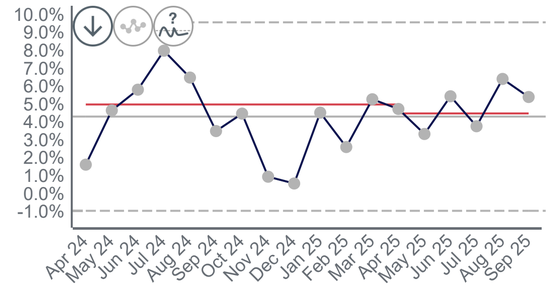
Patient Safety Incidents rated No Harm



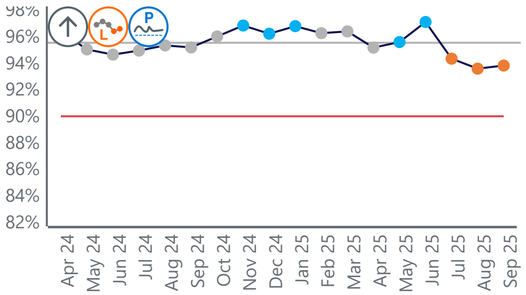
Staff Turnover



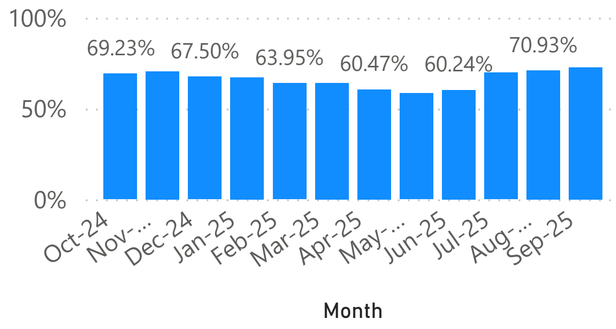
Sickness Absence (Total)



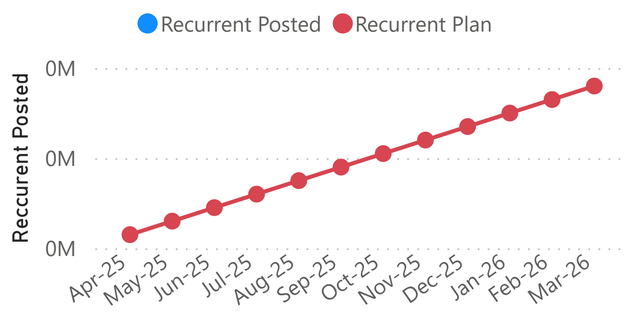
Mandatory Training



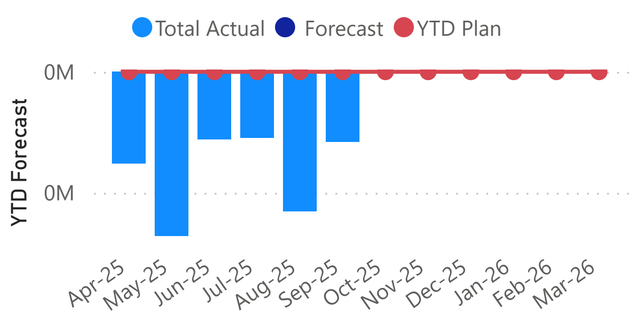
Workforce Stability



Recurrent Efficiency Plans Delivered (Forecast)

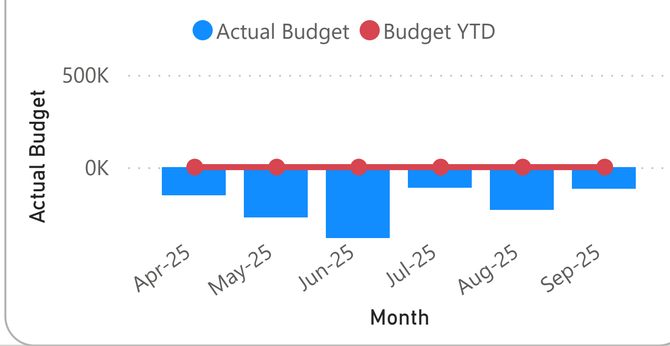


I&E Year End Forecast



Number of Patients Recruited into Research Studies

I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative met on 13th October; highlights from the September 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 £5.2m, £4.3m recurrently.
- 90% of risks in date.

Areas of Concern

- Overall PDR compliance 67%.
- Overall sickness outside of Trust target at 5.5% which, despite a decrease from 6.8% from previous month remains above the 4.5% trust target.
- Long term sickness is currently sitting at 4% against a target of 2.5%
- Return to work compliance saw a decrease from 81% to 79%.
- There is still a £0.6m gap in recurrent CIP to be identified.

Forward Look (with actions)

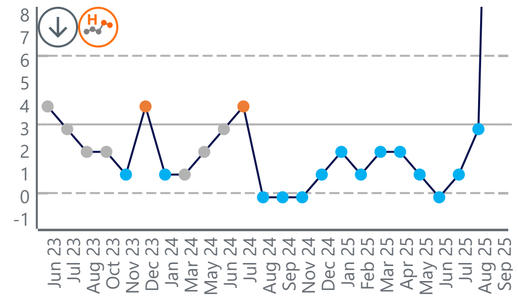
- Sickness Management Project established to help support a reduction in sickness absence. Detailed report to come to November meeting.
- Continues focus on financial position, system finance and internal controls/opportunities including WTE
- Deep dive on return to work being presented to November meeting.

Integrated Performance Report | October 2025

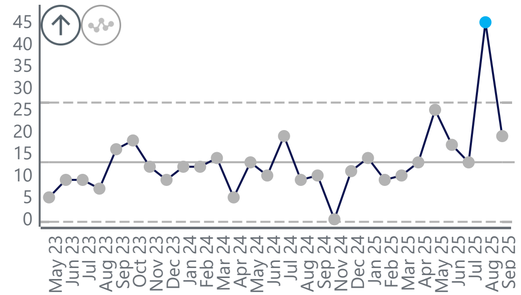
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

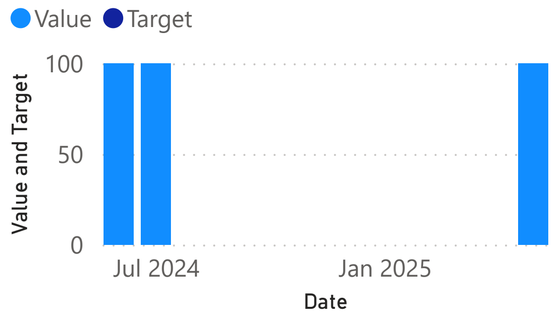
Patient Safety Incidents rated Low Harm & Above



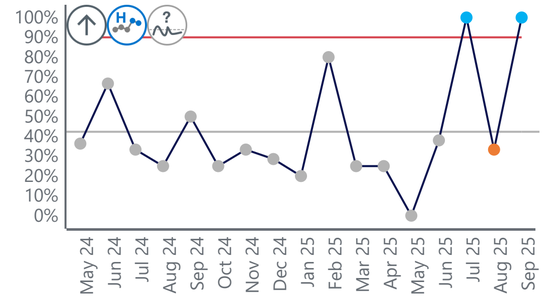
Patient Safety Incidents rated No Harm



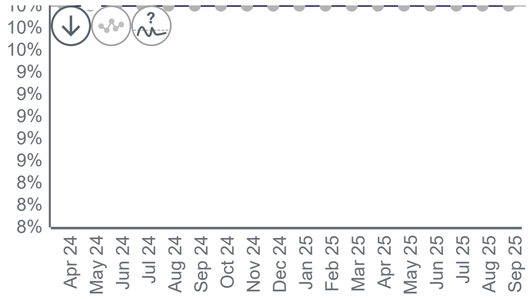
% Complaints Responded to within 25 working days



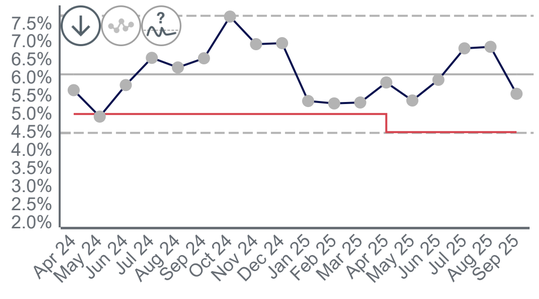
% PALS Resolved within 5 Days



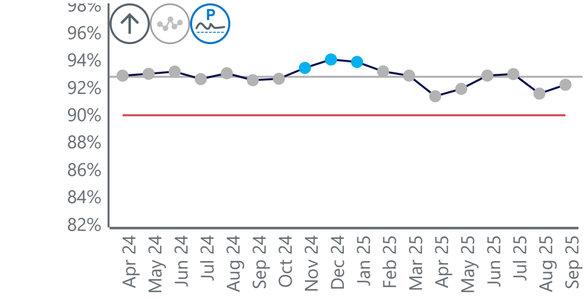
Staff Turnover



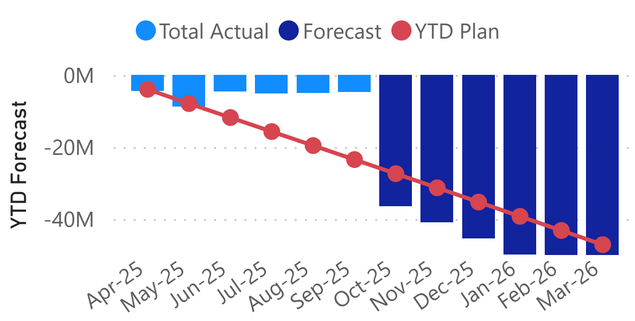
Sickness Absence (Total)



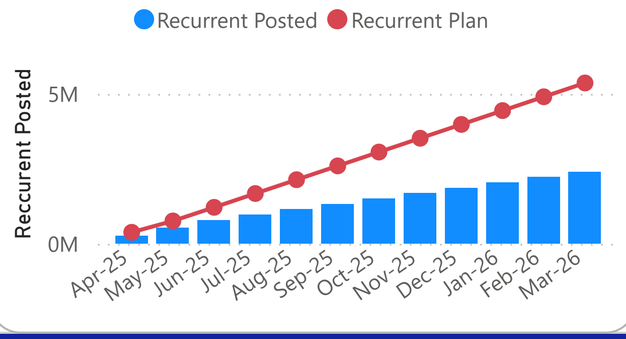
Mandatory Training



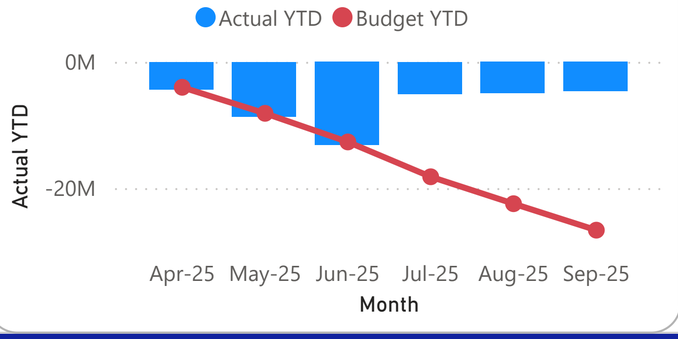
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

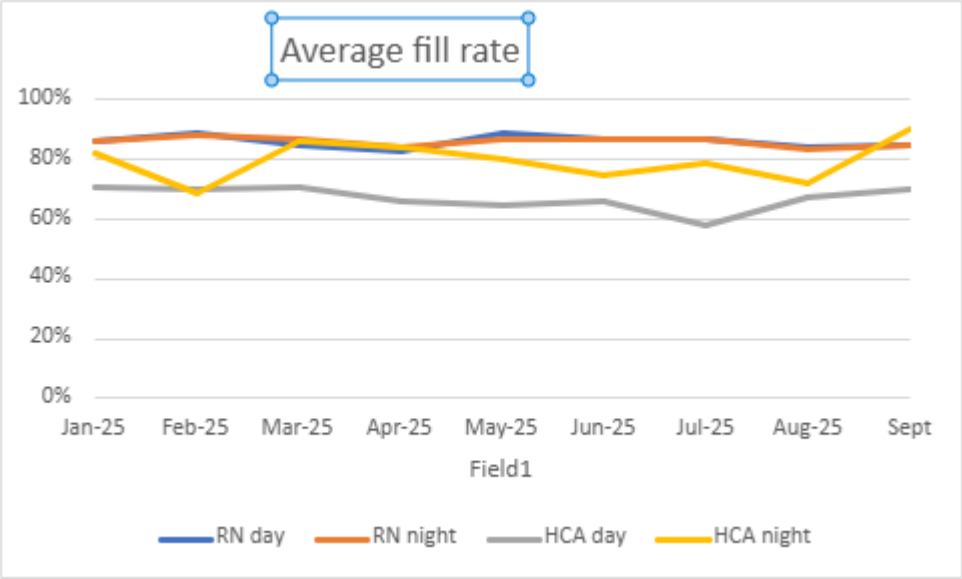
Safe Staffing & Patient Quality Indicator Report September 2025 Staffing, CHPPD and Benchmark

	Day		Night		Patients	CHPPD	National benchmark	Availablity		Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registere	Average fill rate - care staff	Total count of Patients at Midnight	CHPPD Rate	Jul-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		
Burns Unit	101%		100%		107	18.9	22.06	559.8	30	0	0%	0	0%	0.00	0.00%	0.00	0.00%	13.83	2.47%	0	0.00%	2	10	0	2	4	75%	0	0
HDU	72%	50%	66%	53%	255	27.5	52.29	2,000.35	57	2.53	0%	3.21	6%	0.00	0.00%	0.00	0.00%	153.43	7.67%	0	0.00%	2	50	2	2	3	100%	0	0
ICU	83%	80%	83%	47%	445	37.1	41.68	4,742.35	120	0.00	0%	0.00	0%	0.00	0.00%	0.00	0.00%	263.98	5.57%	16	13.33%	12	87	0	0	0	0%	0	0
Ward 1cC	92%	76%	88%	82%	565	12.4	11.04	1,835.28	150.8	0	0%	0.08		1.92	3.16%	0.00	0.00%	176.35	9.61%	12.8	8.49%	14	52	6	44	5	80.00%	1	0
Ward 1cN	92%	0%	109%		209	18.1	19.53	1,068.80	24	0	0%	1.63	7%	0.00	0.00%	0.00	0.00%	100.07	9.36%	24	100.00%	5	28	0	0	1	100%	0	0
Ward 3A	87%	58%	88%	95%	634	10.7	7.86	1,619.56	381.36	0	0%	2.62	1%	0.00	0.00%	0.00	0.00%	157.82	9.74%	103.67	27.18%	2	34	7	15	17	100.00%	1	0
Ward 3B	92%	104%	93%		337	16.5	14.27	1,253.38	171.68	0.56	0%	0.00	0%	0.00	0.00%	0.00	0.00%	86.01	6.86%	3.8	2.21%	4	23	0	1	6	100%	1	0
Ward 3C	75%	52%	76%	85%	620	11.7	11.42	1,775.45	501.09	0.02	0%	2.26	0%	0.00	0.00%	0.00	0.00%	142.85	8.05%	81.12	16.19%	8	95	0	1	6	100.00%	0	0
Ward 4A	82%	68%	81%	239%	724	11.4	9.4	2,030.40	143.6	0	0%	3.37	2%	0.00	0.00%	0.00	0.00%	217.28	10.70%	31.28	21.78%	6	53	0	5	11	91%	0	0
Ward 4B	77%	81%	67%	78%	543	13.5	5.19	1,150.16	1,213.40	0	0%	4.23	0%	0.00	0.00%	0.00	0.00%	109.66	9.53%	67.95	5.60%	5	74	0	8	2	50%	0	0
Ward 4C	81%	58%	87%	43%	553	11	10	1,753.68	267.4	0	0%	3.00	1%	0.00	0.00%	1.00	11.48%	117.2	6.68%	27.68	10.35%	8	62	0	1	18	89.00%	1	0

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Fill rates are produced by setting out the planned number of hours required for Registered Nurses (RN) across days and nights and the same for Health Care Assistants (HCA) for a full month period and is captured daily. The electronic roster produces the percentage fill for the month and accurately reflects the hours worked against the planned number. The percentage fill rates include any hours worked by bank staff. The benchmark for CHPPD for the above tables is based on July 2025 data, which is the latest information available from the model hospital so may not be comparable in regard to activity and acuity. Those areas highlighted red (Burns, HDU, PICU and 1C Neonatal) fall below this reported benchmark. Sickness across the Trust remains high at 7.84% average across RN's.To note occupancy across the Trust has been low through the month of September.

Nursing and care staff average fill rate September 2025	
Day and Night average fill rate	
Registered (%)	**Care Staff (%)**
85% ⇑	80% ⇑

Fill rate for both RN and HCA has increased since last month and is over 80%. The increase in HCA fill rate which correlates with substantive HCA posts successfully being recruited too.



Summary of Staffing models January – September 2025 Registered Nurses

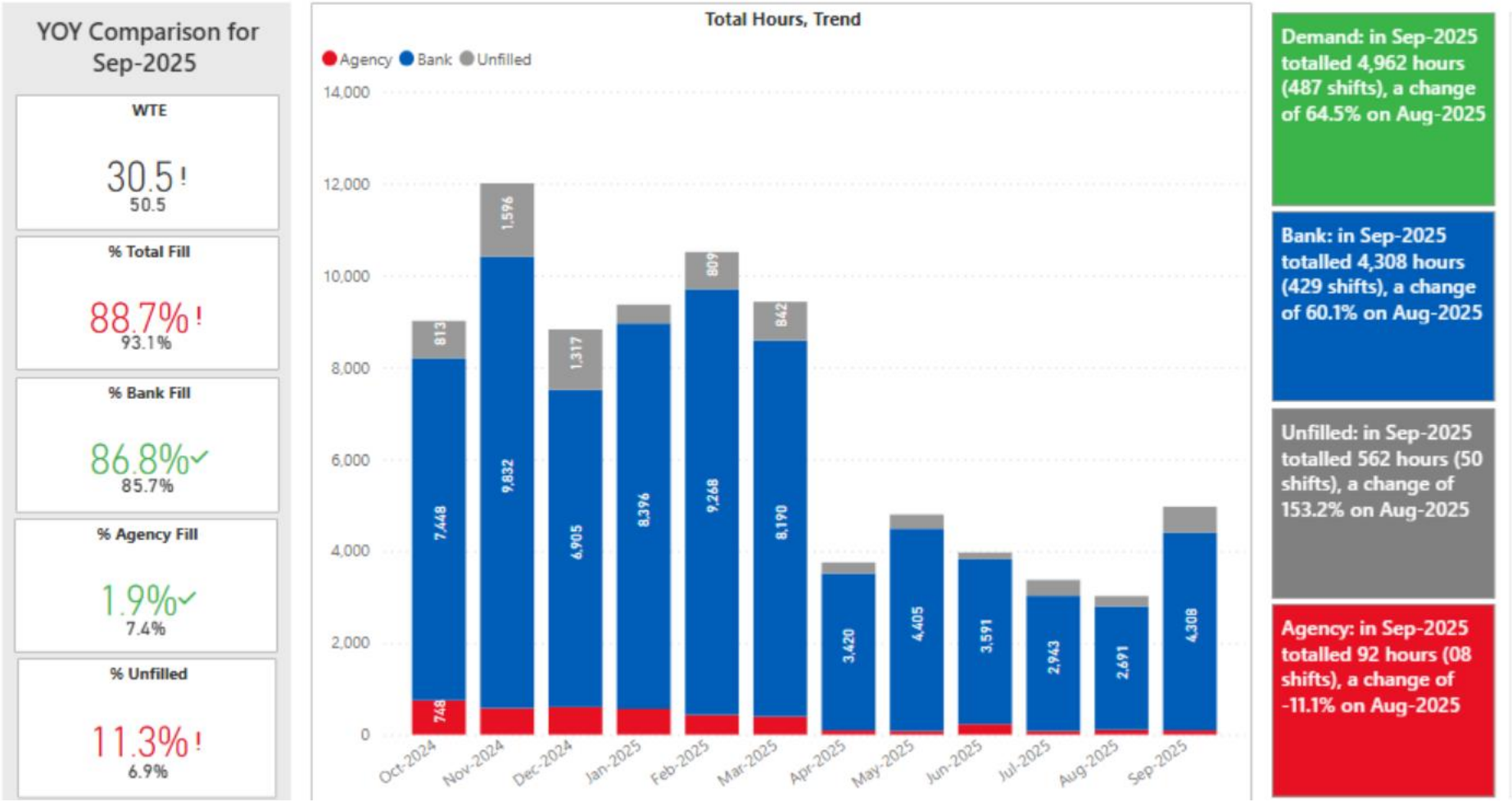
To Note only red, amber, and green staffing status is now reported via the staffing template.
September staffing status has seen a reduction in green staffing model from 83% to 73% being reported and 1 episode of a red staffing model.

NHSP Bank Spend September 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. However Registered Nurse bank spend in September has seen an increase of 60.1% from August despite low occupancy but high sickness. The areas with notable high bank spend are within critical care HDU & ICU where there are staffing gaps and specific nursing skills are required. 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 continued decrease in agency for the month of September which has reduced by 11% from the previous month. 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.
Within the month of September, 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 an increase of 6.3% from the previous month but still remains low compared to previous year and taking into account substantive gaps across the trust 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. In addition Ward 4b where the demand for 1-1 nursing is high and where we have seen significant vacancies due to a change in nursing model resulting in higher ratio of HCA,s has now recruited to all substantive posts. As a result of the active recruitment to vacant substantive posts we are expecting to see a further and consistent reduction in our HCA temporary spend from October.

Registered Nurse Bank Spend September 2025



Unregistered Nurse Bank Spend September 2025

YOY Comparison for Sep-2025

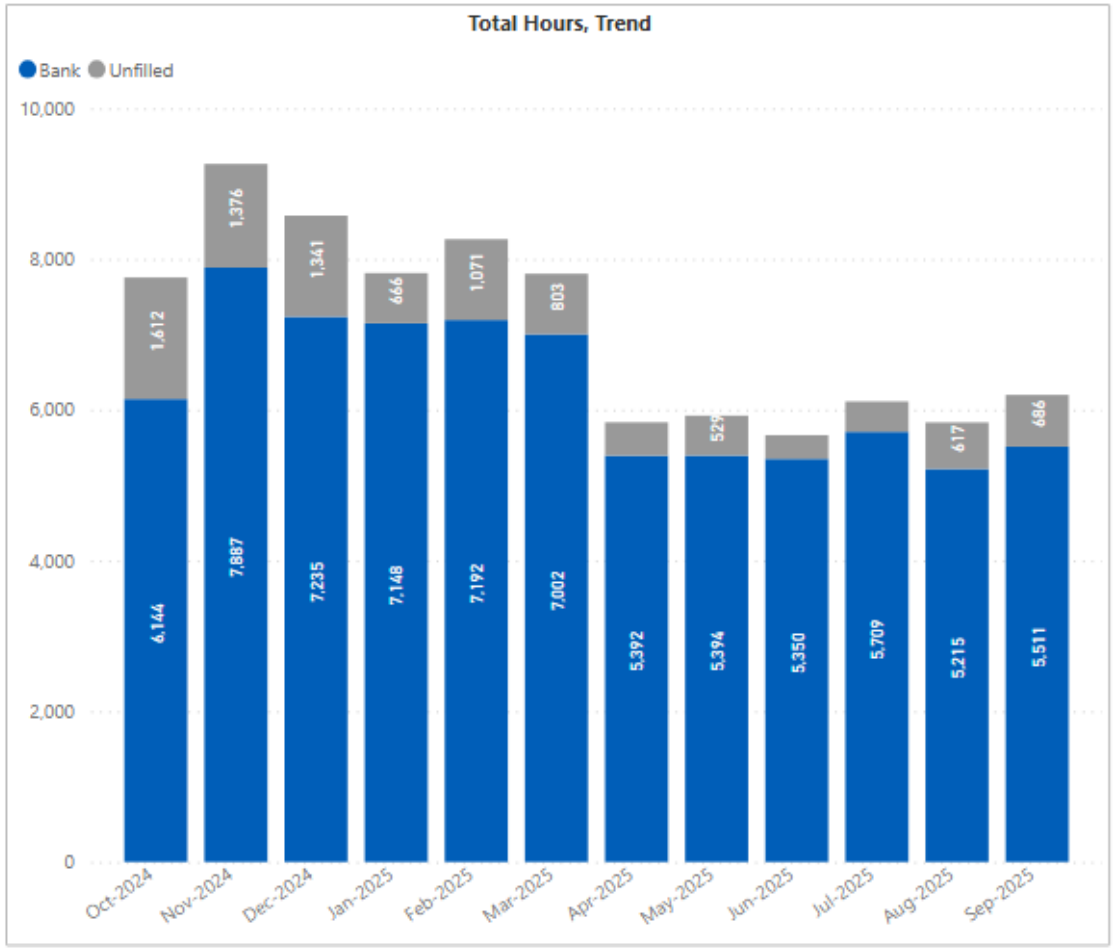
WTE
38.1 !
40.1

% Total Fill
88.9% !
93.3%

% Bank Fill
88.9% !
93.3%

% Agency Fill
(Blank)

% Unfilled
11.1% !
6.7%



Demand: in Sep-2025 totalled 6,197 hours (587 shifts), a change of 6.3% on Aug-2025

Bank: in Sep-2025 totalled 5,511 hours (525 shifts), a change of 5.7% on Aug-2025

Unfilled: in Sep-2025 totalled 686 hours (62 shifts), a change of 11.2% on Aug-2025

Agency: in Sep-2025 totalled hours (shifts), a change of -100.0% on Aug-2025

KPI E-Roster Data 18th August -14th September 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 **(18th August - 14th September 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	32.08%	80.00	-70.53	0.00%	0		42.70%	15.11%	6.45%	0.00%	16.13%	0.00%	37.68%
Accident & Emergency - Nursing (912201)	41	17.18%	720.00	156.47	0.12%	10.75		22.14%	17.08%	1.69%	0.59%	7.01%	7.13%	33.85%
Burns Unit (915208)	44	26.98%	140.00	-7.68	4.47%	84.5		14.40%	15.01%	0.00%	1.08%	3.66%	15.48%	36.44%
Critical Care Ward (913208)	44	19.01%	1200.00	833.55	4.84%	837.25	7	20.32%	17.02%	3.16%	0.39%	5.98%	7.11%	33.66%
High Dependancy Unit (HDU) (913210)	44	23.77%	640.00	281.85	5.23%	363.5		32.67%	14.68%	1.13%	0.99%	9.80%	7.33%	34.18%
Medical Daycase Unit (911314)	44	14.61%	50.00	4.5	1.15%	9	2	20.48%	13.33%	0.00%	0.00%	3.19%	0.00%	16.52%
Outpatients (916503)	47	22.50%	420.00	-161.28	0.75%	29.5	2	27.66%	16.36%	0.16%	1.59%	10.37%	2.31%	36.45%
Sunflower House (912310)	45	46.62%	190.00	73.97	30.12%	1388.2	91	17.66%	15.10%	6.20%	1.08%	5.54%	3.03%	32.95%
Surgical Daycase Unit (915418)	23	36.77%	85.00	-87.25	9.54%	229.25		31.95%	19.53%	0.82%	1.41%	14.68%	5.73%	42.16%
Theatres - Cardiac & Cardiology (915405)	45	16.54%	130.00	1	0.00%	0		27.93%	21.96%	0.08%	0.19%	11.19%	3.12%	36.54%
Theatres - Emergency (915420)	45	29.04%	230.00	-40.5	4.53%	97		4.65%	14.08%	1.61%	0.00%	9.04%	0.00%	24.73%
Theatres - IP Anaesthetics (915423)	45	22.59%	82.00	3.17	1.35%	43	3	9.41%	18.06%	0.74%	2.26%	7.58%	0.00%	28.64%
Theatres - IP Porters (915435)	45	28.10%	101.00	16.5	3.43%	37.5		1.29%	17.44%	0.00%	0.00%	9.91%	0.00%	27.34%
Theatres - IP Recovery (915422)	45	32.23%	103.00	15.97	8.41%	116.83	2	12.26%	24.37%	0.00%	6.58%	6.35%	0.00%	37.29%
Theatres - IP Scrub (915424)	45	18.63%	128.00	4	3.53%	59		11.47%	25.02%	0.00%	0.72%	6.06%	6.00%	37.80%
Theatres - Ortho & Neuro Scrub (915436)	45	27.24%	37.80	0	0.85%	18.5		16.73%	17.77%	1.44%	0.61%	13.07%	7.99%	40.87%
Theatres - SDC Anaesthetics (915429)	44	52.69%	58.40	-4.61	33.30%	265.75		27.41%	17.93%	0.23%	5.94%	15.05%	8.49%	47.63%
Theatres - SDC Recovery (915430)	44	29.37%	177.30	-7.35	5.24%	60.75		17.04%	19.22%	0.74%	2.36%	9.40%	7.62%	39.34%
Theatres - SDC Scrub (915421)	44	33.33%	532.00	-3.83	2.18%	48		21.57%	17.32%	0.00%	2.51%	12.66%	4.27%	36.75%
Ward 1C Cardiac (913307)	44	20.34%	361.00	191.83	2.73%	186	4	12.91%	13.67%	0.81%	1.46%	12.31%	4.56%	32.80%
Ward 1C Neonatal (913310)	41	42.27%	556.00	1950.07	0.00%	0		16.92%	12.75%	3.12%	1.39%	11.95%	9.49%	43.19%
Ward 3A (915309)	44	24.69%	371.00	136.37	9.66%	607.25	2	19.61%	15.09%	0.58%	4.56%	11.60%	9.30%	41.94%
Ward 3B - Oncology (911208)	44	24.95%	555.00	225.27	9.84%	515	12	15.55%	18.63%	0.66%	1.44%	10.11%	1.31%	32.47%
Ward 3C (911313)	47	20.56%	607.00	188.37	0.16%	11.5	13	29.56%	13.83%	1.88%	1.80%	9.42%	6.58%	33.89%
Ward 4A (914210)	27	34.85%	634.00	194.37	11.37%	891	24	18.93%	15.20%	0.98%	1.01%	11.45%	4.13%	34.61%
Ward 4B (914211)	41	31.97%	533.00	253.42	3.77%	310.5	3	21.91%	15.85%	3.10%	1.82%	6.06%	5.05%	31.87%
Ward 4C (912207)	47	25.48%	280.00	96.96	0.41%	23.25		31.64%	15.07%	2.81%	2.95%	9.10%	6.92%	37.70%

Trust KPI 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 increased from 3446 to 4245 (KPI 9001 to allow for up to a day to owe or be owed).
- Bank/Agency has decreased from 6310 to 66243 hours.
- Sickness consistently remains high at 9.6%.
- Annual leave 16.9% (11%-17%) & other Leave 1.7% (<5%) all within the agreed KPIs.
- Study leave 1.4% (KPI 2%).
- Additional duties have continued to decrease from 226 to 165 shifts.

To note we are seeing increased oversight and management of the E-Roster by the ward managers which is reflected in the improving compliance with associated KPI, s.

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**Outpatient Pharmacy Outsourcing Business Case**
Report of:	**Medicine Division**
Paper Prepared by:	Paul Sanderson, Chief Pharmacist Ronnie Viner, Programme Manager Emily Kirkpatrick, Deputy Director of Finance Phillipa Compson, Programme Manager

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:	• Minor works (£30k) for estate changes. • Staff transfer under TUPE/SLA • Ongoing monitoring of financial impact and workforce needs.

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 business case proposes outsourcing the Trust's outpatient pharmacy service to PharmaC/CPL, a well-established NHS subsidiary, to improve patient experience and achieve significant financial benefits through VAT savings.

After evaluating four options—including maintaining the current service, establishing a wholly owned subsidiary, outsourcing to PharmaC/CPL, and running a competitive tender—the preferred option is to transfer the service to PharmaC/CPL.

PharmaC/CPL are best placed to meet the requirements for Alder Hey and its patients and are thereby deemed to be the "most suitable provider". Under The Health Care Services (Provider Selection Regime) Regulations 2023 the Trust may be able to select and award a contract to PharmaC/CPL without having to undertake a competitive tender process.

This approach offers the quickest route to financial benefit, minimal disruption, and enhanced service quality.

The estimated full-year financial benefit is at least £249k per annum from year two onwards, with a part-year saving of up to £39k in 2025/26.

The Board are asked to approve the outsourcing of outpatient pharmacy services to PharmaC/CPL using the procurement route defined above.

2. Background and current state

The outpatient pharmacy service at the Trust is currently managed and staffed by the internal Pharmacy department. The service currently dispenses approximately 54,167 items per annum and spends approximately £2.51m+VAT (£3.01m including VAT) per annum on drugs. NHS organisations are currently unable to reclaim the VAT element of the drugs that they purchase.

A number of trusts across the country have opted to outsource their outpatient pharmacy service in order to provide a better patient experience whilst benefitting from the VAT exemption which allows them to reclaim the VAT on drugs costs. The Clatterbridge Cancer Centre in Liverpool has set up its own registered pharmacy subsidary known as PharmaC (The Clatterbridge Pharmacy Ltd or CPL) and have offered Alder Hey Children's Hospital the opportunity to take over its outpatient services.

The Trust has a significant Cost Improvement Programme (CIP) of £25m (5%) that must be delivered to ensure it remains financially sustainable. The proposal will significantly reduce the cost of running the service and thereby help the Trust to ensure financial sustainability; and will provide an opportunity to have a dedicated Outpatient Pharmacy team for a better patient experience. It will also potentially create a platform for other opportunities in the future

The Business Case has been shared and approved at the following meetings:

- Execs. Weekly Meeting
- FTCP Committee

3. Full Options Appraisal

Full Options Appraisal

- Option 1: Continue with the Current Service
    - This option does not allow the Trust to reclaim the VAT on the medicines supplied and does not give the Trust the opportunity to provide an enhanced service to patients
      It has been determined that Option 1 is not suitable.
- Option 2: Set-up an Alder Hey Wholly Owned Subsidary (WOS)
    - This option would provide Alder Hey with more control over the structure and strategy and all the financial benefits would flow through to the Alder Hey bottom line (e.g., if underspent). However, there are a number of challenges with this option:
        - It would take time to set up and a recent directive from NHS England has limited trusts' freedoms to setting up their own subsidiaries.
        - Cost of set up re: legal advice, establishing company status, etc.
        - Overheads – the Trust would have to pay 100% of overheads (only paying 14% in PharmaC model), which would wipe out any VAT savings
        - It is not in line with the ICB system-based approach

      It has been determined that Option 2 is not suitable.
- Option 3: Transfer the Service to an Established Subsidiary
    - This option provides the quickest route to establishing an outsourced service and thereby realising the financial benefits for the Trust, and patients will benefit from a dedicated Outpatient Pharmacy team which should result in an improved patient experience. If PharmaC/CPL are deemed to be the "most suitable provider or MSP" who are best placed to meet the requirements for Alder Hey and its patients, then under The Health Care Services (Provider Selection Regime) Regulations 2023 the Trust may be able to select and award a contract to PharmaC/CPL without having to undertake a competitive tender process.
      This is therefore the preferred option.
- Option 4: Run a Competitive Tender Process.
    - The Trust would have to consider alternative providers who are unlikely to be able to offer the same competitive terms as PharmaC/CPL. Also, the tender process would take 4-6 months.
      Given the anticipated timeframes of a competitive tender process mapped against the relatively high probability of an uncontested (and much shorter) MSP process, it has been determined that Option 4 is not suitable.

Scheme Overview

This scheme if approved will proceed in two Phases:

- Phase 1: Transfer of current Outpatient Pharmacy Services with current opening hours and estate (albeit with some additional storage space), and current outpatient pharmacy workstreams. This Phase will ensure patients benefit from a dedicated Outpatient Pharmacy team which should result in an improved patient experience.
  The business case is focussed on Phase 1 only.
- Phase 2 (new business case required): Further development of the outpatient pharmacy which will include, but would not be limited to:
    - Review of outpatient pharmacy opening hours to better meet the needs of patients.
    - Extension of services offered by the outpatient pharmacy provider
    - Provision of prescription collection lockers.
    - Introduction of a streamlined prescription delivery service using in-house couriers
    - Repatriating homecare medicines, dispensed by external homecare providers, to the outpatient pharmacy.

Workforce Model

The number of staff and the grades of staff required to support all outpatient pharmacy work have been scoped based on the current skill mix and staff roles required to support ALL current outpatient activity. The table below summarises the proposed workforce model.

Grade / Post	WTE
Band 7 Pharmacist	2.0
Band 6 Senior Technician	1.0
Band 5 Technician (Accuracy Checking)	2.0
Band 4-5 Technicians (Dispensing)	2.0
Band 3 Assistant Technical Officer (ATO)	1.0

The existing dedicated members of the outpatient pharmacy staff (Band 6 Senior Technician) will have their employment contract transferred to PharmaC/CPL (under TUPE). The currently vacant Band 3 ATO post will in effect be directly transferred across to PharmaC/CPL. The clinical pharmacist role will operate permanently for Pharmac/CPL under a service level agreement (SLA) arrangement whilst still being employed by Alder Hey. For the remaining 4 x WTE Band 4/5 posts either appropriate staff will be offered the chance to voluntarily transfer their employment to PharmaC/CPL or staff will work for Pharmac/CPL under an SLA for a maximum of 12 months.

As and when appropriate vacancies arise at Alder Hey pharmacy, these vacancies will be used by PharmaC/CPL to fill posts that sit under the SLA arrangement. Apart from the Band 7 pharmacist roles, all outpatient pharmacy staff will eventually be directly employed by PharmaC/CPL).

Financial Overview

The net financial benefit to the Trust of this scheme is summarised below:

Description	Value Year 1	Value Year 2 Onwards
Gross Drugs VAT Saving	£502,773	£502,773
Less the following additional costs from outsourcing to Pharmac/CPL:		
Superintendent Pharmacist (14%)	£-15,443	£-15,443
Share of overhead costs (14%)	£-60,707	£-60,707
Initial Risk contingency (10% of gross costs)	£-60,990	£0
Trust lost interest on cash support for stock acquisition	£-21,000	£-21,000
5% gross profit mark up to PharmaC/CPL	£-34,594	£-31.545
Non-pay not currently budgeted	£-21,536	£-21,536
Wastage not currently budgeted	£-100,555	£-100,555
Pay costs higher in CPL model	£-2,765	£-2,765
Sub-total	£185,183	£249,222
One-off Trust costs (minor works)**	£-30,000	£0
Estimated Full Year Financial Benefit to Alder Hey	**£155,183**	**£249,222***

The estimated financial benefit is predicated on a 4% stock loss provision, however Alder Hey's stock wastage in outpatients for the 12 months between 1st September 2024 – 30th August 2025 was a lot lower than this at £25,470, which if continued to be realised will potentially increase the financial benefit to Alder Hey.

Risks

- Risk 1 - Potential redundancy costs and legal disputes re: TUPE process and for staff working under an SLA. ***Mitigation***: Legal and HR advice sought throughout the process to ensure the correct procedures are followed and that all relevant documentation is watertight.
- Risk 2 - Minor estate works increase in scope and costs and convert to capital spend. ***Mitigation***: Scope kept very tight and clearly defined. Early submission of requirements through appropriate PFI route. Flexibility from CPL to adapt and change requirements to ensure works remain within revenue spend.
- Risk 3 - Delays to implementation. ***Mitigation***: Dedicated project management resource assigned, proactive risks and issues management, clear escalation processes to execs. for when tasks need to be fast tracked.
- Risk 4 - Challenge lodged by other potential providers on the procurement process followed. ***Mitigation***: Legal and Procurement advice sought throughout the process to ensure the correct procedures are followed and that all relevant documentation is watertight.
- Risk 5 – Insufficient band 4/5 vacancies within pharmacy during the first 12 months of the contract to enable a full transfer of staff to CP. ***Mitigation***: Unmitigated however, more than sufficient headroom to be able to absorb any potential cost pressures and still make a saving until such time that all the required vacancies arise, and the full savings potential can be realised.

4. Conclusion

Outsourcing the outpatient pharmacy to PharmaC/CPL is the preferred option, offering significant financial savings, improved patient experience, and the potential for further opportunities.

Approval is sought to proceed with the proposed service model and to attempt to fast track the procurement route on the basis that PharmaC/CPL are deemed the “most suitable provider”.

5. Recommendations and Proposed Next Steps

- Approve the outsourcing of outpatient pharmacy services to PharmaC/CPL.
- Approve the proposed method of procurement.
- Proceed with the implementation of Phase 1 in January 2026, with a commitment to prepare a business case for Phase 2 initiatives once Phase 1 is completed and embedded.

Business Case Form

1. Summary Information

Division:	Medicine
Clinical Director:	Urmi Das
COO:	Adam Bateman
Accountant:	Laura Simon
Prepared by:	Paul Sanderson
Clinical Lead:	N/A
Executive Sponsor:	Rachel Lea
Accountant Authorisation Code:	*Accountant to provide authorisation before submitting*
Date:	18/09/2025

2. Stakeholder Support

Business cases must be sent to the named Divisional contact if the Division will be affected by the case and approval received prior to business case submission.

Medicine Division	*Approval to be confirmed retrospectively*
Surgery Division	*Not required*
Community Division	*Not required*
Estates	*Not required*
Head of IM&T	*Not required*
Head of Contracts & Financial Planning	*Not required*
Capital Accountant	*Not required*

3. Approval Stage

Divisional Accountant	*Approval to be confirmed retrospectively (if required)*
Divisional Board	*Approval to be confirmed retrospectively (if required)*
Investment Review Group	*Approval to be confirmed retrospectively (if required)*
Operational Delivery Board	*Approval to be confirmed retrospectively (if required)*
R&BD / Trust Board	*Approval to be confirmed retrospectively (if required)*

Investment Value	Divisional Board	IRG	ODB	R&BD Committee	Trust Board
Up to £50k	✓				
£50k - £100k	Recommend	✓			
£100k - £0.5	Support	Recommend	✓		
£0.5 - £1m	Support	Review	Recommend	✓	
>£1m	Support	Review	Recommend	Recommend	✓

(✓ = Approval point)

4. Business Case Overview

Summary of the Case	**<u>Background</u>** The outpatient pharmacy service at the Trust is currently managed and staffed by the internal Pharmacy department. Two members of the team have dedicated outpatient pharmacy roles whilst the remainder of the outpatient pharmacy staffing requirement is fullfilled by other members of the team, who rotate between departments/areas. The service operates Monday-Friday, 8.45am-5pm (except Thursdays which operate 9.30am-5pm) and currently dispenses approximately 54,167 items per annum and spends approximately £2.51m+VAT (£3.01m including VAT) per annum on drugs. NHS organisations are currently unable to reclaim the VAT element of the drugs that they purchase.

A number of trusts across the country have opted to outsource their outpatient pharmacy service in order to provide a better patient experience whilst benefitting from the VAT exemption which allows them to reclaim the VAT on drugs costs. This business case is predicated on the Trust being able to take advantage of these qualitiative and financial benefits.

The Clatterbridge Cancer Centre in Liverpool has set up its own registered pharmacy subsidary known as PharmaC (The Clatterbridge Pharmacy Ltd or CPL). PharmaC/CPL currently provide outsourced outpatient pharmacy services to a number of local trusts including Aintree University Hospital and the Royal Liverpool University Hospital, as well as The Clatterbridge Centre itself. PharmaC/CPL have offered Alder Hey Children's Hospital the opportunity to take over its outpatient services.

Options Appraisal

Several options have been considered that would provide as good if not a better level of service compared to the present set-up whilst also being able to reclaim the VAT on drugs costs. Other than doing nothing and not being able to realise the financial benefits of the VAT reclaim, the other three options are for the Trust to set up its own wholly owned subsiudary (WOS); or to take-up PharmaC/CPL's offer to take over the outpatient service; or to run a competetitve tender process for the provision of outpatient pharmacy services.

Option 1: *Continue with the Current Service*

This option does not allow the Trust to reclaim the VAT on the medicines supplied and does not give the Trust the opportunity to provide an enhanced service to patients, as outlined in the other Options below.

It has been determined that Option 1 is not suitable.

Option 2**:** *Set-up an Alder Hey Wholly Owned Subsidary (WOS)*

This option would provide Alder Hey with more control over the structure and strategy and all the finanical benefits would flow through to the Alder Hey bottom line (e.g., if underspent). However, there are a number of challenges with this option:

a) It would take time to set up – a minimum of 6-9 months but likely longer than this in the current political environment (a recent directive from NHS England has instructed trusts that *"…new subsidiaries involving the transfer of NHS staff will now only be approved in a limited number of circumstances, and only where there is clear union support and protection of NHS terms and conditions, including pension access."*)
b) Cost of set up - the Trust would require legal advice to establish company status etc.
c) Overheads – the Trust would have to pay 100% of overheads (only paying 14% in PharmaC model), which is likely to be circa £0.5m – so would wipe out any VAT savings
d) It is not in line with the ICB system-based approach

With this in mind, it has been determined that Option 2 is not suitable.

Option 3: *Transfer the Service to an Established Subsidary (PharmaC/CPL)*

This option provides the quickest route to establishing an outsourced service and thereby realising the financial benefits for the Trust, and patients will benefit from a dedicated Outpatient Pharmacy team which should result in an improved patient experience. PharmaC/CPL are a well established local subsidary who successfully provide outsourced outpatient pharmacy services to a number of local trusts including Aintree University Hospital and the Royal Liverpool University Hospital, as well as The Clatterbridge Centre itself.

If PharmaC/CPL are deemed to be the "most suitable provider or MSP" who are best placed to meet the requirements for Alder Hey and its patients, then under The Health Care Services (Provider Selection Regime) Regulations 2023 the Trust may be able to select and award a contract to PharmaC/CPL without having to undertake a competitive tender process as described below:

- The first stage of the MSP process requires the Trust to publish a notice of its intention to follow this process, which gives other potentially suitable providers 14 calendar days to

make themselves known; if any come forward and are deemed to meet the ***key criteria***, they must either be considered along with Pharmac/CPL or the Trust needs to consider following a competitive tender process.

- One of the ***key criteria*** includes "integration, collaboration and service sustainability", which if weighted heavily by the Trust would likely preclude any commercial provders from being deemed suitable when compared to an NHS subsidary such as PharmaC/CPL

- Once the preferred provider has been selected, the second part of the MSP process requires the Trust to publish an intention to award notice, which gives the other potentially suitable providers 8 working days from the day after the notice is published to make respresentation against the Trust's intention to award.
  - This may ultimately lead to the involvement of the Independent Patient Choice and Procurement Panel established by NHSE, who may - depending whether they agree to review the representations made - require the Trust to either roll back the existing MSP process, restart a new MSP process with the Trust's requirements more clearly and fully articulated to address the representations, or recommend the Trust follow a different route of award such as a competitive tender process.

- In the unlikely event that the Trust has to run a competitive tender process, PharmaC/CPL have indicated that they would be willing to submit a bid.

If the MSP process is followed without any other potentially suitable providers coming forward then it is estimated that the contract could be awarded to PharmaC/CPL in January 2026, thereby realising some financial benefit during 2025/26. This is therefore the preferred option.

Option 4: *Run a Competitive Tender Process.*
PharmaC/CPL have indicated that they would be prepared to bid for the contract as part of a competitive tender process. However, the Trust would have to consider alternative providers who are unlikely to be able to offer the same competitive terms as PharmaC/CPL. Also the tender process would take 4-6 months, which would mean that any financial benefits would not start to be realised until 2026/27. PharmaC/CPL are attractive as a provider as their charging model results in less cost to the Trust (specifically a very small gross mark-up)

Given the anticipated timeframes of a competitive tender process mapped against the relatively high probability of an uncontested (and much shorter) MSP process, it has been determined that Option 4 is not suitable.

Scheme Overview
This scheme if approved will proceed in two Phases:

- ***Phase 1*** : Transfer of current outpatient pharmacy services with current opening hours and estate (albeit with some additional storage space), and current outpatient pharmacy workstreams. This Phase will ensure patients benefit from a dedicated outpatient pharmacy team which should result in an improved patient experience.

- ***Phase 2***: Further development of the outpatient pharmacy which will include, but would not be limited to:
  - Review of outpatient pharmacy opening hours to better meet the needs of patients. Outpatient pharmacy currently operates Monday to Friday 8.45am – 5.00pm (Thursday 9.30am till 5.00pm) and there is no weekend or out-of-hours service provision. This does not align with general outpatient activity which is scheduled 8.00am-5.30pm Monday to Friday, with occasional 'waiting list initiative' clinics held at weekends.
  - Extension of services offered by the outpatient pharmacy provider
    - *Provision of prescription collection lockers*. This would provide a convenient, secure, and contactless way for patients to collect their medications at any time. It would improve patient satisfaction and adherence to treatment by making medicine collection more flexible. Benefits for the outpatient pharmacy

team include a streamlined workflow and the freeing up of staff time for clinical and patient-focused activities.

- *Prescription delivery service.* Introduction of a streamlined prescription delivery service using in-house couriers would enable significant financial savings and operational efficiencies to be made (implementation of digital prescription tracking, intelligent route scheduling and enhanced communications/ notifications for patients and families).
- *Homecare services*. Repatriating homecare medicines, dispensed by external homecare providers, to the outpatient pharmacy would offer significant financial incentives (VAT savings) and improved procurement / clinical oversight.

Outpatient prescriptions are currently dispensed across inpatient, outpatient and oncology dispensaries (due to staff versus workload pressures). As part of Phase 1 of this proposal ALL outpatient prescriptions will be processed by PharmaC/CPL outpatient pharmacy. In order to facilitate this shift in workload appropriate resource has been allocated within the PharmaC/CPL staffing model, as outlined below.

Workforce Model

The number of staff and the grades of staff required to support all outpatient pharmacy work have been scoped based on the current skill mix and staff roles required to support ALL current outpatient activity. The table below summarises the proposed workforce model.

Grade / Post	WTE
Band 7 Pharmacist	2.0
Band 6 Senior Technician	1.0
Band 5 Technician (Accuracy Checking)	2.0
Band 4-5 Technician (Dispensing)	2.0
Band 3 Assistant Technical Officer (ATO)	1.0

PharmaC/CPL have largely accepted the above structure but with the proviso that they feel that the service could run with 1 WTE Band 7 Pharmacist rather than 2. However, there is concern that this could compromise both patient safety (resulting in an increase in incidents/complaints) and breach Trust KPIs in terms of prescription waiting times. On this basis, the outsourced service will – at least initially - be implemented on a 'like for like' basis and as such there will be no impact on workforce numbers. Once the outsourced service is in place and established, the workforce model will be re-evaluated especially with respect to the number of Band 7 pharmacists required.

Staff costs will be transferred directly from Alder Hey to PharmaC/CPL. No extra posts will be recruited to support this new service during Phase 1.

In terms of employment contracts:

- The existing in-post dedicated member of the outpatient pharmacy staff (Band 6 Senior Technician) will have their employment contract transferred to PharmaC/CPL (under TUPE).
- The currently vacant Band 3 ATO post will in effect be directly transferred across to PharmaC/CPL
- The clinical pharmacists will operate permanently for Pharmac/CPL under a service level agreement (SLA) arrangement whilst still being employed by Alder Hey.
- For the remaining 4 x WTE Band 4/5 posts:
  - Either: appropriate staff will be offered the chance to voluntarily transfer their employment to PharmaC/CPL;
  - Or: staff will work for Pharmac/CPL under a SLA for a maximum of 12 months (based on HMRC rules for elegibility to reclaim the VAT) whilst still being employed by Alder Hey.
    - (When appropriate vacancies arise within Alder Hey pharmacy department PharmaC/CPL will be able to recruit to the required roles that sit under the SLA arrangement; eventually all outpatient pharmacy staff will be directly employed by PharmaC/CPL, except for the clinical pharmacists. However, there is a risk that there are an insufficent number of posts vacated within Alder Hey pharmacy during the first 12 months of the PharmaC/CPL contract, which could

put a cost pressure on Alder Hey pharmacy's budgets from year 2 – see financial overview below.)

Estate Changes

For the additional storage space required by PharmaC/CPL under Phase 1, the existing pharmacy consultation room will be converted into a dedicated storage room and the consultation room will be moved to a room in outpatients that is close by (subject to relocating some existing pre-op. assessment services); these changes have been agreed with the Community Division. Some minor works will be required to facilitate the additional storage estimated at a maximum cost of £30k*.

The only physical changes that patients will see is with respect to the branding of the service.

*Note: Until the space has been reviewed in detail by CPL, and any changes specified by Mitie, this is an estimate figure only. Depending on the exact nature of works, and value will prescribe whether this spend is capital or revenue in nature. If capital, this spend would need to be prioritised as part of the in-year capital programme. The business case currently assume this spend will be revenue.

Financial Overview

The net financial benefit to the Trust of outsourcing outpatient pharmacy to PharmaC/CPL under Phase 1 is summarised below:

Description	**Value Year 1**	**Value Year 2 Onwards**
Gross Drugs VAT Saving	£502,773	£502,773
Less the following additional costs from outsourcing to Pharmac/CPL:		
Superintendent Pharmacist (14%)	£-15,443	£-15,443
Share of overhead costs (14%)	£-60,707	£-60,707
Initial Risk contingency (10% of gross costs)	£-60,990	£0
Trust lost interest on cash support for stock acquisition	£-21,000	£-21,000
5% gross profit mark up to PharmaC/CPL	£-34,594	£-31.545
Non-pay not currently budgeted	£-21,536	£-21,536
Wastage not currently budgeted	£-100,555	£-100,555
Pay costs higher in CPL model	£-2,765	£-2,765
Sub-total	£185,183	£249,222
One-off Trust costs (minor works)	£-30,000	£0
Estimated Full Year Financial Benefit to Alder Hey	**£155,183**	**£249,222***

The estimated finanical benefit is predicated on a 4% stock loss provision, however Alder Hey's stock wastage in outpatients for the 12 months between 1st September 2024 – 30th August 2025 was a lot lower than this at £25,470, which if continued to be realised will potentially increase the financial benefit to Alder Hey.

With respect to the workforce model – and specifically the four Band 4/5 posts that will initially be set up through an SLA arrangement - there is a risk that there are an insufficent number of appropriate posts vacated within pharmacy during the first 12 months of the PharmaC/CPL contract, which would put a cost pressure on Alder Hey pharmacy's budgets of up to £174,212 from year 2 onwards (worst case scenario). ***Under this worst case scenario, the net benefit from year 2 onwards would be reduced to £75,010 until such time as vacancies arise within Alder Hey's pharmacy.**

If approved the project will aim to be implemented in early January 2026, which will give an estimated part year effect saving for 2025/26 of up to £39k.

Strategic Context / Corporate Objectives	The Trust has a significant Cost Improvement Programme (CIP) of £25m (5%) that must be delivered to ensure it remains financially sustainable. Remaining in control of the Trust's plans is important to meet the current and future health & wellbeing needs of children and young people, as set out in the 2030 Vision. The approach to achieving this level of CIP will be participative and compassionate, guided by the prioritisation of safe and outstanding care, and sustaining Alder Hey as a great place to work.

	The proposal to outsource the outpatient pharmacy service will provide an opportunity to have a dedicated outpatient pharmacy team to provide a better patient experience. This scheme will also significantly reduce the cost of running the service and thereby help the Trust to ensure financial sustainability without having any detrimental impact on safety or the quality of care provided by the Trust to children & young people. It will also potentially provide a platform for other opportunities in the future (Phase 2 – see above).
EQIA	EQIA-Outpatient Pharmacy Outsourci
Risks Mitigated	There are no current risks logged in the Trust InPhase risk reporting system relating to the provision of outpatient pharmacy. The proposal to outsource outpatient pharmacy is based on current volumes of dispensing and current levels of workload intensity. If this increases as current trends suggest, then additional pharmacy staff will be required in future years to manage the service, the cost of which has not been accounted for in the business case. In order to facilitate the smooth transfer of services from Alder Hey pharmacy to PharmaC/CPL a full risk assessment will be undertaken, and any risks identified through this process will be duly mitigated and managed through the project's governance structure.
Financial Impact	Several options have been considered that would provide as good if not a better level of service compared to the present set-up whilst also being able to reclaim the VAT on drugs costs. Other than doing nothing and not being able to realise the financial benefits of the VAT reclaim, the other three options are for the Trust to set up its own wholly owned subsiudary (WOS); or to take-up PharmaC/CPL's offer to take over the outpatient service; or to run a competetitve tender process for the provision of outpatient pharmacy services. Option 3 - the transfer of the service to an established subsidary (PharmaC/CPL) – has been deemed the preferred Option (see "Summary of the Business Case"). <u>The financial impact of Option 3 is detalied below:</u> ***Tables 1 & 2*** overleaf detail the year 1 and year 2+ (i.e.recurrent) estimated costs associated with an outsourced pharmacy solution provided by PharmaC/CPL. It is predicated on an annual dispensing volume of 54,167 items, which reflects the current level of activity at Alder Hey less any items not deemed safe or not deemed approproate for the provider to prepare (e.g., Extemp, Cytotoxic items) – see "Activity Impact" below. ***Table 3*** summarises the income for year 1 and year 2+ that PharmaC/CPL will recover through billing and provides an estimate of their gross profit and of their retained profits after corporation tax (CT). The estimated annual savings to Alder Hey for year 1 and year 2+ are illustrated in ***Table 4*** below and includes some one-off minor estate works required in year 1 to faciliate the PharmaC/CPL storage requirements.

Table 1 – PharmaC/CPL Pay and Non-pay Costs

		54,167 items Year 1 £		54,167 items Year 2 onwards £
Pay cost		**386,373**		**386,373**
Rent		**15,000**		**15,000**
Other non-pay costs				
Staff Uniforms and clothing	857		857	
Other General Supplies and Services	429		429	
Advertising and Staff Recruitment	1,286		1,286	
Stationery	857		857	
Packing and storage	857		857	
Training Fees	5,143		5,143	
Insurance Costs	9,375		9,375	
Minor Works	1,875		1,875	
Computer hardware phones and laptops	2,143		2,143	
Equipment / monitoring	9,000		9,000	
Stock loss provision 4% of annual drug spent	100,555		100,555	
Total Non- Pay		**132,376**		**132,376**
Overhead costs				
Superintendent Pharmacist (14%)		15,443		15,443
Share of overhead costs (14%)		60,707		60,707
		76,150		76,150
Gross costs		**609,900**		**609,900**
Year 1 / Contingency costs				
Initial Risk contingency 10% of gross costs		60,990		
Trust lost interest on cash support for stock acquisition		21,000		21,000
Gross cost with contingency		**691,889**		**630,900**

Table 2 – Cost of Drugs and Dispensing

Estimated Annual contract value:		
Drugs	2,513,863	2,513,863
Dispensing Fee	726,484	662,444
Total	**3,240,347**	**3,176,308**

Table 3 – PharmaC/CPL Income and Profit

Recovered through billing as:		
No. of items pa	54,167	54,167
Dispensing Fee income based @ £12.23	**726,484**	
Dispensing Fee income based @ 11.15		**662,444**
Gross Profit	34,594	31,545
CT	8,649	7,886
Retained Profit	25,946	23,659
Gross Margin	5%	5%

Table 4 – Estimated Annual Savings for Alder Hey

Worked example of annual savings to Trust:	**Y1**	**Y2**
Gross Drugs VAT saving	502,773	502,773
Of which additional costs of contract arrangements:		
Superintendent Pharmacist (14%)	15,443	15,443
Share of overhead costs (14%)	60,707	60,707
Initial Risk contingency 10% of gross costs	60,990	0
Trust lost interest on cash support for stock acquisition	21,000	21,000
5% GP mark up to CPL	34,594	31,545
Non-pay not currently budgeted	21,536	21,536
Wastage not currently budgeted	100,555	100,555
Pay costs higher in CPL model	2,765	2,765
Rental of space		
Minor estate works**	30,000	0
Net benefit to Trust	**155,183**	**249,222**

** Until the space has been reviewed in detail by CPL, and any changes specified by Mitie, this is an estimate figure only. Depending on the exact nature of works, and value will prescribe whether this spend is capital or revenue in nature. If capital, this spend would need to be prioritised as part of the in-year capital programme. The business case currently assume this spend will be revenue.

Regarding the financial data above, the following should be noted:

- The rental of £15k will in effect be cost neutral to Alder Hey
- The estimated stock wastage of 4% has been calculated by PharmaC/CPL. Alder Hey's stock wastage in outpatients for the 12 months between 1st September 2024 – 30th August 2025 was a lot lower than this at £25,470
- Any underspend against Pharmac/CPL costs will be credited back to Alder Hey so long as Pharmac/CPL maintain a 5% gross margin
- The "Other non-pay" costs have been based on PharmaC/CPL's estimates and includes approx. £21k of items that are not currently budgeted within Alder Hey's pharmacy non-pay costs including: Advertising and Staff Recruitment; Insurance Costs; Minor Works; and Equipment/Monitoring. There are also postage costs that haven't been accounted for in PharmaC/CPL's estimates, that will need to be added in. However, this will be more than offset by the stock loss provision, which based on Alder Hey's current wastage rates is likely to be signififcant lower than what PharmaC/CPL have accounted for.
- The workforce model (see "Workforce" section below) is predicated on having 4 x Band 4/5 staff working for PharmaC/CPL through an SLA arrangement for a maximum of 12 months (based on HMRC rules for elegibility to reclaim the VAT). As Band 4/5 posts become vacant within pharmacy, they will in effect be transferred to Pharmac/CPL allowing them to recruit to the posts, until eventually all outpatient pharmacy staff (bar the Band 7 pharmacists) are directly employed by PharmaC/CPL.
  There is a risk that there are an insufficent number of Band 4/5 posts vacated within pharmacy during the first 12 months of the PharmaC/CPL contract, which would put a cost pressure on Alder Hey pharmacy's budgets of up to £174,212 (worst case scenario). **Under this worst case scenario, the net benefit from year 2 onwards would be reduced to £75,010 until such time as appropriate vacancies arise within Alder Hey's pharmacy.**

Activity Impact

The service will be implemented on a 'like for like' basis and as such there will be no impact on activity by virtue of outsourcing it. The estimated volume of dispensing and the drugs spend as recorded on the CareFlow Medicines Management (CMM) stock control system for the period October 2024 – September 2025 is detailed below, and this was used as a basis for estimating the contracted volumes:

October 2024 – March 2025

Row Labels	Count of Net container issue	Sum of Net issue value
BLOOD PRODUCTS	3	£ 4,088.26
Drugs, Foods, Drug Equipment	27609	£ 990,015.15
NONE PBR	1127	£ 521,769.25
Grand Total	**28739**	**£ 1,515,872.66**

April 2025 – September 2025

Row Labels	Count of Net container issue	Sum of Net issue value
BLOOD PRODUCTS	1	£ -
Drugs, Foods, Drug Equipment	24427	£ 1,018,206.68
NONE PBR	1004	£ 486,644.80
Grand Total	**25432**	**£ 1,504,851.48**

Key
Non-PBR: high-cost drugs, which are funded by NHSE.

For the year ended 30th September 2025, excluding blood products, the total values are as follows:

Total no. items dispensed: 54,167
Total drugs spend: £3,016,636 (including VAT)

If as noted in the "Risks Mitigated" section above there is an increase in demand for outpatient dispensing as current annual trends suggest, then staffing levels and costs for the outpatient pharmacy will need to be re-assessed; this would apply irrespective of whether or not the service was outsourced. However, an increase in activity will have an increase in income associated with it.

Capacity Impact

The outsourced service will be implemented on a 'like for like' basis and as such there will be no impact on pharmacy capacity.

Workforce

The workforce model for the outsourced service will be emulated on Alder Hey's assessment of the grades of staff required to support all outpatient pharmacy work. PharmaC/CPL have, with the exception of the Band 7 pharmacist role, largely accepted the proposed structure. For the Band 7 role, PharmaC/CPL have deemed that the service could run with 1 WTE whereas currently there are effectively 2 WTEs in post at Alder Hey. However, the 2 posts are to ensure that the volume of workload can be managed and to address safety/governance expectations (incidents, complaints) and KPIs for the outpatient pharmacy service (prescription waiting times for simple and complex prescriptions). The table below outlines a high-level workplan for 2 WTE band 7 pharmacists:

Pharmacist 1	• Clinical checking, processing acute/waiting prescriptions; this workload emanates from attendances at an outpatient clinic • Misc: responding to enquiries from patients/parents at the outpatient hatch, counselling (which cannot be done by a technician), responding to enquiries from prescribers • Cross cover lunch/breaks
Pharmacist 2	• Clinical checking, processing non-acute/non-waiting prescriptions; this workload emanates from email requests ('repeat prescriptions' e.g. renal and haemophilia, virtual clinics, adhoc supplies) • Support Pharmacist 1 as required to ensure waiting times are maintained. • Misc: responding to non-urgent enquiries from prescribers, responding to non-urgent enquiries from parents/families, service development, policies and procedures, liaison with ICS Medicines Management Teams/GPs regarding queries relating to prescribing/shared care, governance and safety issues (responding to incidents, investigations and complaints), clinical training of staff, FP10 queries/allocation, CD adherence • Cross cover lunch/breaks

Prior to February 2024 all Outpatient Pharmacy work was processed in the outpatient pharmacy however the volume of work/workflow was deemed unsafe, and a decision was taken to split the workload, with some non-urgent/non-waiting prescriptions and emails diverted to the inpatient dispensary for processing, thus easing workload pressure. Moving all outpatient work back to the outpatient pharmacy and only having one B7 pharmacist would potentially mean the volume of workload is unachievable. This could compromise both patient safety (resulting in an increase in incidents/complaints) and breach Trust KPIs in terms of prescription waiting times.

On this basis, the outsourced service will – at least initially - be implemented on a 'like for like' basis and as such there will be no impact on workforce numbers. Once the outsourced service is in place and established, the workforce model will be re-evaluated especially with respect to the number of Band 7 pharmacists required. The way that some staff are employed may change. The table below summarises the current staffing for outpatient pharmacy and the proposed changes to how they will be employed.

Grade / Post	**WTE**	**Proposed Arrangement**	**Comments**
Band 7 Pharmacist	2.0	SLA with PharmaC/CPL	Will remain permanently employed by Alder Hey to ensure paediatric training/education is maintained.
Band 6 Senior Technician	1.0	Employed by PharmaC/CPL	Will TUPE across. 12-week process.
Band 5 Technician (accuracy checking technicians to cross cover breaks etc.)	2.0	Either employed by PharmaC/CPL or SLA with PharmaC/CPL*	Staff will have the opportunity to volunteer to become an employee of PharmaC/CPL. If they decline, they will work under an SLA for a maximum of 12 months and remain employed by Alder Hey*.
Band 4-5 Technicians (dispensing)	2.0		
Band 3 Assistant Technical Officer (ATO) (coordinate and housekeeping support)	1.0	Employed by PharmaC/CPL	Currently a vacant post so will transfer directly across to PharmaC/CPL

* As and when appropriate vacancies arise at Alder Hey pharmacy, these vacancies will be used by PharmaC/CPL to fill posts that sit under the SLA arrangement. Apart from the Band 7 pharmacists, all outpatient pharmacy staff will eventually be directly employed by PharmaC/CPL. There is a risk that there are an insufficent number of Band 4/5 posts vacated within pharmacy during the first 12 months of the PharmaC/CPL contract, which would put a cost pressure on Alder Hey pharmacy's budgets from year 2 onwards as noted in the Financial Impact section above.

Impact on Services

This list to be reviewed by divisions.

Department	Staffing Impact			Other Impact
	WTE	Band	Cost	
Facilities/Estates	-	-	-	Minor works required to facilitate the drugs storage requirements of PharmaC/CPL. New process required for deliveries to outpatient pharmacy as these need to be separate from all other pharmacy deliveries.
I.T.	-	-	-	PharmaC/CPL staff will require Alder Hey IT network and pharmacy system log-ins.
Outpatients	-	-	-	Consultation room in OP pharmacy to be converted to a drug storage room. Pre-op. room will undergo change of use to become permanent pharmacy consultation room; Pre-op. room will be relocated to a room used by OP admin. staff, who will in turn be relocated to an alternative office.
Pharmacy	See "Workforce" section above			
Impact on PFI costs	-	-	-	Minimal – minor works required
Other (e.g. Corporate)	-	-	-	<u>Communication</u> Re-branding of outpatient pharmacy <u>DMO</u> Provision of project management resource to support implementation <u>Procurement</u> To support issuing of contract and signatories <u>Contracting</u> Prepare, agree, and arrange signatories for SLA

5. Milestones for Implementation and Delivery

Highlight timeframe and milestones for implementation, along with any risks which need to be managed to ensure successful benefits delivery.

Work Stream	Task	Lead	Start Date	End Date
Business/Legal/Commerical				
Commercial	AH to complete business case & confirm scope to CPL	Paul Sanderson	01/09/2025	22/10/2025
Commercial	AH/CPL to draft contract & extend existing insurance policies	Procurement	08/12/2025	09/01/2026
Commercial	AH/CPL to sign contract	Rachel Lea	01/12/2025	09/01/2026
Work Stream	**Task**	**AH/CPL Lead**	**Start Date**	**End Date**
People				
HR	AH/CPL HR meeting to confirm staffing approach	HR	01/09/2025	10/10/2025
Work Stream	**Task**	**Lead**	**Start Date**	**End Date**
Pharmacy Operations				
PM/PharmaC Ops	Agree additional storage space and relocation of consultation room	Estates/Kate Holian	01/09/2025	17/10/2025
PM/PharmaC Ops	Agree fit out requirements for new storage space and consultation room	Estates/CPL	20/10/2025	31/10/2025
PharmaC Ops	CPL to apply for GPHC Registration	CPL	27/10/2025	26/12/2025
Work Stream	**Task**	**Lead**	**Start Date**	**End Date**
Supply Chain				
Finance/Procurement	AH to confirm supplier status (invoices, drug volume, contacts)	Finance	20/10/2025	21/11/2025
Finance/Procurement	AH Notify all suppliers of intention to transfer business & contract prices	Procurement	21/11/2025	28/11/2025
Finance/Procurement	CPL contact suppliers, confirm start dates and place orders	CPL	21/11/2025	09/01/2026
Finance/Procurement	Final stock take, valuation and negotiation of purchase price	CPL/Pharmacy	12/01/2026	16/01/2026
Finance/Procurement	Confirm readiness for day one trading	CPL	19/01/2026	16/01/2026
Work Stream	**Task**	**Lead**	**Start Date**	**End Date**
Systems				
IT/Digital	AH/CPL IT to review equipment & systems	IT	27/10/2025	14/11/2025
IT/Digital	AH/CPL IT to confirm integration/system strategy requirements	IT	03/11/2025	21/11/2025
IT/Digital	AH/CPL IT to instigate plan of action to migrate systems to CPL	IT	21/11/2025	16/01/2026
IT/Digital	CPL to prepare and agree transition/migration plan with Suppliers	CPL	21/11/2025	16/01/2026
IT/Digital	CPL to prepare day 1 risk assessment for outpatient pharmacy	CPL	08/12/2025	26/12/2025
IT/Digital	CPL IT to migrate systems confirm readiness for day one trading	CPL	29/12/2025	16/01/2026

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**SARC Declaration against ISO15189 and Forensic Science Codes**
Report of:	Lisa Cooper Director Community & Mental Health Services
Paper Prepared by:	Dr Shiromi Ellis, Clinical Director SARC Sharon Ferguson, GM and Quality Manager SARC

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:	Resource required for Quality Manager role

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

Risk number	Risk description	Score
00289	Delay in building works within the Rainbow Centre required for SARC Accreditation	12
00439	Potential risk of the forensic evidence obtained by the Sexual Assault Referral Centre (SARC) being challenged during legal proceedings and impact on Trust reputation	12
00448	Failure to comply with the standards for 'Medical Laboratories - Requirements for Quality and Competence' (ISO 15189:2012) Accreditation	16

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

1. Report Purpose

This report updates the Trust Board on Alder Hey's Sexual Assault Referral Centre's required declaration of non-compliance with ISO15189 and the Forensic Science Regulator's Code, which is effective from 02 October 2025.

2. Summary and Background

All Sexual Assault Referral Centres (SARCs) in England and Wales must be accredited under ISO 15189 and the Forensic Science Regulator's Code by the 02 October 2025. Compliance is required by law, and UKAS will assess SARCs against these standards.

A readiness for accreditation survey by the Forensic Science Regulator indicates that the majority of SARCs will not meet the Code by the deadline and will need to declare non-compliance with the code.

3. Alder Hey SARC current position on achieving accreditation

Alder Hey SARC underwent a UKAS pre-assessment visit on 11 & 12 September 2025, receiving positive feedback with the SARC expected to achieve accreditation in early 2026. Feedback emphasised the requirement for strict control over standard operating procedures, internal audit against the Codes and clear evidence of staff training and competence records.

Currently, the Community & Mental Health General Manager is fulfilling the responsibilities of the SARC Quality Manager role. However, following recent UKAS feedback and the actions required, there is now a necessity to appoint a full-time Quality Technical Manager on a permanent basis. This position is critical for both achieving and sustaining accreditation, which involves biannual review visits and annual accreditation processes. An interim plan concerning this appointment are pending approval and should be in place by December 2025.

Detailed feedback on the pre-assessment visit is included in **Appendix One**.

4. Declaration of Non-compliance

Alder Hey SARC is required to issue a declaration of non-compliance with the Forensic Science Regulator's Code effective from the 02 October 2025. All reports prepared for the criminal justice system regarding children and young people seen at Alder Hey SARC must now include statements of non-compliance with the Code, accompanied by an annexed table outlining relevant mitigations. Legal advice was sought for the required statements, which have now been included in the necessary reports.

There is concern nationally as to whether the evidence provided in sexual abuse cases will be open to challenge by the defence, due to non-compliance with the code. As well as the risk to the children and young people seeking redress from the criminal justice system, this may represent a reputational risk to the Trust and has been included in the Trust's risk register.

While evidence may still be challenged in individual cases, agencies such as Crime Scene Investigation services who have declared non-compliance with the code have not typically faced significant challenges for this reason alone. The risk should be evaluated in accordance with the national position of SARCs regarding Code compliance and can be effectively mitigated through the implementation of robust mitigation strategies.

The five categories of risk mitigation include:

1. Competence of the practitioners involved in the work is tested
2. Method employed validated
3. Method employed documented
4. All equipment/software used has been tested and is fit for purpose
5. The work is undertaken in a suitable environment

At present Alder Hey SARC has mitigation measures in place for 2 out of the 5 areas, (Competence of practitioners & equipment being fit for purpose). It is anticipated that method validation, method documentation (audits required) and building work to optimise environment will be completed by 31 December 2025.

Declarations against the Code will be reviewed monthly at the Alder Hey SARC quality business meeting, with risk mitigation and actions monitored, and updates regularly reported to the Trust's Quality, Safety and Assurance Committee through the Community & Mental Health divisional report.

5. Conclusion and recommendations

The Trust Board is asked to note:

- The contents of this report and the statutory requirement for Alder Hey SARC to achieve accreditation and compliance with the Forensic Science Regulator's Code.
- Declaration of non-compliance with the Forensic Science Regulator's Code effective from the 02 October 2025.
- All reports prepared for the criminal justice system regarding children and young people seen at Alder Hey SARC now include statements of non-compliance with the Code, accompanied by an annexed table outlining relevant mitigations.
- Increased risk score relating to non-compliance and inclusion of a risk relating to reputation.

Appendix 1: Pre-assessment report

PREASSESSMENT REPORT

Customer Name & Address	Alder Hey Children's NHS Foundation Trust Rainbow Centre Eaton Road Liverpool L12 2AP	**Cust No.**	27152
Assessment Location	The Rainbow Centre Alder Hey Children's NHS Foundation Trust	**Project No.**	316063-01
		Dates of Preassessment	11-12th September 2025
Assessment Standard/ Criteria	ISO 15189: 2022 FSR Code v2	**Date of Application**	7th October 2022
Name & Role of UKAS Assessment Team	Lead Assessors – Ashleigh Knowles monitored by Kristel Smith (ISO15189) and Sonia Marshall (FSR Code). Technical Expert – Keeley Roe (FME) and Technical Assessor Sonia Marshall.	**Report Issued By**	Sonia Marshall
		Report Issued Date	20th September 2025
Customer Representatives	Sharon Ferguson (Quality Manager) Elaine Prescott (SARC Manager) Shiromi Ellis (Clinical Lead)	**Report Acknowledged Date**	TBC

A preassessment visit was conducted at The Rainbow Centre of the Alder Hey Children's NHS Foundation Trust on the 11th and 12th September 2025. The scope for this preassessment was agreed to be the Forensic Medical Examination (FME) of paediatric patients at the SARC where FME includes the assessment, collection and recording of forensic evidence from paediatric patients presenting at the Centre.

Ashleigh Knowles monitored by Kristel Smith (Lead Assessor ISO15189), Sonia Marshall (Lead Assessor & Technical Assessor FSR Code & ISO15189) and Keeley Roe (Technical Expert – SOE) attended to provide feedback on the quality and technical aspects of systems in place with regards their suitability for meeting the requirements of ISO 15189:2022, ILAC G19 (06:2022) and the Forensic Science Regulator's Code of Practice (FSR Code v2) including the specific requirements of FSA-BIO 100.

The discussions have highlighted a number of points that need to be considered by The Rainbow Centre SARC before an initial assessment is performed against the respective Standards and supporting documents; these are detailed below. The organisation should also consider that there may be other opportunities and indeed necessities for improvement that are not mentioned in the preassessment report.

Pre-assessment report

Impartiality (ISO 15189 clause 4.1) and Confidentiality (ISO 15189 clause 4.2)

The quality manual (SARC-MAN-0001) defines processes in place to manage impartiality and confidentiality. There is a system for declarations of threats to impartiality which aligns with the Trust policies and doctors are required to make an annual declaration. Where any threats to impartiality are identified these are managed in accordance with the nonconforming work procedure.

Staff sign a copy of the NHS Confidentiality Standards on employment. In addition FME's sign a Non-Disclosure and Confidentiality Agreement. All staff are required sign up to the FSR Standards of Conduct (SARC-MTEM-0002).

All staff have an open opportunity to declare all conflicts of interest to the Trust and to their line manager on a case-by-case basis. This process is not currently documented, to define the process.

All staff are subject to enhanced DBS checks, which are managed by the HR department. Notifications are issued to line managers when renewals are due and expiry dates are monitored on a monthly basis.

The SARC is considering bringing these elements together into a single matrix to enable more effective local monitoring.

Contracts of employment will need to be provided at the initial assessment.

Legal Entity (ISO 15189 clause 5.1) and Structure (ISO 15189 5.4.1)

The legal entity is defined within the quality manual as Alder Hey Children's NHS Foundation Trust (AHFT) (checked online 03/09/2025 NHS England » Alder Hey Children's NHS Foundation Trust. As the legal entity the Trust assumes overall responsibility.

The service is commissioned by NHSE North West commissioners and Merseyside Police with referrals made from Merseyside Police or Children's Social Care. The SARC sits within the Community and Mental Health Division within Alder Hey.

The SARC team consists of 7 consultant paediatricians, 5 specialty registrars, 2 specialty doctors, 2 specialist nurses, 1 HCA and 1 administrator. Overall, 10 FMEs are available.

Pediatricians are AHFT employees. FMEs are provided via an SLA with Manchester Foundation Trust. Triage is undertaken by Manchester FMEs and the Children's SARC only become aware of patients at the time of booking in. This means that the SARC do not triage directly or determine appropriateness for an examination. This will need to be covered in the SLA.

An organisation chart is established in the quality manual. It is noted that the role the Senior Accountable Individual (SAI) is not represented.

Senior Accountable Individual

Lisa Cooper (Director of Community & Mental Health Services) has assumed responsibility as SAI and has signed up to relevant responsibilities documented in SARC-DOC-103 (signed March 2025). The scope of delegated activities is clearly set out. The mechanism by which delegates are made aware of these responsibilities, and how they are held accountable for them, will need to be formally documented.

Service Agreements (ISO 15189 clause 6.7)

The SLA between AHFT and Manchester Foundation Trust (MFT) for AHFT service provision using MFT FMEs was seen.

Overall, the process for managing service agreements needs to be fully documented to include defined statements of what is considered when setting up an SLA (e.g. resources, specifications and review).

Objectives and Policies (ISO 15189 5.5)

The policy for objectives and policies is documented in the quality manual. This includes appropriate statements on maintaining quality, meeting the requirements of ISO 15189:2022, and providing a service the meets the needs of users. However, the policy does not reference the FSR Code or ILAC G19, both of which are relevant to the service.

Alder Hey Children's NHS Foundation Trust has established a set of Quality Objectives which are detailed within the Trust Strategy – "Vision 2030" (SARC-REF-0086). However, no SARC specific objectives are defined; the standard requires these are defined with clear timescales, identified responsible persons and a mechanism for monitoring and review. The policy, together with its implementation, requires further development. Evidence of this implementation, along with supporting records will be reviewed at the initial assessment.

SARC Director (ISO 15189 clause 5.2) and Personnel (ISO 15189 clause 6.2)

Dr Shiromi Ellis holds the roles of both Clinical Director and SARC Director. While they carry out the associated duties in practice, not all of the responsibilities set out in ISO 15189:2022 are formally documented within the Quality Management System. Documenting these responsibilities is required.

A Personnel Procedure (SARC-SOP-0009) is in place. Qualification requirements for each position are documented in the Training & Competency Framework (SARC-WTEM-0012). The role of Quality Manager is not yet included and will need to be added. All records of personnel competency are recorded and stored in the trust K Drive within the SARC QMS. K:\Rainbow Centre\SARC QMS\Personnel and Training. Work is needed to define the FME training requirements for shadowing.

A range of Job Descriptions were provided for review. Each covers the confidentially requirements, responsibilities and qualification/experience requirements for the roles. At present, there are no documented responsibilities that reference compliance with ISO 15189:2022 and the FSR requirements. The SARC state that this is being managed through staff signing the FSR Code of Conduct declaration. The SARC is reviewing how these responsibilities can be documented to explicitly include this information. Defined responsibilities and documentation of any delegated responsibilities will be reviewed as part of the initial assessment.

Induction is in place for staff both at the Trust and local level. A presentation for quality induction and awareness was seen.

FMEs are provided by MFT and hold an honorary contract with the SARC. They are treated in the same way as internal personnel and are expected to complete all required local training and competency assessments. Different grades of paediatricians are referenced in the Personnel Procedure; however, the grade does not affect the role they perform in relation to SARC activities; this needs to be clear.

Documented evidence of competency across all areas of the service - including role-specific awareness training as defined in FSR Code 11.1.3, as well as QMS training and competence

covering areas such as nonconformance management and document control - will be reviewed as part of the initial assessment for a range of personnel. These records are expected to include objective evidence supporting the training completed and the competence achieved.

Staff vetting and DBS Levels

SARC staff are required to undergo enhanced DBS checks. Evidence of agreement of this clearance level with commissioners will be reviewed at the initial assessment.

The process for and management of DBS status including the frequency of checks requires fully documenting. This will need to be established, with supporting records available for the initial assessment.

Elimination samples

SARC-SOP-0021 documents the SARC approach to elimination databases. The SARC is part of the Merseyside Police SED which is implemented with Cellmark. There is no involvement with the CED. Although the procedure defines roles and responsibilities for the management of SED samples, it lacks flow and clarity in describing the overall process including who is responsible for each step and when. The procedure requires review and update.

Additional areas requiring attention include providing justification for a retention period of two years post-employment, taking into account the potential length of time cases may take to reach court, ensuring there is appropriate oversight to confirm that the database relating to the SARC samples is properly maintained by Merseyside and recognising Merseyside Police as a 'supplier' of SED services.

Facilities and Environmental Conditions (ISO 151589 6.3) and Equipment (ISO 15189 6.4 / 6.5)

The SARC facilities including the 'forensic pod' at Rainbow House were seen to be secure, clean, tidy and fit for purpose. The potential benefit of removing the door handle on the waiting room side of the examination suite door was discussed.

Discussions identified that the Accommodation and Environment procedure (SARC-SOP-0010) requires reviewing and updating to ensure it reflects the required working practice of the SARC.

Anti Contamination

Anti-contamination procedure SARC-SOP-0002 describes the various anti-contamination measures in use by the SARC including use of PPE, cleaning and environmental monitoring. While the measures in place appear comprehensive there is no corresponding risk assessment identifying the critical control points within the end-to-end process. Without this, there is limited objective evidence that all necessary measures have been identified and addressed.

The SARC is currently reviewing the requirement for wearing PPE over disposable scrubs in the waiting room, with consideration being given to reserving this outer PPE for use within the examination suite only.

Environmental monitoring

All rooms within the 'forensic pod' are cleaned according to the same regime however, only the examination suite and patient bathroom are subject to environmental monitoring.

Cleaning is undertaken by SARC personnel after each examination or, if no cases have been seen, then at 7 days. Deep cleans are undertaken monthly. No cleaning is undertaken before an examination. Verification will need to demonstrate that the examination room is 'clean' at the time of use.

Environmental monitoring samples are taken every 3 months and is undertaken by Merseyside Police Crime Scene Investigators. The SARC will need to provide an appropriate evidence base to support the EM sampling frequency including coverage of areas/items sampled. The system along with monitoring results, will be reviewed at the initial assessment. Further, evidence of supplier evaluation and approval and evidence of how the SARC is assured that the EM requirements are understood and implemented by the supplier will need to be put in place prior to initial assessment.

Equipment

There is an asset spreadsheet (SARC-RSK-0008) in place which documents the details of all equipment in place however, there were no asset IDs seen on the equipment. Service records for equipment are embedded into the asset spreadsheet. However, there is no system in place for the review and acceptance of such reports.

A temperature monitoring system is in place for the freezer which holds DNA elimination samples. Ranges are built in with alarms and emails to notify for any breaches in temperature. A process for managing out-of-hours breaches is in place however, this does not consider the contamination risk associated with accessing the freezer, which is located in the examination room. As such, both the process and the location of storage would benefit from review.

Currently, it is not known if the probes used in the temperature monitoring system are calibrated, and the risk for the criticality of ranges has not been reviewed.

Overall, the equipment procedure requires review and update. Implementation will be reviewed at the initial assessment.

With regards the colposcope, the equipment procedure requires this to be white balanced with a white sheet of paper. However, the requirement is not captured in the examination procedure nor in any training and competency for personnel. This needs addressing.

Reagents and Consumables (ISO 15189 6.6)

A consumables procedure is in place (SARC-SOP-0004), however, there are areas where further detail is required. For example, the processes for stocking the consumables store (from receipt of items) and for stock checking are not defined and the procedure does not specify what constitutes a 'time-sensitive good.' In addition, work is needed to ensure that batch numbers for individual consumable items are recorded beyond the initial kit batch reference, to allow traceability to other cases should an investigation into a contamination event be necessary.

Discussions were held regarding the meaning and purpose of acceptance testing. Acceptance testing is an evaluation process designed to ensure and demonstrate the validity of reagents and consumables at the point of use. It is distinct from batch testing, although batch testing may form part of the overall acceptance testing evaluation. A documented process for acceptance testing must be in place for the initial assessment (see also process-based risk assessments below).

Externally Provided Products and Services (ISO 15189 6.8)

An External Services & Supplies Procedure SAR-SOP-0012 is in place and references the Trust's procurement team and procedure. The SARC Nurse Manager is responsible for approving suppliers and recording them on the Approved Suppliers List (SARC-WTEM-0035). However, the specifications/criteria for external services and supplies have not been documented meaning there is currently no clear justification of evidence base for supplier selection.

The criteria for FMEs (external personnel) are set out in a Service Level Agreement, with requirements defined in the contract. Similar contracts will also be required for the provision of Merseyside police personnel who undertake EM and provide services for the management of the SED.

Examination Processes (ISO 15189 7.2, 7.3 and 7.4)

Procedures are in place for the pre-examination, examination and post examination processes. These cover the referral of patients to the SARC through to the handing over of samples to the police and storage of generated records. All are based on FFLM guidelines. Although it is accepted that these guidelines might inform a method, they cannot be relied upon as a procedure to be followed; the organisation must define their own method(s) in the QMS.

The pre-examination procedure (SARC-SOP-0015) requires review and restructuring to ensure clarity, consistency, and alignment with SARC practices. Key issues identified include lack of clarity on what records must be made, when and by whom, the inclusion of processes outside of SARC control, and references that do not make it clear whether they are to be followed or provided for information only. It needs to be clear that the SARC does not undertake triage and that this is undertaken by Manchester staff.

The examination procedure (PHL-SARC-SOP-014) also requires review and updating to ensure it clearly describes the method to be followed and to ensure consistency of its application. Key gaps identified include the need for a description of the patient examination method and the requirement to formulate and document an examination strategy (which is distinct from a forensic strategy). Packaging requirements also need to be reviewed to ensure they reflect SARC practice. Discussion was also had that any injury photography undertaken outside of the SARC environment would fall outside the accredited scope.

The post examination procedure describes the processes for onward handling of samples and records, including storage and transfer to the police. However, there is no documented process for how items will be checked against examination notes by someone other than the practitioner who generated them (FSR Code 29.2.10) prior to storage or handover. A process must be documented and implemented.

The organisation will need to document if there are any activities that can be undertaken away from the SARC facility, where they can be performed and the controls in place to manage them (see FSR Code 23.2). Such activities might include, for example, taking referrals, providing clinical advice and report writing.

Infrequently used methods

There is currently no procedure and no process in place for managing infrequently used methods. The procedure must consider how infrequently used methods are identified, how their validity is

assured and competency requirements for undertaking such methods (FSR Code 24.2.8 to 24.2.16).

Validation and verification

A wide range of documents were provided under the heading of verification. However, upon review with the SARC during the preassessment, it became clear that many of these documents are in fact process audits. These will benefit from review to ensure they are captured appropriately within the QMS.

Discussions were held regarding the critical areas that will require verification, such as cleaning and examination processes, in order to ensure that end-to-end activities are addressed. Some work has been carried out through the FCN-led collaborative exercises, but these will require local review and formal reporting. Documentation must clearly identify that all validation/verification activities are specific to the methods, staff and equipment of the SARC rather than being exercises completed by external parties or other organisations. Where reliance is placed on validation or verification work undertaken elsewhere, the SARC must document a clear justification showing how this work meets its own operational needs and requirements.

The validation & verification procedure (SARC-SOP-0019) is written to meet the requirements of the FSR Code. However, the section relating to end users requires further development to clearly describe how end users are to be identified - recognising that this extends beyond the court (e.g. police, FSPs etc) - and to consider what the method is intended to deliver to those different end users, noting that this is not limited to expert evidence.

Discussions identified several key concepts that the SARC must take forward in the design and execution of validation and verification activities. Within the context of the SARC, validation and verification represent the demonstration that a method, process, or device is fit for purpose. For methods, the specific method or SOP(s) being validated or verified must be clearly identifiable.

End-to-end validation/verification is required to demonstrate that the method - from referral through examination to reporting (i.e. encompassing pre-examination, examination, and post-examination – including reporting - activities) - is fit for purpose and provides consistency in service provision and outcomes. This extends beyond quality assurance from a DNA contamination perspective and is not intended to function as a test of staff competency, as is currently documented in Verification Plan SARC-VER-0007 (examination process). Verification plan SARC-VER-0004 describes an experimental design fitting with what might be expected for the verification of the SARC end-to-end method. However, end users and their requirements are not identified, the specification or methods being tested are not documented or referenced, the experimental design is limited to swabbing only and does not consider all activities encompassed by the end-to end process.

The verification of the cleaning regime was discussed. As no cleaning is carried out immediately prior to an examination, verification will need to demonstrate that the examination room is ‘clean’ at the point of use.

Overall, verifications still require considerable input to meet the requirements of the Standard and the FSR Code.

Evaluation of Measurement Uncertainty

The Quality Manual refers only to thermometers when referencing the evaluation of measurement uncertainty. While the SARC examination methods do not involve quantitative analyses, measurement uncertainty is still applicable in the qualitative context. Here, it relates to the potential for procedural variability, such as incomplete evidence recovery, mislabelling, contamination, or deviations from SOPs. ISO 15189 and the FSR Code require that all sources of variability -

quantitative or qualitative - are evaluated to ensure the integrity and reliability of evidence. This needs addressing in the QMS.

Proficiency testing (EQA) and Quality control (IQC)

The is no documented quality assurance procedure that documents the approach to IQA/IQC and EQA.

The SARC has participated in Proficiency testing (PT) via the FINDS swabbing exercise and also the FCN-led collaborative learning exercise which included swabbing and strategy setting. There are plans to participate in an inter-SARC comparison program with Newcastle, Lancashire, Gloucestershire and Sheffield NHS Trusts. A procedure is required to describe the SARC's approach to EQA and it must include a plan to identify the level and frequency of participation and how the scope of SARC activities will be covered (see also UKAS document TPS47). The organisation is responsible for horizon scanning for additional opportunities and for documenting the rationale for deciding whether or not to participate. Plans, decision-making and records of participation will be reviewed at initial assessment.

Although various IQC measures are evidently in place these are not documented as required by the standard – 7.3.7.2 and the FSR Code clause 20 (checking and review). Definitions will be required for the term 'peer review' as its use within the SARC and by the FSR Code can refer to different processes.

The SARC has obtained data from its police customer on DNA success rates from swabs collected by its practitioners. This data provides a valuable measure that could be used to support practitioner competence and to support ongoing monitoring of quality assurance.

Reporting of Results (ISO 15189 7.4.1)

Examples of FME and paediatrician reports were reviewed at the preassessment. The FME report was completed on a Merseyside Police document, which will need to be reviewed and aligned with the SARC QMS. The paediatrician report included reference to the forensic examination.

A reporting and release of results procedure is in place (SARC-SOP-0016); this specifies the required report contents, including a requirement to declare compliance with the FSR Code. It is noted however, that the procedure references FSR-C-100 which predates the current regulatory FSR Code. In light of this and the mandatory compliance deadline of the 2nd October, the declarations included in the procedure will need to be reviewed and updated where necessary to ensure alignment with the FSR Code (it should noted that updated guidance from the office of the FSR is imminent).

The requirements of UKAS GEN6, whereby the accreditation status must be included in any results reports referencing the forensic examination was also discussed. This requirement applies not only to formal written reports but also to reports provided as Med Ex forms that accompany exhibits handed to the police.

Defence access for review:

The reporting procedure states that the SARC will provide the defence with access to material identified as relevant by the prosecution. The process for handling and managing defence requests requires documenting.

Control of Data and Information Management (ISO 15189 7.6)

The SARC uses the Trust systems and shared drives.

SARC- WTEM-0042 IT testing protocols and SARC specific SOP has been established.

It was discussed that at the initial assessment assessors will need speak to the team and see any validation records for fit for purpose testing and sign-off of the system for SARC requirements. Also, information backup and failsafe processes will be assessed. An example visit plan for an FSR Code information security assessment has been provided to the SARC to help them understand and identify the personnel they will need to involve at the initial assessment.

Complaints (ISO 15189 7.7) and Feedback (8.6.2)

Feedback is sought from patients and recorded by the patient experience team at Alder Hey Children's NHS Foundation Trust. Clients are provided with a feedback form on the day and a QR code is provided for them to take away to provide feedback via the Trust IQUVIA system. Requirements for addressing negative feedback or complaints against FMEs are described in the Service Agreements (SARC-SOP-0020).

Complaints are managed via the Trust complaints and concerns policy (RM6) and are recorded on the PAS system. The SARC does not have a specific SARC complaints policy of its own. The Trust policy will need to be reviewed to ensure it meets the requirements of the SARC.

A monthly report is received by the management team and reviewed. It was reported that there have been no complaints and no negative feedback for the SARC in at least 2 years.

The documentation and systems in place will be reviewed as part of the initial assessment.

Continuity and Emergency Preparedness Planning (ISO 15189 7.8)

The Business Continuity Procedure (SARC SOP-0018) identifies a good range of risks/scenarios that may require the plan to be invoked. The associated actions are detailed in action cards provided in the appendix, along with key contact information. Currently, access to the policy and action cards is electronic only, and consideration must be given to how these will be accessed in the event of an IT failure.

The section on testing the plan refers to the Trust's training and exercise programme; however, no testing has yet taken place at the SARC. As the Standard and the FSR Code requires that Business Continuity Plans include defined and planned testing, a testing programme for the SARC will need to be established.

Management System Documentation (ISO 15189 8.2)

The Quality management system is managed using shared drives in the Trust IT systems.

The QMS relies on many processes being performed according to the Trust Policies. There has no local review to ensure that Trust policies meet the requirements of the SARC Quality Management system.

The preassessment identified multiple incorrect references across a range of QMS policies, processes, and procedures. These documents require review and correction to ensure accuracy and to provide assurance of compliance with the appropriate reference documents.

Overall, the SARC will benefit from a detailed document review to ensure that local practices are fully recorded and appropriately defined for the SARC. This may be supported by a gap analysis against the requirements of the standards. In addition, it will be important to ensure that all processes performed are comprehensively documented in procedures, as discussed elsewhere in this report and during the preassessment.

Control of Management System Documents (ISO 15189 8.3)

A Document Control Procedure (SARC-SOP-0005) is in place. It specifies that procedures and other documents are restricted documents held on the K drive. Staff can access PDF versions of procedures via the Document Management System (DMS) on the Trust internet.

A Master Document List (SARC-WTEM-0017) is maintained to log all controlled documents with appropriate sections to collate information on the status of them. Separate tabs are in place for 'external' (Trust and reference) documents. However, as with the incorrect references seen in some procedures, several of the external reference documents were also out of date.

The review interval for internal documents is set at 3 years, but there is no review set for external documents. This requires review to ensure appropriate intervals are identified and justified. Consideration also needs to be given to the control of hard copy versions of documents (e.g. ensuring their location is recorded) and in ensuring that any hard copy documents created as aide memoirs from documents or as standalone document are also controlled.

Currently, the system for staff acknowledgement of new or updated documents relies on logging responses using the email vote function. This process is not documented and there is no timescale for acknowledgements to be made.

Control of Records (ISO 15189 8.4)

Discussions identified that the Control of Records procedure (SARC-SOP-0006) requires review and update.

The retention period for records is given as at least 30 years. The SARC will need to ensure it can manage retention periods in line with the 30 years required by the FSR Code, specifically for validation records (from last use of the method) and for complaints and nonconformities (retained in accordance with the casefile retention period). While the procedure includes steps for disposal, the SARC will need to demonstrate that it can map where all records relating to a given case are stored such that disposal requirements can be met.

Forensic medical records are initially stored in a locked cupboard inside what was the Interview Control room. Access to the room and records is via keys stored in the passkey protected cupboard within the Front Administration Office. After 2 years, paper medical records are sent for electronic archive in Meditech at the request of the SARC Manager. This practice does not align with the process documented.

Case records were reviewed during this preassessment. While the documentation content was generally as expected, a number of fields in records were left blank, making it unclear whether the activity had been undertaken or the question asked. In addition, the role of the individuals contributing to the notes was not always clear, reducing transparency and traceability. The requirements for record-keeping need to be clearly defined and documented to ensure that casefiles are complete, accurate, and reliable.

The unique ID for a case has not been defined to enable full traceability for each case at the SARC. This needs addressing to meet the requirements of the FSR Code.

Bins for confidential waste are managed under contract by an external third party. The SARC has not assessed the suitability of the provider for their purposes, nor are the bins included in the risk assessment (SAR-RSK-0009) undertaken to identify key data and critical control points.

Risks and Opportunities (ISO 15189 8.5 and 5.6)

The SARC-WTEM-0020 form records both risks and opportunities. A second form, SARC-WTEM-0021, is for minor issues. However, there is nothing to define what is considered minor and what would be more serious.

Serious risks are recorded in InPhase. Currently 2 risks are logged - building work and risk of not gaining accreditation.

Risk and opportunities also form part of case paperwork whereby staff can complete it and submit to management. All technical procedures undergo an initial risk assessment as part of the Method Validation Procedure (SARC-SOP-0019); records of the completed process risk assessments are saved on the QMS.

This process for the management of risks and opportunities requires documenting.

Process-based risk assessment

There are several areas where process-based risk assessments will be reviewed at the initial assessment.

- Critical control points for key data. i.e. places where data is entered, transferred, stored or processed in a manner where it may be vulnerable to corruption, errors, unauthorised manipulation – for records and data.
- Critical control points on the consumable pathway. i.e. how manufacture, distribution, storage, retrieval, preparation and use may adversely impact the end forensic result – controls contribute to acceptance testing
- Critical control points for DNA contamination across the SARC activities including control measures such as PPE, cleaning, environmental monitoring etc. – controls contribute to acceptance testing

Improvement (ISO 15189 8.6) and Non-conformities (7.5) and Corrective Actions (ISO 15189 8.7)

The SARC communicates to its personnel (at bimonthly peer review) the importance of meeting the needs and requirements of users as well as the requirements of the QMS.

The SARC follows the Trust policy RM2 for managing non-conformities. The policy does not detail the SARC specific process. However, in practice the SARC maintains records that capture of the nature of non-conformities, their cause(s), actions taken, and evaluation of the effectiveness of corrective measures. These records are within the Quality Log (SARC-WTEM-0019), with additional records stored on InPhase if a non-conformity is classified as an 'incident'.

SARC specific requirements need to be documented. This must include how trending of non-conformities will be undertaken, as well as criteria and process for escalation to the FSR and UKAS.

Evaluations (ISO 15189 8.8)

The procedure for evaluation and audit is set out in SARC-SOP-0007. This is supported by audit schedule SARC-WTEM-0029 which is managed by the Quality Manger. The schedule lists audits by SOP and identifes the frequency, type of audit, who will perform the audit and completion status. Audit frequency is determined by audit process risk assessment SARC-RSK-0006. Any need for rescheduling is documented on a separate tab with justification.

The audit schedule covers a number of key areas but does not cover all areas of ISO 15189, ILAC G19 and the FSR Code. The SARC may benefit from reviewing the format of the schedule to align it with processes rather than SOPs, and to map it against the clauses of the applicable Standards. This would provide assurance that the audit programme achieves full coverage of requirements.

Management Review (ISO 15189 8.9)

A Management Review Procedure (SARC-SOP-0008) is in place with key attendees identified, including managerial and clinical personnel as well as the SAI. Meetings are scheduled to take place every 6 months and the first meeting has already taken place. There is a blank template for the meeting agenda and minutes, however, the agenda would benefit from review to ensure that the items listed meet the requirements of the Standard.

Implementation of the management review process including supporting records will be reviewed at the initial assessment.

Next Steps

The organisation must ensure that it has undertaken a review of the comments made in this report in conjunction with the requirements of ISO 15189, ILAC G19, the FSR Code v2 and related documents and have addressed any identified gaps prior to the Initial Assessment. A report detailing action taken must be provided to UKAS prior to any initial assessment (see documentation requirements detailed below).

The manner by which UKAS will formally witness/assess SARC examinations at the Initial Assessment will need to be determined by the organisation

The organisation is to determine when they would like to proceed to an Initial Assessment; this will need to be discussed with the UKAS Development Project Manager before any formal booking can be made.

In order that a booking for Initial Assessment can be processed by UKAS and dates for the visit secured, the organisation must submit a finalised AC6 to UKAS detailing the precise scope of their application. Ideally, documentation listed below should accompany the finalised AC6 submission, however if this is not possible then the organisation must provide a plan to demonstrate assurance that the documentation will be in place and have been implemented (including auditing) for the required 2 months prior to the Initial Assessment.

Initial Assessment Supporting Documentation Requirements

The following documentation will need to be provided at least 2 months prior to the initial assessment. This will be subject to a high level evaluation to determine whether there are any significant gaps which could prevent the assessment going ahead.

- Updated AC6 form detailing expected scope for accreditation
- Documentation detailing how any gaps identified during the UKAS preassessment have been addressed

- Validation plans – to cover each aspect, for example cleaning, the end-to-end process and other specific methods in the applied for scope
- Validation reports detailing results and conclusions
- Procedure for training and competence management including ongoing monitoring of staff
- Confirmation that staff training and competence records comply with the organisations' procedures
- Evidence of progress against internal audit schedule
- Copy of completed assessment readiness review audit
- Evidence of meeting the requirements of TPS 47 (EQA) – completed ILC /PT including issued reports and internal review
- Formal plan by which UKAS will be able to witness the technical aspects during the Initial Assessment (to cover the full applied for scope)

Ideally documentation listed will be provided in its published/finalised form. Where this is not possible then the organisation must provide a plan to demonstrate assurance that the documentation will be in place and, where relevant, have been implemented (including auditing) for at least 2 months prior to the initial assessment.

A list of documents required in advance of the initial assessment will be provided in the assessment plan for the initial assessment.

Please discuss the above with the UKAS Development Project Manager prior to booking the Initial Assessment visit.

Initial Assessment Timeline

The final Initial Assessment documentation must be received at least 4 weeks before the assessment date, including final live documentation of implemented and audited procedures, otherwise UKAS reserves the right to cancel the visit due to lack of customer preparedness and charges will be incurred by the customer in line with cancellation fees outlined in UKAS' Standard Terms of Business, the latest copy can be downloaded from our website (https://www.ukas.com/standard-terms-of-business/).

Where possible, the Assessment Team that undertakes your Initial Assessment will include your preassessment team, however, it should be noted that this may not always be possible.

If you have any queries in relation to your assessment, please contact the UKAS Development Project Manager and/or your UKAS Assessment Manager.

END of REPORT

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	Learning from Patient Safety Incidents Q2 July-September 2025
Report of:	Chief Nursing AHP and Experience Officer
Paper Prepared by:	Associate Director of Nursing Governance and Risk Patient Safety Incident Investigation Leads

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide the Trust Board with a summary of activity and system-wide learning following the transition to the Patient Safety Incident Response Framework (PSIRF) for Q2 2025/26 and next steps, noting that this is an iterative process as we continue to transition and embed PSIRF.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☐ **Support** our people ☑ **Pioneering** breakthroughs ☐ **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. Purpose

The purpose of this report is to provide the Trust Board with a summary of activity during Q2 July-September 2025 following the transition to the patient safety incident investigation framework (PSIRF) on 1 January 2024, highlighting any identified areas of system-wide learning and improvement and next steps.

2. Activity to date

2.1 Learning from Patient Safety Events (LFPSE)

The Trust continues to meet the reporting requirements of the LFPSE v5 with LFPSE v6 taxonomy due to be implemented following the completion of the national InPhase update has been completed in Autumn 2025.

2.2 Commissioned Patient Safety Incident Investigations (PSIIs)

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

During Q2 2025/26 the Trust commissioned **1** PSII following an incident which met the Never Event criteria for a retained foreign object post procedure. This incident type is classified as a national priority.

PSII: Retained swab following cardiac surgery (national priority) InPhase ID: 25682

The incident related to a swab retained in a patient following cardiac surgery, which was detected via X-ray 24 hours later. The incident occurred in September 2025 within the Surgery Division and met the national Never Event category of a *retained foreign object post procedure*.

Further surgery was undertaken for the safe removal of the swab. The patient was discharged from hospital on 14 September 2025 and has been referred to the Trust's Psychology Service for psychological support following the two surgical procedures.

A PSII has been commissioned and will be led by the Patient Safety Investigators in collaboration with the patient's family and key stakeholders. Terms of Reference (TOR) were developed jointly with the Surgery Division, incorporating key questions shared by the family. The final TOR was shared with the Surgical Division Leadership Team, Chief Nursing Officer (CNO), Chief Medical Officer (CMO), and the Corporate Patient Safety Team on 2 October 2025.

Discussions are ongoing with the Walton Centre to obtain subject matter expertise to support the investigation in the Theatre setting.

It is anticipated that the final report will be presented to the Trust's CMO and CNO for approval on 9 December 2025, before being shared with the patient's family. The investigation remains on track for completion within the specified timeframe.

2.2 Commissioned Learning Responses (excluding PSIIs).

During Q2 2025/26 there have been **3** learning responses (excluding PSIIs) commissioned by the weekly PSIRI panel to investigate those incidents initially reported as moderate physical or psychological harm or above or those meeting the Trust's patient safety priorities.

Table 1

Commissioned Learning Response Types Q2 2025/26	Number Commissioned	Number completed
After Action Review (AAR): A method of evaluation that is used to analyse what happened, why it happened, and how it can be done better by the participants, in the future. It is not an investigation process, but its purpose is to learn, support effective teamwork, motivation and implement improvements in a timely manner.	**2**	**2**
Learning Together Review (LTR): An LTR replaces previously named MDT and supports teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to obtain staff recollections of events either because of the passage of time or staff availability.	**1**	**1**
Thematic Review (TR): A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative rather than quantitative data to identify safety themes and issues.	**0**	**0**
Individual Learning Review (ILR) a focused review undertaken to explore the circumstances and contributory factors surrounding a single patient safety incident. It aims to identify learning and improvement opportunities to prevent recurrence, without the level of depth or resource required for a full Patient Safety Incident Investigation (PSII).	**1**	**0**

2.3.1 Timescale Compliance for Learning Responses Q2 25/26

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

- Medicine – 0% compliance (1 completed but not within timescale)
- Surgery – 0% compliance (1 completed but not within timescale)

Extensions for both AARs were required due to staff leave/ unavailability of key contributors.

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

- 100% compliance (1 completed in Q2, within the timescale)

Thematic reviews

- There have been **zero** Thematic Reviews commissioned for Q2 2025/26.

2.3.3 System wide learning

Learning Together Review: InPhase ID: 22606

A Learning Together Review was undertaken following a data breach where a family accessed information via the Healthcare Communications portal without permission.

The review identified that delays in removing access occurred due to the absence of a defined process for notifying the external provider (Healthcare Communications). Interim arrangements are now in place to ensure timely consent updates are activated with the portal, with updated guidance issued across the Trust.

Longer term, the Trust will decommission the current portal and implement an internally managed system which will improve control over the system.

2.4 Training and Education

2.4.1 Patient Safety e-learning

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

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

2.4.2 Level 2 Patient safety Training

69 staff to date have completed L2 patient safety training available via ESR.

However, this figure does not currently reflect training undertaken by staff via the E learning for Health (ELfH) platform as this is not aligned with ESR.

Work remains ongoing to align training completed on ELfH on ESR in addition to reviewing staffing groups who require L2 training and add to their ESR record as a blue competency- (which is not mandated).

2.5. Patient Safety Investigators

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

To continue promoting awareness of PSIRF among clinical and non-clinical staff across the Trust, the team held a stall at three corporate inductions and delivered three training sessions to clinical teams during Q2 2025/26, introducing the Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Strategy to all employees.

2.6 Patient Safety Partners

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

Throughout Q2 2025-26 our PSPs have been actively involved in a variety of patient safety projects and workstreams to help the Trust implement the NHS Patient Safety Strategy including patient journey mapping in the Cardiology Department (August 2025) and World Patient Safey Day (September 2025). As of October 2025, the Trust has 27 active Patient Safety Partners.

3. Next Steps

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

Feedback from both divisions and ICB have noted that our initial timescales for completion of After-Action Reviews (AARs) have been too ambitious, resulting in limited compliance with 1 month timeframe and multiple meetings with staff. Following this feedback there is a planned audit of this work to review issues with completion and a potential plan to extend the AAR completion timescale to 8-weeks.

4. Recommendations

The Trust Board is asked to note the activity that has been undertaken during Q2 2025/26 following the Trust's transition to and embedding of PSIRF and next steps.

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**Chairs Report from the Safety and Quality Assurance Committee meeting held on 22nd October 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 22nd October 2025, along with the approved minutes from the 24th September 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 ☐
If "No", is a new risk required? Yes ☐ No ☐

Risk number	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	3x3 =9 4x5=20 3x5=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	☐	**Not Assured** Evidence indicates poor effectiveness of controls

				improve their effectiveness		

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 24.9.25	Minutes Approved
Divisional updates	Reports x4 noted
Liverpool Neonatal Partnership Monthly update	Report noted
Patient Safety update	Report noted
Sepsis Quarterly report	Report noted
Drugs & Therapeutics Committee Quarterly Report	Report noted
Quarter 1 Safeguarding Report	Report noted
Clinical Effectiveness and Outcomes Board Chairs Highlight report	Report noted
Board Assurance Framework	Report noted
Gender Development Service Report	Report noted
Fuller Public Inquiry – Phase 2 report	Report noted
Discharge Planning Policy	*Policy ratified
Mass Fatalities Policy	Policy ratified
Hospital Evacuation & Shelter Plan	Policy ratified

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

None

4. Positive highlights of note

- SQAC noted a number of absences and acknowledged the understanding of the reasons for those absences. Despite the absences the committee provided good attention to the reports presented, with clear and assuring updates received. With a good level of discussion on a number of key items.
- Strong discussions took place, particularly regarding mandatory training, with proposal to escalate to the People & Wellbeing Committee
  SQAC welcomed the Sepsis Quarterly update
- SQAC welcomed the Drugs & Therapeutics Committee quarterly Report
- SQAC welcomed the update regarding the
- SQAC welcomed the Patient Safety update
- SQAC welcomed the Quarter 1 Safeguarding Report
- SQAC welcomed the Gender Development Service Report
- SQAC welcomed the Fuller Public Inquiry – Phase 2 Report
- SQAC welcomed the Clinical Effectiveness & Outcomes Board Chairs Highlight report
- SQAC welcomed the Board Assurance Framework

- *SQAC received, Noted and Ratified the Discharge Planning Policy, but remitted for consideration of how Patient Initiated Follow Ups should be incorporated.
- SQAC received, Noted and Ratified the Mass Fatalities Policy
- SQAC received, Noted and Ratified the Hospital Evacuation & Shelter Plan

5. Issues for other committees

SQAC discussed the persistent issues regarding mandatory training compliance, particularly amongst medical and dental staff and noted the concerns regarding the operational impact on the teams who provide the mandatory training sessions. SQAC welcomed this issue being escalated to the People & Wellbeing Committee to enable a systemic review of mandatory training compliance, with the aim of improving attendance at Mandatory Training

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 24th September 2025
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing Officer	NA
	Alfie Bass	Chief Medical Officer	AB
	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	ABa
	Kerry Byrne	Non-Executive Director	KB
	Lisa Cooper	Divisional Director, Community & Mental Health Division	LC
	Gerald Meehan	Non-Executive Director	GM
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health	JP
	Laura Rad	Head of Nursing – Clinical Research	LR
	Jackie Rooney	Associate Director of Nursing & Governance	JR
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Ian Gilbertson	Deputy Chief Digital and Information Officer	IG
Observing	Debbie Hughes	Head of Nursing & AHP's Medical Division	DH
Observing	Ava Kilbride	Governor	AK
	Jill Preece	Governance Manager	JP
Observing	Lowri Smith	Governor	LS
	Amy Tantum	Head of Nursing & Allied Health Professionals, Surgery Division	AT
	Veronica Greenwood	Director of Allied Health Professionals	VG
25-26-123	Kelly Black	Deputy Head of Neonatal Nursing, LNP	KBl
25-26-126	Lachlan Stark	Associate Chief Operating Officer	LS
25-26-127	Beatriz Larru	Director of Infection prevention & Control	BL
25-26-128	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	NO
25-26-130	Jacob Gray	Emergency Preparedness, Resilience & Response Manager	JGra
25-26-136	Julie Grice	Trust Mortality Lead, Consultant in ED	JGri
Apologies:	Rachael Pennington	Associate Chief Nurse – Surgical Division	RP
	Susan O'Neil	Head of Neonatal Nursing, Liverpool Neonatal Partnership	SON

25/26/118 Welcome and Apologies
The Chair welcomed everyone to the meeting and apologies were noted.
FB welcomed Debbie Hughes, who had recently commenced in post as Head of Nursing & AHP's in the Medicine Division.

FB also welcomed Ava Kilbride and Lowri Smith, Governors who were also observing the meeting.

25/26/119 Declarations of Interest - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

25/26/120 Minutes of the Previous Meeting
The Committee members were content to **APPROVE** the minutes of the meeting held on 23rd July 2025.
FB reminded committee members that there was no formal meeting held in August 2025 and that the data pack had been circulated in August 2025, with no exceptional issues raised by SQAC requiring a meeting to be held in August following the review of the data pack.

25/26/121 Matters Arising/Review of Action log
The action log was reviewed and updated.

25/26/122 Divisional Updates

Division of Medicine

CW presented the Medicine Division update and drew attention to a few key points from the report including:

Highlights:-

- ED had achieved a Gold rating and CQC outstanding performance in the Ward Accreditation
- There is continued focus on safety, engagement, and openness across the Division, with regular meetings to address concerns and maintain safety standards.

Challenges:-

- SQAC noted the ongoing financial challenges which are impacting safety, requiring careful management and engagement with staff to mitigate risks.
- There had been a notable increase in C difficile cases over the past three months, especially on ward 3B among Oncology and Haematology adolescent patients, who are at higher risk due to intensive treatments, prolonged hospital stays and extended antibiotic use. Despite robust reviews showing no lapses in care, the Division is proactively seeking further improvements as follows:-
  - A Deep dive into C.difficile cases is to be led by Infection Prevention and Control (IPC), with findings to be reported back to SQAC.
  - Increased testing of all patients on admission, which may contribute to higher case identification, including asymptomatic cases.
  - Collaboration with national working groups and the UK Health Security Agency (UKHSA) to review environmental factors and ensure all possible measures are in place. A UKHSA visit is planned in October to assess the environment, particularly in Oncology.

SQAC **NOTED** the ongoing efforts to address high-risk areas and the commitment to keep Trust Board informed and ensure all risks are mitigated, particularly in the approach to winter.

Resolved: FB referred to the risks within the Medicine Division and welcomed an offline discussion with CW and UD to ensure all mitigations are in place.

Surgery Division

AT presented the Surgery Divisional update and drew attention to a few key points from the report including:

Highlights:-

- The Anaesthetics BI clinical outcomes dashboard is now live and had been developed for use for data collection.
- A Medical photographer within the Division had recently received a Silver IMI 2025 award for a clinical image of a patient with Poland Syndrome.

Challenges:-

- Workforce issues due to reduced administrative support across the division remain challenging, with reviews being undertaken of current working processes and patterns to redistribute workload to provide assurance. A risk-based approach is being worked through to enable full assurance and oversight in relation to changes planned and made.
- High sickness rates in theatres, compounded by theatre teams working to rule due to changes in their pay framework.
- Three cardiac theatre heater-cooler machines are out of action; three loan machines are in use, with a new machine expected in 2026. Urgent capital requests and plans for replacement of existing devices, loan costs will contribute to the purchase.

Quality and Safety metrics

- 5 sepsis cases were reported, all received antibiotics within 60 minutes.
- There had been an increase in overdue incident reviews after previous improvement; meetings are scheduled with specialties to address and reduce overdue reviews.
- 100% compliance with Complaints and PALS responses.
- Friends and Family Test results were strong: 99% rated care as particularly good or good, with special recognition for surgical day case, burns, and HDU.

FB thanked AT for informative report, with clear visibility of challenges whilst noting that the division is managing workforce and equipment challenges while maintaining high standards in sepsis management, complaints handling, and patient experience.

Clinical Research Division
LR presented the Clinical Research Divisional update and drew attention to a few key points from the report including:-
Highlights:-

- The Clinical Research Department (CRD) educator introduced Research Consent Simulations into the research essential skills program to enhance knowledge and confidence in obtaining consent for research. The initiative has received positive feedback.
- Improvements are underway for research induction and competency programmes, expanding access beyond CRD staff to include research PI's and support services.

Emerging Challenges:-

- The Division had identified a recurring issue of inadequate compliance with Good Clinical Practice (GCP) and undue pressure from Principal Investigators (PIs) on delivery teams to deviate from established policies and procedures. To address this, meetings are being conducted with the involved PIs, and a new research policy is being implemented to clarify expectations and enhance data management. Additionally, there is a strong emphasis on communication and patient advocacy, particularly for research nurses.
- A vacancy in the biochemist labs had resulted in the current biochemistry team being unable to support future studies due to their own clinical risks. Constructive meetings with the labs team had led to a plan to move some equipment to the Clinical Research Facility (CRF), where it will be held in-house with oversight and support from the labs team. A new risk has been added for this issue, improvement are expected in the next few weeks, with new studies likely to open after an estimated 8-week delay.
- Ongoing pressures across the Trust, with concerns that increased service and financial pressures may impact the research team relationships and patient safety.

Patient Experience

- The NIHR had changed its feedback system, impacting on the patient feedback survey; workarounds are being explored.
- There had been a slight dip in patient satisfaction particularly relating to deferred consent, with a live patient complaint in this area. Plans are in place to improve information and support for families regarding deferred consent, especially in critical and emergency care.
- Some staff had felt dismissed when raising concerns, with a few cases of incivility and inexperience among new research PIs. The Division is addressing this through direct conversations, emphasising patient safety and the importance of staff voice. The new Research Charter is expected to support a positive culture.

GM queried whether recent reports of staff feeling dismissed when raising concerns reflected a cultural shift within the research division, emphasising the need to maintain supportive relationships and prioritise patient safety amid heightened pressures. LR acknowledged incidents of staff feeling unheard, often due to incivility or inexperience among new principal investigators, and provided assurance that patient safety remains paramount. LR clarified these issues do not indicate a significant cultural change and highlighted the Research Charter as a means to reinforce positive interactions and uphold Alder Hey's values.

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:-

- An error in the InPhase system led to under reporting of overdue risks; JP confirmed that the actual number was 6, and not 0. The interface team is implementing a workaround, and ongoing monitoring is in place.
- The Division established the inaugural Restrictive Practice Forum to focus on leadership and governance of restrictive practices, previously managed under the Parity of Esteem Programme Board.

- Sepsis training compliance is improving and remains above threshold.
- The Division achieved 100% compliance with the 25-day complaint response targets.

Challenges:-
- There are ongoing issues with the anti-barricade doors and swipe card access at Sunflower House and Blossom House, affecting service delivery. Engagement with relevant services continues to try and resolve these issues.
- Poor quality Translation services are proving challenging, especially in Speech and Language Therapy, raising patient safety concerns. This has been escalated to the Director of Nursing and the Patient Experience team.
- The Division is actively addressing environmental and operational risks while maintaining a focus on patient safety and compliance.

FB emphasised the need for prompt progress and resolution regarding the ongoing issue with the doors at Sunflower House, which is impacting on service delivery, JP acknowledged this concern and confirmed the ongoing efforts to address this issue.
Resolved: SQAC received and **NOTED** the Divisional Assurance Reports.

25/26/123 Liverpool Neonatal Partnership update

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

Highlights:-
- Robust joint governance processes continue, including daily and weekly multidisciplinary meetings to review incidents, themes, and areas for improvement.
- Targeted improvement work had led to a reduction in skin injuries for two consecutive months.
- Quality improvement project has resulted in consistently low rates of unplanned extubations.
- Alder Hey site achieved Level 2 BFI accreditation in September; LWH site is preparing for accreditation in March.

Challenges:-
- August saw increased acuity, occupancy, and staff sickness (11% for Neo, 8% for NICU), impacting compliance with breastfeeding and breast milk KPIs.
- Staff from the feeding team at LWH had to work clinically due to pressures, reducing available hours for feeding support.
- Sickness figures are improving in September as staff return from long-term absence.
- There are two emerging risks to be added to the joint risk register: a 21-week build delay for the new unit (pushing the opening back to early summer 2026), and a risk regarding the potential impact of reduced cot numbers at LWH site, especially during periods of high acuity.
- Incident reporting and management remain robust, with two moderate harms on the LWH site which had been reviewed and actioned as expected.

KB expressed concern regarding the build delay, noting that the build delay had increased from 6 to 12 to 21 weeks and suggested a post-implementation review at the end of the project.
ABa confirmed that the build delay is due to be discussed at the FTPC on 26.9.25

SQAC **NOTED** that the service is working on a plan to mitigate the impacts of this build delay and would report on this in future. SQAC **NOTED** that FTPC would be discussing the build delay on 26.9.25

GM referred to the impact of bank pay reduction on shift coverage; KB explained that fill rates remain healthy, however staff are reconsidering additional shifts, and the team is monitoring and engaging with staff to collect accurate data.
Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership update

25/26/124 Care Quality Commission Inspection: Alder Hey Community Mental Health, ASD & ADHD Services

JP presented the Care Quality Commission Inspection: Alder Hey Community Mental Health, ASD & ADHD Services update.
The Care Quality Commission (CQC) conducted an unannounced inspection of Mental Health, ASD, and ADHD services, prompted by a major incident rather than specific concerns. The last inspection in January 2020 rated the services as "Good" overall, with "Outstanding" for caring. The latest inspection resulted in an "Outstanding" overall rating, with recognition for both caring and well-led domains.

Most actions identified by the CQC were completed promptly, with a few remaining actions being addressed within the division and in partnership with the Chief Nurse, Chief Information Officer, and other relevant representatives. The action plan is monitored through the Divisional governance group, with Trust-wide attention to areas that would benefit from broader focus.

Two internally generated actions were added: transitioning community therapy services from EMIS to Meditech to improve system visibility and enhancing PDR standards. The committee highlighted the importance of improving EDI data visibility and completeness across the Trust, with plans for further discussion on actionable steps.

FB welcome the Division's decision to transition community therapy services from EMIS to Meditech and commended the inclusion of internal actions alongside CQC recommendations. FB expressed interest in the EDI action, emphasising the need for improved visibility and completeness of patient outcomes and experience data across the Trust. FB advised that she would follow up offline to discuss actionable steps, and would arrange an offline discussion to further explore how to make EDI data more visible and complete Trust wide.

Resolved: SQAC received and **NOTED** the Care Quality Commission Inspection: Alder Hey Community Mental Health, ASD & ADHD Services Report

---- Safe ----

25/26/125 Patient Safety Update

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

- The Patient Safety Board met virtually in August, reviewing IPR data from that month.
- Positive reporting culture continues across the Trust, with increased PALS responses within 5 days and a reduction in formal complaints.
- 18 Patient Safety Partners had been recruited, and introduced on World Patient Safety Day, and had begun mapping cardiac patient journeys with the QI team.
- The antimicrobial work stream has a reestablished steering group, and new metrics are being developed.
- The deteriorating patient work stream had rolled out PEWS and device integration across inpatient areas.
- There is a new work stream focusing on patient safety culture, using survey data to identify teams requiring support.
- Mortality review processes had improved, with over 85% of cases reviewed within four months.
- Challenges include an interface issue between Meditech and PACS (no patient safety concerns), overdue incident reviews - especially in surgery, and slow progress on trauma peer review recommendations.
- Implementation of NatSIPPS2 (National Safety Standards for Invasive Procedures) had been delayed due to workload and absences, with the annual report still outstanding. JR recommended prioritising NatSIPPS2 as a quality improvement (QI) project across the organisation to gain traction, and noted an upcoming meeting with the Chief Medical Officer and divisions to progress this. NA agreed NatSIPPS2 should be considered for prioritisation, but suggested it be reviewed by the Executive Team alongside other QI projects, emphasising that successful implementation would require cultural change in theatres, not just procedural compliance. NA confirmed that the meeting with the Chief Medical Officer and the division was planned to address this.

FB requested that the outcome of these discussions be reported back to SQAC for clarity on the plan.

IG referred to the Meditech and PACs interface issue and stated that he did not have a date for the fix and committed to providing an update to JR and the team by close of play on 25.9.25. IG also highlighted the successful transition to integrated observations (PEWS rollout), thanking AT and the ward managers for their multidisciplinary leadership and support, noting this significant achievement

Resolved: SQAC received and **NOTED** the Patient Safety update and welcomed an update on the outcome of NatSIPPs 2 prioritisation.

25/26/126 Cleaning Standards Report

LS presented the Cleaning Standards Report and provided an update on progress against the cleaning action plan shared in June 2025.

- The Trust is enhancing use of the My Audit system to identify persistent areas of failure, with data now feeding into the Environment and Cleanliness Group and soon to be shared with clinical Divisions.
- A star rating system for cleanliness is being implemented, though digital display screens for wards had been delayed; laminated posters would be used instead, pending sign-off of the cleanliness charter.
- A standard operating procedure (SOP) had been developed for departments whose star rating decreases, ensuring action plans are created and followed.
- Policy RM49 is under review by the Cleaning Collaborative, with ratification targeted for November.
- Cleaning product standardisation is complete, reducing the range to only approved products.
- Functional risk review process is finalised, ensuring cleaning resources align with risk areas; some resource reallocation is ongoing.
- Benchmarking visits had occurred at Salford Royal, with plans to visit Birmingham Women's and Children's Hospital to learn from high-performing sites.
- A business case for new cleaning machinery was approved in the capital review round but is not prioritised for 2025, meaning current aging equipment will remain in use.
- Progress is being made despite financial constraints and resource challenges, with improvements attributed to collaboration between domestic services, nursing, estates, and IPC teams.

Resolved: SQAC received and **NOTED** the Cleanliness update report and welcomed an update at December 2025 SQAC meeting

--- Caring ----

25/26/127 Infection Prevention & Control Report

BL presented the Infection Prevention & Control Report, highlighting recent measles management, norovirus containment, and a focus on C. difficile due to rising cases and a new national ranking criteria.

- BL highlighted the Trust's effective handling of the recent Measles outbreak response, noting positive feedback received from the local health protection team regarding rapid response and collaboration. The Trust contributed to national guidance updates for managing multiple measles cases, and daily IPC practitioner presence on wards helped prevent norovirus outbreaks and bed closures, attributed to daily IPC practitioner presence and swift communication.
- There had been a sustained increase in C difficile cases, mirroring national and regional trends, especially in Cheshire and Merseyside. BL emphasised that controlling C difficile required a Trust-wide approach, with two main strategies: (1) environmental decontamination - especially terminal cleaning of rooms after C difficile patients, and (2) antimicrobial stewardship to reduce unnecessary antibiotic use. BL advised that the highest risk for C difficile is admission to a room previously occupied by a patient with C difficile.
- BL referred to environmental cleaning and technology and in collaboration with Associate Chief Operating Officer and the cleaning/environmental team with a call for more effective cleaning technologies (e.g., fogging and UV machines). The Trust currently has only two UV machines, and BL advocated for a move to fogging for terminal cleaning, especially for C difficile rooms.
- BL suggested implementing microbiological assurance of cleaning practices and expanding daily antimicrobial stewardship (AMS) beyond Oncology and ICU. BL is preparing a Trust-wide C difficile control plan, to be discussed with the local Health Protection Team and potentially challenge the national targets, which may not be realistic for the Trust's patient population.

AB asked about the feasibility of moving to fogging for C difficile rooms, BL confirmed this is necessary and should be discussed with UKHSA.

CW raised the issue of Oncology patients repeatedly testing positive for C difficile due to long-term intensive treatments, prolonged hospital stays and extended antibiotic usage, questioning if each episode must be reported. BL clarified that new cases 20 days apart are counted as new episodes, and antibiotic stewardship is key in Oncology. CW suggested this be discussed with national teams.

ABa suggested a proposal be presented to the Operational Delivery Board to prioritise investment in modern cleaning equipment. ABa recommended making cleaning audit results more visible and proposed that cleaning results be appended to the IPC report, ABa highlighted the importance of distinguishing between lapses in care and population health factors in C Difficile data as national data is not risk-adjusted for paediatrics.

Resolved: FB requested ABa to work in collaboration with BL to develop proposals for improved cleaning technology and data visibility, and to engage with national bodies regarding C Difficile reporting and targets. ABa agreed to meet with BL and colleagues to progress this.

GM referred to any lessons learned from the measles outbreak. BL advised that early recognition of measles cases was identified as an area requiring improvement, as there was a delay in being informed about an outbreak in Manchester. Rapid access testing (results within hours) was a key factor in controlling the outbreak, enabling swift actions compared to other hospitals with slower turnaround times. BL praised the ED's ability to quickly adapt patient flow, which limited transmission.
Resolved: SQAC received and **NOTED** the Infection Prevention & Control Report.

---- Safe ----

25/26/128 Safeguarding Training needs analysis for level 3 safeguarding training report

NO presented the Safeguarding Training needs analysis for level 3 safeguarding training report

- Strong compliance for Level 1 and Level 2 safeguarding training for both adults and children, consistently above the 90% target was **NOTED**
- Level 3 safeguarding training compliance remains static around 85%, despite several improvement actions:
- Staff can now self-book via ESR, and compliance reports had been enhanced to identify those needing training and those already booked.
- Overbooking of training sessions was trialled to offset high DNA (did not attend) and cancellation rates; 1,044 places were booked for 800 available, only 695 staff attended, 181 cancellations and 168 DNAs.
- Additional training sessions were added, and all sessions were maintained despite team capacity issues.
- Both sessions per training date are now delivered face-to-face with 40 places each, increasing capacity.
- A division-by-division data cleanse is planned to ensure staff are assigned the correct training level, which may temporarily reduce compliance rates as inaccuracies are corrected.
- The safeguarding team is working with divisional colleagues to improve timely booking and attendance and will add more sessions as team capacity allows.

KB sought clarity whether the data cleanse would reveal staff needing Level 3 who are not currently assigned, NO confirmed that it is likely to potentially lower compliance further.
KB requested what more divisions and services could do to support compliance, given the safeguarding team's efforts. NA stated that persistent non-compliance with Level 3 training is unacceptable for a standalone children's hospital and called for HR processes to enforce compliance, including consequences for individuals and managers. NA and NO would present a report to the Executive Team.
FB emphasised that responsibility for compliance is Trust-wide, including Executive Team, and that future reports would track progress.
Resolved: NA & NO to present report to Executive Team
SQAC acknowledged the safeguarding team's efforts and the need for stronger Divisional and HR support to improve Level 3 compliance.
Resolved: SQAC received and **NOTED** the Safeguarding Training needs analysis for level 3 safeguarding training report

25/26/129 Safe Waiting List update

AB presented the Safe Waiting List update noting that the safe follow-up care initiative began 18–24 months ago due to a significant gap between the number of children listed for follow-up and the Trust's capacity to deliver these appointments. This was prompted by incidents where delayed follow-ups led to harm, including missed operations and vision deterioration.

- Over the past year, the overdue follow-up list had been halved, however progress had plateaued in recent months.
- A thematic patient safety investigation found: 4% of incidents were associated with harm, all incidents involved children waiting over a year past their expected follow-up; Half of the incidents were due to administrative errors, not just capacity issues.
- AB advised on key actions agreed at the Operational Delivery Board including:-
  - Each specialty will establish a fail-safe meeting and system, modelled on Ophthalmology, which has eliminated its overdue backlog by reallocating some clinical capacity to validation and fail-safe meetings.
  - A digital validation process using Isla Care will contact families overdue by two years to determine if follow-up is still needed or if discharge is appropriate. A new outcome form is being developed to reduce administrative errors and ensure a fail-safe process. The new outcome form will be integrated into Meditech and flagged if incomplete, addressing complexity and ambiguity that previously led to errors. AB stated that the form would be rolled out once ratified.

SQAC agreed to monitor the impact of these changes, within future updates to be scheduled either quarterly or biannually.

Resolved: SQAC received and **NOTED** the Safe Waiting list update and welcomed reviewing the impact of the changes within future updates. Appropriate frequency of future reports to be confirmed.

25/26/130 EPRR Quarterly Update

JG presented the EPRR Quarterly update highlighting several significant incidents:-

- The Trust managed a measles incident, completed an internal debrief, and is finalising the action Plan with the ICB.
- The Liverpool Parade RTC major incident standby was reviewed; no specific Alder Hey learning was identified, but lessons for other Trusts were noted.
- Industrial action in July was managed without major issues due to effective organisational planning.
- Outstanding actions remain from Exercise Nightshield (lockdown), the Southport 2024 major incident, and the November 2024 cyber incident. These are regularly monitored at the Emergency Preparedness Group.
- Progress continues on business continuity plans (BCPs) across Divisions, full compliance is not yet achieved; this remains a gap in the Trust's Core Standards Assessment.
- Training compliance is strong for mandatory training, but local training and exercising enrolment is lower and is being addressed.
- The Trust will submit a partial compliance status to the ICB, reflecting improvements but with 12 standards not fully met, mainly in business continuity, CBRN, governance, and incident response plans.

NA commended the significant progress in the EPRR core standards, compared to the previous year but expressed concern regarding the outstanding actions from Exercise Nightshield and Southport incidents noting that some outstanding actions are over 12 month old. NA stated that the EPRR team spend excessive time chasing updates. NA proposed that the Executive leads for the delayed areas be tasked with promptly closing those outstanding actions, which FB supported.

Resolved:JG to prepare a summary to Executive Team colleagues to expedite closure of overdue actions.

Resolved: SQAC received and **NOTED** the EPRR Quarterly update

25/26/131 Quality Assurance Rounds – Themes and Risks Biannual Report

JR presented the Quality Assurance Rounds – Themes and Risks Biannual Report -1st March -31st August 2025

- 8 QARs were conducted (3 face-to-face, 5 via Teams); 6 were rescheduled due to service pressures, mainly staffing shortages and annual leave.
- Main challenges identified: included Workforce and recruitment issues, including staffing levels, resilience, sickness, and burnout. Environmental issues such as clinic room shortages; capacity, demand, and waiting list backlogs.
- Successes included: Staff commitment and strong leadership; Effective governance processes; Positive patient and family feedback (FFT).
- The report now includes a full list of QARs in Appendix 1 and a summary of risks identified during the period. Risks are noted as "moment in time" and may have since been mitigated or closed, with ongoing oversight at the Risk Management Forum.
- Next steps: QARs will now be chaired by an Executive lead; The process will be triangulated with fortnightly quality rounds and revised ward/service accreditation. Strengthening links between quality assurance and improvement and streamlining the QAR process for small teams.

FB noted the report's clarity and the ongoing efforts to improve both the QAR process and the integration of findings with other quality mechanisms.

Resolved: SQAC received and **NOTED** the Quality Assurance Rounds – Themes and Risks Biannual Report

25/26/132 Quarter 1: Children & Young People Engagement Leads Report

JP presented the Quarter 1: Children & Young People Engagements Leads Report

SQAC acknowledged the breadth of engagement undertaken by C&YP and welcomed the positive report. FB expressed her thanks to the Children & Young People & wider teams for their ongoing work.

Resolved: SQAC received and **NOTED** the Quarter 1: Children & Young People Engagement Leads report

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

25/26/133 Risk Appetite Annual Review

ES presented the Risk Appetite Annual Review noting that the Trust Board will focus on risk appetite in October 2025 due to external pressures.

- The Committee risk appetite remains unchanged: no appetite for patient safety risks and a low-moderate appetite for quality risks, as set previously.
- The approach piloted in the Community and Mental Health Division would be rolled out across all divisions, aiming for more consistent risk management and clearer focus on controls and actions.

FB invited comments from SQAC and sought clarity whether committee members had any comments or disagreements regarding the risk appetite, no disagreement or comments were raised.

FB sought clarity regarding how the organisation ensures that other committees or departments with potentially higher risk appetites will recognise and respond to the low risk appetite set for quality and safety set by this committee and how this is prioritised across the Trust. ES advised that detailed work at Divisional and corporate levels is required, with risk appetite to be a core part of upcoming risk management sessions. ES referred to the piloting of risk appetite application in the Community & Mental Health Division and plans to roll this out more broadly. ES & JPo discussed the usefulness of risk appetite in driving more focussed conversations regarding risk management, controls and actions within divisions.

ES advised that at the last Risk Management Forum discussions took place regarding plans for an extraordinary session on risk management, with risk appetite as a core part of the discussion and referenced the impact of financial pressures on risk. ES stated that a cross systematic approach is required.

FB referred to failsafe mechanisms, and prioritising safety and the need for further conversations at both Divisional and Trust Board level. ES advised that discussions would take place within the Growth & Opportunities Committee.

FB stated that there would be future opportunities to discuss through Divisions and Trust Board.

Resolved: SQAC confirmed that there are no changes to the current risk appetite

Resolved: SQAC received and **NOTED** the Risk Appetite Annual Review

25/26/134 Clinical Effectiveness and Outcomes Board Chairs Highlight report

JR presented the Clinical Effectiveness and Outcomes Board Chairs Highlight report

- There is continued improvement and learning from clinical audit processes
- Ongoing work to monitor and track actions arising from clinical audits, with future reporting to ARC and through the Chair's report.
- There is improved compliance with NICE guidance.
- Regular national audit feedback, with the latest session featuring the National Paediatric Diabetes Audit, which demonstrated service improvements based on enhanced data.
- There is sustained compliance with documentation standards on DMS; research and corporate services maintain over 90% compliance, with support provided to Divisions to improve their rates.
- 15 wards achieved "outstanding" for caring within the Ward Accreditation process
- No escalations or significant risks were reported from the Clinical Effectiveness & Outcomes Board.

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

25/26/135 Board Assurance Framework

ES presented the Board Assurance Framework and provided an overview of the BAF risks relevant to SQAC, noting that several remain highly scored and had been recently reviewed. There is slow, cautious improvement in the ADHD medication risk (1.6), which is monitored at Trust Board level. No specific changes to other BAF risks were **NOTED.**

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

Deep Dive: Risk 1.2 – Timely and Safe Access to Elective, Urgent, and Follow-Up Care

ABa presented the deep dive on Risk 1.2, and drew attention to the following:

- The Trust had achieved segment one for overall performance, but there are mixed results beneath this headline.

- The current risk score is 15 (consequence 5, likelihood 3), reflecting the potential for high impact if not managed, but also acknowledging areas of strong performance.
- Good assurance was provided for access to diagnostics, cancer care, and urgent/emergency care.
- Two main areas of challenge: Elective care: The Trust is ranked around 60th nationally for the 18-week RTT measure and is working to reduce the number of children waiting over 52 weeks for treatment (targeting a reduction from over 400 to around 280).
  Follow-up care: Thematic patient safety investigation revealed that 4% of incidents were associated with harm, all related to waits over a year, and half due to administrative errors.

ABa advised on improvement actions which included:-
- Establishing fail-safe meetings and systems in each specialty, modelled on ophthalmology's successful approach.
- Implementing digital validation for families overdue by two years, using Isla Care.
- Redesigning the outcome form in Meditech to reduce administrative errors.
- Using technology (ambient voice/lyrebird) to improve clinic efficiency and piloting overbooking to maximize capacity.
- Targeted insourcing in ENT and dentistry to address long waits.
- ABa highlighted the link between financial controls (e.g., reduced premium pay, less weekend operating) and increased staff sickness, both of which impact access and capacity.
- The improvement plan aims to address both the capacity gap and administrative fail-safes.

ABa acknowledged that actions related to follow-up care need to be better reflected in the Board Assurance Framework documentation and that he would ensure these are included.
FB emphasised the importance of understanding the impact of financial controls and staff absence on risk, and the need to closely monitor these factors.

SQAC agreed to review progress at an appropriate interval (three months or biannually).
Resolved: SQAC received and **NOTED** the Deep Dive: Risk 1.2 – Timely and Safe Access to Elective, Urgent and Follow-up Care

25/26/136 Mortality Report

JG presented the Quarter 1 Mortality Report
- The number of deaths remains consistent with previous years, with a typical seasonal trend (higher in March/later in the year, lower in summer).
- Up to June, there were 36 deaths; 18 had been reviewed, with 17 completed within the required timeframe.
- No avoidable deaths were identified, either from internal or external factors.
- PICU deaths are within the expected safe range, and the Trust is below expected deaths per external benchmarking.
- The Medical Examiner (ME) process has scrutinised 100 deaths since implementation, with only 4 incidents over the year.
- Neonatal deaths: Of the 18 cases reviewed, 44% were neonatal. Most were due to congenital/ genetic/chromosomal anomalies (75%), with the remainder due to neonatal/perinatal causes (mainly prematurity and necrotizing enterocolitis). In 75% of these cases, no further treatment options were available.
- Learning disabilities: The number of deaths is consistent year-on-year; no recurrent concerning themes were found in the last deep dive.

Key learning points:
- Increasing complexity and time demand for multi-agency meetings, including external experts.
- Improved coronial feedback processes to ensure organisational learning.
- Challenges in determining ownership and timely review for cases where the lead consultant is from a non-admitting team (e.g., ID, palliative care).
- Difficulties in timely completion of reviews across multiple divisions.

Ongoing and future actions:
- Enhanced engagement with DGHS and GPs for feedback; Continued collaboration with other paediatric hospitals to share learning; Closer working with safeguarding, CDOP, NWAS, and police to improve case review and learning, especially for pre-hospital issues.

FB thanked JG for the clear report and presentation, noting that the committee is assured by the findings.

Resolved: SQAC received and **NOTED** the Mortality Report

---- Well Led ----

25/26/137 Ward/Department Accreditation Bi-annual report 2024/25

NA presented the Ward/Department Accreditation Bi-annual report 2024/25

- A celebration event was held to recognise the hard work of ward and department leaders and staff involved in the accreditation process, which was well received.
- The report included a new table aligning CQC domains with ward accreditation scores, showing how departments rank against the old Gold, Silver, and Bronze system.
- There is year-on-year improvement in many departments, with more achieving "outstanding" status, though some areas have seen a drop in scores due to realignment with the new CQC assessment framework.
- The bar for achieving "outstanding" had been raised, and next year's requirements will be stricter (e.g. two outstanding domains, one of which must be "well led").
- The Gold, Silver, and Bronze system will be phased out, moving fully to CQC-aligned ratings.
- Plans are in place to expand accreditation to non-acute areas, including community and outpatient settings.

KB stated that more departments appeared to have lower scores than previously and requested clarification. NA advised that this was due to the realignment with the new CQC framework and the raised standards and advised that it is not necessarily a decline in performance. NA emphasised that, despite some departments appearing to have lower scores, the overall direction is positive, with continuous improvement and higher standards.

Resolved: SQAC received and **NOTED** the Ward/Department Accreditation Bi-annual Report 2024/25

25/26/138 Self Harm reduction and Suicide Prevention Policy – RM40

KB sought clarity where the Self Harm reduction and Suicide Policy is monitored.

JPo confirmed that this is monitored through the Community & Mental Health Divisional Governance meeting, the Parity of Esteem Programme Board (where the detailed work is completed) and also reports into the Clinical Effectiveness & Outcomes Group Board.

Resolved: SQAC received, **NOTED** and Ratified the Self-Harm reduction and Suicide Prevention Policy – RM40

25/26/139 Transition to Adult Services Policy – C62

Resolved: SQAC received, **NOTED** and Ratified the Transition to Adult Services Policy – C62

25/26/140 Informed Consent Policy

Resolved: SQAC received, **NOTED** and Ratified the Informed Consent Policy

25/26/141 Management of Inspections and Accreditations Policy

Resolved: SQAC received, **NOTED** and Ratified the Management of Inspections and Accreditations Policy

25/26/142 M49 – Research Policy

Resolved: SQAC received, **NOTED** and Ratified the M49-Research Policy

25/26/143 Adverse Weather Plan

Resolved: SQAC received, **NOTED** and Ratified the Adverse Weather Plan

---- Any Other Business ----

25/26/144 Any Other Business

None received

---- Board Assurance ----

25/26/145 The key assurances and highlights report was presented to the Board meeting held on 3rd July 2025

Date and Time of Next Meeting: 22nd October at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**LNP Chair's Report to Trust Board**
Report of:	**Co-Chair of the LNP Board, Alfie Bass**
Paper Prepared by:	Natalie Rixon, Project Manager AHCH and Vicky Clarke, Associate Director of Operations, LWH

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	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

Liverpool Neonatal Partnership

Alder Hey Children's NHS Foundation Trust

LIVERPOOL NEONATAL PARTNERSHIP BOARD

6th October 2025

Paper title:	**Chairs report to LNP for onward reporting to Trust Board**
Report of:	**Co-Chairs of the LNP, Alfie Bass and Chris Dewhurst**
Paper prepared by:	Natalie Rixon, Project Manager AHCH and Vicky Clarke, Associate Director of Operations, LWH

Purpose of paper:	Decision / Assurance / **Information** / Regulation
Action / decision required:	**Note** / Approve

1. Purpose

This paper provides a summary of the key activities undertaken by the Liverpool Neonatal Partnership (LNP), a collaborative partnership between Alder Hey Children's NHS Foundation Trust (AHCH) and Liverpool Women's NHS Foundation Trust (LWH), in preparation of the opening of the new surgical NICU in March 2026.

2. Overview of partnership & activities in month

Programme overview

There are several items to highlight including:

- The LNP Clinical Director has been appointed to, with a robust interim arrangement in place to maximise the skills and expertise required through the development and transformation phase.
- The LNP have successfully appointed a neonatal speech and language therapist. This post has been vacant for some time and therefore this is a fantastic enhancement for the partnership.
- The LNP governance review is advancing with experts from Corporate Governance and NHS England / ODN supporting the LNP board with the development of an options appraisal for discussion and agreement at the Exec to Exec meeting.
- The Head of Medical Engineering, Chief Finance Officers and Head of Nursing have agreed an equipment loan plan, this will provide operational flexibility and

delivery of equipment requirements in line with the agreed budget. The leads are working together to finalise the arrangements to ensure a safe and effective process is implemented.

- The build programme continues to progress, but a number of potential issues and delays are being worked through with the Capital Projects Team and the Contractors.
- The water safe workflows are progressing well, with a multidisciplinary approach adopted. The team are working closely with the national experts to develop the water safe workflows and supporting documentation.
- The LNP funding requirements aligned to the national specification for AHP and diagnostic services, was discussed at an executive subgroup of the board and the first draft will be presented to the LNP Board in October, identifying the funding required to deliver the neonatal critical care service specification across the 68 cots. The aim being to develop a single business case to review and agree with specialist commissioners.
- The integrated performance report will be presented to the October Board
- The LNP continues to make good progress to recruit to all agreed and funded posts across all disciplines.
- The Chief Nurses and Head of Nursing has agreed a standardised uniform, aligned to the national recommendations for uniform, across both units
- The simulation programme continues to run each week, with additional equipment added regularly to support the education plan
- There is a robust training and competency framework schedule in place that is reviewed on a monthly basis and remains ‘on track’
- The Maternity and Neonatal Voices Partnership for a neonatal specific role is out to advert, with a view to appoint by end September.

LNP Partnership working

The corporate governance leads from AHCH and the Liverpool Group, supported by a national expert in neonatal service delivery have developed a scoring tool to appraise the four options available in relation to partnership governance. A detailed review of the working arrangements, legal framework and existing structures, with recommendations will be presented to the October Board and then to the Exec-to-Exec meeting in once scheduled.

Collaborative working, safety and culture

Meetings with surgical divisional leads to review pathways

The LNP clinical leads are engaging with all speciality teams within AHCH to ensure the pathways are clear for when the new unit opens. The leads also meeting with the response teams, patient flow and complex discharge to provide a seamless transition, once the surgical NICU is operational.

The LNP culture review relaunched in September, with 1:1 meeting scheduled with the SLT in the first phase. Dr Jo Potier will provide regular updates to the LNP Board moving forward.

Build

The SLT continue to meet with the Senior Capital Project Manager on a fortnightly basis to help provide timely input and direction to the new build. The build timescales are reviewed regularly and quick action can be taken through the effective communication channels developed. The current build timeframe is under review

Digital strategy

The LNP board have requested a digital strategy be developed to ensure all of the complex and detailed delivery requirements have been captured alongside any associated risk. The senior responsible officer for digital has highlighted a number of emerging risks with interconnectivity between Mindray and System C, as well as the implementation of HERO at AHCH.

The SLT are in contact with Mindray to review potential mitigation and solutions to the HeRO requirements and an options appraisal will be prepared to support effective decision making.

Ready to occupy

The SLT in partnership with the Deputy Development Director, Senior Capital Project manager and acute ground floor team, have now established a group that will focus on the actions required to occupy the unit safely. The group are focusing upon the interim arrangements and trust commissioning period to identify opportunities to maximise time saving actions.

In addition, a tactical response team will be deployed throughout the moving and settling in period to respond immediately to any concerns raised.

The SLT have identified a number of ‘in situ’ simulations that are to take place in advance of the unit opening, these include evacuation of the unit, medical emergency for a parent, medical emergency for a baby with the family room occupied.

Finance and Commissioning

There are three important pieces of work that the operational and finance leads are working through:

1. The LNP business case to ensure the team can delivery the agreed standards within the national specification
2. A capacity and demand review of the cots remaining at LWH
3. A review of the HDU/PICU capacity once the surgical NICU is operational

These items will be worked through and shared with specialist commissioners and commissioners from the Welsh Board.

3. Key risks / issues to escalate to LNP

- The risk associated with the build timescales is being carefully managed by the senior capital projects lead and all key stakeholders will respond as required, to help mitigate any further delays that may be identified.
- The LNP Governance recommendations will be presented to the October LNP Board to provide clear recommendations for the future governance arrangements to the exec to exec group
- A business case has been developed to identify the necessary pay and costs for the partnership to deliver against the nationally approved service specification, that weren't recognised in the original business case approved in 2018.

4. Recommendations

The LNP Board are asked to:

- Note the content of the report and key updates

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**Liverpool Neonatal Partnership Governance**
Report of:	**Alfie Bass – Chief Medical Officer AHCH** **Christopher Dewhurst – Medical Director LWH**
Paper Prepared by:	Natalie Rixon – Programme Manager AHCH

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 Liverpool Neonatal Partnership (LNP) represents a progressive alliance between Alder Hey Children's Hospital, Liverpool Women's NHS Foundation Trust, and The University of Liverpool Hospitals Group. Formed in 2018, the LNP seeks to deliver a unified, high-quality neonatal service by merging the distinct expertise and strengths of each organisation. Through the integration of neonatal and surgical specialisms, the partnership strives to minimise hospital transfers, thereby reducing associated risks, enhancing clinical outcomes, and providing families with a smoother and less distressing journey.

On 14th October 2025, Chief Executives, Executives, and Directors from AHCH, LWH, and LUHG convened and, following thorough discussion, selected the joint governance framework as their preferred approach. This framework involves strengthening the existing governance systems to establish a jointly managed service, with all parties committed to developing and implementing a shared governance structure. This model encourages collaborative decision-making, shared responsibility, and resource sharing, whilst retaining adaptability and staff involvement. While it necessitates robust governance mechanisms, the advantages of inclusive leadership and system-wide resilience are considered to outweigh the added complexities.

2. Context and Background

In December 2024 the Executives and Directors from both LWH and AHCH met to review the ongoing challenges with alignment within key areas of the LNP governance. The recommendation from the exec – to – exec group was to engage input and guidance from the corporate governance experts from AHCH and the Liverpool Group and input from the neonatal nurse lead from NHS England. The LNP SLT have been working with the leads for a number of months to carefully review the governance options available to ensure a robust and comprehensive approach is adopted.

The SLT, supported by the Chief Corporate Affairs Officers and the National Neonatal Nurse Lead, completed an options appraisal that was endorsed by the Chief Medical Officer AHCH and Medical Director LWH and presented to the LNP Board. The options appraisal, supporting paper and addendum were discussed in detail at the Exec-to-Exec meeting on the 14th of October 2025 and a decision made to proceed with the partnership model, bolstered by taking the following actions:

1. To develop a scope to discuss with MIAA to enable a review of governance arrangements and provide the third line assurance to confirm that the proposed model is safe to go live from a governance perspective. It was agreed this would be funded on a 50/50 basis between the trusts.

2. To meet with Specialist Commissioners to confirm the governance arrangements and ensure that there is clarity in terms of the commissioning implications.

3. To meet with the Care Quality Commission to confirm the governance arrangements and registration details for all aspects of the neonatal pathway.

4. To progress the LNP communication plan for both internal and external stakeholders, with a focus on the scope of the partnership arrangements together with examples of how work undertaken is supporting staff and benefiting our communities.

3. Development of the LNP Operational Policy and Governance Framework

AHCH, LWH, and LUHG have collectively determined that the remit of the LNP encompasses neonatal services across a total of 68 cots—comprising 46 cots at LWH and 22 at AHCH. The operational policy and governance framework will be drafted to reflect this arrangement.

Furthermore, at the Exec-to-Exec meeting, it was agreed that joint liabilities and responsibilities would be established for all 68 cots, further strengthening the partnership agreement.

The Senior Leadership Team will now concentrate on formalising the collaborative agreement. This will involve clarifying any areas of uncertainty, with input from corporate, legal, and external specialists. The intention is to develop an operational policy and governance framework that is fully fit for purpose and provides a robust legal foundation for the partnership.

4. Next Steps

Our next steps include:

1. To liaise with HR colleagues to agree a process to align terms and conditions to agreed model
2. To obtain legal advice for the pharmacy and medicines management requirements
3. To develop our proposal and share with the the MIAA For formal review to ensure due diligence in decision to proceed in preferred model
4. To re-review all SLAs and align to the agreed model
5. To review data security across the LNP and interconnectivity aligned to the agreed model
6. To meet Specialist Commissioners to discuss commissioning arrangements
7. To meet with our Care Quality Commission relationship manager to confirm the governance arrangements and registration details for all aspects of the neonatal pathway.
8. To continue to work with communication leads to promote the benefits of the partnership model

4. Recommendation

The Board is asked to note the content of the report.

Alder Hey Children's NHS Foundation Trust

Futures Committee

Confirmed Minutes of the meeting held on Wednesday **25th June 2025 at 13:00**
VEC Meeting Room, Innovation Hub

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. A. Bateman	Chief Operating Officer/Deputy Chief Executive	(AB)
	Dr. J. Chester	Chief Scientific Officer	(JC)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. R. Lea	Interim Chief Financial Officer	(RL)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
In Attendance:	Ms. K. Birch	Academy Director	(KB)
	Mr. D. Cole	Senior Project Adviser	(DC)
	Mr. D. Hawcutt	Clinical Director of Research	(DH)
	Ms. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Ms. S. Leo	Head of Research	(SL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. L. Rad	Associate Chief Nurse (Research)	(LR)
Observing:	Ms. J. Preece	Governance Manager	(JP)
	Ms. A. Prendergast	Assoc. Director of Strategy and Partnerships	(AP)
Apologies:	Ms. F. Ashcroft	Chief Executive of the Charity	(FA)
	Mr. N. Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)

25/26/01 Apologies

The Chair welcomed everyone to the meeting and noted the apologies received.

25/26/02 Declarations of Interest

Non-Executive Director, Mark Jennings, declared that he is the Chief Solutions and Services Officer for Strasys.

25/26/03 Minutes from the Meeting held on the 26th of March 2025

The minutes from the meeting held on the 26.3.25 were agreed as an accurate record on the meeting, pending an amendment to the job titles of DH, SL and LR.

25/26/04 Matter Arising and Action Log

Matters Arising
There were none to discuss.

Action Log

Action 24/25/60.2: *Strasys Partnership (agree a direction of travel and contract for Y2)* – It was confirmed that collaboration will continue in a non-financial/non-contractual capacity. **ACTION CLOSED**

It was confirmed that all previous actions have been reviewed, with updates provided and outstanding items scheduled for future meetings.

25/26/05 Pillar 1 Overview and Update: Discover

The committee received an update on the Discover Pillar, noting progress in streamlining reporting formats and the successful awarding of seven research capability grants over the past two months. Strategy funding has been secured from the Regional Research Delivery Network for a mobile research unit, and ongoing partnership work was acknowledged. The Committee discussed the significant capacity challenges within clinical teams, exacerbated by financial pressures, which are impacting the ability to support research and innovation.

During the discussion, members emphasised the need for improved incentivisation and job planning to embed research and innovation (R&I) as core responsibilities for respective staff. Concerns were raised regarding the lack of positive metrics and recognition for research involvement, and the Committee felt that a cultural shift is required to value these activities. Suggestions included a change to how the Trust recruits people, career development opportunities, and transparent reporting mechanisms to reward departments and individuals for their contributions to research and innovation.

Resolved:
The Futures Committee noted the update on Pillar 1: Discover.

25/26/06 Liverpool Institute Child Health and Wellbeing

The committee was provided with an update on the Liverpool Institute for Child Health and Wellbeing, a collaborative initiative involving the Trust, the University of Liverpool and the Charity. Progress was reported on the recruitment for the appointment of a Foundation Director, and it was confirmed that shortlisting will take place in July with interviews to be held in September.

It was reported that a comprehensive strategy is being developed to present to candidates, ensuring it is well-formulated so they can effectively evaluate it. A draft document is currently being prepared, which will be available for further refinement once the individual commences in post. Liverpool University is providing strong support and is in the process of applying for ‘Excellence Status’. The Trust is coordinating with the university to organise a roundtable discussion that will bring together organisation leaders and prominent researchers to establish a shared vision and direction. An academic launch meeting is also planned, and updates will be communicated through management meetings, and relevant information will be shared on each organisation's website.

It was pointed out that this joint initiative is vitally important and further efforts are required to ensure cohesion and alignment across the organisations. The hosting of a roundtable meeting at the university marks an initial step towards strengthening the partnership. It is essential that researchers and innovators develop a clear vision and understand their role within it. It was confirmed that a further update on recruitment will be provided during the next meeting.

Resolved:
The Futures Committee noted the update on the Liverpool Institute of Child Health and Wellbeing collaboration.

25/26/07 Pillar 2 Overview and Update: Develop

The committee received an update on the Develop Pillar, which is focused on enhancing R&I skills and capabilities across the organisation. It was reported that a matrix approach is being implemented to ensure a universal offer for workforce development, extending beyond the medical workforce to include all staff involved in research and innovation. The Committee noted strong support from the Charity across research, and it was reported that thought is being given to professional development, as well as ongoing initiatives to promote career pathways, including external recruitment.

During the discussion, the Committee emphasised the importance of shifting the organisational culture to better incentivise and support skill development in research and innovation. The Committee acknowledged challenges related to capacity, funding models, and the costs associated with training programmes. There was consensus on the need for aligning R&I pathways, ensuring that innovation is accessible to all staff groups, and avoiding siloed approaches.

Resolved:
The Futures Committee noted the update on Pillar 2: Develop.

25/26/08 Pillar 3 Overview and Update: Grow

The Committee was provided with an update on Pillar 3: Grow. The following points were highlighted:

- A £1.5m bid has been submitted for 2025/26 NIHR capital to support a joint initiative with the University of Liverpool to create a Children's Commercial Research Centre in the centre of Liverpool providing improved capacity and equitable access to research across the city. The Trust is currently awaiting the outcome.
- Confirmation has been received of a £387k award to Futures from Alder Hey Charity for 2025/26 with discussions underway to secure further funding for travel, conferences, and training.
- An expression of interest has been submitted to the Children's Hospital Alliance to apply for £20m funding from the Charity at Great Ormand Street Hospital (GOSH) to develop a national paediatric secure data environment.
- An agreement has been signed with Hartree National Centre for Digital Innovation to support a project looking at mathematical optimisation techniques to compute efficient consultant schedules.

DH provided an overview of the ongoing collaboration with GOSH, focusing on data sharing, technical infrastructure alignment, and joint funding initiatives. The Committee discussed the challenges related to regional data access, comparative analytics, and the integration of technical systems, noting that GOSH operates on a more advanced infrastructure than some partners. The importance of a clear data strategy, transparency in data-sharing decisions, and the rationale for participation in national paediatric data projects was emphasised. Concerns regarding data ownership, hosting responsibilities for national datasets, and the need to maintain influence and access to future funding opportunities were raised. The Committee agreed on the strategic

importance of playing a leading role in national data collaborations to ensure continued organisational growth and research leadership.

Resolved
The Futures Committee noted the update on Pillar 3: Grow.

25/26/09 Paediatric Open Innovation Zone (POIZ) Update

The Committee received an update on the POIZ Innovation Strategy. A number of slides were shared that provided information on the following areas:

- An update on the grant funding agreement.
- An update on the approach.
- An update on progress against targets.
- Governance.

Following the update, the Committee engaged in a detailed discussion regarding the definition and scope of support for businesses that the Trust will partner with, the criteria and process for funding allocation, and the governance structure required to ensure transparency and accountability. It was suggested that support could include funding, introductions, access to facilities, or acting as a trial site, and that clear definitions should be established for both internal and external stakeholders.

The committee emphasised the importance of a robust evaluation matrix for funding decisions, ongoing monitoring of supported businesses, and a parallel governance structure. The Committee highlighted the need to set ambitious targets, focus on strategic priorities, and market the program effectively to attract relevant partners. The discussion also underscored the value of openness and collaboration in partnerships, as well as the importance of establishing clear, measurable success criteria to maximise the impact of POIZ.

It was reported that the entire team is aligned with the outputs generated by POIZ and is a primary focus of the Innovation team. At this stage, no new positions have been assigned and anything historical is only being pursued if it is funded. The Chair queried as to whether an operational plan has been developed. It was reported that this is in the process of being addressed and programme management is being aligned with POIZ to avoid duplication. The governance structure remains unchanged.

For Noting
The Committee was informed that a number of SOPs require updates due to the new funding, and that work on this process has begun. It was agreed that the updated SOPs will be submitted for approval to the Futures Management Board which meets on a monthly basis.

Resolved:
The Futures Committee noted the update on the POIZ Innovation Strategy.

25/26/10 Pillar 4 Overview and update: Transform

The Committee was provided with an update on Pillar 4: Transform. Attention was drawn to the following key points:

Ambient AR (Lyrebird)

- It was reported that there is a total of 198 users across Community, Medicine and Surgery.
- Benefits work is ongoing, with time-in-motion baselines being conducted over the last two weeks. Interviews have also been undertaken and user surveys circulated.
- Integration solutions have been identified, and the Trust is collaborating with Lyrebird to develop a clinic feed that allows users to select patients instead of manually entering their details. An auto sign feature has also been procured to provide a sleeker workflow, with users given the option to approve the letter within Meditech. The aim for this is to go live in early July.

Patient Portal

- A meeting has taken place with the supplier to review the proposed plan, which they have taken to gain approval.
- The revised governance structure has been approved, and plans are in place to schedule a meeting to discuss this matter further.

Etiometry

- Clinical and technical kick off meetings have taken place. Ongoing clinical meetings will continue with clinical leads and the Etiometry team.

Resolved:
The Futures Committee noted the update on Pillar 4: Transform.

25/26/11 Artificial Intelligence (AI) Implementation Plan

The Committee received an update on the progress that has been made in implementing the AI strategy and resource requirements. A number of slides were shared that provided information on the following areas:

- AI Strategy;
  - AI Strategy has been signed off including design.
  - Mobilisation plan underway with a range of stakeholders.
  - 4 key themes: Enhancing CYP centred care, empowering professionals, advancing clinical practice, revolutionising diagnostics.
- POIZ and AI alignment.
- Delivery plan outline phases.
- Current AI programmes.
- Resources identified.
- Education offer.
- Statement of planned benefits.
- Investment and ROI.
- Partnerships.
- Summary;
  - The AI Strategy has been well received internally/externally and is now in the mobilisation phase.
  - Next steps include building a strategic investment case, implementation of AI governance for progression and further work on investment and ROI for each project that sits within the strategy.
  - Work continues at pace across current in-flight AI programmes and benefits realisation.

Discussion highlighted the need for clear, measurable benefits and targets for each AI initiative, with suggestions to publish these to attract partners and demonstrate impact. The Committee raised questions about the use of new technology to improve

patient pathways, research opportunities, and the importance of consistent internal and external messaging to ensure understanding and buy-in. The importance of capturing patient and family feedback on AI's impact across the Trust was also noted.

A discussion was held on developing a clear Communications Strategy for POIZ, the AI Strategy, and GO. The Committee considered cross-branding and presenting a unified narrative, with the suggestion of having a coordinated launch for greater impact. It was noted that AI is unique and should be treated accordingly, and that timely, cohesive communication is essential. The group agreed to schedule a meeting to discuss a co-ordinated launch in greater detail.

25/26/11.1 Action: KW/DJ/JC/CB

Resolved:
The Futures Committee noted the progress that has been made in implementing the AI Strategy.

25/26/12 Board Assurance Framework (BAF) and Risk Register Overview

The Committee received the Board Assurance Framework Report (BAF) for May 2025. Attention was drawn to the following points:

- It was reported that key risks have been drawn out in the document and risks relating to Futures are to be updated.
- A risk appetite document is in the process of being developed for the Futures Committee. The Committee considered whether to formally submit the document once completed or incorporate it into the GO process for reference purposes. The Committee determined that integrating this work into the GO process would offer valuable context.

Resolved:
The Futures Committee noted the contents of the BAF report for May 2025.

25/26/13 Overview of Operational Performance in Research (including the Third MRI Scanner) and Innovation

The Committee received the 2024/25 Annual Report for the Clinical Research Division and the 2024/25 Annual Report for Innovation, for noting purposes. It was reported that additional metrics have been included in the Integrated Performance Report which is to be submitted to the Committee on a regular basis going forward.

The Committee received a summary of operational performance in R&I, which highlighted ongoing financial challenges, including an estimated £250k deficit linked to a stretch target. The discussion highlighted concerns regarding the sustainability of R&I activity amid current financial pressures, with particular emphasis placed on the need to protect growth and avoid adverse impacts on future opportunities.

The Committee discussed the third MRI scanner as an example of the significant benefits that can result from R&I investments, noting that the scanner has delivered value exceeding its net cost to the Trust. This was raised in the context of emphasising the importance of recognising the wider impact of such initiatives when considering future funding and resource allocation.

Resolved:
The Futures Committee:

- Noted the update.
- Received the 2024/25 Annual Report for the Clinical Research Division and the 2024/25 Annual Report for Innovation.

25/26/14 Overview of Financial Performance & CIP in Research and Innovation

The Committee received an overview of the financial performance in R&I for M2. The following points were highlighted:

- Research has a £250k adverse position linked to a stretch target.
- Innovation forecast shows a £600k adverse variance.
- POIZ agreement has yet to be signed.
- *RPA Business Case – It was reported that* benefit realisation has not been identified to date. This is work in progress, with an upcoming meeting planned to determine the benefit split between Divisions and Corporate services.
- Fixed-term posts have been terminated, and £250k removed from posts that remain unfilled.
- It was highlighted that the innovation budget is under pressure due to the reallocation of existing team support for the Voice programme and the need to finalise the Voice function agreement.

Attention was drawn to the importance of having clarity and transparency in financial reporting, particularly regarding how investments and benefits are accounted for. It was agreed to establish a set of accounting principles for GO, including expectations and ground rules. It was felt that it is also necessary to determine allocation methods and define clear guidelines.

25/26/14.1 Action: MJ/RL

Resolved:
The Futures Committee noted the overview of financial performance and CIP in Research and Innovation.

25/26/15 Discussion: Shaping the Growth and Opportunities Plan and Future Committee Oversight

The Committee held an in-depth discussion on the transition from the Futures Committee to a new structure aligned with the Growth and Opportunities plan. The Committee agreed that the primary objective is to enhance coherence across existing initiatives by connecting them more effectively and articulating a unified strategic direction. It was noted that the new GO Committee should prioritise clinical leadership, aim to increase clinician involvement and ensure that the legacy of the Futures Committee is preserved and built upon.

The discussion emphasised the importance of identifying which initiatives and partnerships have delivered the greatest impact, as well as learning from those that have been less successful. Members highlighted the need to break down organisational silos, foster greater collaboration, and embed R&I into everyday practice.

Questions were raised regarding the best approach to capturing and prioritising problem statements, structuring the Committee membership, and ensuring that the transition to the new model does not lose valuable legacy or momentum. The Committee also discussed the importance of clear and effective communication, both internally and externally, and considered the potential value of engaging external expertise to help articulate strategy and messaging. Members agreed that honest reflection on past successes and challenges will be essential to shaping the future direction and oversight of the committee.

Resolved:
The Committee noted the presentation on Shaping the Growth and Opportunities Plan

and Future Committee Oversight

25/26/16 Any Other Business

There was none to discuss.

25/26/17 Review of the meeting

The meeting concluded with acknowledgments and expressions of thanks to Non-Executive Director, Shalni Arora whose term of office is due to end, particularly recognising Shalni's contribution and leadership as Chair of the R&I Committee/Futures Committee.

Date and Time of the Next Meeting: 7th October, 1:30pm –3.30pm, LT1, Institute in the Park.

BOARD OF DIRECTORS

Thursday 6th November 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 R Information R Regulation ☐
Action/Decision Required:	To note R 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 R **Pioneering** breakthroughs ☐ **Strong Foundations** R
Resource Implications:	

Does this relate to a risk? Yes R 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 current and 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.

2. Colleague Engagement & Culture

- **Staff morale**

Through our work in SALS, OD and across People Services we are continuing to hear reports of lowered morale across the organisation. Referrals to SALS continue to be high with the main presenting issues being work-related stress and high mental health distress (including crisis). For the first time since SALS was founded, the number of referrals from the community division has equalled those from medicine and surgery reflecting the increased number of challenges specifically facing community teams including the impact of the Southport Inquiry on staff. Referrals remain high to SALS with 80 new presentations a month for the July-September period.

The team are seeing higher staff presentations to SALS where reasonable adjustments and flexible working applications are the cause of stress. 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. Concerns about racism, in our communities and in the Trust, also feature in the concerns and struggles that staff bring to SALS and across our People Services.

Our people are also telling us that access to mental health services has become more difficult, with staff having to wait longer to access effective treatments. For our staff with more severe mental health difficulties, this is leading to more crisis presentations in SALS.

- **Values and 'Connected Leadership'**

The new values facilitated team conversations continue to be an important source of connection and communication and to date over 650 staff have been engaged through 38 separate team listening sessions across hospital and community sites.

The new connected leadership approach which takes effect in November will be crucial in conveying clear messages about the operating environment and importantly messages of hope for positive change in the future. The approach has built into it increased support for leaders and managers in communicating with their teams and in identifying and finding solutions for challenges that they are facing quickly and effectively. Our SALS and OD teams are also offering increased support for leaders through the ongoing Strong Foundations leadership programme where current cohorts are proactively targeted at leaders of teams who are struggling (as evidenced in data from the 2024 Staff Survey), with individual coaching offered to those where an ongoing need is identified.

- **2025 Staff Survey**

The 2025 NHS Staff Survey is now live and will be open until the end of November. The first results will be available for internal use only from 15th December onwards and will provide an up-to-date assessment of engagement and morale across the trust. This coming year will also see the development of the Thriving Teams Index providing more frequent and comprehensive

team-based culture, wellbeing and safety culture assessments. 39% of colleagues have completed their survey so far, which is over 1750 people.

3. Education, Learning & Development

Full details of all education, learning and development activity are provided to Education Governance and considered at People Committee, but some highlights which may be of interest to the Board include:

- Our evolving work with Edge Hill University has led to us recently supporting delivery of their new flagship PGCE Primary (Mental Health and Wellbeing) programme – the first of its kind in the country, designed to equip trainee teachers with a better understanding of CYP mental health and how to support pupils across the primary age range.
- A series of five masterclasses launch on 31st 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). Speakers include Dr Paul McGee – SUMO Guy, Franklin Covey and Team Boo.

- ***Medical Education: Quality Review / GMC Survey Feedback***

Further to a NHSE / GMC quality review in June 2025 (the key findings of which have been reported previously) a number of actions have been agreed with NHSE with the aim of enhancing resident doctor experience. These reflect specific local priorities as well as ensuring we consider our position against the Improving Resident Doctors Working Lives framework which was released in the form of a ten-point plan from NHSE in the Summer. Our current compliance with the IWL standards is provided below.

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: **ALDER HEY CHILDREN'S NHS FOUNDATION TRUST**

Amenities

Access to Lockers	Yes
Rest facilities	Yes
Designated on-call parking access	No
Access to hot and cold food 24/7	Yes, but not all
Access to cold food 24/7	Yes
Access to inductions specifically designed to meet the needs of Resident Doctors	Yes
Beds/sleeping pods available free of charge	Yes
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes
Is there access to free psychological support treatment?	Yes
Are there positive feedback mechanisms in place to reward and promote staff?	Yes
Are there protected breaks?	Yes
Do you promote the Safe Learning Environment Charter?	Yes
Offer sexual safety/harassment training and awareness?	Yes

Annual Leave

Do you have a local policy to encourage good annual leave management which explicitly includes reference to resident doctors?	Yes
Is good annual leave practice covered at resident doctor induction?	Yes
Do you allow resident doctors to carry over annual leave between rotations?	Yes (internal rotations)
How much leave can Resident Doctors carry over?	5 days
Do your rostering systems for Resident Doctors allow for self/preferential rostering?	Yes

Payroll and Expenses

Have you implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Yes
Have there been changes in payroll errors over the last 12 months?	No change
How do you process course related expenses?	After course attendance

Appointing senior leads to take action on Resident Doctor issues

Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	Yes
If yes, please provide their name and role.	Lakshmi Ramasubaramanian, Director of Medical Education
Do you have a peer representative Resident Doctor who your Board consults with on local issues relating to Resident Doctors?	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (Executive team, Trust Board, People Committee or All)	
GMC Training survey	People Committee
NETS survey	People Committee

Mandatory Training & Learning

Do you accept mandatory training completed by resident doctors elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training AND do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025?	Yes, both

* Baseline assessment score 83%

The Board are asked to note our position against these requirements and ongoing monitoring of this, and the wider resident doctor action plan will be undertaken by People Committee.

- ***Changes to Apprenticeships / Post 16 Education and Skills White Paper (October 2025)***

The government's new post-16 education and skills white paper is jointly fronted by the Department for Education, Department for Science, Innovation and Technology, and Department for Work and Pensions. Spanning proposals to address the number of NEET young people to widening access to postgraduate study, the plans break down into three key areas:

- joining up skills and employment throughout the system including through Skills England and funding reform;
- reforms in the further education/college sector; and
- reforms in the higher education sector

For Alder Hey, some specific areas which will require further consideration relate to:

- **changes to the growth and skills levy** (formerly the apprenticeship levy) - the White Paper signals clear intent to create greater flexibility in how employers use levy funding through the introduction of short modular learning and apprenticeship units, both underpinned by employer designed occupational standards, and to position the Levy alongside the Adult Skills Fund as part of a streamlined public investment system in adult skills. Moving forwards, we will be able to use the Growth and Skills Levy to fund short, flexible apprenticeship units and modular courses. However, please note that questions remain about delivery, coherence and pace.
- supporting young people to secure apprenticeships, in particular those who are NEET or at risk of becoming NEET, through tailored support as part of the **Youth Guarantee**
- **Introduction of new V level qualifications -** V levels will be new Level 3 qualifications that offer a vocational pathway for students who want to explore different sectors before deciding where to specialise.
- Introduction of the **Lifelong Learning Entitlement**, giving each individual access to 4 years' worth of loan funding for higher level education or training to use over their working lives
- Wider **reform to the HE sector**, as this may impact our HE partners and their priorities / focus.

Further detail will be brought back to People Committee and Board as applicable as these new changes embed.

Employee Relations & Wellbeing

- **Sickness Absence**

The Trust current sickness position (in-month) as of October 2025 is 6.7% and significantly higher than the Trust target of 4.5%, with an equal split of both long term and short-term sickness absence (LTS at 3.4%, with a target of 2.5%, and STS at 3.3%, with a target of 2%). 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 temporarily restructured to enable the release of 3 HR team members, to focus solely on addressing sickness absence, supporting both managers and staff. Weekly reporting and progress are provided to the Chief People Officer. Development of an enhanced sickness dashboard is almost finalised to provide improved data insights into absence. Action plans are in place for all those on LTS.

- **Resident Doctor Industrial Action in November 2025**

The British Medical Association Resident Doctors' Committee (BMA RDC) has announced that resident doctors in England will stage a round of industrial action in November.
The five-day strike will run from **7am 14th November to 7am 19th November.**

In response, the Trust has re-established the operational group responsible for managing the impact of the strike action, overseeing patient safety and activity during these five days. Industrial Action rates for covering shifts during the strike have been agreed at a C&M system level and will be implemented as and when required.

3. Establishment Control Measures

The weekly workforce establishment and vacancy panel continues to scrutinise all elements of workforce establishment, including premium and substantive pay. This group also ensures the Trust delivery of key workforce actions that emerge from the Financial Control and Oversight Group (FCOG) for the C&M system that is held every two weeks and is chaired by the ICB Chief System Improvement and Delivery Officer. Table 5.1 shows the Trust Workforce WTE for September 2025 (month 6).

Table 5.1

	Actual	Actual	Actual	Actual	Actual	Actual	Actual
	M12 24/25	**M01 25/26**	**M02 25/26**	**M03 25/26**	**M04 25/26**	**M05 25/26**	**M06 25/26**
Substantive	4,136.71	4,079.84	4053.46	4051.37	4054.61	4054.49	4041.24
Trainees	178.20	161.87	165.21	169.41	163.97	178.97	178.07
Bank	140.71	101.17	98.54	91.03	94.18	88.69	94.16
Agency	8.11	6.49	4.64	5.69	5.76	4.61	3.33
Total Workforce	**4,463.73**	**4,349.37**	**4,321.85**	**4,317.50**	**4318.52**	**4326.76**	**4316.8**
Budget Plan	4,273.40	4,337.18	4,311.51	4328.04	4328.82	4327.81	4297.25
Difference	***-26.27***	***92.85***	***-10.34***	**10.54**	***10.30***	**1.05**	**-19.55**

n.b. The above table is now reporting a revised plan to reflect what has been submitted in the most recent finance submission to the ICB

The above position in respect of WTE numbers against plans, shows a negative variance despite significant achievement in respect of reducing bank, agency and overtime, as well as the implementation of specific controls. Numbers of new starters have remained high, due to the commitment to honour start dates of those jobs offered in the last quarter of 2024/25 and the first quarter of 2025/26. It is unlikely that we will see the effects of the recruitment freeze that has been implemented until the last quarter of 2025/26, due to recruitment that was already in progress at the point of the decision to pause recruitment in some areas.

The mutually agreed resignation scheme (MARS) is due to close on 31st October 2025. An update on the final MARS scheme will be shared at December Trust Board.

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.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**NHS England's National Oversight Framework Capability Self-assessment**
Report of:	Chief Corporate Affairs Officer
Paper Prepared by:	Executive Directors

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Action/Decision Required:	To note ☐ To approve ☑
Summary/ supporting information:	Assessing Provider Capability: Guidance for NHS Trust Boards documentation provided to September 2025 Board 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 Impact:	None identified

Does this relate to a risk? Yes ☐ No ☐					
Risk Number/s	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

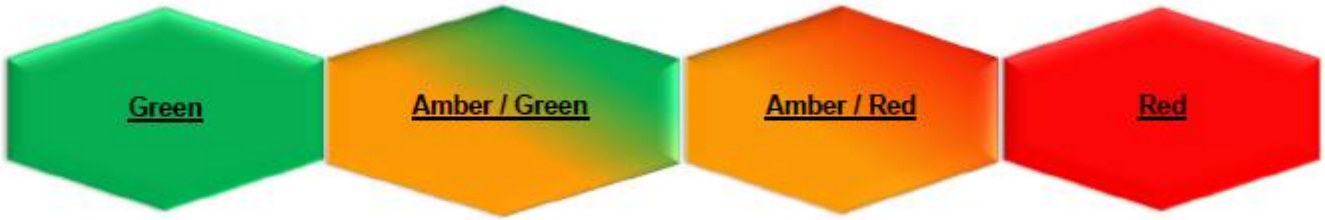
NHS England's National Oversight Framework (NOF) Capability Self-Assessment is a core component of the NOF and is designed to promote transparency, self-awareness, and continuous improvement within NHS trusts and foundation trusts.

Its aim is to enable NHS England to determine the level of external support or intervention required based on a trust's capability rating.

Trusts (both NHS trust and foundation trusts) are required to:

I. Complete an annual self-assessment using the published NHS England template
II. Assess their capability across six domains
III. As part of the assessment outline supporting evidence and conclude the organisation's position as either 'Confirmed' 'Partially Confirmed' or 'Not Met' for each Domain.
IV. Where the organisation is unable to make a positive self-assessment the organisation needs to clearly outline the reasons why, the extent to which these reasons are outside the organisations control to address, how long the reasons have persisted, summary of any mitigations the organisation has or is taking and if not already shared a high level description of the organisation's action plans including deadlines and KPIs
V. Submit the completed self-assessments to their NHS England Region following Board sign-off.

Following receipt of the assessments, NHS England's Oversight Teams will triangulate the self-assessment with other information sources and allocate each Trust one of the following ratings:



This will then be used to monitor in year-performance with an expectation that Trusts will update the Oversight Team if there are any material year end changes.

The Trust's self-assessment against each of the six domains is detailed below.

2. NHS England provider capability self-assessment (October 2025)

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
Strategy, leadership and planning				
The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners.	• Are the trust's financial plans linked to and consistent with those of its commissioning integrated care board (ICB) or ICBs, in particular regarding capital expenditure	• Alder Hey`s financial plans are consistent and aligned to that of the C&M. Throughout the planning process information is shared between the organisation and the ICB to ensure this is the case. Particular attention is undertaken on activity and commissioning plans to ensure agreement by all parties. • With regards to the capital expenditure limit (CDEL), the current in year plan is consistent with the ICB allocation for the Trust with regular information provided to the ICB on the capital developments of the Trust.		
	• Are the trust's digital plans linked to and consistent with those of local and national partners as necessary?	• Alder Hey's digital transformation programme has been purposefully designed to ensure full alignment with both national and regional strategies, including the NHS Long Term Plan, the Cheshire and Merseyside Integrated Care Strategy, and the recently published 10-Year Plan. o **Direct alignment to system priorities**: Alder Hey's digital, data and AI strategies have been mapped against national frameworks such as *What Good Looks Like*, and regional strategies including the		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		Liverpool Place Neighbourhood Working agenda. Key programmes, such as the Expanding Virtual Care, Advancing Artificial Intelligence, Optimising Systems, Data Driven Care and Enhancing safety through Digital all contribute to priorities outlined in the 10-year plan. ○ **Virtual Care and AI**: Alder Hey's plans for a Patient Engagement Portal will offer appointment access, clinic letters, access to the health record for patients and a single platform for advice and guidance. This ensures responsiveness to shared priorities such as shifting care closer to home, improving pathways for children and young people, and embedding digital-first approaches across clinical and operational domains. ○ **Contribution to system sustainability**: Alder Hey's Digital Strategy supports the NHS's 2% productivity target through innovations such as ambient voice technology and AI coding platforms. Workforce development, governance, and infrastructure planning are embedded within the strategy to ensure long-term sustainability. ○ **Evidence of integration and collaboration**: The Trust is actively progressing neighbourhood working with other care providers in Liverpool Place, having hosted strategic workshops to discuss the concept of a shared digital neighbourhood strategy. Alder Hey is actively collaborating with partners across C&M on several 'at-scale' cost improvement initiatives to help leverage economies of scale and financial sustainability. This collaborative approach reinforces Alder Hey's role as a system convenor and trusted partner in delivering equitable, innovative care for children and young people.		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
	• Do plans reflect and leverage the trust's distinct strengths and position in its local healthcare economy?	• Alder Hey's Vision 2030 strategy was developed in response to four areas of need identified by children and young people. The Trust's strategic objectives reflect the strategic aims of our partners, at local, system and regional levels. In Cheshire and Merseyside, Alder Hey have established the "Beyond" Children & Young People's transformation programme and the system architecture for CYP. Our Trust has strong relationships with academic, local authority, public health and city region partners which have resulted in a shared focus on the needs of CYP in the local healthcare economy.		
	• Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?	• The Trust's transformation programme has been developed to ensure full alignment with the wider system strategy, with a clear line of sight from national priorities through to ICB strategy and place-based delivery. The approach ensures that transformation is not only responsive to local needs but contributes meaningfully to the collective ambitions across the system. ○ **Direct alignment to system priorities:** Each of the transformation programmes – covering urgent & emergency care, elective care, neighbourhood and prevention, digital & data, and organisational design – has been mapped against the ICB Integrated Care Strategy and NHS Long Term Plan. This demonstrates clear contribution to system-level goals, including reducing health inequalities, improving access and outcomes, and achieving financial sustainability. ○ **Responsive to strategic priorities:** Plans have been iteratively shaped through engagement, ensuring responsiveness to shared priorities such as reducing avoidable demand, shifting care closer to home, improving pathways for children and young people, and embedding digital-first approaches.		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		○ **Contribution to system sustainability:** The Trust's financial and workforce plans are designed to support system sustainability, alongside commitments to protect patient safety, experience, and quality of care.		
The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England.	• Is the trust currently complying with the conditions of its licence?	• Compliance with the requirements of the Provider Licence is routinely monitored through the NHS England Single Oversight Framework (SOF), but on an annual basis after the financial year end, all Trusts must self-certify as to whether they satisfy the requirements of the licence, specifically, that they have the required resources available if providing commissioner requested services (CRS) (condition CoS7). At its June 2025 meeting, confirmation of compliance was approved by the Board. The Trust has continued to undertake a full self-assessment of compliance against its licence throughout its lifetime as a foundation trust and this can be evidenced through its Board papers which are publicly available. The Board views this as an important demonstration of the discharge of its public accountability.		
	• Is the trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?	• Not applicable		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
The board has the skills, capacity and experience to lead the organisation.	• Are all board positions filled and, if not, are there plans in place to address vacancies? • What proportion of board members are in interim/acting roles? • Is an appropriate board succession plan in place? • Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?	• The Boards composition demonstrates a good balance of skills, experience and knowledge with all positions filled as per the Trust Constitution. • None • There is a high level succession plan in place at Board level, based on existing 'ready now, ready later' analysis developed by the CPO. Consideration is also being given to an appropriate replacement for the Chair following the conclusion of her final term of office in February 2027. • Job descriptions agreed and in place along with Trust governance structure detailing each Executive area of responsibility. Alder Hey operates a unitary Board which is collectively responsible for the long-term success of the organisation which is understood and met. Alder Hey's Non-Executive Directors bring a diverse range of skills and experiences to the table including a registered Statutory Social Worker, those with particular interests in Health Inequalities, global technology expertise, Chartered Accountants, equality, diversity and inclusion specialist, Professors of Law, and a Medical Practitioner. This wide range of expertise ensures that we maintain a suitable balance of power and independence on the Board. It also facilitates the level of scrutiny and challenge needed to effectively lead our assurance committees.		
The trust is working effectively and collaboratively	• Is the trust contributing to and benefiting from its NHS trust collaborative?	• *Collaborate for children and young people* is one of the Trust's strategic aims. During 2024/25, Alder Hey continued to drive partnerships and collaborate within the		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.	• Does the board regularly meet system partners, and does it consider there is an open and transparent review of challenges across the system? • Can the board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?	Cheshire and Merseyside ICS to sustain and improve quality of care provided to children, young people and their families. • The impact Alder Hey aims to have on the health of children and young people (CYP) goes beyond the provision of treatment and care. Alder Hey is part of a wider health and financial and social economy and takes seriously its emergent role in preventing ill health as well as treating it. This is enshrined in Alder Hey's Vision 2030. Alder Hey plays a part in Cheshire and Merseyside (C&M) Integrated Care Board/System C&M ICB/S) as an "Anchor Institution", working alongside others to improve the lives of all in the communities around us significantly and positively. Alder Hey can provide significant evidence of our commitment to building and sustaining strong partnerships at local, regional, national, and international levels to improve outcomes for children and young people, and their families. Collaborations and system leadership roles include; Collaborations and system leadership roles include; **System Leadership and Governance** • Alder Hey's CEO serves as the Senior Responsible Officer (SRO) for CYP within the Cheshire and Merseyside Integrated Care Board (C&M ICB), while the Chief Strategy & Partnership Officer leads CYP transformation. • Both roles are instrumental in the C&M ICB's CYP Committee, which unites system-wide partners—including local authorities, public health, mental health, NHS organisations, and the voluntary sector—to address key issues such as neurodiversity, oral health, and mental health.		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		Major Programmes and Collaborations • The Trust leads the *"Beyond"* CYP Transformation Programme, which delivers evidence-based improvements, to date, to over 300,000 children and professionals. Alder Hey hosts Beyond on behalf of the Cheshire & Merseyside Integrated Care Board (C&M IC). Beyond has a major focus on addressing health inequalities across C&M, playing a leadership role in overseeing the Core20+5CYP in partnership with C&M's Population Health Board. Beyond-led initiatives include the All Together Smiling oral health campaign and the development of a nationally recognised Health Equity Framework. • Alder Hey is a key member of the C&M Provider Collaborative, chairing the CYP Alliance and leading digital transformation efforts across the region. • The Trust is actively involved in the ICS Digital Programme and chairs the North West Digital, Data and Technology Skills Development Network. **Local and Regional Partnerships** • Alder Hey leads the transformation of children's services in Liverpool, including the development of urgent and emergency care pathways, a Paediatric Assessment Unit, and digital tools such as the Symptom Checker. • The Trust partners with local authorities and NHS trusts to implement neighbourhood models, mobilise family hubs, and improve lung health. • In partnership with Mersey Care, Alder Hey delivers Liverpool's 0-19 services, modernizing public health		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		nursing and integrating mental health support in schools and communities. • A tripartite partnership with Mersey Care and Liverpool University Hospitals Group aims to shift care towards prevention and community-based services. **Community and Mental Health Initiatives** • Alder Hey continues to expand community and mental health services for CYP, with a focus on neurodevelopmental support and crisis care. • The Wellbeing Hub, launched in November 2024, centralises health, wellbeing, and poverty-proofing services, securing significant financial support for families. **Innovative Models of Care** • Alder Hey and the Beyond Programme are pioneering neighbourhood multidisciplinary teams (MDTs) for CYP, delivering integrated care closer to home. • Liverpool has been designated a national 'Wave 2 Test Learn and Grow' pioneer site, focusing on lung health for CYP and families. **Addressing Health Inequalities** • The 'Improve My Life Chances' Partnership Group led by Alder Hey's Consultant in Public Health Medicine, focuses on reducing school absences due to illness, creating job opportunities and tackling health inequalities. • Multiple key initiatives described – such as the "Beyond" Programme, the Wellbeing Hub, the Liverpool 0-19 partnership, Neighbourhood MDTs and 'Test, Learn & Grow'- all have targeted action on health inequalities at their core, applying proportionate universalism and the		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		focusing of resources to areas of highest deprivation/need. **Specialised and National Leadership** • Alder Hey is a core member of the North West Congenital Heart Disease Partnership and co-leads the Liverpool Neonatal Partnership, advancing specialised care and workforce development. • The Trust collaborates with Royal Manchester Children's Hospital to enhance regional clinical networks and access to specialist services. • Nationally, Alder Hey hosts the Children's Hospital Alliance and maintains leadership roles in NHS transformation programmes for CYP. **System-Wide Impact** • Throughout 2024/25, the Trust has fostered greater openness and transparency across Cheshire and Merseyside, enabling innovative partnership solutions to system-wide challenges.		
Quality of care				
Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and	• The trust can demonstrate and assure itself that internal procedures: ○ ensure required standards are achieved (internal and external) ○ investigate and develop strategies to address substandard performance	The Trust has a long-standing and fully embedded approach to monitoring performance against all applicable quality and safety regulations, standards and metrics. It has a Safety and Quality Assurance Committee (SQAC) which meets every month and holds each of the clinical divisions to account as well as Executive directors for all relevant measures within the Integrated Performance Report. Specifically the Trust has in place: • Mandatory reporting to Board and SQAC: ○ Complaints, PALS & Compliments ○ Mortality		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	○ plan and manage continuous improvement ○ identify, share and ensure delivery of best practice ○ identify and manage risks to quality of care • There is board-level engagement on improving quality of care across the organisation. • Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients. • Board assesses whether resources are being channelled effectively to	○ Friends and Family Test ○ Patient Safety Incident Investigations • Aggregated analysis report also presented to SQAC to enable safety intelligence and triangulation of data from several sources • Brilliant Basics improvement system in place and assessments against NHS IMPACT reported through to Board. • Patient Safety Programme Board reporting into Board via SQAC to monitor delivery of Patient Safety Strategy aligned with the National and Trust Patient Safety Strategies. • BAF Risk pertaining to Inability to deliver safe and high-quality services reviewed monthly at SQAC and Board. Now includes reference to the current financial environment. • Quality Assurance Rounds have been in place for a number of years, which are attended by both Executive and Non-Executive Board Members. These are structured around CQC domains. Learning from the process is shared across services and through to the Board. • Patient and staff stories received at Board support strategic and operational quality improvement discussions, underpinned by the Integrated Performance Report which brings together all key performance metrics. This data is tested against qualitative experiences including the QAR's and visibility visits to operational areas. • Complex discharge team in place which assesses complex and long stay patients, seeking to move care to community where possible.		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
	provide care and whether packages of care can be better provided in the community. • Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its trust's internal governance arrangements are robust. • Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.	• The Trust Board acts on insight and quality issues elsewhere in the NHS, examples of this include self-assessments undertaken in response to the Fuller Inquiry, learning from maternity reviews which is applicable to neonatal care. The Trust receives updates from HSSIB and where learning is appropriate this is assessed against trust services • Following approval by the Trust's Education Governance Committee, the Trust mandated the completion of NHSE Patient Safety Training Syllabus Level One – essentials for patient safety for all clinical and non-clinical staff within the Trust. Furthermore, Level One - essentials of patient safety for Board and senior leadership teams - has been mandated to all executive members of the Trust. The overall Trust compliance is monitored through the Integrated Performance Report and achieved 98% compliance in 2024/25.		
Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.	• Does the board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?	• Our aggregated analysis report triangulates patient experience data internally. The CQC inpatient survey is completed and shares external benchmarking for patient experience. SQAC receives a quarterly Patient and Family Feedback Report which brings together progress against delivery of the Patient Experience Strategy, service developments, feedback from national and local surveys with actions to address thematic feedback. The IPR reviewed monthly by the Board contains a wide range of metrics relating to outstanding care and experience bringing together patient safety incidents,		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		complaints, HAIs, patient safety training, deteriorating patients, FFT, clinical quality, Martha's rule requests and forward look with actions.		
	• Does the board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the trust's communities? • Is the board satisfied that it receives timely information on quality that is focused on the right matters? • Does the board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this? • How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?	• Patient and Carer Race Equality Framework being led within the community and mental health division, to be rolled out across the organisation. Recording of protected characteristics needs to be improved and a programme of work will be underway. • IPR and Flash Report presented to Board monthly reflects CQC domains and aligned to Trust's strategic objective and priorities from the Annual Plan along with a range of locally determined measures tailored to CYP. • FFT, complaints and PALS information is shared with the board monthly, with SQAC overseeing divisional level performance related to these through the divisional reports. Patient and staff stories received at Board enable operational quality discussions and real time improvement. • The Trust has a range of mechanisms for involving children, young people and families in improvement activities including PLACE assessments, Patient Safety Partner roles, our Patient Experience Group and Young Volunteers. In addition, we take the views of children and young people very seriously and actively ensure that the voice of The Youth Forum is at the heart of everything we do as our partners. They are proactively involved in a plethora of quality assessments and improvement projects across the Trust.	Systematic recording of protected characteristics not embedded	Programme of work to commence.

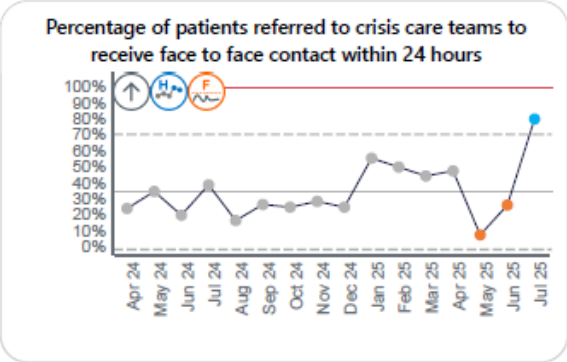
Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
	• Is the board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns?	• Every Board member understands their accountability for quality and there is a clear organisation structure that cascades responsibility for delivering quality performance from Board to ward. Quality is a core part of main Board meetings, both as a standing item and as an integrated element of all major discussions and decisions. Board minutes demonstrate effective challenge from NEDs.		
	• Is the board satisfied that the trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?	• In 2024/25, the PALS Office was developed further to become the Family Wellness Hub; a space where children, young people and their families can talk to staff who will support them and help resolve their concerns as quickly as possible. Complaints are monitored quarterly to SQAC and Board. All complaints are overseen by the CNO and signed off by the CEO.		
People and culture				
Staff feedback is used to improve the quality of care provided by the trust.	• Does the board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement?	• Workforce demographics and workforce metrics reported to People Committee Trust Wide and broken down by Division. The Trust is continuing to make steady progress against the high-impact actions outlined in the NHS EDI Improvement Plan which is monitored by EDI steering group and reported to both People Committee and Trust Board. EDI is integrated into our policies and practices as an employer, healthcare provider and procurer of services. Staff experience survey data is analysed and reported at divisional and team level and by protected characteristics. The main staff networks have presented to the Board and put forward a number of 'asks' for support which have formed a joint work programme which is monitored via the EDI steering group.	Trainee survey participation is very low.	Triangulate Trainee and staff feedback for organisational overview. Further increase the visibility of Executive Walk around not just staff but students.

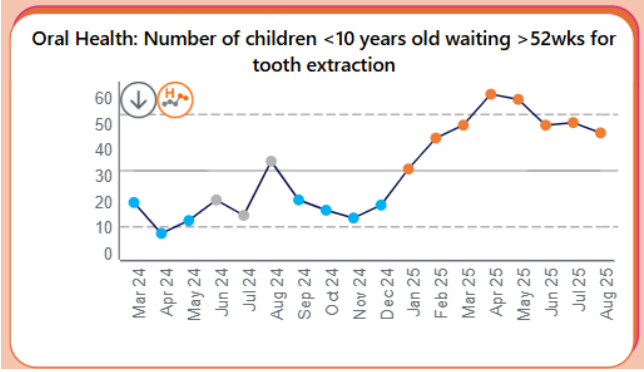
Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
	• Does the board engage with staff forums to continually consider how care can be improved?	• The Equality, Diversity and Inclusion Steering Group (EDISG) reports directly to Trust Board and our EDI agenda is supported by several staff networks including LGBTQIA+, ACE (Disability Network) and REACH (black and minority ethnic). The Trust has signed up to the North West BAME Assembly Anti-Racist Framework and will be working with the REACH Network leads to explore and agree future actions. During the year, the Trust published its new Anti-Racism Statement and Commitment, developed in partnership with a range of stakeholders, including our REACH Staff Network and EDI Lead setting out Alder Hey's responsibilities and actions in this crucial sphere.		
	• Can the board evidence action taken in response to staff feedback?	• Action taken in response to staff feedback evidence  Staff Survey.pdf		
Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	• Does the trust regularly review skills at all levels across the organisation?	• Yes, range of approaches used; following commencement in post (personal training plans linked to role and area of work); annually (as part of organisational training needs framework); bespoke (arising as a result of specific initiatives) • Each individual is required by the Trust to have a PDR each year. Within this they are encouraged to identify and discuss their personal training needs, linked to their role and career. This in turn informs the training needs analysis.		
	• Does the board see and, if necessary, act on levels of compliance with mandatory training?	• Mandatory training is reviewed by the Board monthly (included in IPR)		

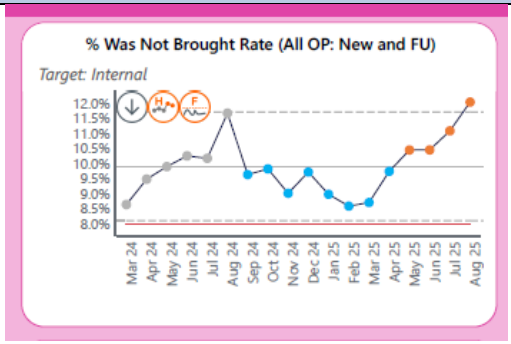
Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
Staff can express concerns in an open and constructive environment.	• Does the board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?	• The FTSU Guardian reports to the Chief Corporate Affairs Officer and meets regularly with the Non-Executive Director champion who is the SID. The FTSUG presents a quarterly report to the Board in person and also reports to the People Committee. • FTSU Visibility Programme in place supported by the CEO, Executive Directors (via walkabouts) and NEDs with regular reporting. • The Guardian also has regular 1:1s with the CEO, CNO & CPO to discuss concerns, actions taken to any potential barriers.		
	• Are all complaints treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?	• Every concern raised is treated seriously with appropriate Board Member oversight/intervention where applicable.		
	• Is there a clear and streamlined FTSU process for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns?	• Trust intranet clearly signposts staff to ways in which they can raise a concern. FTSU Guardian holds regular walk rounds (as above). The Trust has around 15 FTSU Champions in place recruited from all parts of the organisation and all staff groups. FTSU open-door drop-in sessions for staff are held twice a month. A bespoke FTSU app is currently in development for staff to report concerns anonymously. Speaking Up training compliance for 2024/25 was reported at 98%.		
	• Is there a safe reporting culture throughout the organisation? How does the board know?	• Based on data reviewed from the NGO portal and across the North West, Alder Hey is reporting some of the highest number of cases, which may indicate the confidence staff have in raising concerns through this route. The Board receives a quarterly detailed analysis of concerns raised broken down by staff group and theme in order to identify any causes for concern.		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
	• Is the trust an outlier on staff surveys across peers?	• Staff survey data shows an increase in scores across all questions relating to staff feeling safe to raise a concern. Two of these questions attaining the national best and all being significantly above average.		
Access and delivery of services				
Plans are in place to improve performance against the relevant access and waiting times standards.	• Is the trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the trust taking all possible steps towards meeting them, involving system partners as necessary? • Where waiting time standards are not being met or will not be met in the financial year, is the board aware of the factors behind this? Is there a plan to deliver improvement?	• **Metrics** **ED: % Treated within 4 hours.** National standard: 78% Alder Hey: 84.8% YTD **RTT Patients waiting >52 weeks** National standard: 1% of the wait list over 52 weeks by March 26 Alder Hey: 1.7% (current)	High risk for dentistry and ENT	• Plan being met as agreed with region, but actions ongoing on further improving 4hr performance • Alder Hey has been unsuccessful in attempts to recruit a Paediatric Dentist and ENT Consultant. Further attempts ongoing with Specialist Dentist post live on NHS jobs. In response the trust has restarted insourcing in both Dentistry and ENT. Weekend Outpatient clinics restarted in August and weekend operating is due to recommence on 18th October.

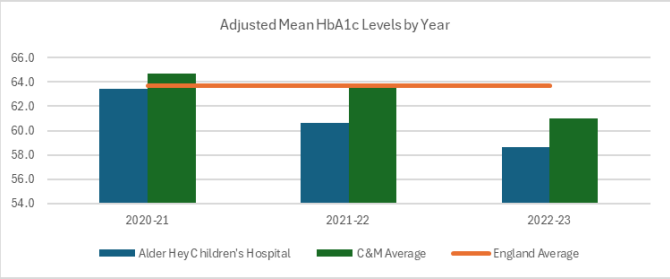
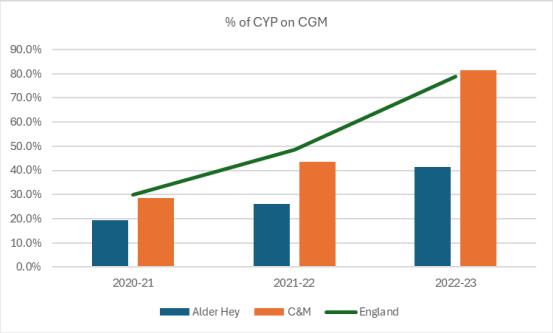
Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		RTT (%) waiting list within 18 weeks National standard: 63% RTT by March 2026. Alder Hey: 60.7% **Cancer: Faster Diagnosis within 28 days** National Standard: 80% Alder Hey: 95% YTD	Medium risk	• Recovery plan in place with actions focusing on - Clinical validation text message for all new patients - Opt-in letter pilot for those who do not respond to text message underway in ENT and Dentistry - Administrative validation of outpatient follow-up (RTT) - Continued focus on chronological booking
The trust can identify and address inequalities in access/waiting times to NHS services across its patients.	• The board can track and minimise any unwarranted variations in access to and delivery of services across the trust's patients/population and plans to address variation are in place.	**Mental Health** In line with Core20&5CYP, Alder Hey seeks to continually reduce inequalities in access, experience and outcomes for CYP with mental health needs, routinely monitoring key factors such as access to crisis support via the Trust's IPR – an example of which is as follows;		

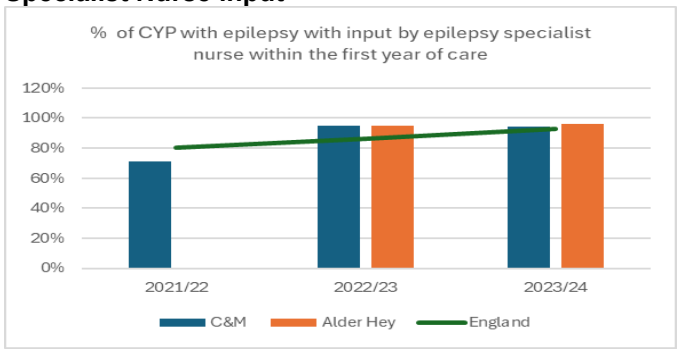
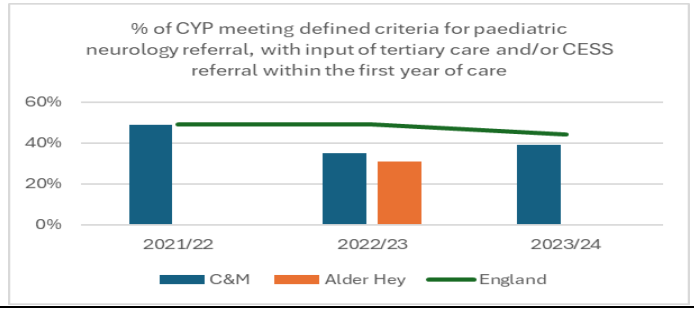
Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		 **Ethnicity data capture** Alder Hey has placed priority focus on increasing ethnicity data capture, given this is fundamental to delivering Core20&5CYP effectively. Greater capture of ethnicity data will allow systems to see inequalities clearly, monitor progress and design culturally and locally responsive interventions that can truly reduce health inequalities. For example, increasing this data capture can allow us to look more closely at unwarranted variation in access for CYP Mental health as evidence shows that CYP from black, Asian and minority ethnic backgrounds can be less likely to have had professional contact for mental health problems compared with their white peers. Current % ethnicity data capture trust-wide c. 75%. **Oral Health** Oral Health is one of the 5 national priority areas within Core20PLUS5 for Children and Young People (CYP). Poor oral health is a marker and a driver of wider health inequalities and children from the most deprived quintile experience over twice the rate of tooth decay as those from the least deprived areas. The trust actively monitors the number of CYP waiting over 52 weeks for tooth extraction –	Medium risk Medium risk	Actions to increase ethnicity data capture include - making key fields mandatory on core systems, data quality lead review of our demographics, to highlight the gaps and develop an education and engagement programme with staff, and CYP and families respectively. The dentistry department are actively trying to expand their workforce to enable a reduction to wait times within the service. The performance standards for the service are reviewed weekly and action plans in place.

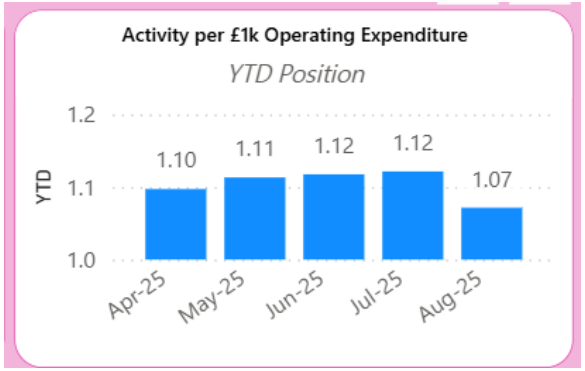
Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		these are heavily concentrated in Core20 populations e.g. in oral health (nationally) we know children from the Core20PLUS population groups are 3.5 times more likely to have dental extractions;  **Was Not Brought (WNB)** Alder Hey Innovation led the creation of a 'was not brought' tool, which risk stratifies children who are likely to miss appointments, based on a high correlation between missed appointments and underlying inequality factors such as poverty, transport barriers, carer stress or health literacy issues. The WNB tool is now utilised nationally across the Children's Hospital Alliance's 11 member trusts. The WNB rate is monitored monthly via the Trust IPR. An example of WNB reporting from IPR is as follows;		Actions to reduce WNB rate include a new opt-in process for ENT and Dentistry supported by a new patient demographic system improving contact accuracy.

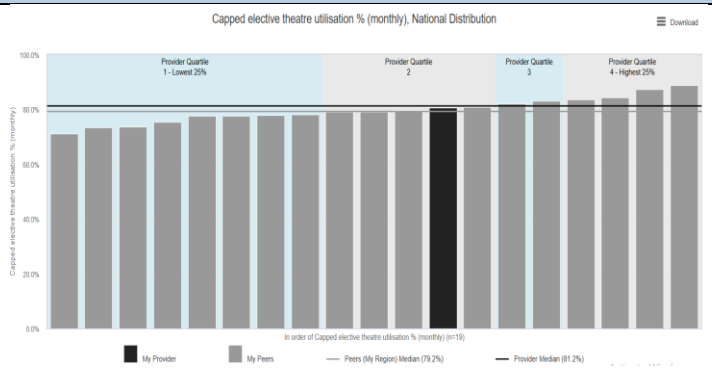
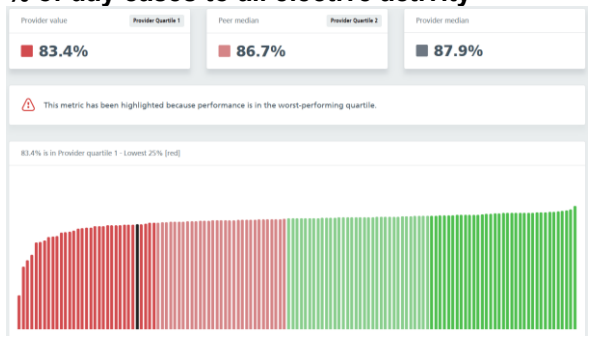
Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
				
Appropriate population health targets have been agreed with the integrated care board.	• Is there a clear link between specific population health measures and the internal operations of the trust? • Do teams across the trust understand how their work is improving the wider health and wellbeing of people across the system?	**Internal Alder Hey work programmes linked to specific population health measures** Alder Hey takes targeted approaches, focussed on CORE 20&5 CYP priority areas and specific population health measures identified in our ICB/region, to address the multifactorial impacts of the wider determinants of health. These include; • Respiratory Consultant-led “Clean Air” clinics • “Parent Champions” - model targeted at the 10 most deprived family hubs in Liverpool addressing respiratory conditions. Subsequently spread across 5/9 Places in C&M by the Beyond programme, to include further focuses such as oral health. • Mini Mouth Care Matters – A targeted Oral Health prevention programme that ensures oral assessments and mouth care are part of everyday care for children admitted Alder Hey • Sophie’s Legacy – addressing non-clinical, but critical factors that affect recovery and wellbeing – such as access to healthy free / low-cost food, play, dignity and family inclusion.		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		• Vaping Cessation Clinic – Alder Hey Consultant in Public Health medicine has led the first national clinic in a 12mth pilot on behalf of NHSE • Flu Fairies – opportunistic vaccination of children onsite at Alder Hey who have not been offered/taken up their flu vaccination through community/primary care routes • The Wellbeing Hub – provided in partnership with Citizens Advice Bureau and Health Junction to support families with social prescribing, financial and benefits advice. **Driving Core20+CYP on behalf of the C&M system through "Beyond" – hosted by Alder Hey** "Beyond" has a major focus on addressing health inequalities across C&M (including Alder Hey's delivery populations) and plays a leadership role in driving improvements across Core20+5CYP in partnership with C&M's Population Health Board. The Beyond programme has focused priorities identified via 9 x C&M Place JSNAs, the NHS Long Term Plan and 10 Year Plan, and which are linked to CORE20+5 CYP delivery for C&M. All priorities are focussed on early intervention and prevention, addressing the impact of the wider determinants of health. Examples below of data monitored and overseen by Beyond; **Diabetes** Glycated Haemoglobin (HbA1c). Data shows that there is a steady improvement in diabetes control for children and young people as evidence by a reduction in mean HBA1c levels which is driven by focussed work on increasing access to CGM / HCL (with focus on BAME communities / CORE 20 populations)		Diabetes – increasing access to technology for type 1, particularly for BAME communities

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		 **Continuous Glucose Monitoring**  **Oral Health** Across C&M, 31.2% of CYP have visibly obvious dental decay at the age of 5 years (2024 epidemiological survey) with local Place areas of St Helens (36.2%) Liverpool (32.6%) and Knowsley (35.8%) showing high rates. These rates are directly correlated to levels of poverty and deprivation. Beyond is commissioned by the ICB to deliver All Together Smiling across C&M – a 3-year, supervised toothbrushing programme, focussed children aged 2 to 7 years in CORE 20 populations. Since inception, this programme has		Oral health – reduction in extractions for dental decay

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		distributed over 315,000 toothbrush and toothpaste packs, 217 settings are participating and over 9,000 children are involved in supervised toothbrushing – including all 3 of Alder Hey's main 'Place' delivery footprints (Liverpool, Sefton & Knowsley). **Epilepsy** Beyond has led work to increase the number of Epilepsy Nurse Specialists and there has been an associated increasing CYP having access within the first year of care, with a particular focus for CYP with LD. Alder Hey have hosted a regional ESN. **Specialist Nurse input**  **Referral criteria**  	**Medium**	Epilepsy – increasing access to specialist nursing in first year following diagnosis Challenges with access to tertiary neurology due to national workforce shortages. Service improvement plan and ongoing work with regional CMO underway – and appointed 2 new Neurology Consultants at Alder Hey (Oct 25)

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		<u>Respiratory</u> Progress is being made on outcomes for children with respiratory conditions / asthma -conditions again correlated with families living in lower IMD populations. 69% of CYP had a written asthma plan on discharge from AH in 2023/24 compared to 26% 2021/22 and 11.8% 22/23.		Asthma – annual asthma review, inhaler review and personalised asthma plan. Reduction in use of saba inhalers
Productivity and value for money				
Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.	• Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to: ○ review its performance against peers ○ identify and understand any unwarranted variations ○ put programmes in place to reduce ○ unwarranted negative variation. The trust's track record of delivery of planned productivity rates.	**Weighted activity vs Operating Expenditure**  The above metric is similar to the implied productivity score but is calculated internally and refreshed more frequently to enable oversight and appropriate actions **Theatre touchtime Utilisation** National standard: 85% Alder Hey: 80.7	Low risk	There are a number of workstreams aimed at increasing clinical productivity Outpatients: Overbooking of clinics started in Sept 25 and is being rolled out across the trust in Oct 25 Theatres: The following programmes are aimed at reducing same day cancellations, increasing productivity and reducing bed days **Same day cancellations** No pre op – no TCI date programme is being rolled out across the surgical specialties. **Theatre cases per session**

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
		 **Opportunity by Consultant** DC Theatres Consultant / Touchtime Uncapped / Time per case / Opportunity Time (Session) / Opp>TT / Extra Cases Possible / % Late Starts / % Early Finish / Target Cases per List CRARATY 59.0% 36 54 Yes 9 25.0% 15.8% 5.56 **Total 59.0% 36 54 Yes 9 25.0% 15.8% 5.56** **% of day cases to all elective activity** 		Opportunity data used at consultant level to show where additional theatre cases can be booked **Reduce bed days** Reviewed historic data of TCIs who were booked for an overnight stay to determine if could be treated via daycase pathway. Several procedures identified and being piloted through daycase.

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
Financial performance and oversight				
The trust has a robust financial governance framework and appropriate contract management arrangements.	• Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data.	• Previous audits of financial controls and systems, including external reviews, have provided substantial or high levels of assurance. The internal audit plan for the year has been approved by the Audit & Risk Committee and covers the following areas: 1. Asset Management Processes – completed with substantial assurance. 2. Balance Sheet 3. Financial Measures (Grip & Control) 4. Key Financial Transactional Processing Controls In light of this year's significant financial challenges and the savings required to deliver the financial plan, the Board has resolved to further enhance financial governance through the implementation of a Financial Improvement Programme. This initiative features a new decision-making framework, an updated EIAQIA process, and the establishment of a clinical cabinet to ensure decisions are both financially effective and clinically safe. An integrated performance report is submitted monthly to the Trust Board and subcommittees, providing a comprehensive analysis of activity, expenditure, income, and workforce data. Additionally, the monthly finance report includes detailed insights into: 1. Workforce metrics, including usage of temporary staff 2. Expenditure trends, notably the run rate over the last 12 months 3. Variance analysis highlighting budgetary pressures 4. CIP performance 5. Contract income 6. Activity delivered		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
	• Have there been any contract disputes over the past 12 months and, if so, have these been addressed? • [Potentially more appropriate for acute trusts] Are the trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the trust had to rely on more agency/bank staff than planned?	• There have been no commissioner contract disputes over the past 12 months. The Trust is currently engaged in a dispute with a building contractor concerning a substantial financial claim, which the Trust believes is inconsistent with the contract terms. NHSE has been informed, and with guidance from legal advisors, the Trust is progressing its defence. It is anticipated that the matter will proceed to mediation. The Board is regularly updated on developments. The hospital operates under a PFI contract, which is rigorously managed by the CFO, with regular oversight and reporting to the Finance Committee. Since April 2025, the Trust has achieved a significant reduction in Bank staffing by 55 WTE. The Trust maintains minimal reliance on agency staff, with only five positions currently filled by agency personnel in critical service areas where recruitment has proven challenging.		
Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do	• Does the board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? • Are there sufficient safeguards in place to monitor the impact of	• The Board receives regular updates during annual planning, covering financial and efficiency assumptions. The Finance Committee reviews these plans in depth to align them with the Trust's strategy. • As part of the Financial Improvement programme, the Board approved a new decision-making framework and established a Clinical Cabinet to ensure financial		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
not adversely affect patient care and outcomes.	financial efficiency plans on, for example, quality of care, access and staff wellbeing?	efficiencies consider safety, quality, and finance. A strategic command structure has been established, with weekly meetings chaired by the COO and attended by the CNO, CMO, CPO, and CFO. • All financial decisions exceeding £50,000 are reviewed at these meetings, incorporating an EIAQIA to evaluate the potential impact on quality and safety prior to approval. The Trust Board receives monthly updates regarding financial decisions. • In response to enhanced controls required to meet financial objectives, it has been acknowledged that additional efforts are necessary to assess and understand the cumulative impact of ongoing decisions. Accordingly, the Risk Management Forum has scheduled an extraordinary session in October to examine the relationship between financial decision-making, risk, and quality.		
	• Does the board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?	• At the start of each year, the finance committee identifies five principal risks, which are RAG-rated, monitored, and updated monthly. Additionally, a recent review of all BAF risks has been conducted to ensure alignment with the current financial environment. • The Trust Board monitors actual performance monthly, comparing results against both the plan and forecast, with detailed explanations provided for key variances observed during the period. Each Divisional Director presents their financial position to the Board each month, highlighting any notable challenges and achievements.		

Self-assessment criteria	Indicative evidence or lines of enquiry	Assurance Evidence	Gap / Risk	Action
The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.	• Is the board contributing to system-wide discussions on allocation of resources? • Does the trust's financial plan align with those of its partner organisations and the joint forward plan for the system? • Would system partners agree the trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?	• Alder Hey participates as a system partner in C&M and represents the interests of children and young people (CYP), focusing on optimizing available resources to achieve desired outcomes. • The CFO is involved with the ICB system and attends biweekly finance meetings where resource allocation and related topics are discussed. • The CFO also serves as a member of the C&M efficiency at scale board, which manages several system-wide programs aimed at achieving financial efficiency and optimal resource usage. • Alder Hey hosts the Children's Board for C&M and participates in additional networks that facilitate system-wide programs to support effective use of resources.		

1. Recommendation

The Board of Directors is asked to approve the 'confirmed' disclosures against all six domains demonstrating a positive assessment and agree to report any significant change in-year to its ability to meet any of the self-assessment criteria to NHS England.

John Grinnell
Chief Executive
November 2025

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*

Signed on behalf of the board of directors

Name	John Grinnell, Chief Executive
Date	6th November 2025

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**Chair's Report from the Finance, Transformation & Performance Committee meeting held on 22nd October 2025**
Report of:	**John Kelly Committee Chair**
Paper Prepared by:	Julie Tsao, Executive Assistant

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☑ ☑ ☐
Action/Decision Required:	To note To approve	☑ ☑
Summary / supporting information:	Approved minutes from the meeting held on the 26.9.25.	
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care **Support** our people **Pioneering** breakthroughs **Strong Foundations**	☑ ☐ ☐ ☐ ☐ ☐
Resource Implications:	None	

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

1. Introduction

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

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

- Top Five Risks update
- M5 Financial update including forecast for year end.
- M8 Integrated Performance Report
- Campus update
- Divisional Updates
- Board Assurance Framework
- Outpatient Pharmacy Business Case

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

- None

4. Positive highlights of note

- Divisions moving forward with financial challenges
- Approval given to Outpatient Pharmacy business case.

5. Issues for other committees

- None

6. Recommendations

The Board is asked to note the Chair's Highlight report for the Finance, Transformation & Performance Committee meeting that took place on 22nd October 2025.

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Confirmed Minutes of the meeting held on **Friday 26th September 2025 at 1:30pm**
Via Teams

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)
	Mr. A. Bateman	Deputy Chief Executive/ Chief Operating Officer	(AB)
	Mrs. R. Lea	Interim Chief Financial Officer	(RL)
In Attendance:			
	Ms. A. Chindiya	Associate Finance Director	(AC)
	Mr. G. Wadeson	Associate Director of Finance	(GW)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Ms. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Ms. N. Palin	Director of Transformation	(NP)
	Mrs. M. Swindell	Chief People Officer	(MS)
25/26/093.3	Mrs J Halloran	Deputy Development Director	(JH)
25/26/097	Ms. C. Lee	Associate Chief Operating Officer - Surgery	(CL)
	Mrs. J Tsao	Executive Assistant (Minutes)	(ER)
Apologies:	Mr. N. Askew	Chief Nursing Officer	(NA)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Mr. A. McColl	Associate Director of Finance	(AMc)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)

25/26/089	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
25/26/090	**Minutes of the Last Meeting** The minutes of the last meetings held on 21st August 2025 were approved.
2526/091	**Matter Arising and Action Log** The action log had not been circulated with the pack. It was noted that all actions had been included on the agenda.
25/26/092	**Declarations of Interest** There were none to declare.
25/26/093 **1.**	**Top 5 Risks** The committee received an overview of the top 5 risks for the month and current status. **Trust Financial Performance** An update was received on the in month position and latest forecast noting the achievement of the plan in month but the Trust remains off plan YTD largely due to the cost of industrial action which was not budgeted in the plan at the start of the year. The risk remains high due to the current forecast gap in delivering the

	fully year plan due to CIP delivery and other emerging pressures which will be covered later in the agenda under closing the gap.
2.	**System financial performance** The system reported a position overall adverse to plan largely due to the cost of Industrial Action and also pressures within the ICB. Ongoing action continues in relation to the financial turnaround and the Trust remain involved in the meetings and actions.
3.	**Campus and Capital Programme** An update was received on the ongoing discussions regarding additional CDEL required to meet the capital requirement for the current year based on the capital prioritisation exercise undertaken earlier in the year. This remains a risk as not fully resolved although positive discussions to date. The capital management group continue to oversee the in-year forecast and any associated risks to ensure all CDEL is utilised and if any movement is required between projects this is managed appropriately. . Due to the number of on-going projects under the Campus and emerging risks, the committee agreed that the Campus would have an extended agenda time at the October meeting. **Action: JH** The Chair noted a number of projects are due for completion at the end of the financial year and asked what contingency plans are in place if deadlines are not met. EK has been working with teams including Medical Engineering to understand the options on bringing forward new equipment purchases from the next financial year if required. JW noted Alder Hey Charity and their support in relation to capital schemes and encouraged ongoing discussions.
4.	**Transforming Alder Hey (ways of working, futures, AI & Digital)** An overview was received on the transformation programme including the work underway on the Target Operating Model and Blueprints with a more detailed update due to the Strategy Board in October. Work continues on closing the gap and managing this programme.
5.	**Operational performance (productivity, access, targets, benchmarking)** AB highlighted that although positive August, September had been challenging in terms of activity due to a number of pressures with staffing. A discussion took place relating to additional sessions and ensuring that all options are looked at to maximise the sessions being undertaken to hit the activity plan for the year. **Resolved:** The Committee noted the Top 5 Risks.
25/26/094	**Finance Report – M5 Financial Position** EK provided an overview of the Month 5 position noting a £1.1m deficit was reported in month taking the year to date position to £2.5m deficit, £0.2m adverse to plan due to the impact of Industrial action in previous months. Activity in the month was positive with Elective income higher than plan which also included a benefit from previous months as part of the second freeze coding.

	The committee received an overview of commissioner risks that are being managed and agreement to receive further updates as the year progresses. Divisional position was highlighted to the committee with noting that next month is the quarterly review and further detail will be shared to understand the run rate as we continue throughout the year. **Resolved:** The Committee received and noted the Financial Report.
25/26/095	**Closing the Financial Gap:** RL provided an update on the latest forecast for the year including status update on the Cost Improvement Scheme. It was noted that the current position includes £19m green schemes, however a movement of £0.7m schemes categorised black due to the low confidence in being able to move them forward following the detail review undertaken. When applying the risk adjusted position on the remaining amber and red schemes, the gap still remains at £2.1m, however further opportunities are being progressed including the roll out of Ambient Voice Technology and realising the financial benefit of this project. An overview of the risk assessment applied was noted at £2.1m. Concern remains on the recurrent position with only 50% currently identified as green. This will be a focus over the coming months through the work of the Target Operating Model. FTPC discussed the non-recurrent schemes within workforce/vacancies and identifying how to manage moving forward safely to deliver financial benefits. JG thanked teams for the improved position on closing the gap. It was noted that assurance on delivery would need to be tracked. MS agreed to take an action around tracking vacancies for the October FTPC. **Action: MS** **System context incl Stretch** RL referred to the presentation shared at the last committee meeting noting progression of one area relating to depreciation charge on system assets. she This would be included in plans to the ICB. Discussions are ongoing with the ICB on the schemes and proposals required to close the stretch plans included in the overall annual plan. RL gave an overview noting two proposals that would be too high risk for Alder Hey to move forward with and the ICB had been advised. DJ summarised efforts to progress stretch initiatives, including investment cases for urgent care and regional transformation. Concerns were noted around the lack of a clear plan and delays in key meetings. JK confirmed the previous Board position in relating to any further stretch initiatives than have not already been agreed. **Latest forecast position** RL presented to the committee the latest overall forecast for the year and also the indicative modelling and assumptions for 26/27 financial year, noting planning guidance is to be received in a few weeks. Key aspects of the update include: - High level financial assumptions in relation to efficiency delivered - Workforce plans required to achieve financial sustainability including the delivery of the 25/25 plans and the actions being taken.,

	- Enablers to achieve the plans - Risks - Next steps. FTPC agreed further work is required on moving WTE to areas of growth and development to clearly show retraction vs growth and external investment. MS and RL emphasised the need for transformational change, including redesigning services and reviewing staff mix. RL thanked FTPC for their support. A further update will be presented at the Strategy Board on 2nd October to continue testing and developing into an agreed plan. **Resolved:** The Committee received and noted the update.
25/26/096	**Future Shape of Alder Hey** NP presented a Target Operational Model (TOM) for how Alder Hey will work in the future to deliver its strategy. This was presented alongside a timeline with implementation in quarter 4. The Chair asked that (TOM) is ready before Q4 to accelerate benefits. NP agreed to review plans. **Action: NP**
25/26/097	**Neonatal Partnership Update** CL highlighted the improved position on the LNP from the last update and governance recommendations that would be taken forward. A draft business case outlining a financial gap for support services was presented at a session. It was noted this was due to changes in specifications since the original business case was approved. The case will be presented to commissioners once the board has agreed the requirements. An ongoing review of non-pay expenditure including a transfer between the two sites continues. Currently no in year budget pressure as commissioners have agreed interim payment for 2025/26. Equipment requirements finalised for NICU floor & budget pressure significantly reduced to £130k forecast overspend following agreed transfer of Liverpool Women's equipment and increased Alder Hey charity support. **Resolved:** FTPC noted the current position in relation to the Neonatal Partnership.
25/26/099	**Risk Appetite and Tolerance** **Resolved:** As Erica Saunders had sent apologies this item was deferred until October FTPC.
25/26/098	**M5 Integrated Performance Report** **Resolved:**

	M5 Integrated Performance Report was received and noted in the meeting., **NHS Oversight Framework** AB presented an overview of the organisation's position in the NHS oversight framework, identifying strengths in urgent care and productivity, and areas for improvement in RTT, infection rates, and staff absence. Under Patient Safety theme a number of infection rates is above average. AB noted the importance for Board to be able to track this going forward. JG suggested tracking themes through the Board sub committees. AB agreed to include in his update at the October Trust Board and update on FTPC themes at the November meeting. **Action: AB**
25/26/100	**Board Assurance Framework** **Resolved:** The Committee received and noted the Board Assurance Framework.
25/26/101	**PFI** **Resolved:** Due to the meeting overrunning FTPC received and noted the latest position on PFI with agreement to include in the next meeting along with the campus update.
25/26/102	**Any Other Business** There was no other business.
25/26/103	**Review of the Meeting** FTPC agreed the transformation piece is critical moving forward.
	Date and Time of Next Meeting: Wednesday 22 October at 1pm, Tony Bell Boardroom.

25/26 FTPC Key Risks – Month 6 Position

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M6
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 6 position reported £1.5m surplus in month and £1m deficit YTD which is in line with plan YTD. The impact of industrial action has been absorbed in M6. ICB forecast (SW) at M6 reported likely forecast of £2.3m surplus position for the year, however still aspiring to reach full £7.1m surplus. PBR/ERF in month performance was significantly lower than plan (£1.1m), offset by a backdated gain from M5 (£0.2m). YTD PBR overperformance (£0.3m) sits within divisional positions. This is offset by non-recurrent benefit in relation to deferred income release (£0.2m) , Rev to cap (£0.1m) and technical VAT (£0.5m) benefit brought forward from later months. CIP delivery is ahead of plan in month 6 and YTD. Total savings of £18.5m have been transacted (green) , forecasting to deliver £20.7m (SW methodology). 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 6 performance was £1.9m favourable to plan ytd (excluding deficit support funding (DSF)). This is £9.6m better than the mid case forecast (SW) implied M6 would achieve. Whilst this is positive, work is ongoing to understand if this is primarily phasing or a genuine underlying improvement to the position. The mid case forecast at M5 (M6 not yet published) for the full year was a £381m deficit against a deficit plan of £178m. If the system to not achieve plan for the year DSF will not be forthcoming, which would take the ytd position to £44.5m adverse ytd. The ytd position includes circa £6m industrial action costs. A significant emphasis in reducing the run rate on a recurrent basis is now the focus for ICB turnaround, with monthly escalation meetings with NHSE/PWC in place for each organisation depending on risk.	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 – M6 capital spend is £2m behind plan (£1m 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	Transformational work continues in line with the agreed plan, alongside the development of a new Target Operating Model that will define the future shape of Alder Hey. Collaborative actions are being prioritised to bring greater simplicity, focus, and accountability to delivery. The **Closing the Gap** programme has been established to strengthen delivery of high-impact value initiatives across key workstreams—such as workforce, procurement, diagnostics, and productivity. A detailed delivery plan, aligned to the emerging TOM, will ensure continued progress, clarity of delivery, and integration within the Trust's transformation oversight framework.	High
Operational performance	National focus on productivity and benchmarking to drive down costs. Efficiency programme contingent on driving up productivity in order to reduce costs.	Medium	The trust's performance regarding patients waiting over 52 weeks continues to be a challenge. A proposal has been submitted and approved that includes strategies for increasing productivity and determining an optimal level of substantive recruitment to meet the standard and achieve CIP.	Medium

BOARD OF DIRECTORS

Thursday, 6th November 2025

Paper Title:	**Board Assurance Framework Report (September 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 September 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	Growth and Opportunities 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 October 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	2x1
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.	GO	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 September 2025 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk has been reviewed - control measures and gaps in control continue and are monitored through SQAC and the executive team.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  Cleo now live, this will hopefully have a positive impact on those that do need prescriptions and may run into stock issues, because the prescription can be picked up from any community pharmacy.
  MIC recommenced- working through long list of children and young people who have been diagnosed and have requested a trial of medication. Supply is more stable but there are still some of the medicines going out of stock, this is having less of an impact partly due to familiarity with the process and what is needed to ensure safety of children and young people.

- ***Children and young people have timely and safe access to elective, urgent and follow up care (AB).***
  September performance against 2025/26 targets
  - Acute (78%) - ED performance remained above target at 87%
  - RTT (63% by March 2026) - Improvement compared to previous month (62% in month)
  - Pts >52 weeks (1% by March 2026) - Reduction to 1.5% in September due to successful action plan with achieved a reduction from approx. 434 to 253
  - DMO1 (95%) - Performance achieved 95%

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***
  Project Co Update

  Water Safety
  Water Safety Group meetings continue to be held alongside operational groups to monitor progress on addressing out-of-range temperatures. An independent report has been provided by Project Co directors. Trust representatives have requested that Project Co develop and submit a project plan based on the recommendations set out in this report.

  Tap Filters
  A notification regarding tap filters has been issued to Project Co.

  Green Roofs
  The green roofs are performing as expected, with no significant issues reported.

  Chillers
  The chillers are experiencing further issues; temporary units have been installed to maintain service continuity.

  Combined Heat and Power (CHP)
  The CHP unit has been offline for nearly a year, and the Trust continues to await an update from Project Co on the status and proposed next steps.

A formal notification on the above items has been sent with no response to date.

- ***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).***
  Controls updated to include audit of dashboards to to provide assurance that risk has been mitigated.

  Control added regarding improvement trajectories. Also updated evidence section to include monthly slides which are shared with ICB.

  Actions reviewed and updated with change made to ROMS actions to 31 October 2025.

- ***Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***
  This risk continues to be closely monitored, the risk score remains unchanged. The weekly workforce establishment and vacancy panel scrutinizes the WTE position closely assessing any impact and plans to mitigate associated risk. To address the higher levels of sickness absence the Trust is currently experiencing, 3 members of the HR team have temporarily been repurposed to support the management of absence.

- ***Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).***
  Risk reviewed. All controls reviewed and amendments made based on feedback from ARC chair. All actions reviewed and updated to reflect progress.

- ***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 remains 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 continues to deliver strategic value across its seven goals, the pace of in-year benefit realisation has not met expectations, resulting in a residual financial gap and increasing pressure on operational budgets.

  To mitigate this, targeted actions within key programmes are being accelerated to maximise in-year savings. A single, aligned plan with strengthened governance is being established to provide clear delivery accountability and oversight. Monthly Transformation Board reviews are supporting dynamic reprioritisation, and enhanced benefit tracking with a focus on recurrent savings logic is being applied. Delivery models are being refined to integrate transactional efficiencies with collaborative transformation, enabling both short-term financial delivery and long-term sustainability.

In addition, a risk remains regarding the ability to appoint a Head of Experience, due to current WTE control measures. This constraint may impact the programme's capacity to deliver experience-led improvements at pace, which could in turn affect the achievement of associated financial and strategic benefits

- ***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 year's 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).***
  Risk, control and actions reviewed. System threats has been added to risk detail, along with controls regarding the GO Committee oversight. Controls have been checked and updated where appropriate.
  No change to risk rating in month.

- ***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 - risk score remains 9. Actions and controls under review.

- ***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. Infrastructure refresh work is in progress and on track to complete by end of December 2025. Resource and recruitment constraints currently impacting Transcription and Clinical Coding with mitigations in place. Good progress being made via Digital, Data and AI Collab. Target Operating Model work in progress and on track to meet deadlines. Cyber Improvement plan is also being progressed.

5. Corporate risks (15+) linked to BAF Risks (as at 1st October 2025)

There are currently 27 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
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
432	Change to Working Visa rules and immigration status ***(NEW)***	5x4	Community	2.1	Sept 2025	Sept 2025
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
319	Deliver the Epilepsy Bundle of Care ***(new to internal monitoring)***	3x5	C&M CYP Programme	2.1	Feb 2025	Sept 2025
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program	4x4	Surgery	3.4	Aug 2022	Feb 2024
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service	4x4	Medicine	2.1	Feb 2023	Oct 2024

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	could have a significant impact on the health and wellbeing of the IR Consultant currently in post.					
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
287	Radiology consultant on-call is at risk of failure ***(NEW)***	4x4	Medicine	2.1	May 2025	Sept 2025
199	Insufficient funding to provide a 52-week radiology service to report images with current imaging demand	4x4	Medicine	3.4	May 2025	Jul 2025
179	Lack of compliance with major trauma standards ***(INCREASED)***	4x5	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	4x4	Community		Jun 2025	Aug 2025
297	Transcription delay and increase of turnaround times	4x4	Corporate Services	2.1	Dec 2024	Apr 2025
293	Staffing in Biochemistry	4x4	Medicine	2.1	Dec 2024	May 2025
1.2 Children and young people have timely and safe access to elective, urgent and follow up care (5x3=15)						
2463	Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)	4x4	Community	1.4	Jul 2021	*Apr 2023
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)						

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
	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
432	Change to Working Visa rules and immigration status ***(NEW)***	5x4	Community	1.2	Sept 2025	Sept 2025
297	Transcription delay and increase of turnaround times	4x4	Corporate Services	1.1	Dec 2024	Apr 2025
424	Lab capacity issues affecting set-up of new clinical trials in the CRD ***(NEW)***	3x5	CRD	4.1	Sept 2025	Sept 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
319	Deliver the Epilepsy Bundle of Care ***(new to internal monitoring)***	3x5	C&M CYP Programme	1.2	Feb 2025	Sept 2025
287	Radiology consultant on-call is at risk of failure ***(NEW)***	4x4	Medicine	1.2	May 2025	Sept 2025
409	Inability to provide safe staffing levels (legacy risk ID 2100)	4x4	Corporate Services	1.1	Jan 2020	*Apr 2023
2774	If an Interventional Radiologist is unavailable there is no emergency cover for seriously ill patients or patients suffering a major trauma. This may result in delay of treatment for a seriously ill child or one suffering a major trauma resulting in serious harm or death. Failure to treat a seriously ill child or one suffering a major trauma resulting in serious harm or death. In addition, the demands of the service and the self-imposed expectations to deliver the service could have a significant impact on the health and wellbeing of the IR Consultant currently in post.	4x4	Medicine	1.2	Feb 2023	Oct 2024
2635	Risk to business continuity of radiography services trust wide due to staffing availability and skill mix resulting in interruption to elective services and delay to non-elective services	4x4	Medicine	1.1	May 2022	Oct 2024
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

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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	4x4	Medicine	1.2	May 2025	Jul 2025
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
424	Lab capacity issues affecting set-up of new clinical trials in the CRD ***(NEW)***	3x5	CRD	2.1	Sept 2025	Sept 2025

Risk	Risk Title	Score (IxL)	Division	Linked	Date opened	Increased to Corporate
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	Safety & Quality Assurance Committee

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

Control description	Control assurance (How is this control monitored?)
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
Administration of IV antibiotics within 1hr for CYP with suspected sepsis	Monitored monthly through SQAC
Brilliant Basics	Formal and informal training and coaching available to support departments to make positive changes. Reported to board bi-annually including update against NHS Impact Self-Assessment.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Internal: Patient safety meeting actions monitored through SQAC External: Care Quality Commission (CQC), MIAA
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC
Proactive programme of work in place to reduce medication errors	Monitored via Patient Safety Board
Programme of quality assurance rounds, ward and departmental accreditation is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC. Triangulation of data through Aggregated Analysis Reports to SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I)	Annual QIA assurance report and reporting into SQAC as directed by the Chair. Clinical Cabinet in place to review all EQIAs
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Internal: Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes. External: Care Quality Commission, MIAA, NHS Improvement

The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
The Trust has a Patient Experience Group that reports against the workplan derived from the Patient Experience Strategy based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures. Chairs report to SQAC.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.

Gaps in Controls / Assurance

1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis
2. Robust reduction programme in the number of medication incidents and near misses
3. Emerging CQC oversight framework which may reduce our CQC ratings
4. The 2030 vision sees a shift towards and experience led organisation without additional resources for delivery of the plan
5. Increased oversight relating to the financial pressures resulting in inability to deliver 2030 Strategy

Action	Description	October 2025	
		Due Date	Action Update
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	1. Continue to monitor KPI's at SQAC and within divisional governance structures (no further controls required, monitoring controls are in place)	31/03/2026	no further controls required, monitoring controls are in place
2. Medication Errors and Near Misses	2. Proactive programme of work in place to reduce medication errors (no further controls required, monitoring controls are in place)	31/03/2026	no further controls required, monitoring controls are in place
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	Regular engagement meetings continue with the CQC on a quarterly basis
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	ESG continues to report into SQAC
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	FTPC & SQAC

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	October 2025	
		Due Date	Action Update
Recruit a Locum Consultant in ENT	The executive board have approved a paper which allows the department to recruit a Locum Consutlant	31/10/2025	The department have a locum consultant post advertised and at least one interested candidate. However one of the locum consultants who is currently working for the department has resigned therefore the department may recruit however it may not lead to an increase in capacity
Restart weekend theatres in ENT	Weekend operating ceased when the AHP local pay rate was reduced from 1st July. The division have been working to reinstate weekend operating as it will increase capacity in ENT.	31/10/2025	The first weekend operating list since June is scheduled for 18th October.
Overbook outpatient clinic with new patients	Roll out overbooking to clinicians whose clinic utilisation consitute it requires an additional patient booked to increase actual clinic utilisation to as close to 100% as possible.	30/11/2025	The following services are now live with overbooking - Dentistry - Plastic Surgery - Community Ophthalmology and Ophthalmology
2. Open Same Day Emergency Care Centre	Actions reviewed and action containing the below split into 5 separate actions on request. 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	30/03/2026	
3. Deploy Ambient Artificial Intelligence to improve productivity	Actions reviewed and action containing the below split into 5 separate actions on request. 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	30/03/2026	
4. Move to a self-check in model for some patients, using a digital solution	Actions reviewed and action containing the below split into 5 separate actions on request. 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	30/03/2026	
5. Establish performance reports on the number of patients seen per clinician	Actions reviewed and action containing the below split into 5 separate actions on request. 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	30/03/2026	
1. Expanded Paediatric Assessment Unit	Actions reviewed and action containing the below split into 5 separate actions on request. 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	Action completion date aligned with new ground floor SDEC build completion.

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	FTPC

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	October 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	Risk Rating		
			Actual	Target	Assurance Committee
▪ Caring ▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Lisa Cooper	15	4	FTPC & SQAC

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
Trajectories developed to support improvement in access and waiting times	Monitored through - leadership meetings - weekly waiting times & access to care - regular meetings with divisional director - regular meetings with commissioners
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.	Week
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 fortnightly This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes availa
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)

Monitored through
- leadership meetings
- weekly waiting times & access to car
- regular meetings with divisional dire
- regular meetings with commissioner

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	October 2025	
		Due Date	Action Update
ROMS collection and reporting	improve recording and reporting of routine outcome measures	31/10/2025	work ongoing -meeting scheduled with ROMS lead, CXIO, GM and Director for Oct 2025
Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	31/12/2025	work ongoing to streamline services, introduction of risk and triage calls to Liverpool CAMHS in Aug 2025.Regular meetings to be scheduled with clinical leads to progress
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/12/2025	work ongoing, crisis document development meeting now prioritised for Sept 2025 (delayed from July 2025) - meeting scheduled with developers for w/c 6.10.2025
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	31/01/2026	Trajectories for improvement are in place, and agreed with commissioners: Liverpool CAMHS: 92% CYP receiving urgent choice within 2 weeks of referral by 30.06.2025 - not achieved by end of June, but achieved and maintained from August onwards

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	SQAC

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	October 2025	
		Due Date	Action Update
Risk 236 - Action 9 (carried over from Risk #70)	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative if necessary	08/07/2025	ongoing
Risk 236 - Action 8 (carried over from Risk #70)	Daily reviews to take place to monitor progress against actions and monitor supply of relevant medications.	09/09/2025	medication shortage continues still reviewing this weekly(not on a daily basis) this is because all other stocks of ADHD medications are now at sufficient supplies within our area . 12 hour medications prep still unable to obtain supplies, Alder Hey ADHD CYP being moved over to different medications . Currently no end date

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

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

Risk Rating		
Actual	**Target**	**Assurance Committee**
16	4	People Committee

Description
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation. 3. Not developing inclusive recruitment and development practices to improve workforce diversity and progression 4. Not developing a Trust wide approach to succession planning and talent management 5. The Trust would be unlikely to successfully achieve the vision set out in both the People Plan and Vision 2030 if the right workforce is not available 6. Impact of national financial pressures on workforce numbers to deliver patient care 7. Not having a sustainable workforce will impact upon culture

Control description	Control assurance (How is this control monitored?)
Apprenticeship Strategy implemented	
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030	reviewed at EDI steering group and monitored at People Committee also reported in the statutory WRES and WDES
Financial Improvement Programme	Monitored at FTPC
Health and Wellbeing Forum	Health and Well being Forum Terms of Reference - reporting through to People Committee
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	progress to be reported PC
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Workforce Efficiencies Programme	Monitored at FTPC, and People Committee

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	October 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. In addition 3 members of the HR team have been repurposed solely to support the management of sickness absence.	31/12/2025	Ongoing interventions remain in place to support the management of sickness, which have increased to 6% from a Trust target of 4.5%
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	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
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	Professional Development hub now established (virtual)
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	EDI Plan monitored at People Committee
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	Action continues to be addressed through the People Plan, monitored at People Committee and reporting into Board.

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	Staff Survey Action Group, People Committee reports
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	People Committee reports and Safety Culture reporting to Patient Safety Strategy Board
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 reporting to People Committee and Board
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, People Committee reports
Occupational Health Service	Referral data, key themes and outcomes reported to People Committee as part of the People Paper
Partnership working with Staff Side representatives and FTSU Guardian	Staff Partnership Forum meeting minutes
People Pulse results available	People Committee reports
Regular communication channels including managers and leaders briefings and all staff Ask the Execs meetings	Internal Communication reports to People Committee
Regular Schwartz Rounds in place	Monthly Schwartz Steering Group meetings
Restorative just and learning principles embedded into key employment policies including Disciplinary Policy	People Committee reports

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	EDI Steering Group and People Committee
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.	Newly revised People Paper to include data relating to fragile teams
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	October 2025	
		Due Date	Action Update
Culture data insights and intelligence	Culture data insights review to determine availability, frequency and effectiveness of culture-related data (including staff survey data, pulse check, bespoke surveys, and other forms of feedback and intelligence). Scope development of new metrics where there are gaps and scope feasibility of culture dashboards. Thriving Staff Index and Thriving Teams Index to be developed.	31/01/2025	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

		10/11/2025	Meeting with Director of NWLA in September confirmed that we should progress with internal leadership offer and ensure national competencies are reflected in this work.
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.		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	
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	31/03/2026	
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 Connected Leadership approach presented to Trust Board in September and agreed. Plan being operationalised through a working group comprising internal comms lead, Brilliant Basics lead and Director of Transformation. New rhythm of briefings planned to begin Oct/Nov as phase one to be followed by phase two focussing on exec connection with teams. New leader connect programme being operationalised by OD team

Values and behavioural framework review, update and implementation	New values and behavioural framework to be developed and embedded across the organisation.	31/03/2026	Over 500 staff engaged with to date via Values in action sessions with teams and groups. These sessions will run until end Oct. Feedback from all of these sessions being analysed to inform further development of the Values in action framework. Launch date for new values extended to allow for design consultation period with targeted groups in the organisation. 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	

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.

Action	Description	October 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	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
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	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
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	Accessible and Inclusive Recruitment Practices working group established. Recruitment and Selection training incorporating EDI throughout now launched.
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	action closed - move to control (Oct 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	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
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
Funding availability and potential market inflation	Continual monitoring of market inflation
Handover of Park	Handover of Park now complete
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. Weather conditions causing potential delays CAMPUS: 1. Stakeholder Engagement 2. Successful realisation of the moves plan.

Action	Description	October 2025	
		Due Date	Action Update
CAMPUS 1: Stakeholder Engagement	Engage with LCC, Friends of Springfield Park and community stakeholders and issue regular Comms	31/03/2026	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.
PARK 2: Weather conditions causing potential delays	Continue to monitor throughout Autumn / Winter 2025/26	31/03/2026	All works now in accordance with revised programme and on target.
PARK 1: Adoption of the SWALE by United Utilities	Engage with planning consultants to assist with planning requirements.	31/12/2026	The developer (Step Places) are progressing the new surface drain and connection to the swale pond. This is due for completion Dec '25. Upon completion, United Utilities require a min of 12 months monitoring prior to adoption - anticipated date Dec '26.

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	October 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	October 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	We continue to closely impact of inflation increases working with HPL
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	Monitoring continues through Trust Board and FTPC
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	Risks around Capital Plan continue to be monitored closely via Capital management group. Reporting into FTPC and Board. Capital remains a key risk on FTPC
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	Regular reporting to strategic execs and assurance to FTP and Trust Board. Regular exec to exec meetings with specialized commissioning continues
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	Transformation programme now in place with weekly check ins on collaboratives reporting into the portfolio board and weekly execs.
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. Oct 25 Update: No further update this month.
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.
Capacity and capability building for the implementation of Vision 2030 is being captured in the forthcoming clinical strategies (blueprints) and target operating model work, to ensure Alder Hey have the ability 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. Oct 25 Update: capacity and capability building continues to be built into the blueprints and TOM, which are in development and due for completion Dec 25. Control details updated.

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. Oct 25 Update: No further clarity on structure or timeframes available.
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 Oct 25 Update: Relationships with ICS and other system partners are active and Alder Hey continue to engage appropriately.
Growth and Opportunities Committee oversight of growth element of Vision 2030, including	Oct 25 Update: New control
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board Oct 25 Update: continue to track developments and report back into the relevant forums.
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. Oct 25 Update: Strategic partnerships will report through the GO Committee, commencing in Oct, with Exec and non-Exec membership. Assurance continues to be provided through Trust Board also.

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 Oct 25 Update: Joint models of care continue to evolve, for example 0-19 services and tripartite lung health.
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 Oct 25 Update: Alder Hey continue to represent at Place.

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 5. System Threats: concerns about system threats to children's services, particularly the risk of being lost within a broader system focused on generic hospital services i.e. importance of maintaining a distinct focus on children's services.

Action	Description	October 2025	
		Due Date	Action Update
1. Uncertainty over future commissioning intentions	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2026	
2. Impact of delegation of Specialist Commissioned services into ICBs	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2026	
3. Stakeholder & Partnerships Plan - Phase 2 of Vision 2030	3. A stand back on stakeholders and approach to partnership governance will be undertaken alongside re-framing of next phase of Vision 2030 - in line with transformation plan shape for 25/26+	31/03/2026	
4. National mandates & system finance forcing us to prioritise unexpected programmes of work	4. Horizon scanning. System scanning (e.g. via assigned ICB leads in turnaround) and local capacity scanning (via Portfolio Board, TX Programme & Executives)	31/03/2026	

Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.	
Risk Number	**Strategic Objectives**
4.1	Pioneering Breakthroughs

CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
▪ Caring ▪ Effective ▪ Safe ▪ Well-Led		John Chester	9	4	

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	October 2025	
		Due Date	Action Update
3. Comms Strategy for Futures	Development of Futures comms approach	30/09/2025	Draft comms plan completed by end of Sept - under review by Futures Management Board
2. Capacity and capability	Create an R&I enabled workforce through the Futures Develop Pillar	31/03/2026	Idea framework business case approved in Oct SDG with launch planned for March 26
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	Actions continue to close financial the gap in MRI and RPA business cases. POIZ transactions up to date to end of Sept.

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	October 2025	
		Due Date	Action Update
Cyber Assurance Framework & Strategic review of Cyber Security	This has replaced the action around Cyber Essentials +.	31/10/2025	
Experienced Resources - Complete Target Operating Model	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce. This will now be completed through the Target Operating Model workstream.	31/10/2025	
Digital systems review	Digital systems review	31/03/2026	
Investment plan for programme and business as ususal resource		31/03/2026	