

**BOARD OF DIRECTORS PUBLIC MEETING**  
**Thursday 5<sup>th</sup> February 2026, commencing at 12:30pm**  
**Lecture Theatre 1, Institute in the Park, Alder Hey**  
**AGENDA**

| No.                                    | Agenda Item | Time               | Items for Discussion                                                                                                                           | Owner                                            | Board Action:<br>Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)                                               | Preparation                                      |
|----------------------------------------|-------------|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| <b>PATIENT STORY (12:30pm-12:45pm)</b> |             |                    |                                                                                                                                                |                                                  |                                                                                                                 |                                                  |
| 1.                                     | 25/26/314   | 12:45<br>(1 min)   | Apologies.                                                                                                                                     | Chair                                            | To note apologies.                                                                                              | N<br>For noting                                  |
| 2.                                     | 25/26/315   | 12:46<br>(1 min)   | Declarations of Interest.                                                                                                                      | All                                              | Board members to declare an interest in particular agenda items, if appropriate.                                | R<br>For noting                                  |
| 3.                                     | 25/26/316   | 12:47<br>(2 min)   | Minutes of the Previous Meeting.                                                                                                               | Chair                                            | To consider and approve the minutes of the meeting held on: <b>8<sup>th</sup> January 2026.</b>                 | D<br>Read enclosure                              |
| 4.                                     | 25/26/317   | 12:49<br>(1 mins)  | Matters Arising and Action Log.                                                                                                                | Chair                                            | To discuss any matters arising from previous meetings and provide updates and review where appropriate.         | A<br>Read enclosure                              |
| 5.                                     | 25/26/318   | 12:50<br>(10 mins) | Chair's/Chief Executive's Update.                                                                                                              | Chair/<br>J. Grinnell                            | To receive an update on key issues and discuss any queries from information items.                              | N<br>Verbal                                      |
| <b>Strategic Update</b>                |             |                    |                                                                                                                                                |                                                  |                                                                                                                 |                                                  |
| 6.                                     | 25/26/319   | 13:00<br>(30 mins) | Vision 2030 Update; including: <ul style="list-style-type: none"> <li>Medium Term Plan.</li> <li>C&amp;M financial position update.</li> </ul> | J. Grinnell/<br>D. Jones<br>A. Bateman<br>R. Lea | To receive an update on progress.<br><br>To receive an update on the current position.<br>To receive an update. | A<br><br>A<br>A<br>Presentations/<br>Read report |
| <b>Performance Against Annual Plan</b> |             |                    |                                                                                                                                                |                                                  |                                                                                                                 |                                                  |

| No.                          | Agenda Item | Time               | Items for Discussion                                                                                                                                                                                                                                                                                                                                                                   | Owner                                                                                                                             | Board Action:<br>Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)                                                                                                                                                                                                                                                                                                                                                             |   | Preparation                  |
|------------------------------|-------------|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|------------------------------|
| 7.                           | 25/26/320   | 13:30<br>(35 mins) | <b>Evidence of Our Performance:</b> <ul style="list-style-type: none"> <li>Flash Report, M10</li> <li>Integrated Performance Report for M9, 2025/26: <ul style="list-style-type: none"> <li>Experience and Safety.</li> <li>Revolutionising Care.</li> <li>Pioneering.</li> <li>People.</li> <li>Collaborating for CYP.</li> <li>Resources.</li> <li>Divisions.</li> </ul> </li> </ul> | A. Bateman<br>A. Bateman<br><br>N. Askew<br>A. Bateman<br>J. Chester<br>M. Swindell<br>D. Jones<br>R. Lea<br>Divisional Directors | To receive the Trust's Integrated Performance Report for scrutiny and discussion, highlighting any critical issues.<br><br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position.<br>To receive an update on the current position. | A | Read report                  |
| <b>Unrivalled Experience</b> |             |                    |                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               |   |                              |
| 8.                           | 25/26/321   | 14:05<br>(10 mins) | <b>Deteriorating Patients Quality Improvement Report.</b>                                                                                                                                                                                                                                                                                                                              | A Bass                                                                                                                            | To discuss the outcomes and broader implications in terms of reflecting on other cases.                                                                                                                                                                                                                                                                                                                                       | N | Read report/<br>Presentation |
| 9.                           | 25/26/322   | 14:15<br>(10 mins) | <b>Learning from Patient Safety Incidents, Q3.</b>                                                                                                                                                                                                                                                                                                                                     | N. Askew                                                                                                                          | To receive the Learning from Patient Safety Incidents report for Q3.                                                                                                                                                                                                                                                                                                                                                          | A | Read report                  |
| 10.                          | 25/26/323   | 14:25<br>(5 mins)  | <b>Safety and Quality Assurance Committee:</b> <ul style="list-style-type: none"> <li>Chair's Highlight Report from the meeting held on the 21.1.26.</li> <li>Approved minutes from the meeting held on the 17.12.25.</li> </ul>                                                                                                                                                       | F. Beveridge                                                                                                                      | To escalate any key risks, receive updates and note the approved minutes from the 17.12.25.                                                                                                                                                                                                                                                                                                                                   | A | Read enclosures              |
| <b>Supporting our People</b> |             |                    |                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                               |   |                              |
| 11.                          | 25/26/324   | 14:30<br>(10 mins) | <b>Strategic People Update; including:</b> <ul style="list-style-type: none"> <li>EDI update.</li> </ul>                                                                                                                                                                                                                                                                               | M. Swindell                                                                                                                       | To receive an update on the current position.                                                                                                                                                                                                                                                                                                                                                                                 | A | Read report                  |

| No.                                         | Agenda Item | Time               | Items for Discussion                                                                                                                                                                                                                                                            | Owner       | Board Action:<br>Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)                                                                          |          | Preparation     |
|---------------------------------------------|-------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------|
| 12.                                         | 25/26/325   | 14:40<br>(5 mins)  | <b>People Committee:</b> <ul style="list-style-type: none"> <li>Chair's Highlight Report from the meeting held on the 29.1.26.</li> <li>Approved minutes from the meeting held on the 19.11.25.</li> </ul>                                                                      | J. Revill   | To escalate any key risks, receive updates and note the approved minutes from the 19.11.25.                                                | <b>N</b> | Read enclosure  |
| 13.                                         | 25/26/326   | 14:45<br>(10 mins) | <b>Freedom To Speak Up – Quarterly Update.</b>                                                                                                                                                                                                                                  | K. Turner   | To receive an update on the current position.                                                                                              | <b>A</b> | Read report     |
| <b>Strong Foundations (Board Assurance)</b> |             |                    |                                                                                                                                                                                                                                                                                 |             |                                                                                                                                            |          |                 |
| 14.                                         | 25/26/327   | 14:55<br>(5 mins)  | <b>Finance, Transformation and Performance Committee:</b> <ul style="list-style-type: none"> <li>Chair's Highlight Report from the meeting held on the 21.1.26.</li> <li>Approved minutes from the meeting held on the 11.12.25.</li> <li>2025/26 top key risks (M9)</li> </ul> | J. Kelly    | To escalate any key risks, receive updates and note the approved minutes from the 11.12.25.                                                | <b>A</b> | Read enclosures |
| 15.                                         | 25/26/328   | 15:00<br>(5 mins)  | <b>Board Assurance Framework Report.</b>                                                                                                                                                                                                                                        | E. Saunders | To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed. | <b>A</b> | Read reports    |
| 16.                                         | 25/26/329   | 15:05<br>(4 mins)  | <b>Any Other Business.</b>                                                                                                                                                                                                                                                      | All         | To discuss any further business before the close of the meeting.                                                                           | <b>N</b> | Verbal          |

| No.                                                                                              | Agenda Item | Time             | Items for Discussion | Owner | Board Action:                                                                                        |   | Preparation |
|--------------------------------------------------------------------------------------------------|-------------|------------------|----------------------|-------|------------------------------------------------------------------------------------------------------|---|-------------|
|                                                                                                  |             |                  |                      |       | Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)                                                     |   |             |
| 17.                                                                                              | 25/26/330   | 15:09<br>(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, 5 <sup>th</sup> March 2026, LT1, Institute in the Park. |             |                  |                      |       |                                                                                                      |   |             |

| REGISTER OF TRUST SEAL                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------|
| The Trust seal was used in December 2025:<br>431: J.106 Agreement Planning Application for Alder Lodge – Hill Dickinson |

| SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION |        |
|--------------------------------------------|--------|
| Financial Metrics, M9, 2025/26             | R. Lea |

**PUBLIC MEETING OF THE BOARD OF DIRECTORS**  
**Confirmed Minutes of the meeting held on Thursday 8<sup>th</sup> January 2026 at**  
Lecture Theatre 1, Institute in the Park

|                      |                    |                                           |         |
|----------------------|--------------------|-------------------------------------------|---------|
| <b>Present:</b>      | 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)    |
|                      | Mrs. R. Lea        | Chief Finance Officer                     | (RL)    |
|                      | 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)    |
|                      | Mrs. K. Warriner   | Chief Digital and Transformation Officer  | (KW)    |
| <b>In Attendance</b> | Ms. S. Almond      | Consultant Paediatric Surgeon             | (SA)    |
|                      | Mr. C. Beaver      | Deputy Director of Marketing and Comms    | (CB)    |
|                      | Dr. J. Chester     | Chief Scientific Officer                  | (JC)    |
|                      | Ms. L. Cooper      | Director of Community and MH Services     | (LC)    |
|                      | Dr. U. Das         | Director of Medicine                      | (UD)    |
|                      | Mrs. D. Jones      | Chief Strategy and Partnerships Officer   | (DJ)    |
|                      | Ms. C. Lee         | ACOO, Division of Surgery                 | (CL)    |
|                      | Mrs. K. McKeown    | Board Administrator (minutes)             | (KMC)   |
|                      | Mr. D. Powell      | Director of Development                   | (DP)    |
|                      | Ms. E. Saunders    | Chief Corporate Affairs Officer           | (ES)    |
| <b>Apologies</b>     | Ms. B. Pettorini   | Director of Surgery                       | (BP)    |

**25/26/288 Welcome and Apologies**

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

**25/26/289 Declarations of Interest**

The following declarations were made:

- Non-Executive Director, Gerald Meehan, declared that he is the Independent Chair of Liverpool's Children's Services Improvement Board.
- Non-Executive Director, Mark Jennings, declared that he is the Chief Solutions and Services Officer for Strasys.
- Non-Executive Director, Bola Owolabi, declared that she is a Chief Inspector for CQC.

**25/26/290 Minutes of the previous meeting held on 4<sup>th</sup> December 2025.**

**Resolved:**

The minutes from the meeting held on the 4.12.25 were agreed as an accurate record of the meeting.

## **25/26/291 Matters Arising and Action Log**

### *Matters Arising*

There were none to discuss.

### *Action Log*

It was confirmed that all actions are on track.

## **25/26/292 Chair's and CEO's Update**

The Chair opened the agenda item by recognising the significant effort and exceptional performance demonstrated by staff across the organisation over recent weeks, noting that teams have continued to deliver to a high standard despite considerable operational pressures. It was confirmed that the Trust remains in a strong position.

John Grinnell drew attention to the recent industrial action/winter surges and commended the exemplary response of services, which ensured continued access for children and young people (CYP) while maintaining the safety of the service.

The Trust's focus on leadership and engagement via the Connected Leaders Programme was highlighted, with the Executive team actively engaging with staff members to improve communication and collaboration.

The Board was advised that during a recent 'Senior Leaders and Managers' session teams reflected on organisational priorities and collectively identified five key objectives that are to be tracked and revisited regularly during the forthcoming quarter;

- AFT application.
- Submission of the Medium-Term Plan in February 2026.
- Launch of the 'How We Work in the Future' Organisational Change Programme and what the next phase means for the Trust.
- Progressing a system model for CYP.
- Delivery of the Trust's Financial Plan by the 31.3.26.

### **Resolved:**

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

## **25/26/293 Future Shape of Alder Hey Update**

### *AFT Application*

It was reported that the Trust has submitted a credible application as part of the Advanced Foundation Trust (AFT) assessment process, which began earlier today with an initial meeting between the Board and the NHS England (NHSE) assessment team. The process will include observation of a Trust Board meeting and its Assurance Committees, stakeholder engagement, and a Board-to-Board meeting in March. A decision on the outcome of the application is expected by April 2026.

### *Medium Term Plan*

On the 12th of December 2025, the Trust submitted the first iteration of its Medium Term Plan, covering 2026/27 and 2027/28. The next key milestone is the submission of a comprehensive three-year Medium Term Plan scheduled for the 12.2.26. It was confirmed that the final version of the Mid Term Plan will be shared with the Board on the 5.2.26.

The Board was provided with a high-level summary of the plan submitted in December, as well as the next steps and work required to develop the plan prior to February.

Divisional presentations on proposed plans will be shared during January's Finance, Transformation and Performance Committee (FTPC), providing Executives with the opportunity to scrutinise assumptions, challenges, and proposed mitigations. FTPC will also allocate significant time to review the financial shape of the Medium Term Plan during the meeting.

During the discussion on the Medium Term Plan, Non-Executive Director, Fiona Beveridge (FB), raised a number of points regarding the new national performance standards, with particular attention on governance, assurance, and committee responsibility. The importance of establishing clearer oversight arrangements was emphasised to ensure that each standard is clearly assigned to the appropriate Assurance Committee, preventing duplication or gaps. It was reported that discussions have taken place regarding the Oversight Framework, and further work is to be undertaken to determine/formalise committee responsibility for each area. It was agreed to discuss this matter further outside of the meeting.

**25/26/293.1 Action: AB/FB/ES**

Non-Executive Director, Bola Owolabi (BO) highlighted the strong narrative on health inequalities in the Board Memorandum for the AFT application and suggested this should be reflected in the Medium Term Plan, especially in terms of new access standards and narrowing gaps in access. BO also recommended including more detail about delivering these standards and explicitly connecting them to reducing inequalities. Additionally, BO referred to the 3<sup>rd</sup> line in the appendix and pointed out that where the organisation is described as 'maturing' on health inequalities, this could be enhanced by including narrative aligned with the NHS Inequalities Matrix.

*C&M Financial Position*

The Board received an update on the Cheshire & Merseyside (C&M) System financial position. It was noted that the Trust's Month 9 financial reporting has been delayed due to the operational and financial impact of recent industrial action. The Board was advised that the system as a whole remains financially challenged, with ongoing discussions taking place with individual providers across C&M to understand forecast positions, remaining gaps, and actions being taken by all providers to support year-end delivery.

It was reported that although the system position remains pressured, there has been some improvement in overall forecast positions with a number of providers having moved their forecasts closer to plan. The Trust continues to work through its own Month 9 position, with a full update to be provided at the next meeting.

**Resolved:**

The Board received and noted the updates.

## 25/26/294 Evidence of Our Performance

### Flash Report, M9

The Board received the Flash Report for M9. The following points were highlighted:

- There has been an improved performance for the percentage of patients waiting under 18 weeks for treatment (62.5%).
- There was 1 Never Event in December for which a Patient Safety Incident Investigation (PSII) is being undertaken.
- Sickness levels rose in M9 to 7.10%. It was confirmed that there is an increased focus to try and address this issue.
- During early December, the organisation experienced an exceptionally high surge in Emergency Department (ED) attendances, driven predominantly by a significant rise in RSV and flu. At peak points, the Trust saw nearly 100 families in the department at one time, placing substantial pressure on flow, clinical capacity, and patient safety. There is a further peak anticipated in January therefore the Trust is taking a proactive stance to strengthening GP capacity at the front door and is running an advert about appropriate service use.
- Supporting clinical cover during the recent period of industrial action was particularly challenging, largely due to the timing of the action and the concurrent winter pressures. Despite this, the organisation succeeded in maintaining safe services through significant operational effort; flexibility from clinical teams, and staff stepping in to support rotas at short notice.

The Board formally recognised the contribution of all staff involved, with specific thanks to the Chief Medical Officer for leading the Trust's operational response and ensuring that appropriate cover arrangements were in place throughout the recent period of industrial action.

### Integrated Performance Report (IPR)

#### *Outstanding Care and Experience – Safe and Caring*

The Board received a detailed update on the Never Event that occurred in the High Dependency Unit (HDU) involving the wrong-route administration of medication. It was explained that although the incident is categorised as a Never Event, the contributing factors were complex and multifactorial. The patient came to no harm, and a full PSII has been commissioned.

It was queried as to whether the increase in Never Events is due to workforce pressures. The Board was advised that initial reviews have not identified staffing levels or workforce pressures as factors in the HDU incident, although this will be fully explored as part of the investigation. The Board noted that an external subject-matter expert (SME) has been appointed to undertake a Trust wide review across theatres due to the increase in Never Events and that the Trust has up to six months to complete the work.

#### *Community and Mental Health Division*

- *Backlog of clinical letters* - Ambient Voice Technology (AVT) has been rolled out for clinicians, with licences issued in December. It is expected that once this AI solution is fully adopted, it will significantly reduce the backlog of clinical

letters, though it may take a couple more months to see sustained improvement.

#### *Division of Medicine*

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

#### *Division of Surgery*

- The Board was advised of the first ever same-day discharge for a total hip replacement, which was described as hugely significant. The success was attributed to strong coordination across pre-op, post-op, and various support teams. The team followed up with the patient's family, identified further areas for improvement, whilst noting some learning around prescribing practices.
- Dentistry remains a significant area of concern. The team is maximising every opportunity internally and developing a Sustainability Strategy for the service.
- There is a high volume of long-term sickness in anaesthetics. It was reported that the team is managing it well but despite this long-term sickness is impacting the service.

#### **Resolved:**

The Board:

- Noted the Flash Report for M9.
- Noted the content of the IPR for Month 8.

#### **25/26/295 Mortality Report, Q2**

##### **Resolved:**

The Board received and noted the contents of the Mortality Report for Q2.

#### **25/26/296 Organ Donation Annual Report, 2024/25**

The Board received the Organ Donation Annual Report for 2024/25, which underwent detailed scrutiny by SQAC in December. The report highlighted ongoing improvements in organ donation performance, governance, and practice within the Trust. As a result of Dr Carla Thomas's leadership, the service has made significant strides, overcoming previous challenges and enhancing outcomes for CYP and their families.

It was felt that it would be beneficial for the Board to hear from Dr. Thomas at a future meeting due to the complexity and importance of the work that the team undertakes.

##### **25/26/296.1 Action: KMC**

##### **Resolved:**

The Board received and noted the content of the Organ Donation Annual Report for 2024/25.

#### **25/26/297 Safety and Quality Assurance Committee**

The approved minutes from the meeting held on the 26.11.25 were submitted to the Board for information and assurance purposes.

It was reported that the Committee received the action plan associated with key recommendations from the Southport Internal Learning Review and is to receive monthly updates on this area of work. Attention was drawn to Appendix 1 in the Chair's Highlight Report which provides an overview of progress on the

implementation of the actions. It was confirmed that the Board will receive a progress update on a quarterly basis.

**Resolved:**

The Board noted the Chair's Highlight Report from the meeting held on the 17.12.25 and the approved minutes from the meeting held on the 26.11.25.

**25/26/298 Liverpool Neonatal Partnership (LNP) Board**

The Board received an update following a meeting of the LNP Board on the 1.12.25. The following points were highlighted:

- It was reported that Jo Minford (JM) retired in December from her role as Co-Director and Clinical Lead of the LNP. The Trust Board formally noted its thanks and appreciation for JM's contribution to establishing and strengthening the LNP.
- Two new Surgical Leads, who are both paediatric surgeons, were appointed in December and will work closely with LNP leadership.
- Further discussions are taking place with Specialist Commissioners regarding cot numbers and capacity across ICU/HDU, and a paper has been submitted in respect to another set of financial expectations to achieve national specification for neonate units.
- After a slow start, the LNP's cultural improvement work is now gathering momentum, with strong engagement.

The Chair referenced the Neonatal Review and inquired whether the scope of the review will extend beyond Liverpool to include other neonatal units within the region. It was confirmed that the review in its entirety will cover the whole of the regional footprint, not just Liverpool. However, it was noted that this process will take time before it is concluded.

**Resolved:**

The Board noted the LNP Board update.

**25/26/298 Collaborate for CYP Partnerships Update**

*System update*

The Board received a number of slides that provided the following information:

- Alder Hey is continuing to define the CYP system model, leading/convening partners, and aiming to improve access and outcomes for CYP in C&M.
- Building upon the CYP system in partnership, working with the developing strategic commissioning model of ICB's and across the Provider Collaborative.
- Working in partnership to shape the CYP system architecture.
- The aim is for the system to focus more on the three shifts of the NHS 10 Year Plan; sickness to prevention, hospital to community, analogue to digital, with a focus on affordability through sustainable care models.
- The next step is to build upon the network of CYP secondary care providers, working closely with Provider Collaborative partners in C&M.
- Alder Hey is also helping shape healthcare through local, regional, and national strategic partnerships.
- Partnerships;

- CYP Neighbourhood development.
- Test, learn and grow (*prioritised lung health cohort of pre-birth and 0-5 with a focus on neighbourhoods/early interventions and prevention*).
- Beyond CYP Transformation Programme.
- North Mersey Provider Partnership.
- C&M CYP Alliance.
- Liverpool 0-19 Health Child Programme.
- Key updates for Trust Board;
  - Significant system work with C&M Provider Collaborative NHS partner trusts and in Neighbourhoods - This is ongoing.
  - Major change and executive shifts still ongoing at the ICB – mitigating risk via CEO/Chair engagement.
  - Scale of system partnership work continues to grow.
  - Capacity challenge - but for the right reasons.
  - Strategic Partnership governance now formally via Growth and Opportunities Committee per Terms of Reference. Rightsized and refreshed approach under design.

### *Neighbourhood Working for CYP*

The Board received an update on the Trust's Neighbourhood Plan and substantial initiatives currently being undertaken by Alder Hey in collaboration with primary and community care, mental health services, local authority, public health, early help, social care, education, and voluntary/community/social enterprise partners.

These efforts aim to establish effective neighbourhood-based approaches for CYP, both locally across the Trust's principal 'Places,' and more widely across the whole system through the Alder Hey-led C&M 'Beyond' CYP Transformation Programme.

A question was raised, in terms of looking forward, as to whether there will be an opportunity to quantify the amount of CYP that will be seen via neighbourhood working, acquire prevalence data and determine what it is that the Trust is aiming to achieve, for example, projected numbers of Primary Care Networks (PCNs), Places, and CYP who will be supported, etc. In respect to general paediatrics, it was queried as to whether there is a defined ambition, for example, is there consideration that a third of outpatient clients may transition to neighbourhood multi-disciplinary teams (MDTs).

The Board was advised that pilots are currently underway and the cohort of CYP has been identified. Once the structure of the MDT becomes clearer, next steps will be determined to enable implementation. It was pointed out that the MDT described in the national documentation may not align perfectly with the needs of local services and populations. Collaboration with local authorities is critical to effectively identify larger groups of CYP. While comprehensive data on all CYP is not yet available to fully define objectives, the approach will continue to be measured and purposeful.

It was reported that neighbourhood working is part of a cultural programme that will require some time to implement. Currently, 6 out of 9 sites have launched their test bed MDT at C&M level within the national framework. Following this, an evaluation will be undertaken and recommendations made to determine what an optimal model will look like. It is anticipated that this approach will evolve into a more standardised component of a commissioning approach for CYP Neighbourhoods.

It was noted that Alder Hey's Beyond programme places the organisation in a strong position to lead on neighbourhood health, particularly on health equity-driven models, and a suggestion was made about making health inequalities central to the Trust's developments supported by concrete evidence. The Core20PLUS5 framework was highlighted as a readymade structure for neighbourhood health initiatives, offering clarity and a shared language for Alder Hey and its partners.

The Chair offered thanks for the update and pointed out that while neighbourhoods may present certain complexities, numerous partners are involved in offering support due to their commitment to making a positive impact for CYP.

**Resolved:**

The Board noted the system CYP partnership update and Alder Hey's Neighbourhood Plan.

**25/26/299 Growth and Opportunities Committee (GO)**

The approved minutes from the meeting held on the 7.10.25 were submitted to the Board for information and assurance purposes.

During December's meeting the Terms of Reference were formally approved. Under the ambition section of its agenda, the Committee reviewed the development of growth metrics, acknowledging that further work is required to finalise a consistent set of measures. The Committee received a presentation on system-wide opportunities across C&M and undertook a deep dive into research, innovation, and the Paediatric Open Innovation Zone (POIZ). As part of this, the Committee requested that a financial strategy for research and innovation be developed to enable a clearer understanding of cost, contribution, and future opportunity. The Committee also considered the proposals for International and Private Patients.

Under the assurance section of the agenda, the Committee discussed the governance and oversight of the Trust's extensive network of strategic partnerships. It was noted that work is underway to rationalise and streamline governance arrangements, including consideration of a dedicated Sub-group. The Committee also reflected on the need to clarify the governance route for digital transformation, recognising the risk of duplication across committees and the importance of aligning digital reporting between GO and FTPC.

**Resolved:**

The Board noted the update and the approved minutes from the meeting held on the 7.10.25.

**25/26/301 Strategic People Update**

The Board was provided with a strategic update of the key people issues during December 2025. The following points were highlighted:

- Following formal approval of the Trust's new values in December, rollout has commenced, including distribution of new lanyards to staff and ongoing work to embed the associated behavioural framework across the organisation.

- It was reported that significant progress is being made within the Equality, Diversity and Inclusion (EDI) agenda, including the introduction of Active Bystander training funded through charitable support, a new development programme for internationally recruited colleagues in response to feedback regarding progression opportunities, and planning for a Day of Inclusion scheduled for April 2026.
- Sickness absence remains a substantial workforce challenge, with overall sickness at approximately 7%, the highest rate seen by the Trust. The top reason for sickness absence continues to be attributable to stress, with an equal split of both long term and short-term sickness absence. 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. It was confirmed that sickness absence is being closely monitored

During discussion, the Board queried whether stress-related absence could be distinguished between workplace and personal causes. It was reported that this information is generally available from the occupational health provider, and it was agreed to obtain and report back on this breakdown. The Board also sought assurance regarding support for internationally recruited staff following recent concerns. It was confirmed that issues raised previously had been resolved and that the new development programme forms part of a proactive and structured approach to supporting international colleagues.

**26/26/301.1 Action: MS**

The Board received further clarification that the Active Bystander programme is aligned to the Trust's Anti Racist Strategy, FTSU, and ambitions to strengthen a zero-tolerance culture.

**Resolved:**

The Board noted the strategic people update and the 'Improving Lives for Resident Doctors' report that was submitted to the People Committee in November 2025.

**25/26/302 NHSE Board Capability Assessment Feedback**

It was noted that formal written feedback from NHS England (NHSE) regarding the Trust's Board Capability Assessment has not yet been received. Therefore, it was agreed to keep this agenda item open until NHSE provides the written outcome of the capability assessment.

**Resolved:**

The Board noted the update on the NHSE Board Capability Assessment feedback.

**25/26/303 Emergency Preparedness, Resilience and Response Annual Report for 2024/25**

The Board received the Emergency Preparedness, Resilience and Response (EPRR) Annual Report for 2024/25. The report summarises the Trusts overall preparedness in reference to NHSE's EPRR Core Standards from October 2024 to September 2025, and outlines organisational plans, training and exercising, Divisional business continuity compliance, and declared incidents over the previous year.

It was reported that the Trust's overall compliance score has increased substantially: previously in the high-30% range, now improved to 77%, with a trajectory to reach the compliance threshold of 85% in the next cycle.

A question was raised about the Trust's performance in comparison to others and it was queried as to whether 77% is strong relative to the wider system, or does it appear only modest in isolation? The Board was advised that the C&M system wide results have yet to be released and that an update on formal benchmarking will be provided once available.

It was suggested prioritising certain areas such as infectious diseases to gain full compliance which will contribute towards achieving the compliance threshold in the next cycle. It was confirmed that this will be addressed as part of the improvement plan.

Thanks were offered to the EPRR manager, Jacob Gray, and his team for the considerable amount of work and effort undertaken to improve the Trust's EPRR compliance.

**Resolved:**

The Board noted the Annual EPRR Assurance Report for 2024/25 and the self-assessment assurance rating of partial compliance in line with the NHSE's EPRR Core Standards for 2025.

**25/26/304 Audit and Risk Committee**

**Resolved:**

The Board noted the Chair's Highlight Report from the meeting held on the 10.12.25 and the approved minutes from the 18.9.25.

**25/26/305 Finance, Transformation and Performance Committee**

The approved minutes from the meeting held on the 24.11.25 that were submitted to the Board for information and assurance purposes.

Attention was drawn to the importance of all Divisions delivering the forecasts that they have committed to or exceeding them where possible to protect the organisation's year-end position. It was noted that Divisions will participate in January's FTFC, where their delivery plans will be scrutinised, assumptions will be challenged, and assurance provided regarding the achievability of the Q4 financial position. This session was emphasised as critical due to the limited time left before the financial year concludes.

**Resolved:**

The Board noted the update, the approved minutes from the meeting held on the 24.11.25, and the Committee's top key risks in M8.

**25/26/273 Board Assurance Framework Report (BAF)**

The Board was provided with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 14 principal risks aligned to the Trust's strategic objectives. The following points were highlighted:

- It was reported that the BAF has been updated following a review with Executive risk owners and will continue to be monitored.
- The risk score relating to infrastructure and defects has increased to 16 due to ongoing contractual challenges specifically tied to the PFI and the Neonatal Intensive Care Unit (NICU).

**Resolved:**

The Board received and noted the contents of the Board Assurance Framework Report for November 2025.

**25/26/275 Any Other Business**

There was none to discuss.

**25/26/276 Review of the Meeting**

It was noted that January's public Board agenda was streamlined due to the day's demanding schedule, which included the AFT assessment meeting and Board cyber training. The Chair felt that matters pertaining to safety and quality were thoroughly considered and hoped that colleagues agreed with this. It was noted that the AFT Assessment Team will observe February's Board meeting, which will feature a patient story. The Chair requested that Board members consider the possibility of convening the public Board session prior to the private element on 5.2.26 depending on the availability of the AFT Assessment Team.

**Date and Time of Next Meeting:** Thursday 5.2.26, 12:30pm, LT1, Institute in the Park.

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

| Date                          | Ref         | Item                                            | Action                                                                                                                                                              | By whom?                                    | By when? | Status             | Update |
|-------------------------------|-------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------|--------------------|--------|
| <b>Actions for March 2026</b> |             |                                                 |                                                                                                                                                                     |                                             |          |                    |        |
| 8.1.26                        | 25/26/293.1 | Mid Term Plan                                   | Discussion to take place to determine/formalise Assurance Committee responsibility for the new national performance standards.                                      | A. Bateman/<br>F. Beveridge/<br>E. Saunders | 5.3.26   | On track<br>Mar-26 |        |
| 8.1.26                        | 25/26/301.1 | Strategic People Update                         | Obtain data from the Trust's occupational health provider to determine whether stress-related absence could be distinguished between workplace and personal causes. | M. Swindell                                 | 5.3.26   | On track<br>Mar-26 |        |
| <b>Actions for April 2026</b> |             |                                                 |                                                                                                                                                                     |                                             |          |                    |        |
| 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/<br>K. McKeown                     | Feb-24   | Apr-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   | Apr-26             |        |
| 6.11.25                       | 25/26/223.1 | Alder Hey in the Park Campus Development Update | Strategic planning session to be scheduled in the new financial year to explore future development opportunities for the Campus.                                    | D. Powell                                   | Apr-26   | On track<br>Apr-26 |        |
| <b>Actions for May 2026</b>   |             |                                                 |                                                                                                                                                                     |                                             |          |                    |        |
| 8.1.26                        | 25/26/296.1 | Organ Donation Annual Report, 2024/25           | Invite Dr. Carla Thomas to a future Board meeting to share an insight into the complexity and importance of the work that the Organ Donation service undertake.     | K. McKeown                                  | 7.5.26   | On track<br>May-26 |        |
|                               |             |                                                 |                                                                                                                                                                     |                                             |          |                    |        |

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

| Date     | Ref | Item | Action | By whom? | By when? | Status | Update |
|----------|-----|------|--------|----------|----------|--------|--------|
| Status   |     |      |        |          |          |        |        |
| Overdue  |     |      |        |          |          |        |        |
| On Track |     |      |        |          |          |        |        |
| Closed   |     |      |        |          |          |        |        |

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

| Date          | Ref         | Item                                  | Action                                                                                                                                                             | By whom?  | By when? | Status | Update                                                                                                                                                                     |
|---------------|-------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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   | Closed | <b>30.1.26</b> - This data has been included in February's FTSU report. <b>ACTION CLOSED</b>                                                                               |
| 6.11.25       | 24/25/222.1 | Integrated Performance Report         | Submit a report on the QI work relating to deteriorating patients in order to discuss the outcomes and broader implications in terms of reflecting on other cases. | A. Bass   | Nov-25   | Closed | <b>30.1.26</b> – This item has been included on February's Board agenda. <b>ACTION CLOSED</b>                                                                              |
| 4.12.25       | 25/26/258.1 | Advanced Foundation Trust Application | Discuss the implications of changes to particular relationships resulting from attaining AFT status.                                                               | Board     | Jan-26   | Closed | <b>30.1.26</b> – An introductory session took place with the AFT Assessment Team on the 8.1.26 which provided further clarity on the overall process. <b>ACTION CLOSED</b> |
| 4.12.25       | 25/26/259.1 | Medium Term Plan                      | Further analysis/validation required of the £31m savings target and the 2% productivity target.                                                                    | R. Lea    | Jan-26   | Closed | <b>30.1.26</b> – The final version of the Mid Term Plan has been included on February's Board agenda. <b>ACTION CLOSED</b>                                                 |
|               |             |                                       |                                                                                                                                                                    |           |          |        |                                                                                                                                                                            |
| <b>Status</b> |             |                                       |                                                                                                                                                                    |           |          |        |                                                                                                                                                                            |
| Overdue       |             |                                       |                                                                                                                                                                    |           |          |        |                                                                                                                                                                            |
| On Track      |             |                                       |                                                                                                                                                                    |           |          |        |                                                                                                                                                                            |
| Closed        |             |                                       |                                                                                                                                                                    |           |          |        |                                                                                                                                                                            |

## BOARD OF DIRECTORS

Thursday, 5<sup>th</sup> February 2026

|                    |                                                 |
|--------------------|-------------------------------------------------|
| Paper Title:       | Integrated Medium Term Plan, 2026/27 to 2028/29 |
| Report of:         | Chief Operating Officer                         |
| Paper Prepared by: | Head of Service Development and Performance     |

|                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Purpose of Paper:                  | Decision <input checked="" type="checkbox"/><br>Assurance <input type="checkbox"/><br>Information <input type="checkbox"/><br>Regulation <input type="checkbox"/>                                                                                                                                                                                                                                                                          |
| Action/Decision Required:          | To note <input type="checkbox"/><br>To approve <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                         |
| Summary / supporting information   |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Strategic Context                  |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| This paper links to the following: | <b>Outstanding</b> care and experience <input checked="" type="checkbox"/><br><b>Collaborate</b> for children & young people <input checked="" type="checkbox"/><br><b>Revolutionise</b> care <input checked="" type="checkbox"/><br><b>Support</b> our people <input checked="" type="checkbox"/><br><b>Pioneering</b> breakthroughs <input checked="" type="checkbox"/><br><b>Strong Foundations</b> <input checked="" type="checkbox"/> |
| 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<br>(as defined against the risk in InPhase) | <input type="checkbox"/> Fully Assured<br>Controls are suitably designed, with evidence of them being consistently applied and effective in practice | <input type="checkbox"/> Partially Assured<br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness | <input type="checkbox"/> Not Assured<br>Evidence indicates poor effectiveness of controls |
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|



# **Integrated Medium Term Plan**

**2026/27 to 2028/29**

## Contents

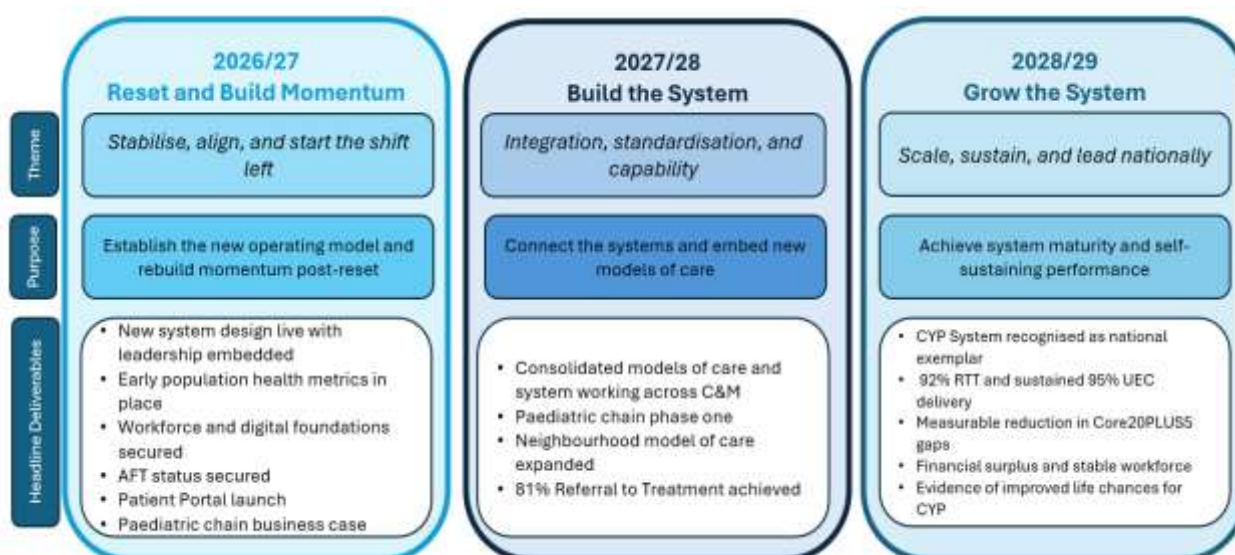
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# 1. Executive Summary

Alder Hey's Vision 2030 is for a healthier, happier, and fairer future for children and young people. This three-year plan is designed to make significant progress in making this vision a reality for the Children and Young People (CYP) we serve. Alder Hey will move from being a high-performing health care provider to forming, with partners, the *leading children and young people's health system in the United Kingdom*: a clinically-led, needs-based children and young people's health system across Cheshire & Merseyside and beyond, that reduces inequalities, improves access and experience, and strengthens population health through service integration and clinical innovation.

To deliver this the Trust will evolve its approach to health care provision, collaboration, and the commissioning of services for the population as follows:

- Year 1: resetting, aligning leadership and building momentum
- Year 2: building and establishing the new system, integrating services, and standardising care
- Year 3: grow the system to be financially sustainable, digitally connected and delivering more equitable outcomes for CYP in Cheshire & Merseyside and beyond.



By the end of Year 3, Alder Hey and partners aim to realise the following ambitions:

1. **Build a single, coherent CYP System** — integrating community, acute, and specialist care, with unified leadership, governance, and pathways.
2. **Reduced inequity in outcomes and improve life chances**— with measurable progress in Core20PLUS5 indicators and CYP life chances. providing earlier support and fewer avoidable hospital attendances.
3. **Revolutionise CYP's experience of, and access to, care** — achieving national elective and diagnostic standards and an outstanding experience for families. This will be enabled by patient navigation, digital access, and a new Patient Portal.
4. **Established Alder Hey as an Advanced Foundation Trust and a national test site** for system-based care, digital transformation, and innovation.

5. **A thriving workforce** through a culture where staff feel connected, safe, healthy, supported, and empowered to perform at their best.

To achieve the above ambitions, the plan is focused on the delivery of five big enablers:

1. **How we will work in the future:** establishing a new operating model for Alder Hey, that is more clinically led, reduces running costs and provides the capabilities to seize future opportunities (i.e. enabling the shift of services into the community and the creation of a CYP health system).
2. **Transformation that revolutionises care models to deliver high performance & productivity:** the clinical transformation programmes are focused on new service models for neighbourhoods, neuro-developmental needs, urgent and outpatient care.
3. **Digital, Data & AI Advancement:** expand digital-by-default service provision, launch a new patient portal, AI-enabled diagnostics, and population health insights data insights to inform the service models of the future.
4. **Build a CYP System, Growth, Opportunities and Futures:** partners across Cheshire & Merseyside to build a single, coherent children and young people's health system that integrates community, acute and specialist care, replacing today's fragmented landscape with unified leadership, governance, and pathways. The Paediatric Open Innovation Zone and Liverpool Institute of Child Health and Wellbeing as key accelerators.
5. **Financial Improvement Programme:** reducing running costs, diversify income (for example, private patients, global partnerships, and commercial research), efficient allocation of CYP resources across the system and optimised capital investment plan.

The safety, workforce, financial and performance measurables to guide and underpin this plan are summarised in the table below:

|                    |                          | Baseline<br>2025/26<br>(Dec'25) | Year 1<br>2026/27 | Year 2<br>2027/28 | Year 3<br>2028/29 |
|--------------------|--------------------------|---------------------------------|-------------------|-------------------|-------------------|
| <b>Safety</b>      | Harms per 1,000 bed days | 15                              | 14                | 13                | 12                |
| <b>Workforce</b>   | WTE Employed             | 4,298                           | 4,000             | 4,000             | 4,000             |
| <b>Finance</b>     | Control Total Surplus    | £7.16m                          | £0.7m             | £6.4m             | £8.9m             |
|                    | CIP                      | £22.7m                          | £21m              | £13.2m            | £15.4m            |
| <b>Performance</b> | Referral to Treatment    | 62.5%                           | 70%               | 81%               | 92%               |
|                    | Patients seen in 4 hours | 84%                             | 95%               | 95%               | 95%               |

## 2. Board Assurance Statement

NHS England has asked each provider board to ensure that the planning process includes a robust board led check and challenge process, and that consideration has been given to finance, workforce, and activity levels whilst ensuring that the national ambitions for 2026/27 and beyond can be met and that quality of patient care is prioritised. The Board of Alder Hey Children's NHS Foundation Trust can provide assurance that the following statements apply:

1. National priorities: The Board has systematically reviewed and assured itself that it has plans in place to address the key opportunities to meet the national priorities for the NHS as set out in the Medium-Term Planning guidance.
2. Local prioritisation decisions: The Board has reviewed its existing quality and finance governance arrangements and is putting in place a robust clinically led process to support local prioritisation decisions relating to the quality and safety of the services we provide.
3. Deliverability of our plan: The Board has assured itself of the deliverability of its plans and identified mitigating actions to address key delivery challenges and risks.

Appendix 1 contains the Board's detailed response to the assurance statements. In addition, the Board is committed to ensuring that this plan:

- Accounts for the short-term financial pressure in the NHS and ICB, whilst ensuring we account for our long-term vision of a healthier, happier, and fairer future for children and young people.
- Enables us to make progress towards, and is aligned to, our Vision 2030 strategy, including our strategic goals of providing outstanding care and experience, collaborating for CYPF, revolutionising care, supporting our colleagues and pioneering breakthroughs.
- Assess the risks of the financial environment of the NHS to our plans to improve the life chances of CYP, the outcomes of the care we provide and reduce inequalities.
- Ensure our decision making is safe and compassionate, and we remain committed to being a great place to work.

The Integrated Operational Plan for 2026/27 – 2028/29 is approved on behalf of the Board of Directors by:

**Role:** Chair

**Name:** Dame Jo Williams

**Signature:**

**Role:** Chief Executive Officer

**Name:** John Grinnell

**Signature:**

**Role:** Chief Financial Officer

**Name:** Rachel Lea

**Signature:**

## 3. Introduction & Context

### Where we are now

Alder Hey is an NHS provider within the Cheshire & Merseyside's (C&M) Integrated Care System (ICS). However, Trust services and expertise reach far beyond this, delivering hospital and community health care services across local places in C&M, the Northwest Region, Isle of Man, North Wales, nationally and globally.

Alder Hey has a formidable reputation for clinical excellence and innovation, continuous improvement. The Trust has a track record for delivering high services to children and young people. The organisation is in segment 1 (highest performing) of the new NHS Oversight Framework (league table) and was the highest-ranked specialist children's health care provider.

In November 2025, the Trust was one of just eight Trusts selected to apply, in Wave 1, for Advanced Foundation Trust status. In the Care Quality Commission National CYP Patient Experience we were ranked second overall for experience of care. In late 2025 our Mental Health, ADHD and ASD services were rated as Outstanding by the CQC.

Alder Hey is guided by the experience of CYP and families, supported by robust governance, financial sustainability, and a culture of collaboration with system partners to improve population health and tackle inequalities. The Trust has been revolutionising care models, supporting people to use the latest technologies to deliver the absolute best outcomes for children and young people. We take the views of children and young people and families very seriously and actively ensure that their voice is at the heart of everything we do as partners in care, including to support the Alder Hey Children's Charity with national advocacy and influence.

Alder Hey is nationally recognised for leading paediatric research and innovation. The Liverpool Institute of Child Health & Wellbeing is a research partnership with the University of Liverpool and Alder Hey Children's Charity, which brings together clinical, academic, and civic expertise to tackle health inequalities, advancing prevention and treatment interventions. We have a dedicated Innovation Hub—the largest hospital-based centre of its kind—and we host the Paediatric Open Innovation Zone of the Liverpool City Region, bringing industry and academic partners together to deliver pioneering breakthroughs in child health.

### National Context

The NHS 10 Year Health Plan signalled three radical shifts for the NHS:

- **Analogue → Digital.**
- **Sickness → Prevention**
- **Hospital → Community**

Alder Hey's Vision 2030 strategy was set in advance of these shifts, and they align very closely. This medium-term plan sets out our commitment to these three shifts, to support the current and future needs of CYP, and the modernisation of the NHS.

| NHS 10YP 3 Shifts     | Vision 2030 CYP Needs alignment                               | What we will do in the next 3 years – examples;                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Sickness → Prevention | Improve my Life Chances<br>Get me well<br>Personalise my care | <ul style="list-style-type: none"> <li>Targeted action on health inequalities – through e.g. expanding the Wellbeing Hub, and via Public Health system partnerships</li> <li>Lead C&amp;M-wide delivery of Core20&amp;5CYP prevention programmes such as Oral Health, through the Beyond CYP transformation programme</li> <li>Expand our mental health in schools programmes</li> </ul>                                                                                           |
| Hospital → Community  | Improve my life chances<br>Get me well<br>Personalise my care | <ul style="list-style-type: none"> <li>Implement the Neighbourhood model of care</li> <li>At-scale virtual ward</li> <li>Lead the C&amp;M CYP system in delivery of a Paediatric chain model that ensures consistent standards for CYP across all secondary care</li> <li>Right care first time – through acute ground floor reorganisation</li> <li>Elective care transformation – diagnostic straight to test and consolidated models of care delivery across C&amp;M</li> </ul> |
| Analogue → Digital    | Bring me the Future<br>Get me well<br>Personalise my care     | <ul style="list-style-type: none"> <li>An AI to enhance patient care, empower staff, and transform operation</li> <li>Launch of a Patient Portal in 2026/27</li> <li>Launch Alder Care 2.2</li> <li>Generate CYP knowledge by building a robust Insights capability</li> </ul>                                                                                                                                                                                                     |

The NHS Medium Term Planning Framework set out the following priorities for Trusts:



The national priorities are at the core of Alder Hey's medium-term plan, in conjunction with internal priorities and ambitions. To support plan development and to set direction, the Executive team set five core planning assumptions. From the outset, the Trust planned to:



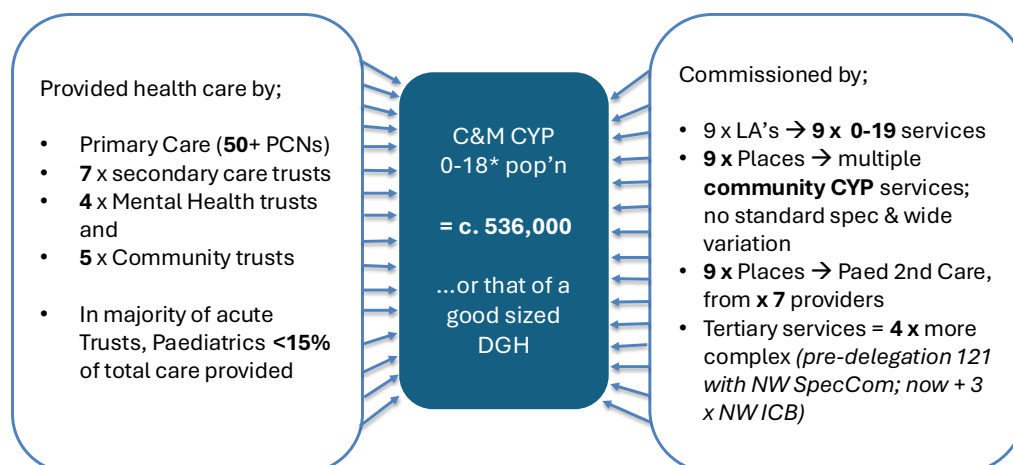
## Local context

**Children and young people in the Northwest of England and Cheshire & Merseyside experience significant health inequalities;** being a child or young person is a health inequality in itself.

**The Darzi Review (2024) underscored several challenges for children and young people (CYP) which are reflected in Alder Hey's population,** including rising rates of severe health conditions, longer treatment waits and consistently high paediatric intensive care unit occupancy. Despite increased A&E visits, emergency admissions remain static, indicating many CYP could be cared for outside hospital settings. Concerns were raised about NHS capacity and training to deliver high-quality paediatric care, alongside declining vaccination rates, and rising obesity. Mental health and neurodiversity needs are also escalating, with record numbers of referrals, lengthy waits for CAMHS, autism and ADHD assessments and demand far exceeding capacity.

**Alder Hey's Vision 2030 recognises that CYP outcomes are dependent upon education, local authorities, social conditions, public services, and the NHS.** C&M is a complex integrated care system, given its size and scale, and C&M the ICB and the 9 Local Authorities carry significant statutory duties pertaining to CYP's health and care. Within this complexity, significant opportunities exist to prioritise transformation within certain NHS CYP services. By doing so, Alder Hey can boost efficiency and capacity to deliver on the neighbourhood model, and build stronger, long-term partnerships with local authorities, schools, and communities, ensuring families benefit from a cohesive system.

### Fragmentation & Complexity - The current C&M CYP Landscape



\*Some services go up to 25yo – illustrative only – but also recognising many CYP are healthy majority of the time

**The C&M system is facing substantial challenges,** including financial instability with the urgent need for significant savings, fragile clinical services with inconsistent quality, considerable health inequalities and difficulties in staff recruitment and retention. At the beginning of this parliament, the NHS was subject to a £6.6 billion deficit, resulting in a £178.2m deficit plan for the Cheshire

& Merseyside ICB in 2025/26. Ongoing financial improvement programmes at ICB level has meant the Trust continues to be operating in a challenging financial environment.

**The C&M 0–18 population (c.0.5m) is comparable to a medium-sized hospital, yet health provision and commissioning are too fragmented and complex** to achieve scale or deliver integrated, holistic care.

**For several years, through Vision 2030, Alder Hey has been at the heart of designing and leading the CYP system across C&M, working with partners across multiple sectors** to address the wider determinants of health, to transform CYP outcomes, for example through hosting the C&M Beyond CYP Transformation Programme, and delivering key CYP system improvements in elective care, urgent and emergency care and in Community, Mental Health and Neurodiversity.

**In line with Vision 2030, Alder Hey, with partners, are continually working to shape a simpler C&M health system which focus on** the voices and needs of children, early intervention, reducing health inequalities, delivering safe services, innovative/ digital first care and affordability. Integrated, holistic care that combines physical and mental health, education and wellbeing is essential, especially for those with complex needs. Streamlining the system and encouraging collaboration will improve outcomes and sustainability.

**The ICB governance structure continues to evolve** under new leadership and to align with the NHS Operating Model, and the ICB is increasingly formalising Alder Hey's CYP system leadership role. This is reflected through C&M ICB's 5-Year Strategic Commissioning Plan 2026-31 for Alder Hey to work as key partners to co-create and develop a collaborative health and care system that is jointly accountable for children and young people.

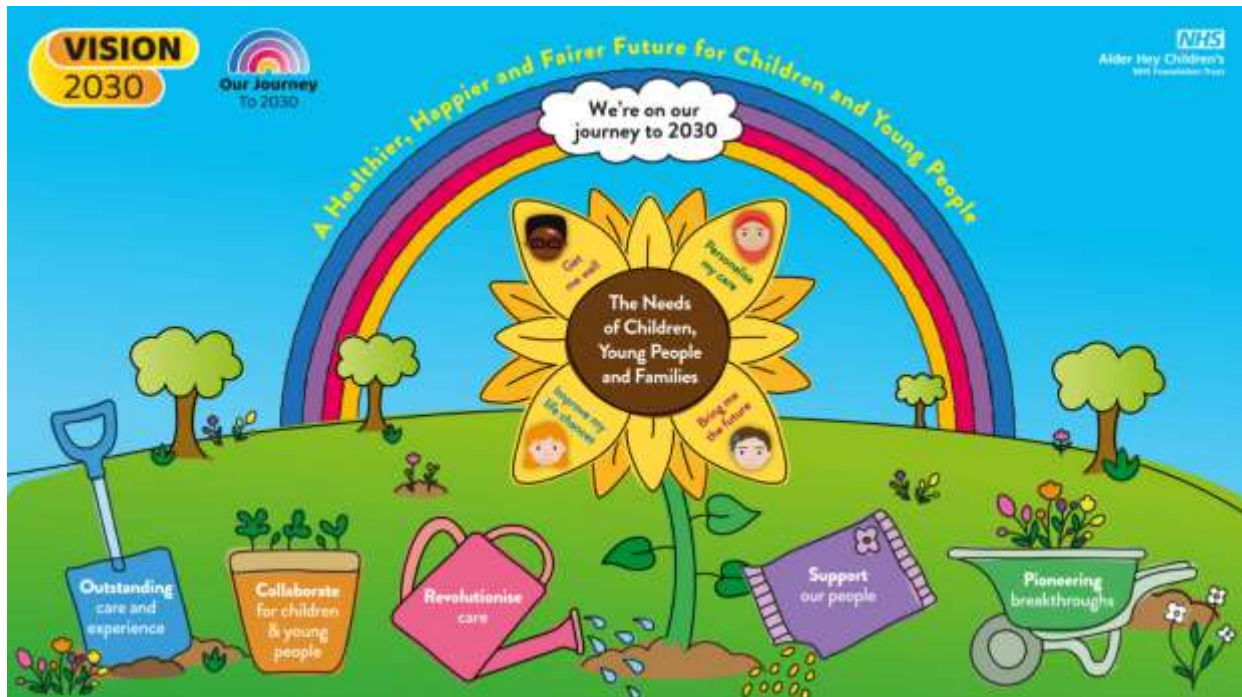
## 4. Our vision, and ambitions for children and young people

### Vision 2030

Alder Hey's vision to 2030 is to create a 'healthier, happier and fairer future for children and young people'. Born out of conversations with thousands of children and young people and extensive population health needs analysis, our vision is centred on meeting the needs of children, young people, and families. The four areas of need are:

- **Get me well:**
  - Children and young people in this group told us they need a quick fix.
- **Personalise my care:**
  - Children and young people in this group are living with a long-term condition or complex health need and are often looked after by lots of different specialities
- **Improve my life changes:**
  - Children and young people in our community need support from many different services, not just Alder Hey
- **Bring me the future:**

- Children and young people are ambitious for their own futures, for their families, and for their communities.



## Our ambitions

1. **Build a single, coherent CYP System:** integrating community, acute, and specialist care, with unified leadership, governance, and pathways.
2. **Reduce inequity in outcomes and improve life chances:** with measurable progress in Core20PLUS5 indicators and CYP life chances. providing earlier support and fewer avoidable hospital attendances.
3. **Revolutionise CYP's experience of, and access to, care:** achieving national elective and diagnostic standards and an outstanding experience for families. This will be enabled by patient navigation, digital access, and a new Patient Portal. *See Chapter 5 for more detail.*
4. **Establish Alder Hey as an Advanced Foundation Trust and a national test site** for system-based care, digital transformation, and innovation.
5. **Sustain a thriving workforce** through a culture where staff feel connected, safe, healthy, supported, and empowered to perform at their best. *See Chapter 5 for more detail.*

## Build a CYP System and secure Advanced Foundation Trust status

**A more coherent future CYP system will enable the NHS 10-Year Plan by** moving more care closer to home through community and primary care partnerships; standardising and improving acute paediatric care across the region; centralising specialist services to reduce duplication and raise quality; and simplifying service and commissioning arrangements.

**The C&M Provider Collaborative (CMPC), working with Alder Hey as CYP system lead, has prioritised CYP** as a population and recognised the need to simplify the complex CYP health service arrangements, aiming for standardisation, reconfiguration, and consolidation. The CMPC Blueprint articulates the requirement for: a CYP strategy, a holistic CYP neighbourhood/Place model, an acute paediatric chain model and clear CYP health leadership to bring all this together. C&M ICB has endorsed both the Blueprint and the CYP plans within and is embedding these priorities into the developing 5-year plan and commissioning intentions.

**Creating a holistic Neighbourhood/Place model for children, young people (CYP), and families is central to Alder Hey's Vision 2030**, the 10-Year Plan, making it a priority for the overall CYP system and a focus in both the Beyond Programme and the CMPC Blueprint. Neighbourhood working relies heavily on partnerships, bringing together key organisations such as C&M NHS Community & Mental Health trusts, Primary Care, Education, 0-19 services, Local Authorities, Voluntary, Community & Faith Sector partners, along with CYP, their families and communities. The CMPC Blueprint recognises the need to support neighbourhood working for CYP (and beyond) through convening providers for community, mental health, and neurodiversity services outside hospital settings. The C&M Beyond Programme, led by Alder Hey, is overseeing the roll out of a CYP multidisciplinary team model at Place across C&M, with targeted action on health inequalities as a core aim of the model (aligned with NHSE CYP Neighbourhood guidance, with governance through the C&M ICB's Neighbourhoods group).

**The CMPC Blueprint also establishes a revolutionary new model where Alder Hey leads hospital-based paediatric services with C&M provider trusts.** This aligns with Vision 2030 and builds upon Alder Hey's expertise in CYP by consolidating care to leverage clinical expertise and economies of scale. Alder Hey is committed to developing this as a co-designed and collaborative C&M paediatric community, which takes the best of what each site/unit is doing and brings together this excellence to improve overall CYP population outcomes.

The **paediatric chain** is predicted to be a two-year year health system transformation programme that will see services delivered at local trusts under Alder Hey's clinical and operational leadership. The paediatric chain aims to improve quality, consistency, value, and outcomes for CYP and families, while aligning with Alder Hey's Vision 2030 and wider NHS goals. This will focus on hospital paediatric services across C&M, and emergent design principles include:

- designed as locally as possible.
- with as much patient choice as possible.
- with expansion of 'at home' and digital first services.
- with minimum waiting times.
- where CYP are only treated outside of their local area for clinically justifiable and service configuration reasons, because of expressed patient choice and/or to improve equity.
- enabled by standardisation of paediatric education, training, and recruitment across C&M.

A programme plan is in development that prioritises clinical engagement and leadership from the C&M paediatric community; Executive buy-in and support from the ICB Board, trust chairs, and CEOs; local engagement and consultation with children, young people, families and carers; early

site-based adopters and co-design; a detailed service chain model; baseline data across trusts and clinical, workforce, and financial modelling to build a case for change and evaluate options. Work is initiating now, with strong support from C&M ICB, though end-game financial and activity benefits are yet to be quantified – this must be done in partnership across the CMPC community. The business case for the Paediatric Chain will be developed in Q1/2 of 26/27.

Advanced Foundation Trust status would provide Alder Hey with the platform, autonomy, and freedom to develop the Paediatric Chain and build the CYP System with our partners. AFTs are expected to work collaboratively with the ICB and local providers and where appropriate, taking on greater responsibilities at system level. Becoming an AFT would give Alder Hey, as a C&M system asset, the opportunity for a greater system mandate for accountability for CYP health leadership in C&M, which supports the ICB's strategic commissioning developments. AFT status enables opportunities to improve CYP outcomes and tackle challenges in key performance indicators.

### Reduce inequity in outcomes and improve life chances

Alder Hey is passionate about improving the life chances of children and young people, and through the Improve My Life Chances strategic programme of work from Vision 2030, it is aligned with the ICB's developing Population Health Improvement Plan, and local Public Health plans in the 9 Place areas of Cheshire & Merseyside. Through hosting the Beyond CYP Transformation Programme in Cheshire & Merseyside, the Trust is supporting improvements to the CORE20+5 priority areas for CYP, and the regional Child Poverty Agenda led by CHAMPS Public Health Collaborative and Directors of Public Health in Cheshire & Merseyside, with the ambition that no child in Cheshire and Merseyside lives in poverty.

The Trust will continue to work collaboratively with partners to support shift left initiatives for CYP and families, including a focus on reducing health inequalities using the Core20PLUS5 framework. We have a Consultant in Paediatric Public Health Medicine to lead the organisation's 'Improve my life chances' area of work. At Alder Hey, a Wellbeing Hub has been established with charity partners to deliver integrated health-linked social welfare advice to families—particularly those caring for CYP with long-term or life-limiting conditions. This pioneering model, part of Liverpool's Health Justice Partnership, demonstrates how embedding welfare advice within clinical settings can reduce health inequalities, improve mental wellbeing, and enhance clinical engagement.

Collaborating with local communities in Liverpool, Sefton, and Knowsley to deliver local population-based care, particularly within neighbourhoods.

Alder Hey is an anchor institution for CYP and families in Liverpool and beyond, the Trust will grow its employment and education opportunities for CYP, and the local community. The youth participation groups empower CYP to share their ideas, and work as partners in care to make Alder Hey a world-renowned service. Alder Hey also recognises that education and access to good work are central to lifelong health and wellbeing. *Inspiring Futures* is Alder Hey's strategic programme aimed at improving the life chances of children and young people across the Liverpool City Region; an area with some of the highest levels of deprivation in England. By working with schools, universities, NHS partners, local authorities, and community organisations, Alder Hey is expanding pathways into learning and work, developing skills and confidence, and contributing measurable social value across the region.

The Trust is committed to understanding the causes and presentations of health inequalities in childhood. The Liverpool Institute of Child Health & Wellbeing, a centre of excellence in research and innovation, whereby inequality and prevention are one of four priority research themes, enabling us to share learnings and convene expertise to ensure we make meaningful improvements to outcomes for children and young people.

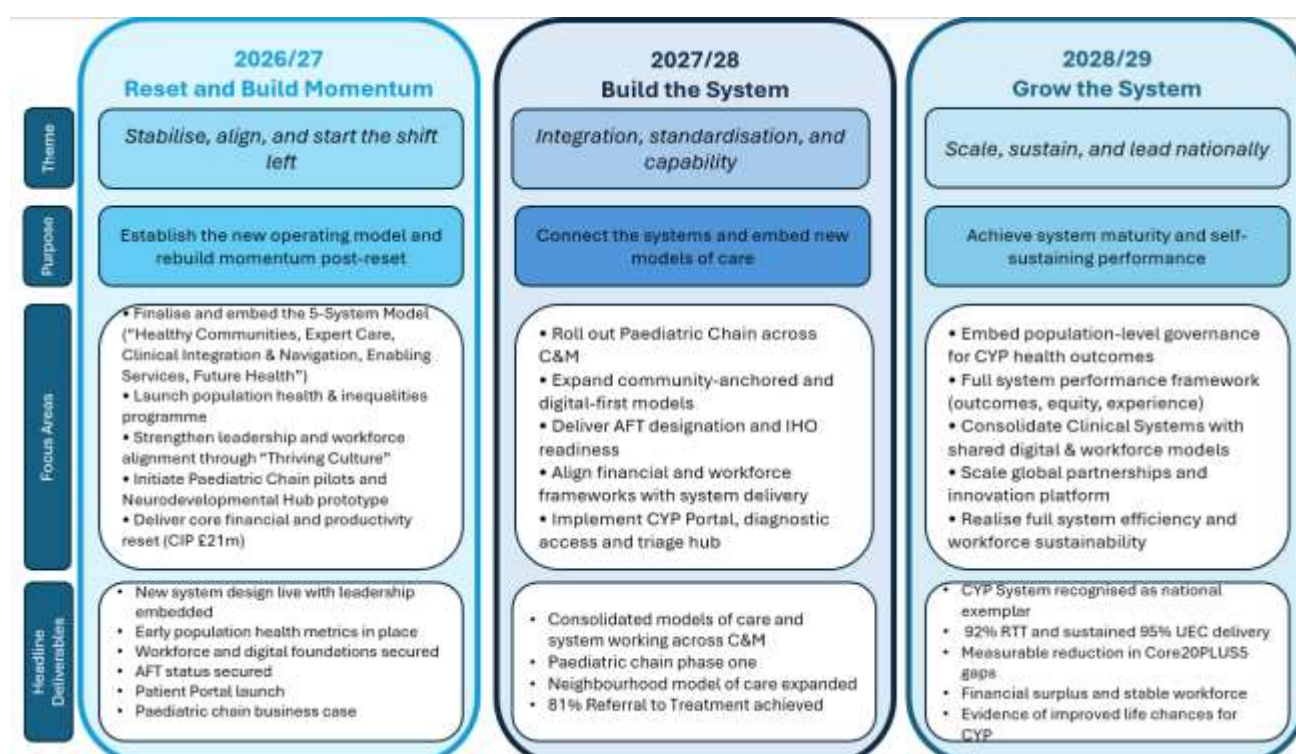
## 5. Three-year delivery plan

### Overview

The Trust plan for the next three year composes of:

- Year 1: resetting, aligning leadership and building momentum
- Year 2: building and establishing the new system, integrating services, and standardising care
- Year 3: grow the system to be financially sustainable, digitally connected and delivering more equitable outcomes for CYP in Cheshire & Merseyside and beyond.

An ambitious plan has been set to transform workforce models, revolutionise services, and to create the most efficient and effective services for children and younger people. The diagram below provides an overview of the next three years, including areas of focus and headline deliverables which are consistent with the Trust ambitions, Vision 2030, and the NHS 10 Year Plan.



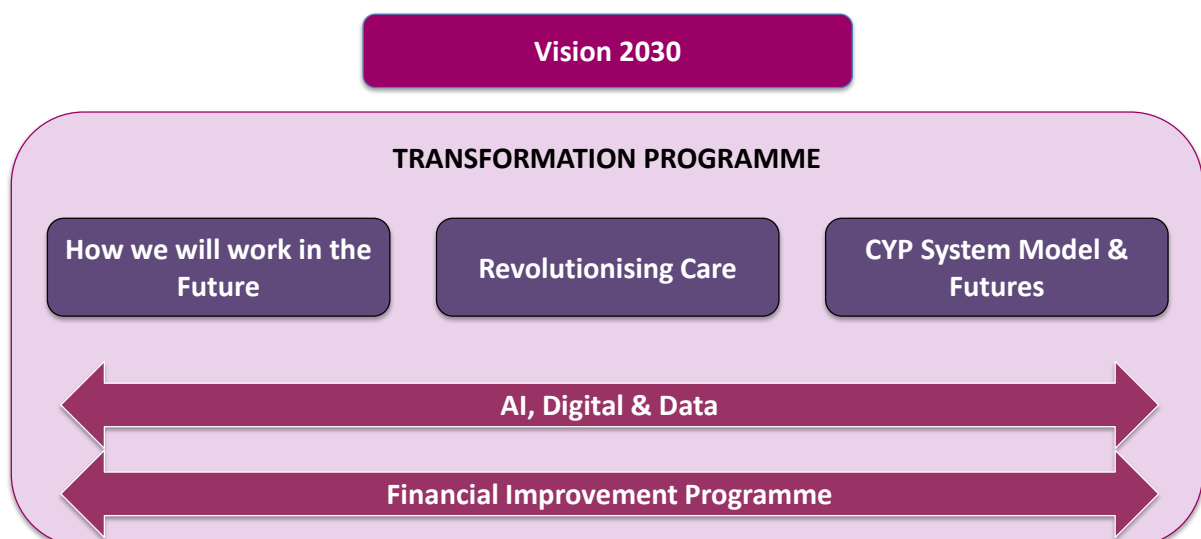
Alder Hey's application for Advanced Foundation Trust status reflects the Trust's ambition to be at the forefront of NHS transformation, delivering outstanding care, driving innovation, and supporting the health and wellbeing of our population now and into the future.

## Our big 5 enablers to deliver Vision 2030

To achieve the plan, there are five key enablers to realising our ambitions in the plan our Vision 2030. These are outlined below:

1. **How we will work in the future and our culture:** establishing a new operating model for Alder Hey, that is more clinically led, reduces running costs and provides the capabilities to seize future opportunities (i.e. enabling the shift of services into the community and the creation of a CYP health system). Our new values, connecting Alder Hey conversations and “Thriving Culture” and “Thriving Teams” programmes will strengthen culture.
2. **Transformation that revolutionises care models to deliver high performance & productivity:** our clinical transformation programmes are focused on new service models for neighbourhoods, neuro-developmental needs, urgent and outpatient care.
3. **Digital, Data & AI Advancement:** expand digital-by-default service provision, launch a new patient portal, AI-enabled diagnostics, and population health insights data insights to inform the service models of the future. Digital tools should also empower colleagues and reduce administrative burden.
4. **Build a CYP System, Growth, Opportunities and Futures:** build upon partnerships across Cheshire & Merseyside to build a single, coherent children and young people’s (CYP) health system that integrates community, acute and specialist care, replacing today’s fragmented landscape with unified leadership, governance, and pathways. The Paediatric Open Innovation Zone and Liverpool Institute of Child Health and Wellbeing as key accelerators.
5. **Financial Improvement Programme:** reduce running costs, diversify income (for example, private patients, global partnerships, and commercial research), efficient allocation of CYP resources across the system and optimised capital investment plan.

The big five enablers will be delivered and governed by our Vision 2030 Transformation Programme:



## Enabler 1: How We Will Work in the Future & Our Culture

### A new target operating model

Achieving Vision 2030 requires a way of working that is clinically led, responsive to changing need, and financially sustainable over the long term.

How We Will Work in The Future (HWWWITF) is about how Alder Hey will be designed and operate in the future: how decisions are made, how services are aligned, how leaders are supported, and how the organisation remains safe, sustainable and focused on what matters most—outcomes for children and young people.

The Trust will:

- organise care around the needs of children and young people, rather than organisational functional boundaries.
- future-proof Alder Hey clinically, so we are ready for rising demand, increasing complexity and new models of care.
- make better use of digital, data, AI, and scientific innovation to improve outcomes, experience, and efficiency; and
- do all of this in a way that is affordable and financially sustainable.

HWWWITF provides the organising framework to do this. It moves the Trust from a divisional structure to a system-led operating model, with clear accountability, stronger clinical leadership and closer alignment between clinical services and professional support functions. By sequencing change, strengthening leadership, and aligning services and professional support within clear design and affordability guardrails, the programme enables workforce change to be delivered in a controlled way that protects patient safety, maintains service continuity, and supports our people. This approach ensures that workforce reductions are achieved through structural redesign and changes to ways of working, rather than short-term or reactive measures. The intention is not simply to change structure, but to enable:

- better flow across pathways and settings.
- more consistent and joined-up experiences for children, young people, and families.
- clearer leadership and decision-making closer to care.
- reduced duplication and unnecessary complexity; and
- a more streamlined and sustainable organisation.

Alder Hey is in a period of significant strategic transition and organisational redesign, moving from a traditional acute focused structure toward a future facing, system lead model aligned to Vision 2030. This includes reshaping services around five system pillars spanning neighbourhood care, acute and specialist care, clinical support, professional services, and innovation through *Bring Me the Future*.

| System                                   | Primary outcome this system exists to deliver                                                                | What success looks like for CYP & families                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Healthier Communities</b>             | Children get the right support earlier, closer to home, reducing the need for hospital care.                 | <ul style="list-style-type: none"> <li>• More children supported safely outside hospital</li> <li>• Fewer crises and avoidable admissions</li> <li>• Better outcomes for children with mental health, neurodiversity, and complex needs</li> <li>• Reduced inequalities for disadvantaged children</li> </ul>                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Specialist &amp; Acute Care</b>       | Children who need hospital or specialist care receive timely, high-quality care, first time.                 | <ul style="list-style-type: none"> <li>• Children are seen quickly and treated in the right settings</li> <li>• Care feels reliable and joined up across pathways and sites</li> <li>• Fewer delays, hand-offs, and avoidable length of stay</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Precision Health &amp; Navigation</b> | Children experience faster access to tests, therapies, and follow-up, with fewer unnecessary appointments.   | <ul style="list-style-type: none"> <li>• Shorter waits for diagnostics and therapies</li> <li>• Fewer repeat or unnecessary outpatient visits</li> <li>• Smoother journeys across hospital and community care</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Future Child Health</b>               | Children benefit earlier from new models of care and innovation that improve outcomes now and in the future. | <ul style="list-style-type: none"> <li>• Earlier access to innovation and improved treatments, and care models that keep pace with rising and complex need</li> <li>• A children's health care system is sustainable and future-focused, where services for CYP work together smoothly, and care feels simple, consistent, and connected wherever they live</li> <li>• A trusted brand that CYP and families feel confident in and proud of, and which attracts the top organisations and innovators – leading to better experiences and outcomes</li> <li>• Bringing in money from more places, not just the NHS, so we can grow, invest, and protect the services CYP rely on.</li> </ul> |
| <b>Professional Services</b>             | Care is delivered safely, consistently, and sustainably because staff and leaders are properly supported.    | <ul style="list-style-type: none"> <li>• More reliable, responsive, and safer services</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

## Workforce plan

The workforce plan for 2026/27 to 2028/29 sets out the workforce assumptions to ensure that national ambitions for 2026/27 can be met, in addition to meeting our strategic ambitions to achieve 2030, while taking full advantage of productivity improvements.

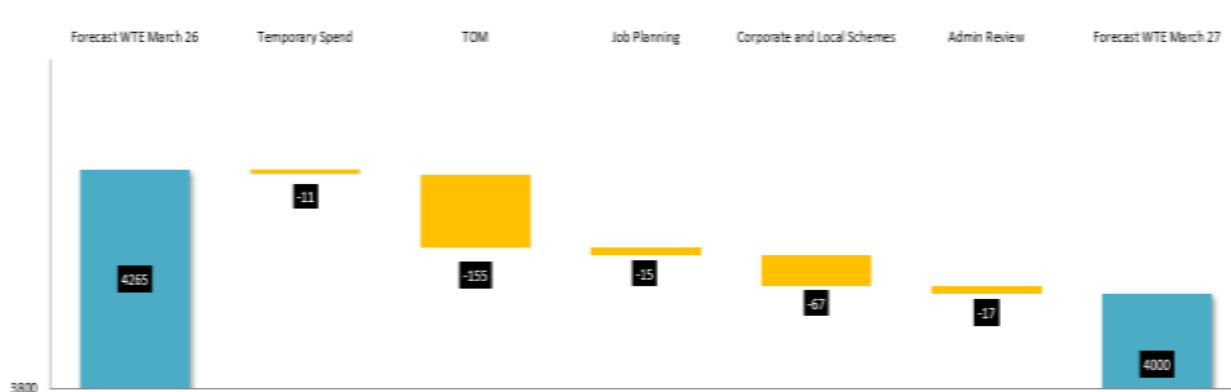
The workforce plan is based on the following assumptions and projected changes and will involve the redesign of services in line with the Trust's Target Operating Model (HWWITF).

- Building sustainable workforce models in all services
- Increase staff availability by reducing sickness absence by 1%
- Reducing temporary spend in bank (by 10%) and agency (by 30%) staff
- Embedding Trust values, tackling discrimination and sexual misconduct
- High quality leadership and reducing spans of control
- Improving Resident Doctors' working lives ensuring compliance against the 10-point plan
- Improved and compliant Consultant job planning
- Statutory mandatory training reforms

Between March 2026 and March 2027, analysis of the WTE (Whole Time Equivalent) movement indicates a projected overall reduction of 265 WTE from current establishment. The Trust's consistently low vacancy rate, alongside robust controls on bank and agency expenditure, is expected to decrease temporary staffing by 11 WTE (10% reduction in bank spend and 30% reduction in agency spend). Of the total reduction, 155 WTE will result from service re-design and innovation, specifically linked to the HWWITF programme, and 17 WTE through enhancements to the digital capabilities of administrative functions. Additionally, improved, and compliant Consultant job planning will contribute to a further reduction of 15 WTE. The remaining 67 WTE reduction will be realized through the implementation of both corporate and local schemes.

Between March 2027 and March 2029, the number of WTE will remain static. Delivery of a 1% workforce reduction will be achieved through lowering sickness rates by 1%, minimising temporary staffing costs and driving further innovation and digital capability improvement. This reduction will be offset by investment in new areas to support the growth and ambition outlined in years 2 and 3 of the plan.

### Waterfall diagram: movement in WTEs from March 2026 to March 2027



Whilst 2026/27 has a significant reduction in WTE as part of our Year 1 reset, the number of WTE will remain static between March 2027 and March 2029 and can be summarised below:



A detailed breakdown of the staff movements can be found in appendix two.

## Our culture

To achieve the strategic and transformation ambitions the Trust has set out, it is essential that we look after our people. The cultural priorities set out in the NHS Medium Term Planning Framework aim to create an empowered, inclusive, and patient-centered environment that supports staff wellbeing and drives continuous improvement, and this is something Alder Hey is striving to adopt. Alder Hey's Thriving Culture programme is designed to create a safe, inclusive, and high-performing environment where staff and patients thrive.

Aligning with national NHS priorities for culture, leadership, and workforce engagement, the programme has a specific focus on the development of a robust "problem sensing" climate with a unifying patient and staff safety culture at its heart. Evidence-based and grounded in listening to staff, the programme emphasises the importance of engagement through strong connections across Alder Hey, comprising work focused on individual, team, leader, and organisation levels that is values-based and empowering.

In line with the three key shifts described in the 10 Year Health Plan, the Thriving Culture programme aims to build connections and harness the power of community, increase empowerment through team-based, data-informed digital intelligence, and prioritise interventions that are focused on early intervention and prevention by creating the right workplace conditions to enable people to thrive.

These conditions include having the right resources, compassionate and effective leadership, value congruency at all levels, providing multiple and effective sources of intelligence, effective and restorative people processes, networks of compassion and belonging, learning and development, and robust systems of decision making and accountability.

## Engagement & Connection

As a listening organisation, Alder Hey already has in place a range of networks of noticing and listening, supplementing the data gathered through pulse checks and surveys, including four staff networks, one hundred well-being champions (SALS Pals), our FTSU Guardian and champions, and well-established Staff Advice & Liaison Service (SALS). Additionally, a new Connected Leadership approach will strengthen visibility between executives and teams, supported by a monthly rhythm of engagement activities such as Exec Briefings, Connecting Alder Hey sessions, and a team based "Ask for an Exec" programme.

## Values & Behaviours



A new set of organisational values – Compassion, Courage, Commitment & Community - agreed in April 2025, will underpin *how* we operate and *how* we care and are already embedded across transformation and OD initiatives. A new Values in Action framework and toolkit will be developed in 2026 and will help teams to live these values daily, closing the culture gap and ensuring behaviours align with the Trust mission and principles.

## Staff Experience & Empowerment

Staff wellbeing and empowerment are central to a thriving culture. The Thriving Staff Index, an Alder Hey innovation, provides real-time insight into morale, complemented by integrated data from the Staff Survey, People Pulse, FTSU and SALS. This enables proactive interventions and fosters a supportive environment. In 2026/27, the Thriving Staff Index will link to a new Thriving Teams Index.

## Safety Culture

Developing an adaptive safety culture aligned with the NHS Patient Safety Strategy is a priority. Safety Culture training, rolling out in 2026/27, and a new Thriving Teams Index will monitor team health and promote a proactive approach to preventing harm and learning from excellence. Safety culture will be strengthened through restorative and learning based practices.

## Thriving Teams

The Thriving Teams Index, delivery scheduled for Q3 2026, will combine data on staff experience, safety culture, patient safety, and HR metrics to provide targeted support. This integrated approach will help to identify strengths and areas for improvement, enabling timely interventions to enhance team performance and wellbeing.

## Thriving Leaders

Leadership development is a cornerstone of the culture programme. Initiatives include Strong Foundations and Strong Foundations Management Essentials, Clinical Leadership design, development and support, in-house coaching, BAME Aspiring Leaders programme, and Connected Leadership approach. Aligning current programmes with the new NHS Management & Leadership Framework and competency standards in 2026/27 will be key to ensure that leaders thrive.

## Enabler 2: Revolutionising Care

Alder Hey fundamentally transforming our models of care across the entire patient pathway, encompassing urgent care; re-imagined outpatient care model; neighbourhood-based services, and preventative health; and scaling centres of excellence to offer world-class, and specialised individualised care.

| Outcome for CYP                                                                      | Primary Measure                                                                               | Enabled through the following Transformation Programmes                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Right care, first time – safe and timely access for children and young people</b> | 4-hour ED performance<br><br>Referral-to-treatment (RTT)<br><br>Patient Experience            | <b>Revolutionising Care:</b> <ul style="list-style-type: none"> <li>A new Paediatric Assessment Unit &amp; Same Day Emergency Care Centre</li> <li>Digital first virtual urgent care model</li> <li>Expanding neighbourhood care services for CYP</li> <li>New neuro-developmental service model</li> </ul> <b>HWWITF:</b> Specialist & Acute Care; Healthier Communities; Precision Health & Patient Navigation<br><br><b>Digital, Data and AI:</b> Upgraded Electronic Patient Record (Alder Care 2.2). |
| <b>Faster access with fewer unnecessary appointments</b>                             | Referral-to-treatment (RTT)<br><br>% digital-first care<br><br>Time to diagnosis for ASD-ADHD | <b>Revolutionising Care:</b> <ul style="list-style-type: none"> <li>Centres of Excellence</li> <li>Re-imagined outpatient care model (Diagnose to refer and Straight to Test)</li> </ul> <b>HWWITF:</b> Precision Health & Patient Navigation (Accountable System)<br><br><b>Digital:</b> Portal, AVT, Insight-led decision-making<br><br><b>CYP System &amp; Futures:</b> Paediatric Chain; Innovation.                                                                                                  |
| <b>Care delivered in the most appropriate setting, closer to home where possible</b> | % care delivered in communities<br><br>Reduction in hospital admissions                       | <b>Revolutionising Care:</b> <ul style="list-style-type: none"> <li>Neighbourhood Care Model</li> <li>Digital first virtual urgent care model</li> </ul> <b>HWWWITF Accountable System:</b> Healthy Communities System<br><br><b>Digital, Data and AI:</b> Insights; Patient Portal.                                                                                                                                                                                                                      |
| <b>Joined-up, compassionate care for children with complex needs</b>                 | Avoidable admissions<br>Length of stay                                                        | <b>Revolutionising Care:</b> Neighbourhoods, Clinical Centres of Excellence<br><br><b>CYP System &amp; Futures:</b> Research.<br><br><b>HWWITF:</b> Specialist & Acute Care System and Healthier Communities System.                                                                                                                                                                                                                                                                                      |

A key driver within the medium-term planning guidance and NHS 10-year plan is the expansion of neighbourhoods. The below is a short case summary on the work completed to date and the role in which Alder Hey is playing in Neighbourhood development in Cheshire & Merseyside.

## Case Study: Neighbourhoods

The Trust has a long-standing track record of delivering services at neighbourhood level, providing a strong foundation for future development. Aligned with the mobilisation of Vision 2030, Alder Hey has established a Neighbourhood Clinical Collaborative to lead Alder Hey's contribution to Liverpool's CYP neighbourhood model, with clear reporting into the Trust's governance structures. The collaborative has outlined the following as its neighbourhood approach.

### 0-19 Model and Role of Alder Hey

Liverpool's 0–19 offer is locally delivered by Mersey Care NHS Foundation Trust, and Alder Hey, working in partnership with Mersey Care, is reorganising its appropriate services to improve prevention, early intervention, and team integration, aligning with national strategies like Start for Life, Family Hubs, and Family First for better coordinated child and family support.

### MDT Working: Progress and Challenge

An essential component of the neighbourhood approach involves establishing multidisciplinary teams (MDTs) focused on children and young people. Alder Hey is currently piloting MDT models with partners across three neighbourhoods, with a range of PCNs, to develop a scalable solution. Achieving full implementation will require additional national support.

### Lung Health as a Test Case

Respiratory health remains a central focus among all partners in terms of clinical practice, economic impact, and health equity. A collaborative, multi-agency lung health programme is being established as a “test bed” for neighbourhood-level integration, in alignment with the Cabinet Office's “test and learn” initiative, the Liverpool 2040 Vision, and Alder Hey's objectives to reduce preventable admissions and enhance population health outcomes.

This neighbourhood work is strongly aligned with the Trust's Vision 2030 and key national and local initiatives, including the One Liverpool programme for integrated neighbourhood care, and the Trust's provider partnership work with Mersey Care & Liverpool University Hospitals Group which focuses on coordinating the delivery of services across our shared footprint of Liverpool, Sefton and Knowsley. The work supports Family First, a multi-agency early help programme that works with whole families to address challenges collaboratively and prevent escalation, and Start for Life, a national initiative providing coordinated support from conception to age two through Family Hubs, health services, and parenting guidance to ensure every child has the best start in life.

## Performance Standards

Alder Hey places children, young people, and their families at the heart of everything it does. Staying true to this has led to outstanding care, innovation, and performance. This is evidenced by being in Segment One of the NHS Oversight Framework and being acknowledged nationally for its improvement to improving access to care and reducing elective waiting times. The table provided below is an assessment of the deliverability of the national operational priorities for 2026/27 – 2028/29:

| Priority                                                    | Measure                                                                                             | Current | 2026/27 Target      | 2027/28 Target | 2028/29 Target | Assessment to deliver                                                               |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------|---------------------|----------------|----------------|-------------------------------------------------------------------------------------|
| Improve ED Waiting times                                    | Improve A&E waiting times to treat patients within 4 hours                                          | 87%     | 95%<br>(By Sept'26) | 95%            | 95%            |  |
| Reduce the time people wait for elective care               | % of patients waiting no longer than 18 weeks for treatment (in hospital)                           | 62%     | 70%                 | 81%            | 92%            |  |
|                                                             | % of patients waiting no longer than 18 weeks for treatment (in the community)                      | 65%     | 78%                 | 79%            | 80%            |  |
|                                                             | % of patients waiting no longer than 6 weeks for a diagnostic test                                  | 92%     | 97%                 | 98%            | 99%            |  |
|                                                             | Improve performance against the 28-day cancer faster diagnosis standard                             | 100%    | 80%                 | 80%            | 80%            |  |
| Improve Mental Health and Learning Disability Care          | Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) | 449     | 0                   | 0              | 0              |  |
| Live within budget, reducing waste & improving productivity | 30% reduction in agency spend compared to 2025/26 M6 FOT, working towards £0 in 2028/29             | £518k   | £363k               | £254k          | £0k            |  |
|                                                             | 10% year on year reduction of bank spend compared to 2025/26 M6 FOT                                 | £4.9m   | £4.5m               | £4.0m          | £3.6m          |  |

At a national level, CYP elective recovery remains behind adult elective recovery. Alder Hey has made considerable progress in reducing waiting times, with this being recognised nationally in 2025/26 for this achievement. The aim for 2026/27 onwards is to continue this work.

The Trust is entering a new way of working, reducing waiting times, reducing workforce numbers, and being more productive. Areas of opportunity include expanding advice & guidance, reducing the Trust 'was not brought' rate, and the implementation of ambient voice technology.

An area of challenge identified is '% of patients waiting no longer than 6 weeks for a diagnostic test.' The Trust is working towards onboard audiology into the DM01 submission. This is a challenged area and will significantly impact performance in 2026/27. The Trust is aiming to address the performance concerns in year one of the plan and be compliant with the national target by March 2027 and beyond.

Community waiting times is a priority within the medium-term planning guidance. The Trust has sustained zero patients waiting longer than 52 weeks for community paediatrics and CAHMS services and is working towards the targets outlined in the planning guidance.

In terms of achieving the 18-week RTT requirement of 92% by 2028/29, a capacity model has been created. There are several caveats within this model and there has been close working with the ICB in the RTT forecasting for the next three years. An internal model suggests the following:

|                                                                | 2026/27 | 2027/28 | 2028/29 |
|----------------------------------------------------------------|---------|---------|---------|
| Additional clock stops per <b>month</b> required               | 104     | 298     | 446     |
| Additional clock stops per <b>year</b> required                | 1,248   | 3,576   | 5,352   |
| Total number of clock stops (FYE)<br>(Avg. 45,274 clock stops) | 46,522  | 48,850  | 50,626  |
| % Growth in clock stops required                               | 2.76%   | 7.9%    | 11.82%  |

## Productivity

The Trust has made significant strides in improving its productivity, with this being recognised in the Segment 1 rating for productivity in the NHS Oversight Framework.

Within the medium-term planning guidance, each provider is expected to achieve a 2% year on year improvement for productivity. For Alder Hey, the implied productivity metric for Q2 of 2025/26 is 6.94%. Therefore, the ambition is to improve this to 9% in 2026/27, 11% in 2027/28, and 13% in 2028/29.

To do this, the Trust has utilised productivity packs and internal productivity dashboards to identify areas of opportunity for improvement, a table is shown below:

| Metric                                             | Value  | Peer Median |
|----------------------------------------------------|--------|-------------|
| Outpatient appointments per consultant (July 2025) | 70.5   | 90.5        |
| Change in outpatient appointment per consultant    | -33.0% | 6.1%        |
| Sickness absence rates (May 2025)                  | 5.7%   | 4.5%        |
| Consultant job planning sign-off rates (Sept 2025) | 19.6%  | 76.6%       |

An overview of the Trust's approach to productivity is outlined below; year three schemes are in development and will be dependant upon outputs from year one and two.

| Year One<br>2026/27                                                                                                                                                                                                                                                                                                                                                                                                | Year Two<br>2027/28                                                                                                                                                                                                                                                                                                                                                              | Year Three<br>2028/29                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Trust-wide rollout of AVT</li> <li>• Implement first phase Patient Portal</li> <li>• Support attendance at work</li> <li>• Optimised booking in Outpatients</li> <li>• Medical job planning</li> <li>• Increase A&amp;G and PIFU by further 1%</li> <li>• Reduce WNB rate by 2%</li> <li>• Expand use of FDP</li> <li>• Achieve 85% capped theatre utilisation</li> </ul> | <ul style="list-style-type: none"> <li>• Paediatric Clinical Assessment Service embedded</li> <li>• Expansion of Patient Portal</li> <li>• AI Insights for analytics</li> <li>• AI triage of referrals</li> <li>• Virtual triage &amp; consult in urgent care</li> <li>• Increase A&amp;G and PIFU by further 1%</li> <li>• Expand virtual ward and remote monitoring</li> </ul> | <ul style="list-style-type: none"> <li>• Increase A&amp;G and PIFU by further 1%</li> <li>• Expand virtual ward and remote monitoring offer further</li> <li>• Advance AI enabled clinical capability</li> </ul> |



Digital advancements and AI progress is pivotal to the Trust's productivity success. The Trust has an ambition to be digital-by-default, particularly in Urgent & Emergency Care and Outpatient departments, and is reliant upon digital and AI solutions to enable to productivity improvements.

Through Q3 and Q4 of 2025/26, the Trust has commenced some productivity pilots, one of which is optimised booking. An overview of the impact of this scheme in the surgical division is below.

## Case Study: Outpatients

Through Q3 of 2025/26, the surgical division focused upon clinic utilisation in outpatients across five specialities. The table below compares the planned utilisation and actual utilisation pre/post pilot.

|                    | Planned Utilisation |                |              | Actual Utilisation |                |              |
|--------------------|---------------------|----------------|--------------|--------------------|----------------|--------------|
|                    | Pre-Pilot (%)       | Post Pilot (%) | Variance (%) | Pre-Pilot (%)      | Post Pilot (%) | Variance (%) |
| Plastics           | 97.4                | 102.3          | 4.9          | 81.3               | 82.5           | 1.2          |
| Dentistry          | 97.2                | 105            | 7.4          | 76.7               | 80             | 3.4          |
| Gynaecology        | 94.6                | 100            | 5.4          | 76.3               | 80             | 3.3          |
| Paediatric Surgery | 98.4                | 104            | 5.6          | 84.3               | 89             | 4.4          |
| Urology            | 99.2                | 103            | 3.8          | 85.2               | 87             | 1.5          |
| <b>Average</b>     | <b>97.4</b>         | <b>102.8</b>   | <b>5.4</b>   | <b>80.8</b>        | <b>83.5</b>    | <b>2.8</b>   |

The results show a 5.4% increase in planned utilisation, and a 2.8 % increase in actual utilisation, thus showing additional activity can be provided within the current resource.

## Enabler 3: Digital, Data and Artificial Intelligence

Alder Hey's digital strategy and plans set out a bold, system-wide vision that strengthens collaboration, drives digital first care, and builds the data and infrastructure foundations needed for a more connected and sustainable future. The approach is focused on five pillars:

strong system orientation that aligns digital priorities across Cheshire and Merseyside; a digital by default operating model that modernises care delivery and enhances patient experience; an ambitious interoperability agenda that enables safe, intelligent data sharing; a financially disciplined and sustainable investment strategy; and a commitment to change management that empowers the workforce with the skills, culture and capability to adopt new technologies confidently.

## System Approach

Alder Hey's digital strategy is built on a firmly embedded system approach, reflecting the organisation's commitment to collaborative transformation across Cheshire and Merseyside.

As a recognised digital leader, Alder Hey will continue to play a pivotal role in shaping and delivering regional innovation. The Trust is hosting and coordinating the deployment of Ambient Voice Technology across Cheshire and Merseyside, enabling a shared shift toward modern clinician-supporting digital tools that enhance productivity, safety, and experience.

Collaboration is central to the Trust's ongoing work to develop a new Patient Engagement Portal. Collaborating with a regional partner and building on an already live platform in Primary Care, this initiative will create a single digital doorway through which children, young people and their families can access information and services spanning Primary, Acute, and Specialist Care. This unified experience delivered in partnership embodies the essence of system-enabled digital

transformation: reducing fragmentation, improving accessibility, and empowering families with a cohesive view of their health journey.

## Being Digital by Default

Alder Hey is accelerating a digital first model of care, placing the Patient Engagement Portal at the heart of how children, young people and families manage their healthcare. The portal will become the default route for appointments, clinic letters, test results, virtual consultations, and two-way communication with care teams, ensuring families experience a seamless, modern, and responsive service.

This digital first model is strengthened by the continued expansion of virtual wards and remote monitoring. These innovations allow children to be safely supported at home, reducing avoidable hospital stays and ensuring care is delivered in the most appropriate setting. Through remote monitoring, clinical teams can track symptoms, escalate early when needed, and avoid unnecessary travel for families while maintaining high levels of reassurance and clinical oversight.

Crucially, this transformation is designed to be inclusive. While digital will be the first choice, alternative routes such as printed letters, telephone support and nondigital appointment management will always remain available. This ensures no child or family is disadvantaged or digitally excluded, and that flexibility is retained for those who need additional support.

## Advancing child health through Artificial Intelligence

Artificial Intelligence (AI) will be adopted and scaled at Alder Hey as a practical enabler of the medium-term plan and Vision 2030, strengthening children and young people centred care, empowering colleagues, transforming outcomes, and accelerating diagnostics in paediatrics. In 2025, Alder Hey launched its AI strategy. This AI plan is aligned with the NHS 10 Year Plan expectation that hospitals will become fully AI enabled over the lifetime of the national plan. In the immediate term, the plan builds from proven delivery, with the deployment of Ambient Voice Technology already demonstrating operating cost reductions and productivity gains across clinical services, establishing a strong foundation for safe spread and standardisation.

Over the next phase, Alder Hey will broaden the use of intelligent automation and AI assisted tools to reduce administrative burden, improve workflow reliability, and support timely follow up. This includes scaling ambient AI powered documentation, deploying AI assistants, introducing automated scheduling to optimise rota planning while supporting staff wellbeing, and implementing intelligent ordering and task management to streamline investigations and results tracking.

Alongside workforce productivity, the Trust will advance AI enabled clinical capability through evidence led predictive analytics for early intervention, AI optimised care pathways and remote monitoring, with a clear focus on precision care for children and young people and proactive management of long-term conditions. The diagnostics theme will be progressed carefully and proportionately, recognising the distinct risk and rarity profile in paediatrics, while building capability in areas such as imaging, rare disease identification, genomics, and wearables where appropriate evidence and safeguards are in place.

To enable sustainable scale, Alder Hey will continue to develop strategic AI capabilities that allow safe use of organisational knowledge and secure retrieval of information for staff productivity, including the creation of a local large language model to support retrieval augmented generation and agentic AI, and an AI insights agent to obtain data, perform analytics and find content in documents.

## Enabler 4: Growth & opportunities

### Research

The ongoing development of clinical research at Alder Hey will be enhanced over the next 3 years through the work of the Liverpool Institute of Child Health and Wellbeing which, in partnership with the University of Liverpool and Alder Hey Charity, will create a united and positive force for change for the children of Liverpool, the wider region, nationally and beyond. The goals are:

- To listen to children and young people and get *them* to tell us what their problems are, and which ones are the most important, making the effort to go to them and listen.
- To take the needs of children directly to the scientists and put these problems on their radar, driving discovery and research excellence.
- To find the latest scientific discoveries and apply them to the healthcare and social problems children face, in the hospital and across the community, maximising the research's impact.
- To work with everyone who wants to improve the lives of children, creating a range of partners who are all working to the same goal.
- To make sure that the next generation of paediatric researchers is trained and ready to tackle the problems of the future.

Alongside leading the way through academic excellence, Alder Hey is committed to support to government aim to make Britain the best place in the world to invest in medical research. Alder Hey will use its already established multidisciplinary clinical trial accelerator team to deliver on the 150-day set-up target for clinical trials allowing for improved access to the best treatments and technologies for our patient population and therefore also supporting economic growth.

This will allow Alder Hey to continue to offer extensive research opportunities to children, young people, families, and staff across a broad range of specialties both within the hospital setting and beyond through community delivery models and the use of the Mobile Research Unit. Existing assets will be maximised year-on-year including increasing occupancy within the dedicated Paediatric NIHR Clinical Research Facility, increasing radiology-led research and research scanning opportunities through the NIHR funded MRI scanner and increasing visibility of research outside of the hospital setting through the Mobile Research Unit.

Financial sustainability will be key to continued success over the next 3 years with a continued focus on a robust self-sustaining model which enables reinvestment of capacity and capability funding into areas where Alder Hey is already leading the way and those where there is the most potential to make a difference with a particular focus on reducing levels of inequality. The Trust is already committed to ensuring that externally funded posts are not adversely impacted by workforce reduction targets to ensure that external contracts are delivered to the highest levels of efficiency and quality.

## Innovation

The Paediatric Open Innovation Zone, funded by the Liverpool City Region Combined Authority from 1<sup>st</sup> April 2025 (£4.1m over 4 years) is the platform from which Alder Hey will accelerate groundbreaking projects aimed at improving children's health outcomes and pioneering new medical technologies. It will support Alder Hey's innovative initiatives, including advancements in AI-driven diagnostics, remote monitoring solutions, and personalised treatment approaches. It will also drive collaborations with local and industry leaders, universities, and technology partners to create new opportunities for research and development, positioning Liverpool at the forefront of paediatric healthcare advancements and economic growth. Over the funding period, Alder Hey is committed to delivering:

- An enhanced innovation network through support for 15 NHS organisations and 10 innovation partnership collaborations
- Capacity development through training in innovation methods for a minimum of 30 staff
- Support for at least 34 local business including distribution of dedicated challenge funding to at least 7 businesses
- Improved clinical and academic integration through the creation of 6 clinical innovation fellowships and 4 MSc Students
- Economic impact with the creation of 60 new jobs within the region (20 direct and 40 indirect)
- Enhanced infrastructure for innovation and research through the development of a dedicated paediatric secure data environment
- Company creation with a commitment to spin out at least one company

The Paediatric Open Innovation Zone will be a catalyst for securing further external funding to allow a move towards a self-sustaining financial model for innovation within Alder Hey.

Alder Hey Innovation will continue to work in collaboration with internal and external partners to drive forward the 3 key shifts in the NHS 10-year plan by both leading the way in identifying and testing cutting edge technologies to maximise opportunities to improve healthcare and reduce inequality and by increasing awareness and understanding of innovation through engagement and education.

## Global Health

The Alder Hey Global Health Programme is transitioning from its initial phase during 2024/25 to strategic consolidation, integrating more fully into the organisation's Growth and Opportunities agenda and Vision 2030.

2026/27 will see the programme create an integrated global presence that aligns with education and training, clinical service development, research and innovation, digital health, AI, business development, and as an enabler for international private healthcare. A flexible delivery model will allow the programme to scale activity responsibly, maintaining global visibility and relationships while aligning with the Trust's financial priorities. This approach strengthens shared governance, commercial capability, and organisational coherence, positioning Global Health as a catalyst for cultural transformation and international brand growth.

Looking ahead to 2026–2029, the programme will mature into a balanced and sustainable global portfolio. In the short term, it will consolidate existing partnerships to focus on delivery and

impact. By 2027–28, Global Health will expand our international capacity building, consultancy, and education offers. By 2028–29, Alder Hey intends to be recognised internationally as a reference centre for children's health, innovation, and expertise—delivering value for patients, staff, and partners while contributing to the NHS through reputation, learning, and diversified income pathways

## Private Patients

Alder Hey will continue to expand its Private Patients portfolio as a key enabler of sustainable growth, diversification of income and reinvestment in core NHS services. Building on the progress made in 2025/26, the Trust will develop a high-quality private MRI scanning offer, maximising radiology capacity and meeting increasing demand for private paediatric imaging. Alongside diagnostics, the Trust will actively pursue opportunities in both national and international private surgery, leveraging Alder Hey's reputation for excellence, its unique specialist expertise, and its growing global profile. This includes structured development work to scale planned national partnerships, and exploring targeted international pathways where Alder Hey can provide world-leading paediatric care safely and sustainably. Together, these initiatives will support the Trust's financial strategy, strengthen its international brand, and ensure that private patient activity delivers meaningful benefit for children and young people across all services.

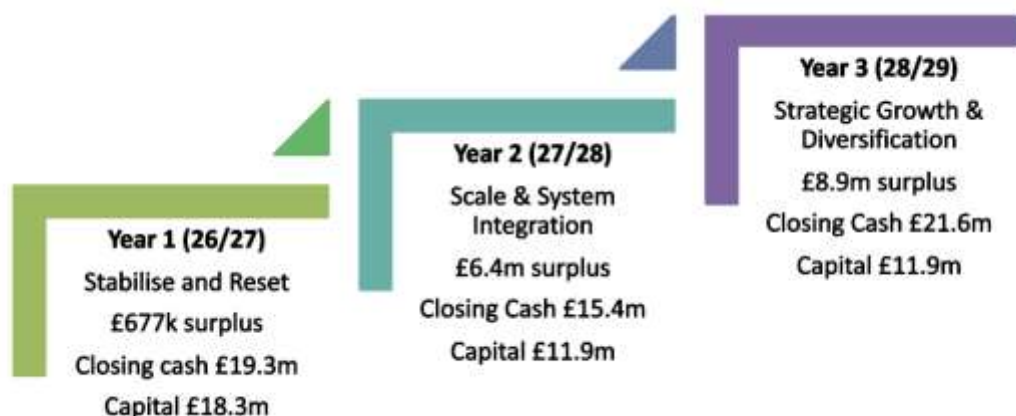
## Enabler 5: Financial Improvement Programme

### Financial Strategy

The Trust will deliver on its financial obligations including:

- **Financial sustainability** across the 3 years built on strong recurrent efficiency delivery in year 1 and a diversification of income by year 3,
- **Reasonable cash balances** maintained throughout the period.
- **Capital expenditure prioritised** in line CDEL allocation and cash affordability, with a focused strategy to secure additional external funding.
- **Financial Improvement Programme** continuing across the 3 years underpinning the delivery of financial benefits and meeting the required CIP levels.

The key financial metrics are summarised below:



## Income & Expenditure Plan

The following table summarises the proposed financial plan for 2026/27 – 2028/29. A more detailed summary can be found at appendix two.

| Category     | 2026/27<br>£'000 | 2027/28<br>£'000 | 2028/29<br>£'000 |
|--------------|------------------|------------------|------------------|
| Income       | 441,011          | 441,741          | 444,574          |
| Expenditure  | (464,922)        | (448,484)        | (451,100)        |
| CIP          | *24,587          | 13,234           | 15,457           |
| <b>Total</b> | <b>677</b>       | <b>6,491</b>     | <b>8,931</b>     |

*\*(26/27 CIP includes £6m of recurrent savings, expected to be delivered by March 26)*

The key principles that have been adopted in the development of the 2026/27 – 2028/29 I&E plan include:

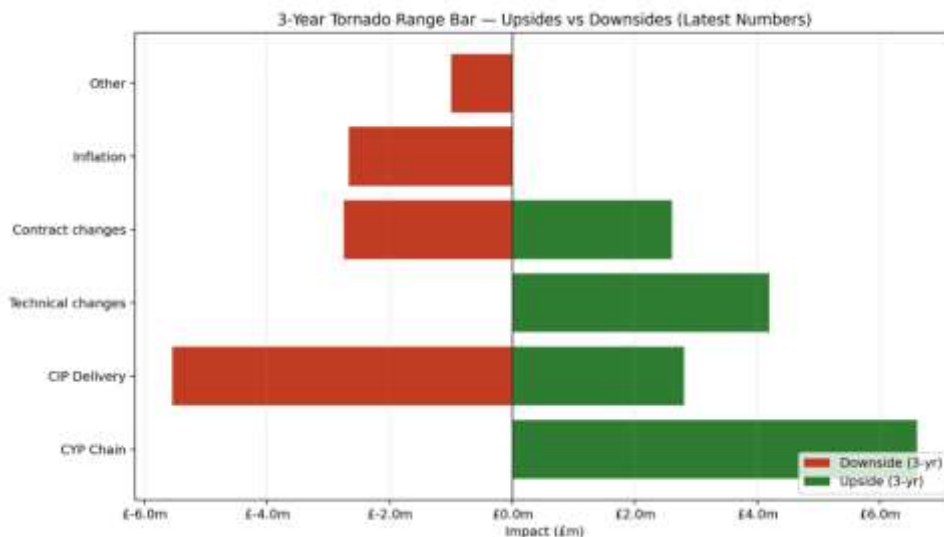
- Recurrent Block contract income levels rolled over from 2025/26 uplifted by inflation (0.03%) and growth as per national guidance. According to national guidance, there is no income inflation for 2027/28 and 2028/29
- Activity based contract income broadly based on 2025/26 activity with a view to maximise income opportunities but whilst remaining within the expected levels. Contract offers have now been received from the main commissioners and reflected in the current I&E plan; however, discussions are ongoing in relation to growth and funding to deliver RTT improvements and this may result in final amendments ahead of the final submission of this plan on the 12<sup>th</sup> February.
- Pay award based on 2.10% across all 3 years, as per the national guidance although this has not yet been awarded with assumption any agreement above 2.1% will be funded additionally by national allocation.
- Non pay inflation based on 2.20% in 2026/27, which reduces to 2% in 2027/28 and 2028/29. Drugs inflation is based on 2.20% in 2026/27 which reduces to 0.73% in 2027/28 and 2028/29. All in line with national planning assumptions.
- Divisional run rate in line with Q4 extrapolation with £4m of legacy cost pressures funded and the remaining expected to be mitigated through continuation of the control measures put in place during the last 12 months.
- A recurrent efficiency target for year 1 of £21m, assuming a carry forward from 2025/26 of £5m. If the expected reduction in carry forward is not achieved this will result in a CIP target greater than £21m. From 2027/28 onwards CIP target reduces to 2% in line with national efficiency, assuming no carry forward from 2026/27.
- The plan includes a recurrent investment reserve of 1% in 2027/28 and 1.5% in 2028/29, in line with national planning guidance delivered through an additional 1% CIP.
- The 2026/27 and 2027/28 plan includes £6.6m adjustment in relation to PFI accounting (IFRS16 (provider accounting requirement) to UK GAAP (DHSC accounting requirement) which providers are required to include in plans. This adjustment reduces to £5.7m in 2028/29, due to a reduction in lifecycle costs in 2028/29.

The 3-year I&E plan provides a base case supported by current information and assumptions. Scenario and sensitivity analysis has also been conducted to test the financial plans' robustness

and account for potential risks and opportunities over the next 3 years, included in table 3 in appendix two.

The key areas reflected are:

- Change in the pace of CIP delivery
- Inflation levels outside of the national expectations
- Development of the paediatric chain model
- Income and contract changes



## Activity planning

The activity model has been developed based on the following assumptions:

- 2025/26 over performance
- Addition of non-recurrent 2025/26 adverse impacts on activity delivery, e.g. Industrial action and sickness/capacity issues
- Pathway changes
- Full year effect of AVT/lyrebird technology

Average prices were assigned to all activity based on 2025/26 case mix. For the PBR/ERF subset this equates to a £3.6m increase (from £99.6m to £103.2m).

It is estimated that if this activity were delivered it would take the Trust's RTT performance to over 74% by March 2027, which is more than the national target of 7% improvement from March 2026 (which is likely to be 70%, TBC).

Initial offers from commissioners have been received, however, further clarification is required in several areas. The current proposals do not provide funding for RTT improvement or growth in 2026/27, reflecting both affordability constraints and the assumption that RTT improvements will be achieved through reductions in follow-up activity, data validation, and increased productivity. The offers therefore do not align with the activity levels considered deliverable by the divisions. In response, the Trust must consider two options:

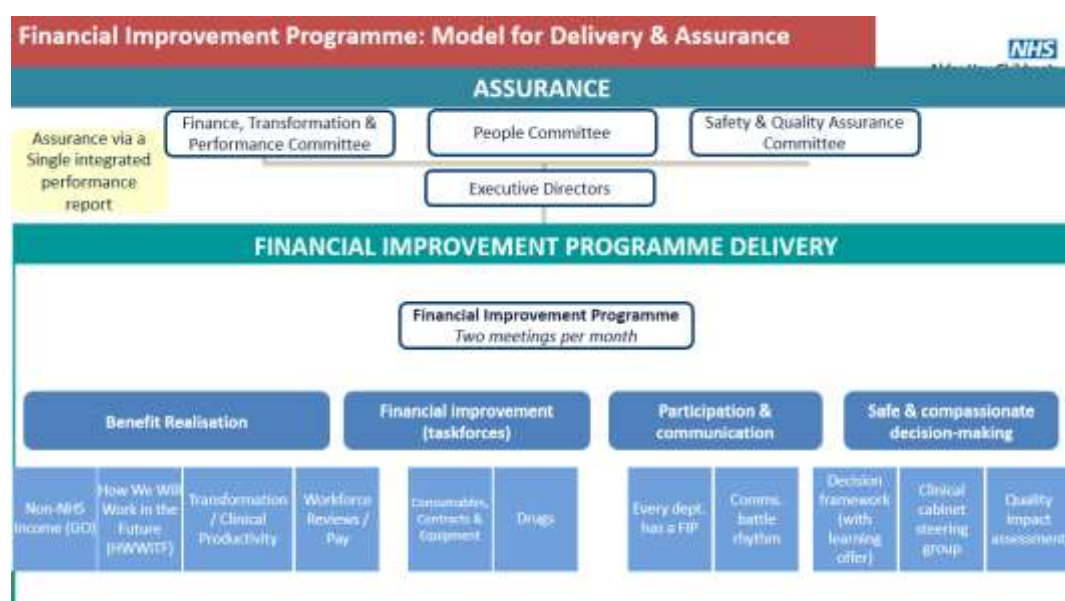
- Adjust activity levels and corresponding costs to align with contract offers, which may provide a contribution towards CIP, or
- Maintain higher activity levels to improve RTT, recognising that this would not result in additional income or allow for cost reductions.

Additionally, for the block PODs, i.e. NEL and A&E, we have assumed national growth rates in both Y1 and Y2.

## Governance

During 2025/26, the Trust introduced significant changes to the governance of the savings programme – with the structure of the Financial Improvement Programme incorporating assurance, clear decision making and delivery. This included standardised Decision Documentation, and more transparency around any potential impact on safety with robust process for EIA/QIA alongside a programme of increasing the financial understanding and awareness across the organisation through improved training and regular reporting of the Trust financial position.

For 2026/27, the core structure of this approach will be maintained – but with wider scope to incorporate financial benefits from Non-NHS Income (“GO”), Target Operating Model and Transformation work, so that there are consistency and clarity regarding delivery of the full recurrent savings target.



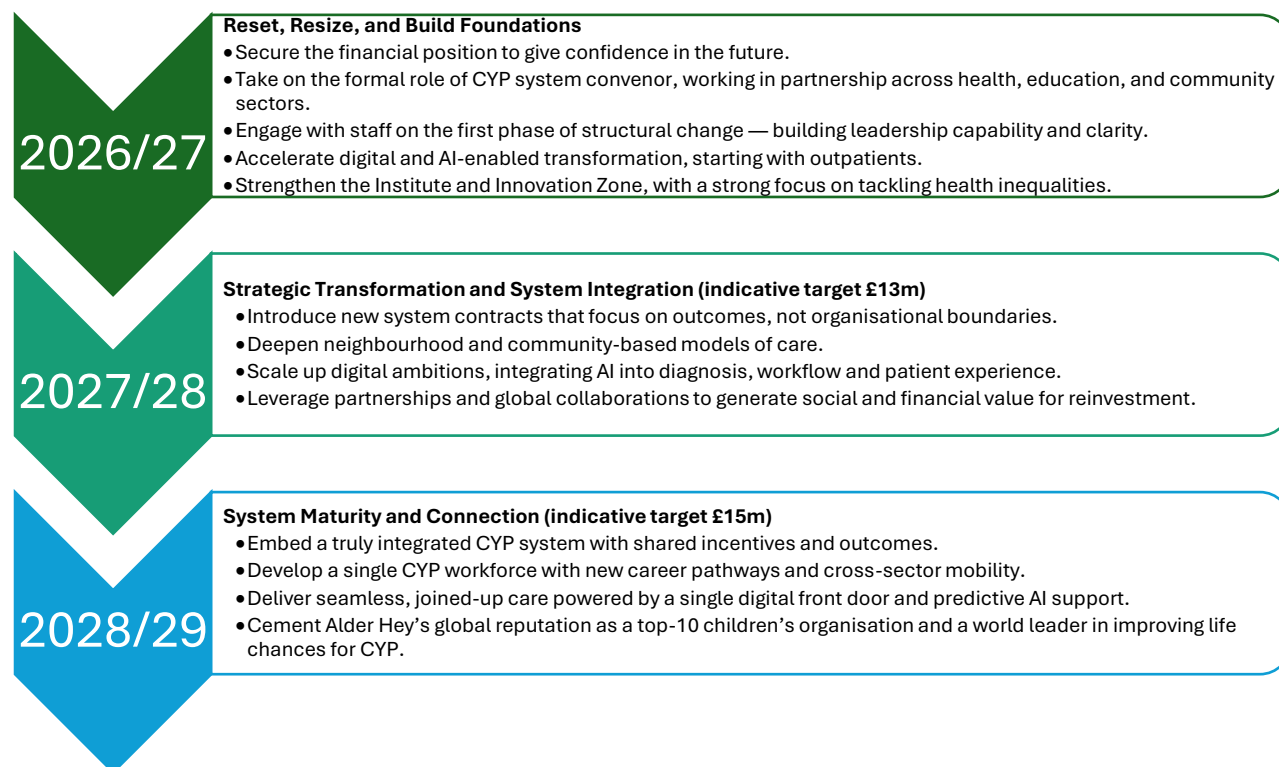
## Financial Improvement Programme

The level of financial savings required to achieve financial sustainability in 2026/27 remains challenging and is driven by both the external financial environment and the carry forward from 2025/26 (resulting from savings that have been delivered non-recurrently).

During 2025/26, £12m of recurrent savings have been posted to date (at Month 9) with a further £5.0m identified yet to be posted. This means 2026/27 recurrent savings required will be £21m with several schemes already in development to achieve delivery from April linked to the transformation and organisational redesign.

This level of savings is especially challenging given the limitations on NHS funded growth, with some productivity benefits no longer permitted towards financial savings as commissioners are managing provider trusts to contractual funding envelopes. As a result, there is now a much greater level of focus on reducing workforce size and controlling pay costs, as this comprises most of the expenditure.

To ensure long term financial sustainability a path for the next three years has been created:



A summary of the overarching themes for savings identified in 2026/27 can be found at appendix two.

## Capital Planning

Capital is an increasingly scarce resource in the NHS and the level of spend is controlled by a Capital Resource Limit (CDEL) set nationally by treasury and then allocated either directly to trusts (core CDEL) or via ICS (Strategic capital funding) to create a CDEL envelope that must not be exceeded.

The CDEL allocation is a 'permission to spend' the Trust's own cash reserves and not necessarily an additional cash allocation although, new national capital investments will take the form of new cash in addition to an increase in CDEL to spend it.

The table below sets out the summary of the capital requirements for 2026/27 – 2029/30 based on known requirements. This shows a current CDEL gap of £15.3m for 2026/27 and a total gap £6.5m across 4 years. A capital prioritisation exercise will take place ahead of 26/27 to confirm prioritised projects for 26/27, with applications for strategic funding for relevant projects ongoing. A more detailed breakdown can be found at appendix two.

| Spend Category                 | 26/27<br>£'000  | 27/28<br>£'000 | 28/29<br>£'000 | 29/30<br>£'000 |
|--------------------------------|-----------------|----------------|----------------|----------------|
| CDEL / PDC                     | 31,658          | 9,512          | 7,105          | 13,797         |
| Donated                        | 3,129           | -              | -              | -              |
| New Charity / External Funding | 14,217          | 44,065         | 54,207         | 30,699         |
| <b>Grand Total</b>             | <b>49,004</b>   | <b>53,577</b>  | <b>61,312</b>  | <b>44,496</b>  |
| Indicative Funding             | 16,334          | 12,648         | 18,462         | 21,165         |
| <b>CDEL Gap</b>                | <b>(15,324)</b> | <b>3,136</b>   | <b>11,357</b>  | <b>7,368</b>   |

## 6. Quality & Risk Management

### Quality Strategy

Whilst transforming services for children, young people, and their families, as well as resizing the workforce and maintain financial sustainability, patient care, quality, and experience must be at the centre of all of this. The Trust Quality Strategy will require a focus on three key areas:

#### **A learning Organisation**

Ensuring that when things do go wrong, we understand all the factors that were involved, and to use this learning to change practice for the future. To ensure that we maximise our learning from where things go right, and ensuring good practice is celebrated and shared across all areas of the organisation. We are supporting the development of a just, restorative and learning culture across our organisation which will support our teams to learn from things that consistently go well, as well as when things go wrong.

#### **Excellent Outcomes**

Ensuring our CYPF excellent clinical outcomes, as well as meeting their own Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS). We will use our outcomes data to benchmark nationally and where possible internationally and use the data to drive improvements in care.

#### **Outstanding Experience**

Ensuring that all our CYPF experience a warm welcome. We will minimise the impact of healthcare on their lives and maximising a positive experience of our care. We will keep the voices of our CYPF at the heart of everything we do.

Now entering the third year of implementation, the Trust will continue to embed the Patient Safety Incident Response Framework (PSIRF) across the organisation. The annual PSIRF plan priorities will be informed by robust analysis of patient safety data and aligned to the revised NHS Patient Safety Strategy once published.

Alongside the data-driven annual patient safety priorities, the following patient safety workstreams will continue their quality improvement journey towards full implementation: the Deteriorating Patient pathway (including the embedding of already launched PEWS programme), National Safety Standards for Invasive Procedures (NatSSIPs2), and Safety Culture training. Progress against these workstreams plus existing patient safety assurance reporting will be supported by clearly defined metrics and milestones, with delivery monitored through

established quality governance arrangements to ensure sustained improvement and organisational learning.

The Trust will continue to strengthen patient safety capability across the workforce by supporting staff in the completion of higher levels of the Patient Safety Syllabus. In parallel, the Patient Safety Partners will be actively involved in relevant patient safety workstreams, contributing to the weekly Patient Safety Incident Response Investigation (PSIRI) panel and the Trust Patient Safety Board, ensuring meaningful patient and family involvement in safety improvement.

## Clinical Effectiveness

The Clinical Outcomes and Effectiveness Board (CEOB) has responsibility for the operational delivery of a range of areas which include (but are not limited to): Clinical Audit (National, local, and divisional), evidence based clinical guidelines, NICE Guidance/Technical appraisals, guidelines and policies, clinical outcomes and patient reported outcomes. CEOB will continue to measure and improve the quality and clinical effectiveness of our care by:

- Improving understanding of healthcare variation/inequalities using clinical benchmarking and by drawing on intelligence from multiple sources (**Insight**)
- Equip children, young people, their families and staff with the skills and opportunities to inform of key changes required to improve and enhance the delivery of clinical effectiveness across the system (**Involvement**)
- Design and support programmes that deliver effective and evidence-based changes in the most key areas (**Improvement**)

## Patient Experience

In 2026, the Trust aims to implement a new Experience Strategy informed by the outcomes of the Trust self-assessment conducted under the Experience of Care framework. The refreshed Experience and Engagement Board will adopt the 'Insights, Involvement and Improvement' model, facilitating a more cohesive connection between experience and outcomes.

In alignment with the newly released NHS Play Standards, the Trust now provides access to play services seven days a week and are transitioning to an updated referral model for play specialists. To enhance the early experience interventions, there is an ambition to continue to embed the Arts for Health Programme, Play Services, Spiritual Care, and Experience teams as a unified function across the Trust.

The overarching quality programme will be monitored by the following driver metrics, with each workstream across safety, experience and effectiveness having its own driver and watch metrics:

- Number of incidents rated low harm and above (Physical and/or Psychological) per thousand bed days: the objective 2026/27 plan is a 5% reduction on 2027/26.
- Number of incidents reported and rated no harm per thousand bed days. The objective 2026/27 plan is a 5% increase on 2025/26.

## Risks

| Risk                                                                                 | Description & Impacts                                                                                                                                                                                                                                                                                                                                                                        | Current Mitigations                                                                                                                                                     |
|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Delivering the required level of cost reduction (£21m CIP in Year 1).             | <p>The scale of the CIP presents a significant challenge to financial sustainability.</p> <p>It challenges the ability to sustain the deliver high quality services and could affect workforce morale.</p>                                                                                                                                                                                   | <p>Financial Improvement Programme</p> <p>New care models.</p> <p>Productivity improvements.</p> <p>Growth &amp; Opportunities</p>                                      |
| 2. Scale of organisation redesign and workforce consolidation (to 4,000 WTE in Year) | <p>Realigning workforce, management, and structures at scale could destabilise services.</p> <p>Distraction and diversion of focus away from quality, safety, and performance.</p> <p>Adverse impact on staff wellbeing and morale.</p>                                                                                                                                                      | <p>Phased implementation; safety impact assessments; open and compassionate communication; active staff engagement and co-design of How We Will Work in the Future.</p> |
| 3. Step change in access & performance targets                                       | <p>There is misalignment between zero growth contracts and commissioner intentions vis-à-vis significant ambition in access targets.</p> <p>Step-change in performance is expected despite a flat funding environment. This could lead to excessive pressure on frontline staff and managers.</p> <p>Financial exposure; inability to meet mandated access standards; reputational risk.</p> | <p>Active negotiation with commissioners.</p> <p>New care models.</p> <p>Productivity improvement.</p>                                                                  |
| 4. Commissioning challenges & contract uncertainty                                   | <p>Flat commissioned activity levels do not support access improvement.</p> <p>CYP system plans are not built into contracts.</p> <p>Commissioning intentions indicate our planned activity levels are not affordable/ will not be funded.</p> <p>Uncertainty over how system-level opportunities should be described and financially reflected.</p>                                         | <p>CYP System investment case to be developed for Trust and ICB Boards</p> <p>Financial scenarios planned for with contingency arrangements.</p>                        |

|                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>5. Capability &amp; capacity to build CYP System and breadth of transformation</p> | <p>Lack of clarity over resource allocation to deliver CYP System</p> <p>Insufficient capability and capacity to manage breadth and scale of transformation.</p> <p>Lack of system building and commissioning skills and capabilities.</p> <p>Programme slippage; failure to realise benefits; inability to deliver outcomes</p> <p>Competing pressures may dilute leadership and operational focus.</p> <p>Declining performance; stalled strategic delivery; morale deterioration.</p> | <p>CYP System investment case to be developed for Trust and ICB Boards</p> <p>Produce investment and benefits plan for transformation.</p> <p>Reduce running costs to release funds to resource a team to lead and build the CYP system.</p> <p>Align resources in change management and data insights to the transformation programme.</p> <p>Portfolio prioritisation; strong programme management; clearer accountability.</p> |
| <p>6. Pressure on staff and decline in morale</p>                                     | <p>Maintaining a thriving workplace in a contracting workforce environment.</p> <p>Reduced retention; recruitment issues; safety and quality risks; cultural decline/change fatigue.</p>                                                                                                                                                                                                                                                                                                 | <p>Connecting Alder Hey conversations and activities; culture and new values; Thriving Leaders &amp; Teams Programme; sustain Staff Advice &amp; Liaison Service.</p>                                                                                                                                                                                                                                                             |

## Appendix One: Board Assurance statements in full

| Assurance Statement                                                                                                                                                                                         | Maturity Assessment          | Trust Response                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Governance and Leadership</b>                                                                                                                                                                            |                              |                                                                                                                                                                                                                                         |
| The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning. This includes reviewing demand and capacity analysis.                                            | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                         |
| The board can confirm strong clinical leadership has been involved in the development of plans.                                                                                                             | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                         |
| The board can confirm that plans reflect the consideration of population needs, underserved communities and inequalities when developing plans.                                                             | 2. Maturing                  | Vision 2030 is a population health needs-based approach to developing the Trust's medium-term plan, with an underpinning strategy that is based around, working with partners, improving the life chances of Children and Young People. |
| Robust quality and equality impact assessments (QEIA) have been undertaken and reviewed by the board to inform the sign off of the organisation's plan.                                                     | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                         |
| The board has played an active role in setting direction, reviewing drafts, and constructively challenging assumptions – rather than simply endorsing the final version of the plan.                        | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                         |
| The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability. | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                         |
| <b>Plan Development</b>                                                                                                                                                                                     |                              |                                                                                                                                                                                                                                         |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                              |                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.                                                                                                                                                                                                                                                                                                 | 2. Maturing                  | Significant progress has been made since the initial draft of the plan, particularly in relation to the development of the new operating model. However there remain some variables that have yet to be resolved in terms of deliverability, most significantly the extent to which commissioners will support the required investment in activity levels to achieve access targets. |
| The board can confirm that plans have been triangulated across finance, workforce, and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.                                                                                                                                                                                                                                                               | 2. Maturing                  | Given its ambitious nature the plan requires final impact assessment to ensure full assurance and to finalise the commissioning triangulation on activity numbers and the associated investment required to deliver access targets.                                                                                                                                                  |
| <b>Productivity</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                              |                                                                                                                                                                                                                                                                                                                                                                                      |
| The Board can confirm that the organisation has fully considered and incorporated productivity opportunities into plans, and that any phasing is credible and realistic. The board can provide justification where any identified opportunities cannot be fully delivered during this planning round, especially in the context of decisions to submit non-compliant financial or performance plans or plans that do not deliver the 2% productivity improvement. | 2. Maturing                  | The plan is underpinned by a productivity opportunity assessment with ongoing work on the implementation of the opportunities identified both in terms of NHS commissioned activity and initiatives identified under the Bring Me the Future system.                                                                                                                                 |
| <b>Risk Management</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                              |                                                                                                                                                                                                                                                                                                                                                                                      |
| The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.                                                                                                                                                                                                               | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>NHS Standard Contract and Commissioning</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                              |                                                                                                                                                                                                                                                                                                                                                                                      |
| The board can confirm that that the organisation has engaged with its ICB to ensure contract values used in                                                                                                                                                                                                                                                                                                                                                       | 2. Maturing                  | The Trust has continued to actively engage with the ICB however there remain some areas of uncertainty which are                                                                                                                                                                                                                                                                     |

|                                                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| planning submissions are agreed across (commissioner and provider) activity and financial plans.                                                                                                                                                                                                     |                              | unresolved at this stage in the planning round. Dialogue continues.                                                                                                                                                                                                                                                                                      |
| The board can confirm that there is an effective process in place to manage the sign-off of contracts.                                                                                                                                                                                               | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                                                                                                                                          |
| The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.                                                                                                    | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                                                                                                                                          |
| <b>Workforce</b>                                                                                                                                                                                                                                                                                     |                              |                                                                                                                                                                                                                                                                                                                                                          |
| The board can confirm the impact of the 10 Year Health Plan on the workforce has been considered in plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention. | 2. Maturing                  | A comprehensive transformation programme has been established to align the three shifts with anticipated future changes in our workforce. The Trust is actively considering how digital and AI advancements will impact our staff. Our CYP system proposition is beginning to evaluate workforce assumptions across different organisations and sectors. |
| <b>Plan development</b>                                                                                                                                                                                                                                                                              |                              |                                                                                                                                                                                                                                                                                                                                                          |
| The board can confirm that the organisation has worked with its ICB to ensure their plans are fully aligned.                                                                                                                                                                                         | 2. Maturing                  | The Trust and ICB are in active discussions about the creation of a CYP system for C&M which is a significant development and step towards achieving Vision 2030. However, there are some year 1 commissioning issues that are yet to be resolved at this stage.                                                                                         |
| The board can confirm plans have been developed in line with the ambition to move care from hospital to community and this shift is evident in plan returns and the integrated delivery plan.                                                                                                        | 2. Maturing                  | The Trust has given a clear commitment that Vision 2030 aligns with the 3 shifts however the plan acknowledges that there is significant work to do both by the organisation and the system to achieve this.                                                                                                                                             |
| The board can confirm that the five-year integrated delivery plan is fully aligned with the numerical returns.                                                                                                                                                                                       | 1. Embedded [Full Assurance] |                                                                                                                                                                                                                                                                                                                                                          |

## Appendix Two: Working Tables

**Table One: Savings 2026/27 to 2028/29**

| Themes                  | Target Savings<br>£000's |               |               |
|-------------------------|--------------------------|---------------|---------------|
|                         | 2026/27                  | 2027/28       | 2028/29       |
| Workforce Reviews       | 7,000                    | 9,264         | 10,820        |
| Transformation - HWWITF | 8,575                    |               |               |
| Non-Pay Savings         | 4,800                    | 3,970         | 4,637         |
| Non-NHS                 | 800                      | -             | -             |
| <b>Total Savings</b>    | <b>21,175</b>            | <b>13,234</b> | <b>15,457</b> |

**Table Two: Proposed Financial Plan for 2026/27 – 2028/29**

| Category                 | Area                                                     | Year 1<br>2026/27<br>Annual Plan<br>£'000 | Year 2<br>2026/27<br>Annual Plan<br>£'001 | Year 3<br>2026/27<br>Annual Plan<br>£'002 |
|--------------------------|----------------------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------|
| Income                   | Block Payments                                           | 250,233                                   | 250,963                                   | 251,296                                   |
|                          | ERF                                                      | 97,861                                    | 97,861                                    | 97,861                                    |
|                          | C&V Drugs                                                | 49,254                                    | 49,254                                    | 49,254                                    |
|                          | C&V Devices                                              | 8,414                                     | 8,414                                     | 8,414                                     |
|                          | LNP                                                      | 4,519                                     | 4,519                                     | 4,519                                     |
|                          | Clinical Other                                           | 1,992                                     | 1,992                                     | 4,492                                     |
|                          | Non-Clinical                                             | 28,739                                    | 28,739                                    | 28,739                                    |
| <b>Total Income</b>      |                                                          | <b>441,011</b>                            | <b>441,741</b>                            | <b>444,574</b>                            |
| Expenditure              | Pay Costs                                                | (303,932)                                 | (309,127)                                 | (318,838)                                 |
|                          | Non-Pay Costs                                            | (140,787)                                 | (146,440)                                 | (152,418)                                 |
|                          | Depreciation                                             | (16,871)                                  | (17,048)                                  | (16,629)                                  |
|                          | Non-Operating Costs                                      | (9,920)                                   | (9,547)                                   | (9,269)                                   |
|                          | Other Technical Charges                                  | 6,588                                     | 6,632                                     | 5,775                                     |
| <b>Total Expenditure</b> |                                                          | <b>(464,922)</b>                          | <b>(475,530)</b>                          | <b>(491,380)</b>                          |
| CIP                      | 25/26 recurrent delivery by March 26                     | 6,000                                     | 6,000                                     | 6,000                                     |
|                          | 26/27 (5.35% based on £24.5m total)                      | 18,587                                    | 18,587                                    | 18,587                                    |
|                          | FYE of 26/27                                             | -                                         | 2,459                                     | 2,459                                     |
|                          | 27/28 (2% National Efficiency & 1% Investment Reserve)   | -                                         | 13,234                                    | 13,234                                    |
|                          | 28/29 (2% National Efficiency & 1.5% Investment Reserve) | -                                         | -                                         | 15,457                                    |
| <b>Overall Position</b>  |                                                          | <b>677</b>                                | <b>6,491</b>                              | <b>8,931</b>                              |

**Table Three: Sensitivity Analysis for 2026/27 – 2028/29**

| Sensitivity Analysis    |                                                                          | Probability | 26/27         | 26/28        | 26/29         |
|-------------------------|--------------------------------------------------------------------------|-------------|---------------|--------------|---------------|
|                         |                                                                          |             | Year 1        | Year 2       | Year 3        |
|                         |                                                                          |             | £'000         |              |               |
| <b>Draft Plan</b>       |                                                                          |             | <b>677</b>    | <b>6,493</b> | <b>8,934</b>  |
| <b>Upsides</b>          | Income/Contract Changes                                                  | 20/20/20    | 600           | 1,000        | 1,000         |
|                         | Further growth/productivity benefit above plan                           | 50/25/25    | 500           | 250          | 250           |
|                         | Additional technical benefits above plan                                 | 50/50/50    | 500           | 500          | 500           |
|                         | Reduce depreciation through revaluation                                  | 50/50/50    | 500           | 500          | 500           |
|                         | Impact on PFI - RPI 1 point lower than assumed in plan                   | 25/25/25    | 23            | 23           | 23            |
|                         | Paediatric chain/system approach developed/IHO                           | 0/20/50     | 0             | 1,600        | 5,000         |
|                         | Rev to cap opportunities                                                 | 25/25/25    | 375           | 375          | 375           |
|                         | Acceleration CIP delivery                                                | 0/10/10     | 0             | 1,300        | 1,500         |
|                         |                                                                          |             |               |              |               |
| <b>Downsides</b>        | Inflation runs 1% higher than CUF (excluding drugs)                      | 25/25/25    | (250)         | (250)        | (250)         |
|                         | Impact on PFI - RPI 1 point higher than assumed in plan                  | 25/25/25    | (23)          | (23)         | (23)          |
|                         | Pay award shortfall due to skill mix, and income that cannot be uplifted | 20/20/20    | (200)         | (200)        | (200)         |
|                         | Income/Contract Changes                                                  | 10/20/25    | (500)         | (1,000)      | (1,250)       |
|                         | PFI costs due to contractual issues                                      | 50/0/0      | (500)         | 0            | 0             |
|                         | Drugs inflation above CUF (assumed 2% higher than CUF)                   | 75/25/25    | (750)         | (250)        | (750)         |
|                         | CIP delivery slower pace                                                 | 75/50/50    | (2,700)       | (1,300)      | (1,550)       |
|                         | Paediatric chain/system approach initial costs not funded                | 50/0/0      | (125)         | 0            | 0             |
|                         |                                                                          |             |               |              |               |
| <b>Revised Position</b> |                                                                          |             | <b>(1873)</b> | <b>9,018</b> | <b>14,559</b> |

**Table Four: CDEL Allocation Breakdown**

| Spend Category                            | Area              | Sum of 26/27    | Sum of 27/28  | Sum of 28/29  | Sum of 29/30  |
|-------------------------------------------|-------------------|-----------------|---------------|---------------|---------------|
| CDEL                                      | Campus            | 10,738          | 3,280         | 650           | 650           |
|                                           | Digital           | 9,817           | 3,798         | 2,632         | 8,048         |
|                                           | Innovation        | 163             | 163           | 163           | 163           |
|                                           | Medical Equipment | 8,616           | 2,211         | 3,564         | 4,876         |
|                                           | Net Zero          | 836             | -             | 36            | -             |
|                                           | Other             | 1,488           | 60            | 60            | 60            |
| <b>CDEL Total</b>                         |                   | <b>31,658</b>   | <b>9,512</b>  | <b>7,105</b>  | <b>13,797</b> |
| Donated                                   | Campus            | 2,279           | -             | -             | -             |
|                                           | Medical Equipment | 850             | -             | -             | -             |
| <b>Donated Total</b>                      |                   | <b>3,129</b>    |               |               |               |
| New Charity / External Funding            | Campus            | 800             | 44,065        | 54,187        | 30,699        |
|                                           | Digital           | 80              | -             | -             | -             |
|                                           | Medical Equipment | 6,046           | -             | -             | -             |
|                                           | Net Zero          | 6,781           | -             | -             | -             |
|                                           | Other             | 510             | -             | 20            | -             |
| <b>New charity/external funding Total</b> |                   | <b>14,217</b>   | <b>44,065</b> | <b>54,207</b> | <b>30,699</b> |
| <b>Grand Total</b>                        |                   | <b>49,004</b>   | <b>53,577</b> | <b>61,312</b> | <b>44,496</b> |
|                                           |                   |                 |               |               |               |
| <b>CDEL Funding available</b>             |                   | <b>16,334</b>   | <b>12,648</b> | <b>18,462</b> | <b>21,165</b> |
|                                           |                   |                 |               |               |               |
| <b>Gap/Surplus</b>                        |                   | <b>- 15,324</b> | <b>3,136</b>  | <b>11,357</b> | <b>7,368</b>  |

\*NB in addition to above £2m Elective Incentive Funding has been granted which is outside of CDEL and recorded under New Charity/External Funding schemes.

**Table Five: WTE movement for 2026/27 – 2028/29**

| Workforce Forecast          | Summary WTE Detail |                   |                   |
|-----------------------------|--------------------|-------------------|-------------------|
|                             | 31/03/2027<br>WTE  | 31/03/2028<br>WTE | 31/03/2029<br>WTE |
| Total Establishment WTE     | 4000.00            | 4000.00           | 4000.00           |
| Total WTE substantive staff | 3925.62            | 3933.56           | 3940.55           |
| Bank staff WTE              | 71.89              | 64.70             | 58.23             |
| Agency staff WTE            | 2.49               | 1.74              | 1.22              |
| <b>Total staff WTE</b>      | <b>4000.00</b>     | <b>4000.00</b>    | <b>4000.00</b>    |

# Flash Report January 2026



Alder Hey Children's  
NHS Foundation Trust

Performance is subject to change



0

Severe/Fatal  
Incidents/Never  
Events

0

Patient Safety  
Incident  
Investigations

92.6%

FFT - %  
Recommending  
Trust

3

Healthcare  
associated  
Infections

9

Patients  
deteriorating from  
an inpatient bed



86.1%

ED: %Treated  
within 4 Hours

236

Number of RTT  
Patients waiting  
>52weeks

62%

% Patients  
waiting within 18  
weeks (RTT)

1.71

Elective activity  
per clinical WTE

90%

Diagnostic  
Performance



+28

Estimated  
Workforce Plan

12.2%

Staff Turnover

76.3%

%PDRs  
Completed



Financial  
Sustainability

£1.1m

I&E position  
(Actual in  
month)

TBC

I&E year end  
forecast to plan  
(Variance)

£-3m

CIP (Forecast  
vs full year  
target)

## HIGHLIGHTS

Sustained performance for time to be seen and treated in ED - 10th consecutive month 80%+.

0 PSIs, Never Events or Severe Incidents.

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

Estimated Workforce above plan.

Reduction of diagnostic performance under six weeks, pending further validation.

CIP (Forecast vs full year target) – £3m in year gap and £10.6m recurrent gap.

**VISION**  
2030

# Integrated Performance Report

Published: January 2026

Performance: December 2025

VISION  
2030

Our Journey  
To 2030



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# IPR – Executive Summary



## Outstanding Care and Experience

|                                                               | Value | Target | Trend |
|---------------------------------------------------------------|-------|--------|-------|
| Patients deteriorating from an inpatient bed admitted to PICU | 14    | n/a    | ↓     |
| Number of Incidents per 1,000 bed days – No Harm              | 75    | 77.4   | ↑     |
| Number of Incidents per 1,000 bed days – Low Harm and above   | 17    | 19.6   | ↓     |

## Executive Summary

Performance this period shows improvement in patient safety and responsiveness, with a reduction in restrictive interventions (noting expected variation based on clinical need), no severe incidents reported, sustained ED compliance above 90% for timely administration of antibiotics in sepsis, no C. difficile cases, and 97% of PALS responses delivered within five working days. Key risks include an increase in MSSA cases to three in the month and seven instances of patients deteriorating in HDU requiring escalation to PICU. The forward plan focuses on reducing infection rates by reviewing and strengthening terminal cleaning and decontamination, updating policy and delivering training with support from UKHSA, alongside continuing delivery of actions through the Deteriorating Patient workstream to reduce preventable deterioration.

## Support Our People

|                          | Value | Target | Trend |
|--------------------------|-------|--------|-------|
| Workforce Plan           | 4,307 | 4,320  | ↓     |
| Staff Turnover           | 11.4% | 10%    | ↓     |
| Sickness Absence (Total) | 6.7%  | 4.5%   | ↑     |

## Executive Summary

Workforce performance remains broadly stable, with mandatory training compliance sustained above 90% and a further review underway to address lower-performing modules. Overtime reduced in November to the lowest level seen this year, indicating improved controls and rostering efficiency. However, overall headcount has remained largely static, and reductions are anticipated in Q4 2025/26, including delivery of the MARS programme with 33 approved applications. Sickness absence presents a mixed picture, with long-term absence reducing but short-term absence increasing again in-month; the refreshed sickness absence support team is providing regular executive reporting and oversight. The forward focus is on closing the gap to the 90% target for PDR completion through targeted manager support from L&D, alongside a continued, comprehensive programme of actions to reduce both short- and long-term sickness absence.

## Revolutionise Care

|                                   | Value | Target | Trend |
|-----------------------------------|-------|--------|-------|
| ED % Treated Within 4 Hours       | 83.8% | 78%    | ↑     |
| % RTT Patients Waiting >52 Weeks* | 1.57% | 1.39%  | ↓     |
| RTT Waiting List Within 18 Weeks* | 61.9% | 62.2%  | ↑     |

## Executive Summary

November performance shows consistent delivery of urgent and emergency care, with 83.8% of patients treated within four hours, and strong diagnostic timeliness with over 95% completed within six weeks. Elective and outpatient income year-to-date remains above plan, and the was-not-brought rate has improved for a third consecutive month. Key access risks remain, with the proportion of patients waiting over 52 weeks still above the 1% target, a fourth consecutive monthly increase in overdue two-year follow-ups, and IHA timeliness sustained at only 50% completed within 20 days for a second month. The quarter four response focuses on improving elective waiting times through the submitted outpatient accelerator plan, deploying Ambient Voice Technology to increase capacity, and seeking system support for paediatric dentistry capacity, alongside reducing overdue follow-ups via the rollout of fail-safe meetings and patient validation sessions in high-risk specialties by February 2026.

## Financial Sustainability

|                                      | Value  | Target | Trend |
|--------------------------------------|--------|--------|-------|
| I&E Year End Forecast                | £7.1m  | £7.1m  | ↔     |
| Recurrent Efficiency Plans Delivered | £4m    | £14.3m | ↓     |
| ERF Income (YTD)                     | £66.5m | £67.7m | ↑     |

## Executive Summary

The Trust delivered a £0.3m surplus in month and £0.4m year to date, in line with plan and including mitigation of £0.3m IA impact. The externally reported forecast remains a £7.16m surplus, with the internal forecast improving to £5.0m, a £2.7m improvement since Month 7. Year-to-date CIP delivery totals £19.3m, including £7.5m recurrent, although this remains £1.6m behind plan. Cash is below plan due to the high level of non-cash savings and capital expenditure running ahead of plan following re-profiling and late funding approvals, including £2.0m additional capital linked to elective performance across 2025/26 and 2026/27. Key risks relate to delivery of recurrent CIPs, £2.2m of SDEC capital funding awaiting NHSE approval, and ongoing cash pressures. Mitigating actions include continued financial control through the FIP, improved divisional recovery actions, development of a cash strategy, support for recurrent savings via target operating models, and progression of a five-year capital plan to support long-term sustainability.

Outstanding Care and Experience - Safe & Caring

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

Highlights:

- No cases of C-diff reported in 2 months; policy / practice regarding terminal clean under review
- Reduction in number of restrictive interventions required; linked to individual patients
- Sustained high performance for six consecutive months in PALS responses

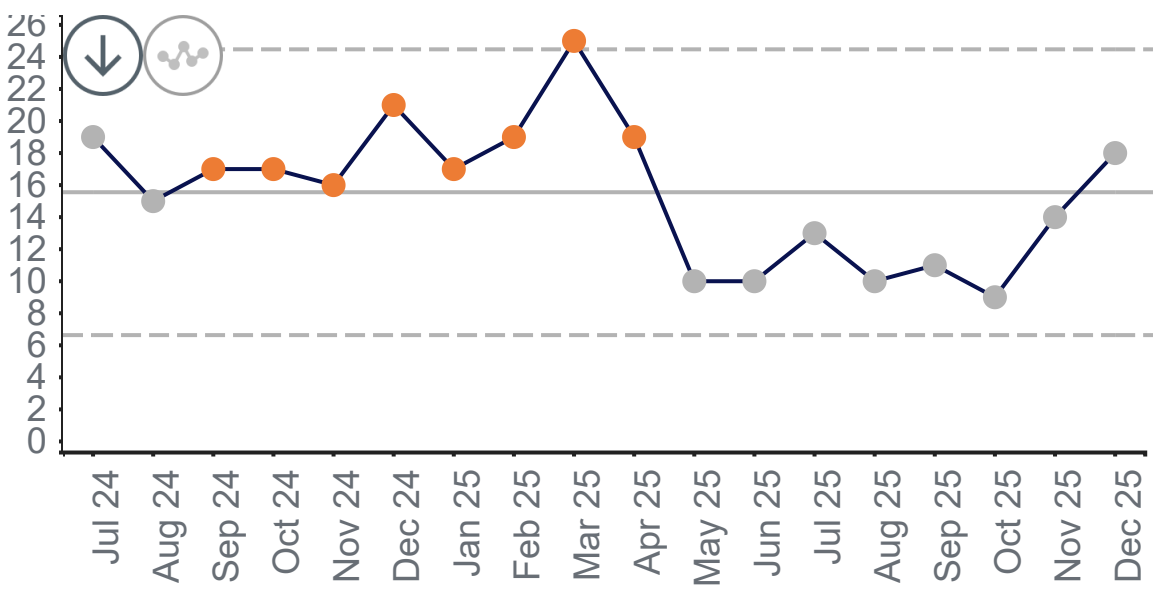
Areas of Concern:

- Never Event reported related to medication administration; no harm to the patient. Statutory requirements met and PSII commissioned. Immediate review undertaken and opportunities for improvement action identified
- Category 3 pressure ulcer reported; incident reviewed and investigated
- ED FFT responses rating experience as good or very good remain around 80%; surge in attendances in December increased waiting times for some patients

Forward Look (with actions)

Additional support in ED at times of predicted / actual pressure which impact on experience

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



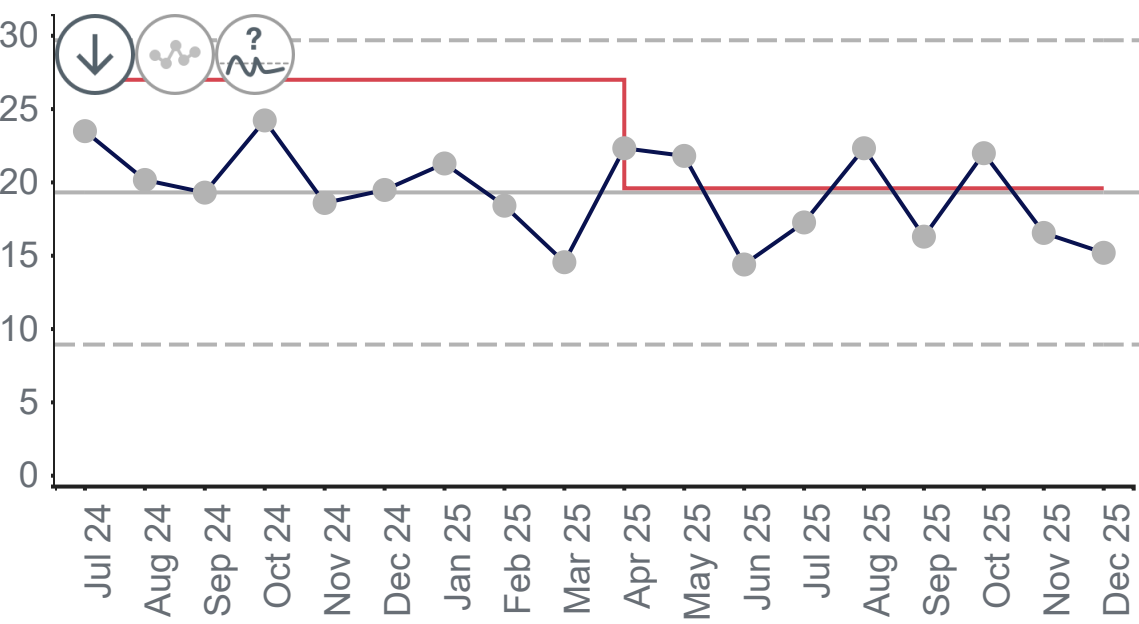
Technical Analysis:

Common cause variation observed with 18 patients deteriorating from an inpatient bed to PICU with an average of 16 a month during the last 18 months. First month above the average after 7 months.

Actions:

Increase in the number of patients in month. Case reviews undertaken by Response Team and reviewed by Deteriorating Patient working group in line with current actions and workstreams

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



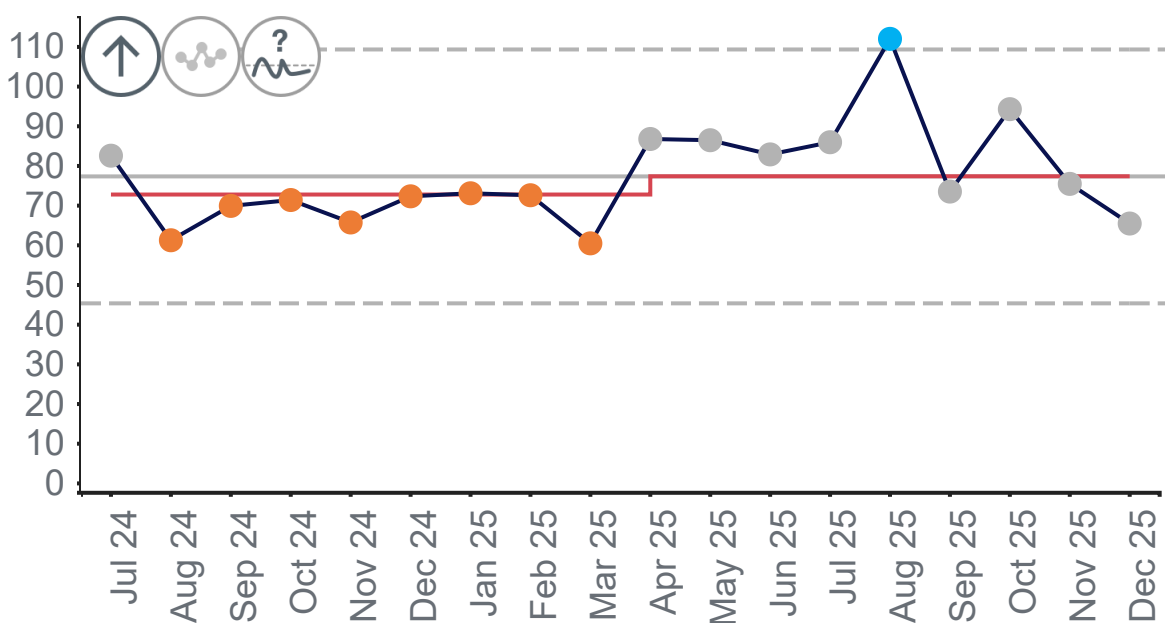
Technical Analysis:

Common cause variation with performance of 15 incidents of harm per 1,000 bed days, with a monthly average of 19 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:

Incidents continue to be reviewed at local, Divisional and Trust level to ensure themes identified, learning shared, appropriate investigations commissioned, and improvement action taken

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



Technical Analysis:

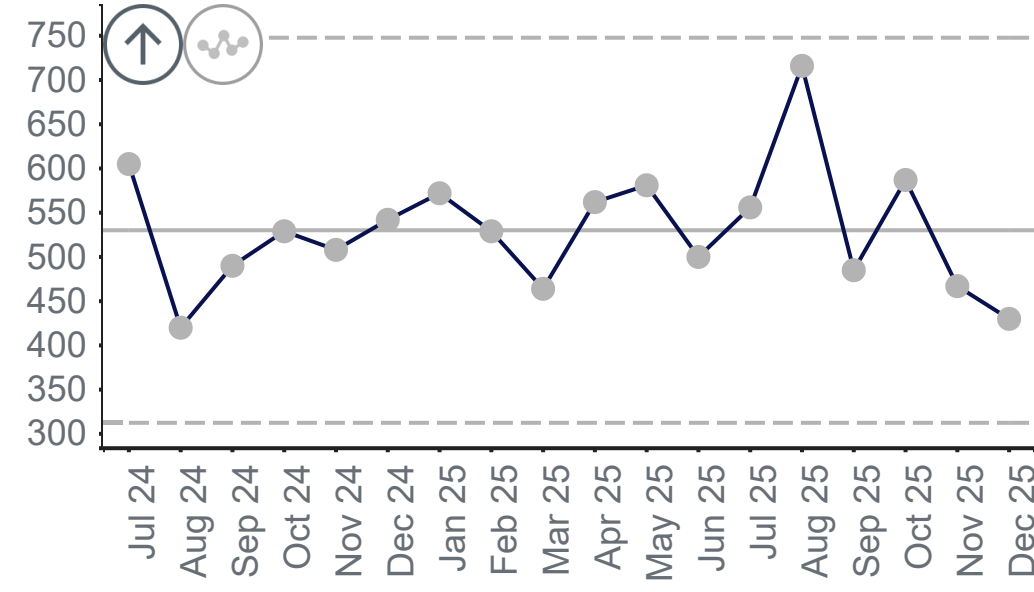
Common cause variation observed with 65 incidents of no harm per 1000 bed days, with a monthly average of 77. Incidents are assessed on both Physical and Psychological Harms. The target is set against a 5% improvement on 24/25 with monthly target 77.4. 2nd consecutive month below target however meeting target year-to-date.

Actions:

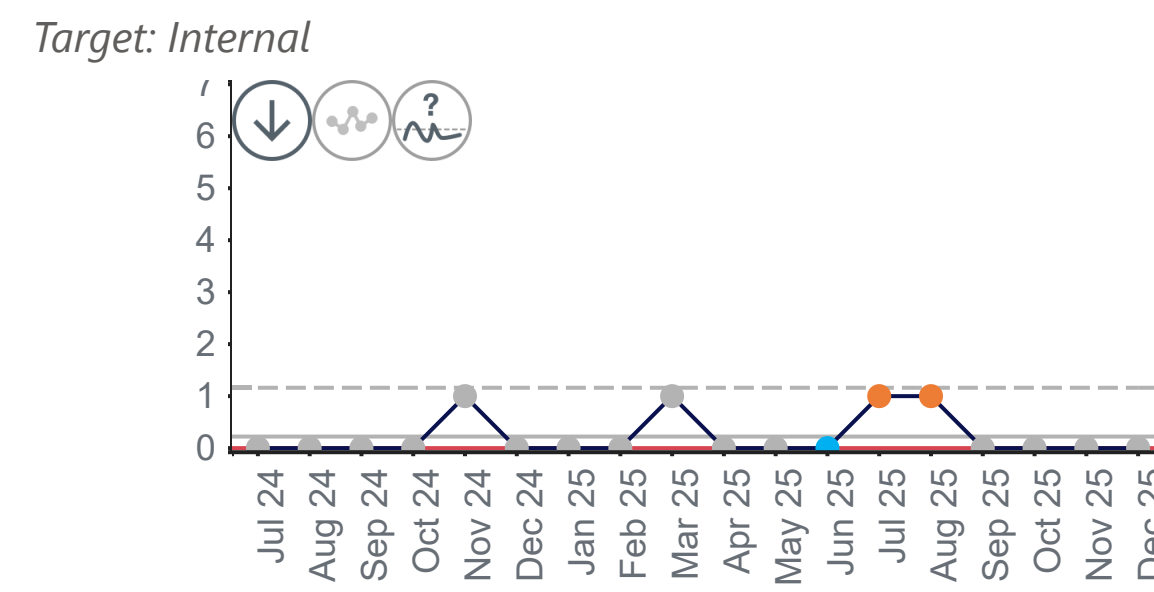
Good Catch incidents and reports of excellence in care recognised at local, Divisional and Trust level

## Outstanding Care and Experience- Safe & Caring - Watch Metrics

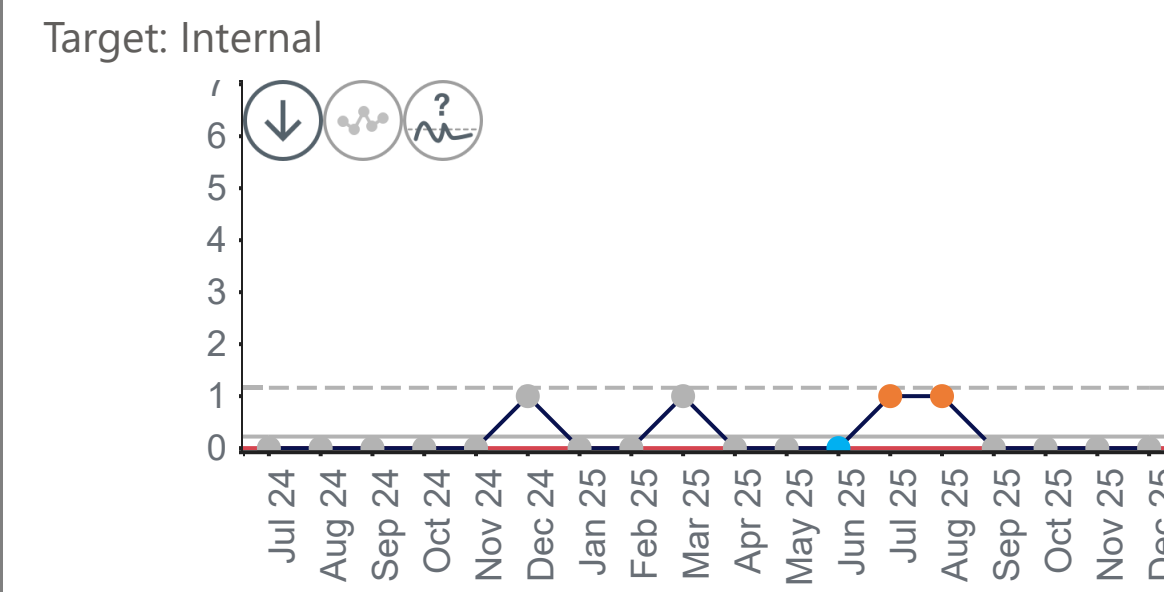
Patient Safety Incidents (All)



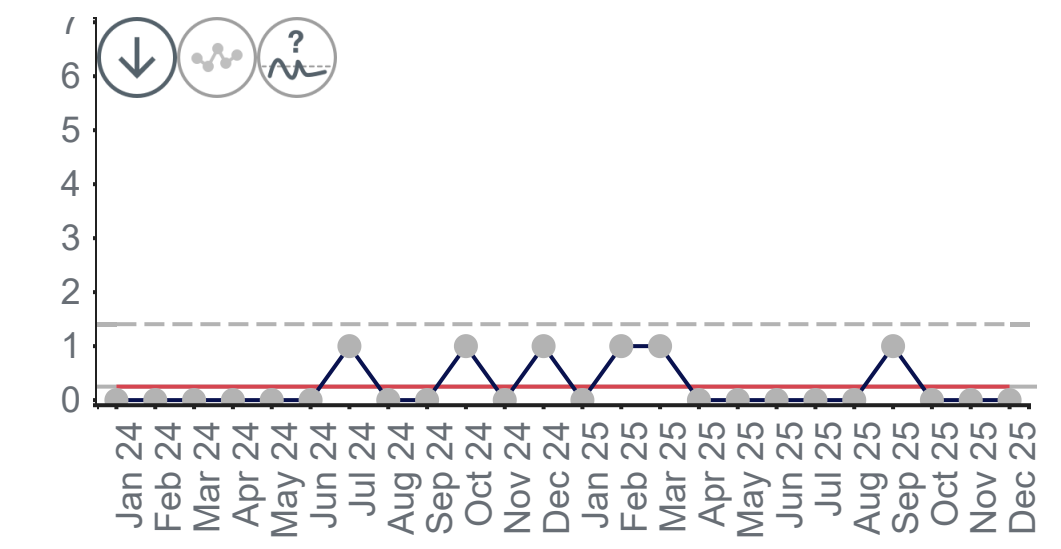
Severe or Fatal Incidents – Physical only



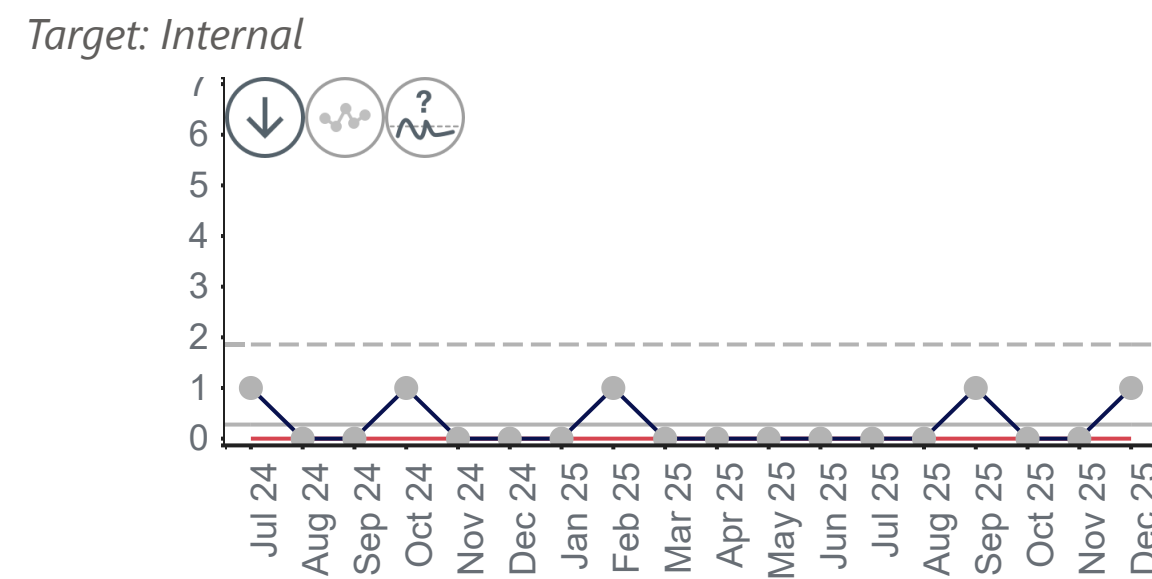
Severe or Fatal Incidents – Physical & Psychological



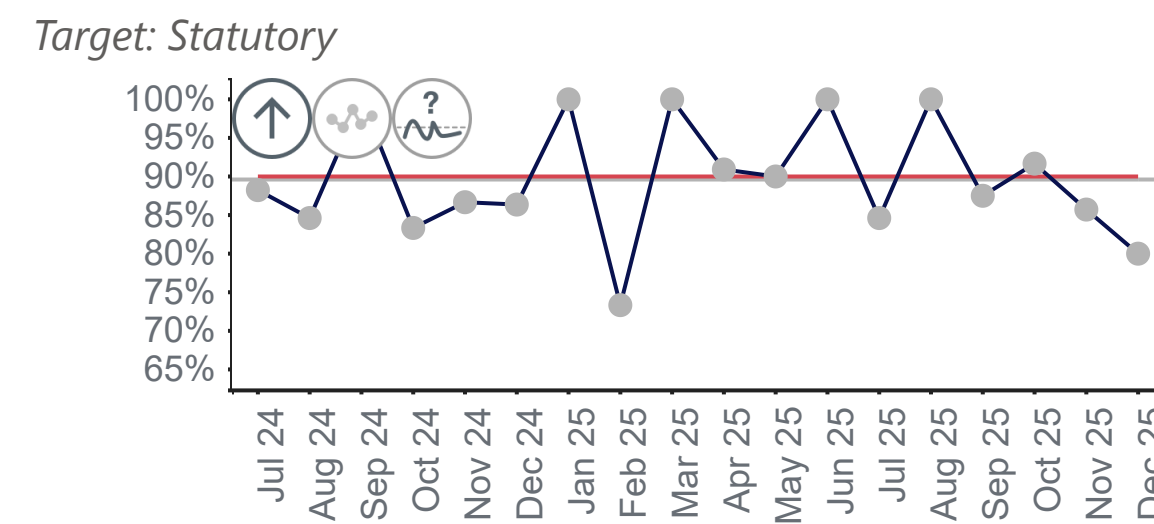
Number of PSIs (Patient safety incident investigation) undertaken



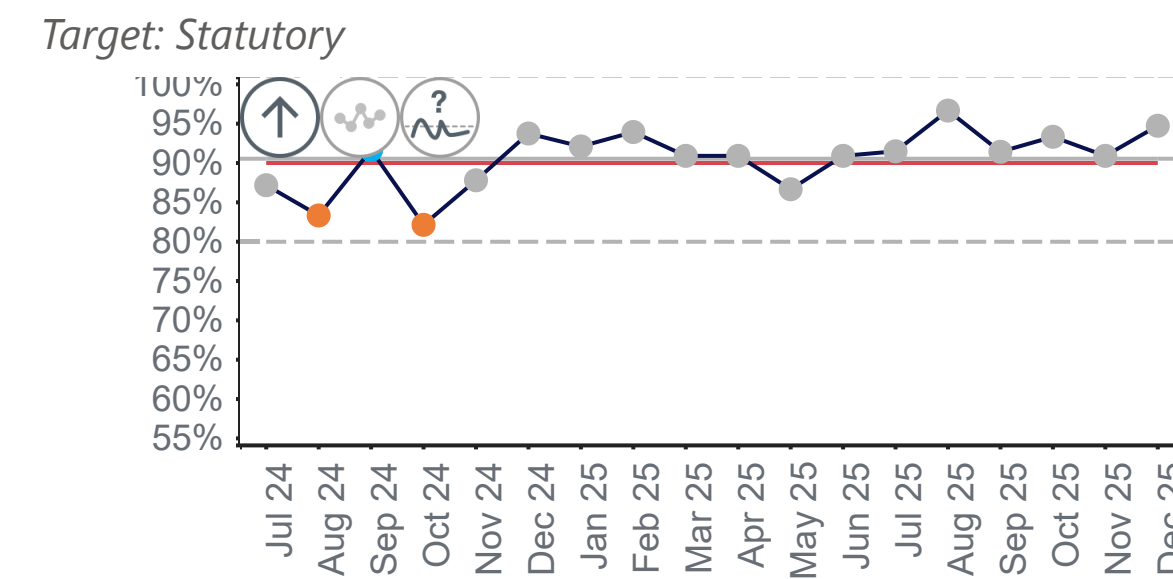
Number of Never Events



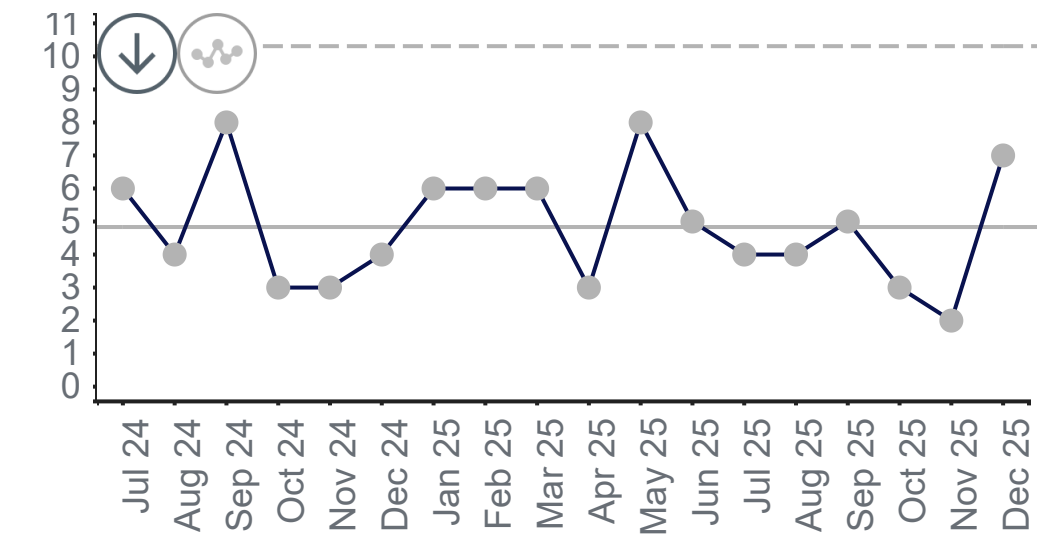
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



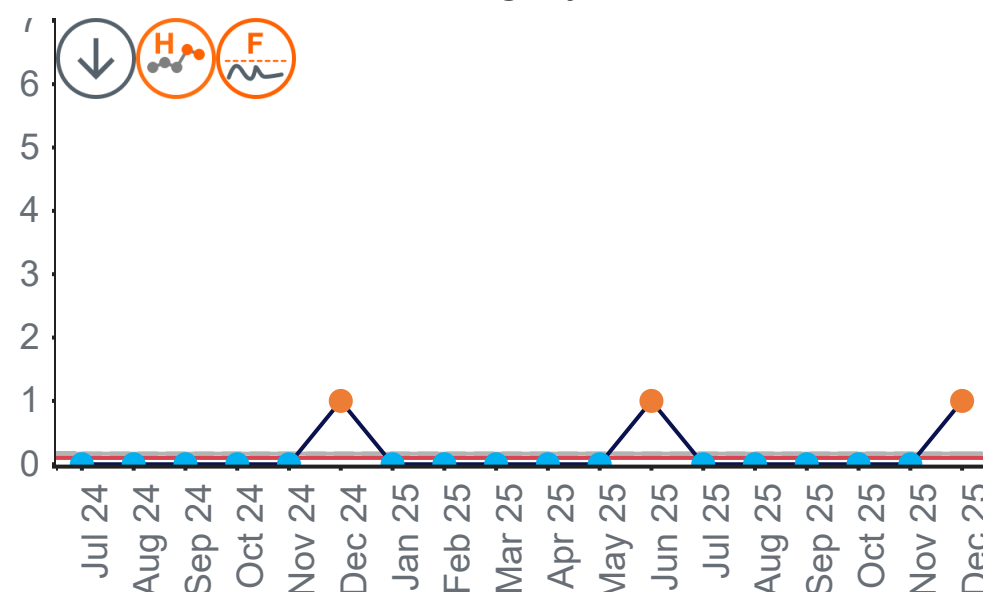
Sepsis % Patients receiving antibiotic within 60 mins for ED



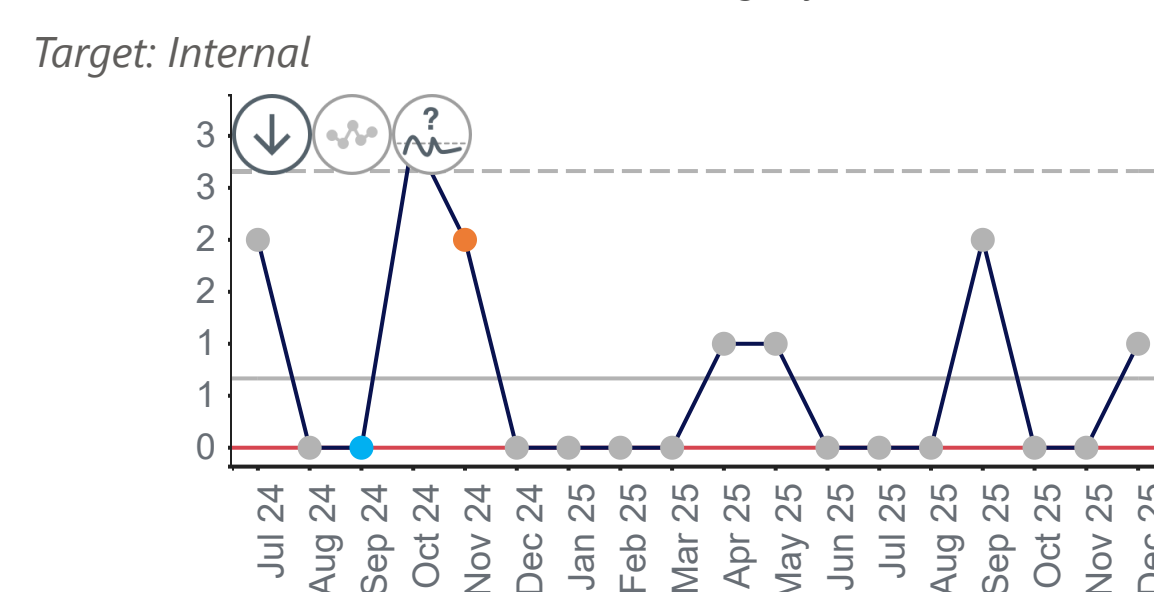
Medication Errors resulting in Harm (Physical and Psychological)



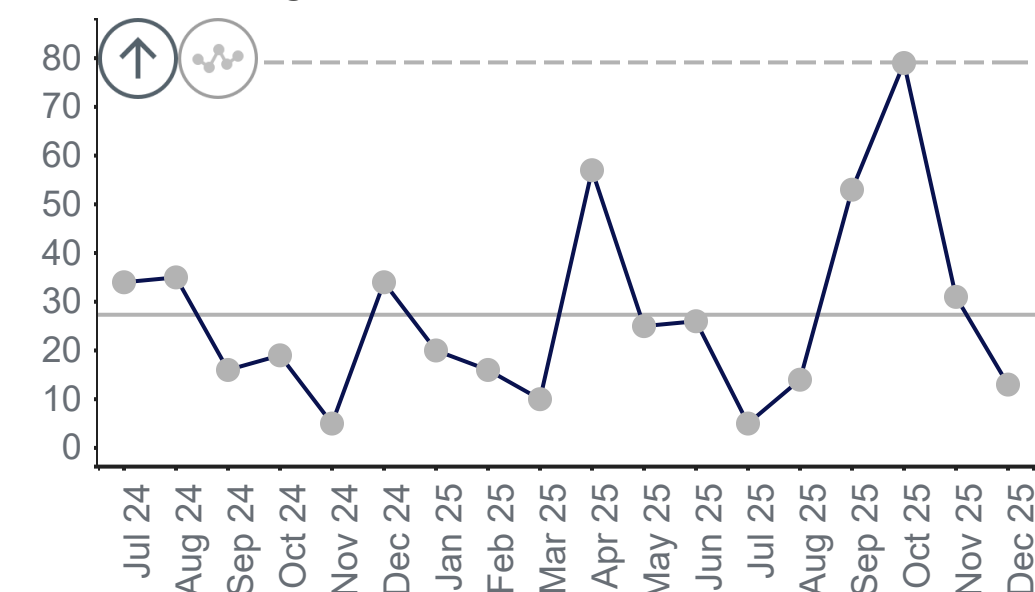
Pressure Ulcers Category 3 and 4



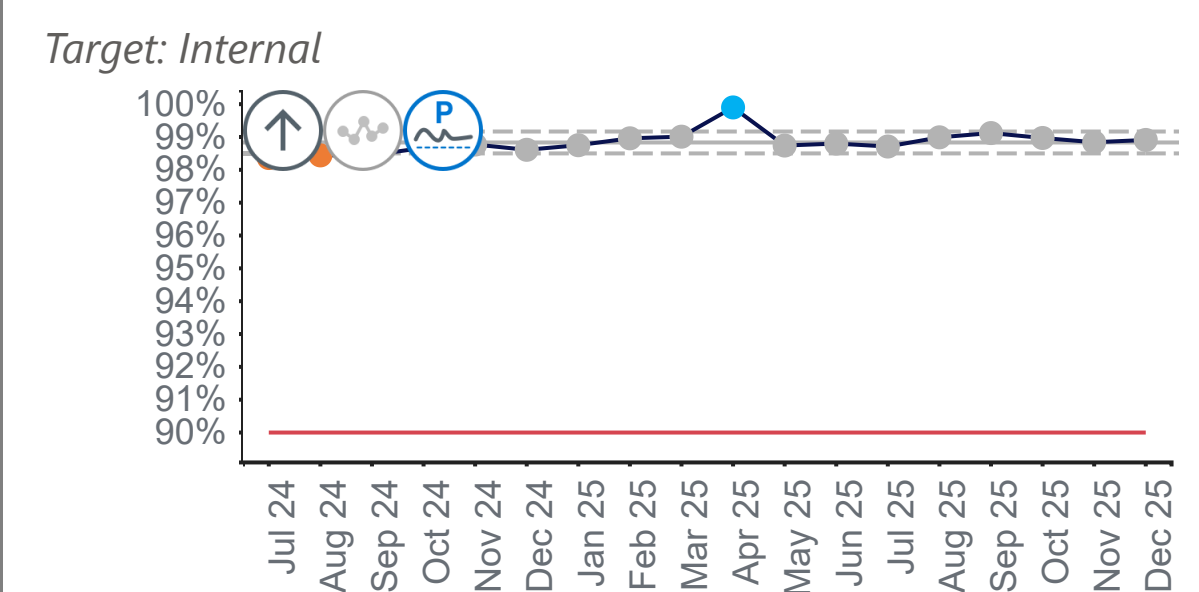
Pressure Ulcers Category 2



Recording of restrictive interventions



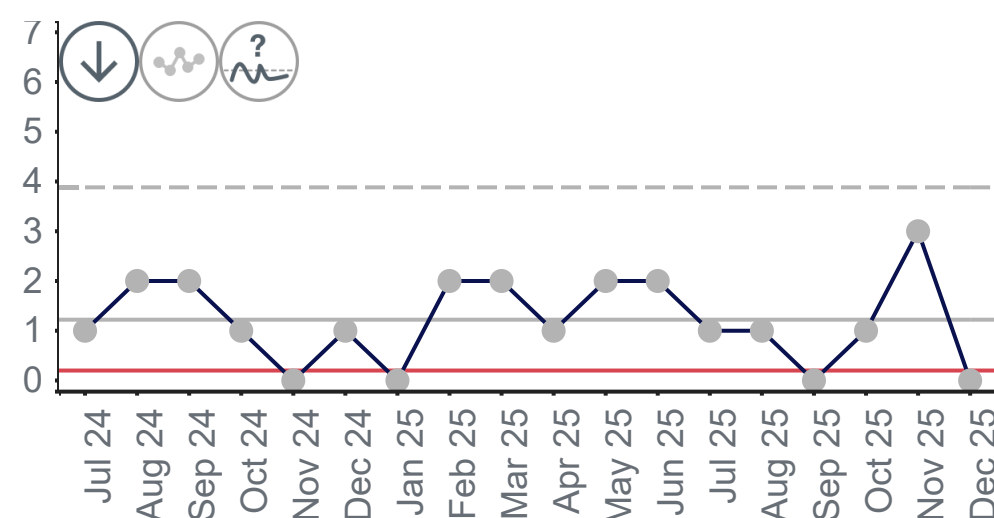
Employees trained in new Level 1 of Patient Safety



## Outstanding Care and Experience - Safe & Caring - Watch Metrics

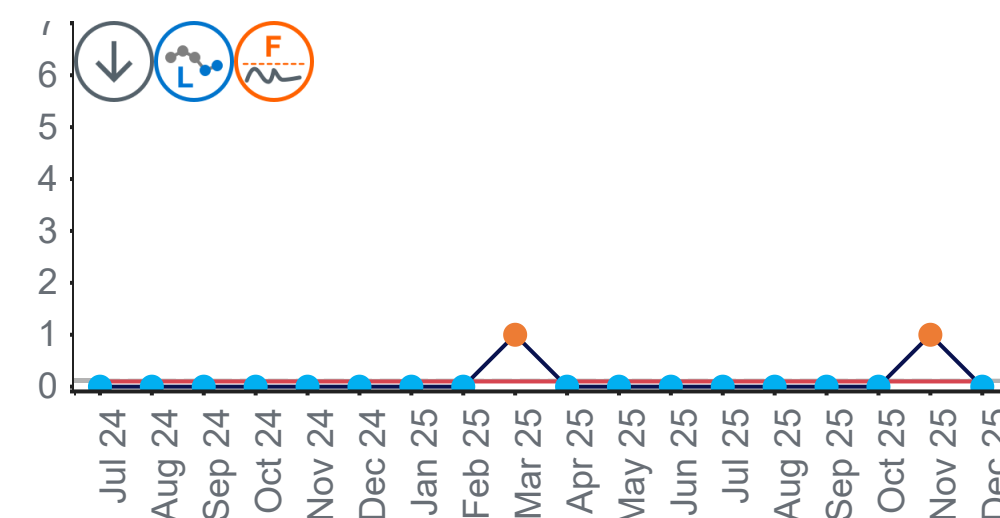
Hospital Acquired Organisms - MSSA

Target: Internal



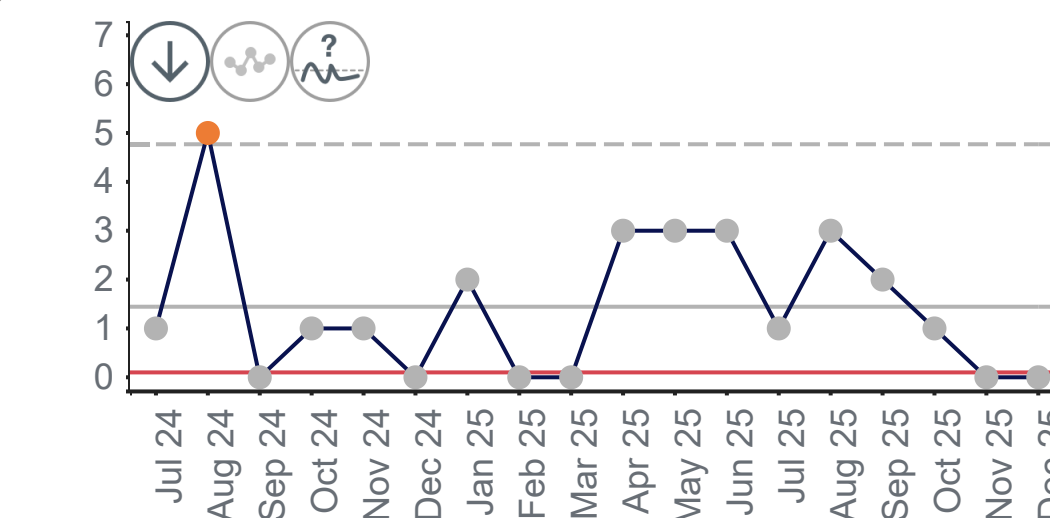
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



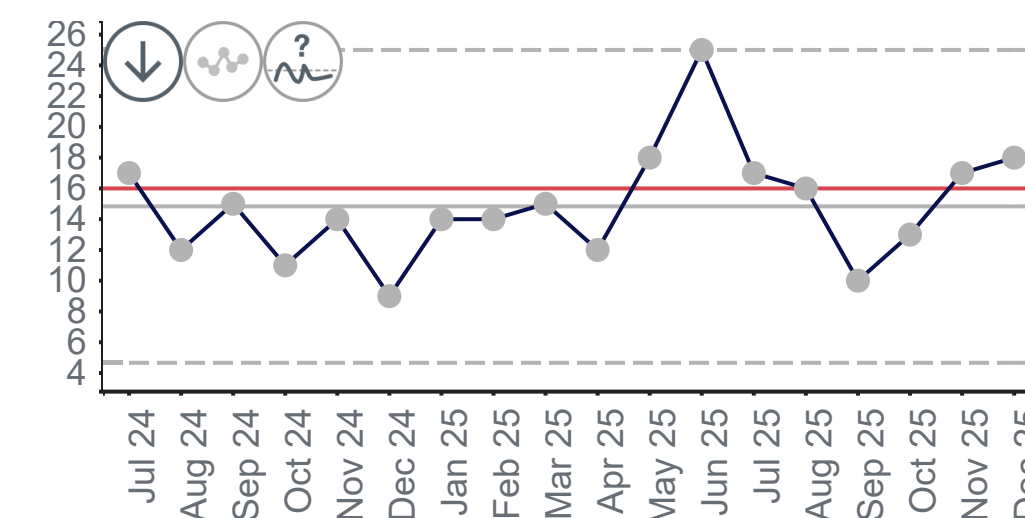
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



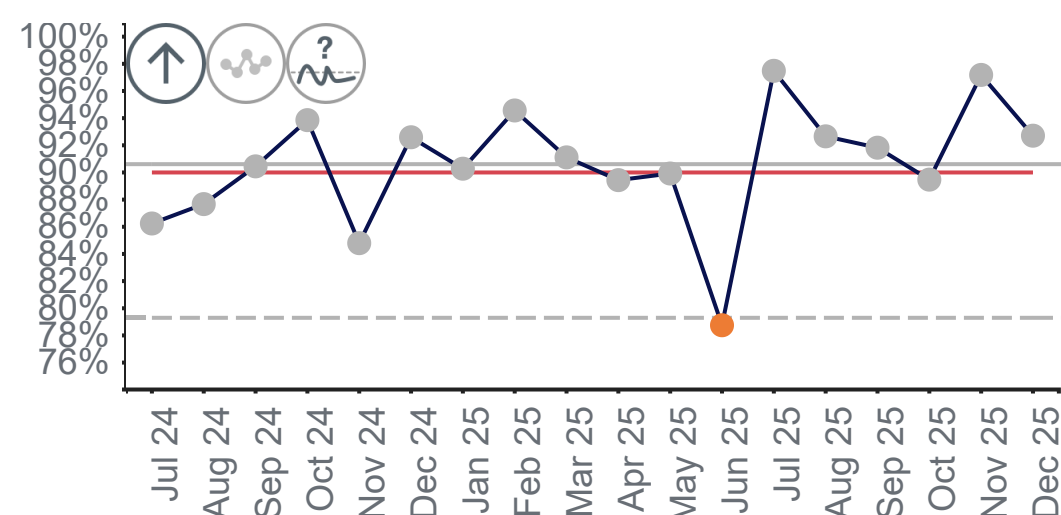
Number of formal complaints received

Target: Internal



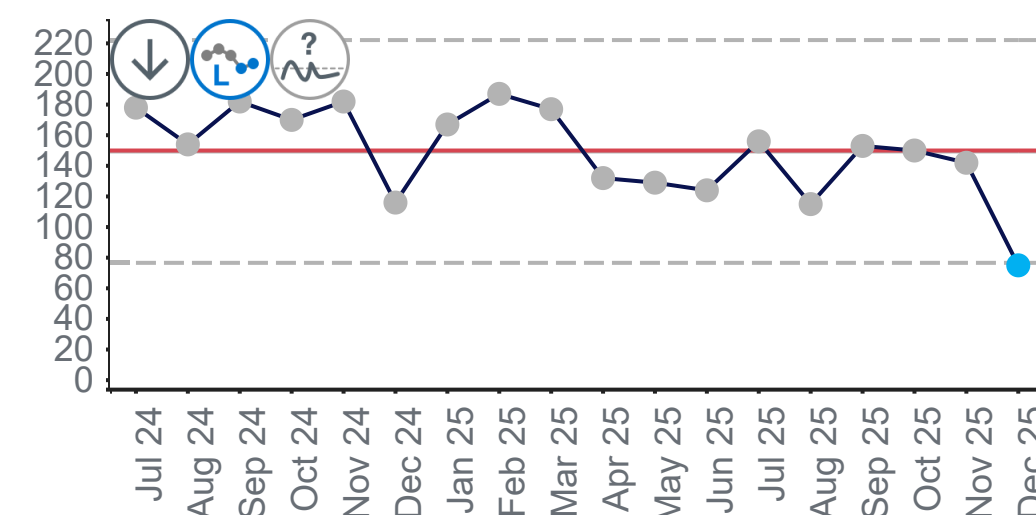
% PALS Resolved within 5 Days

Target: Internal



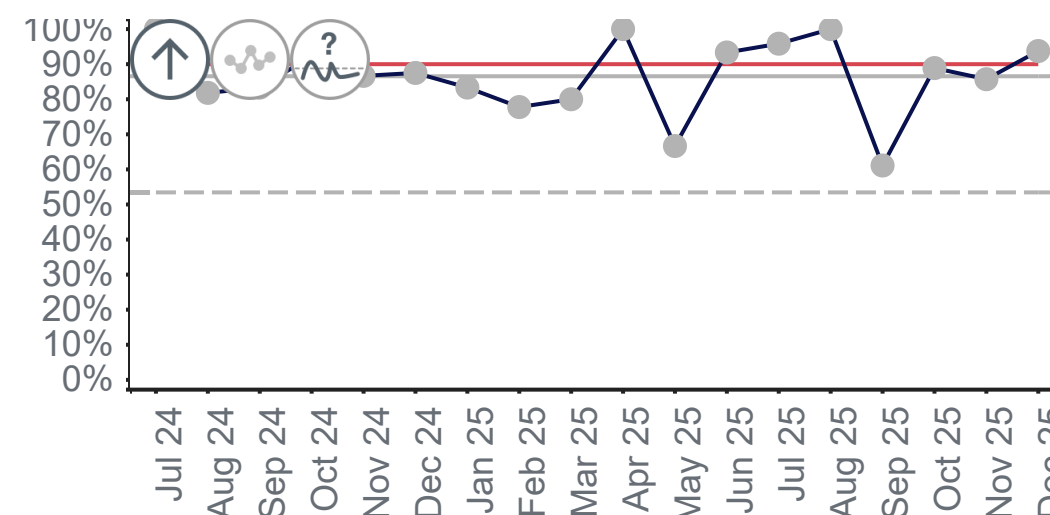
Number of PALS contacts

Target: Internal



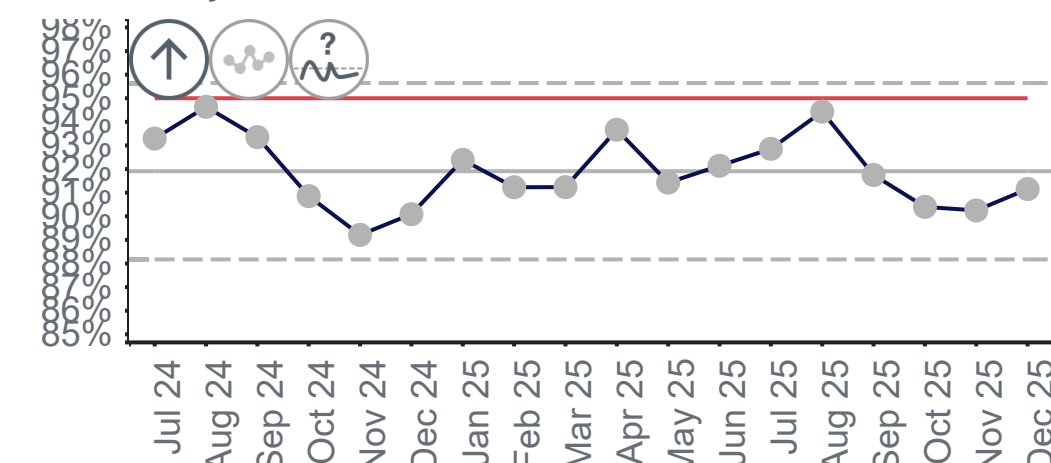
% Complaints Responded to within 25 working days

Target: Internal



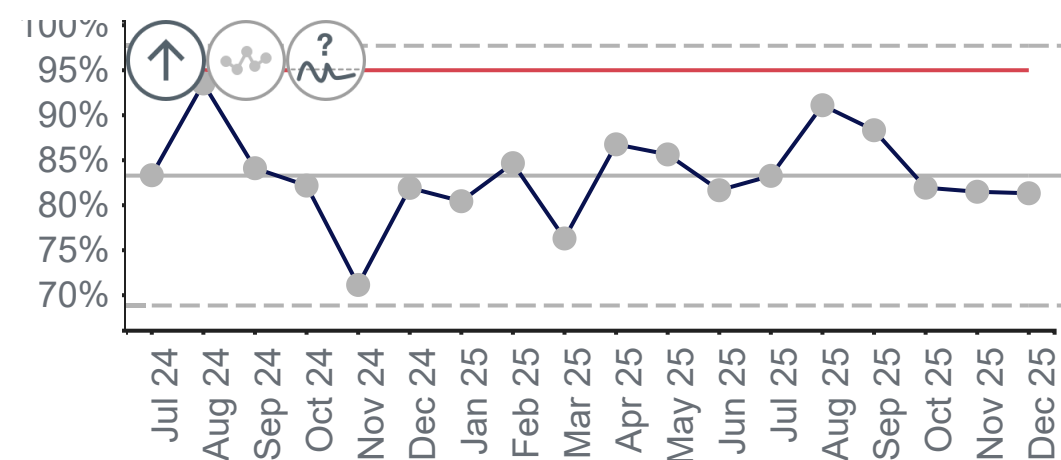
Trust: % of very good/good ratings for 'Overall, how was your experience of our service'

Target: Statutory

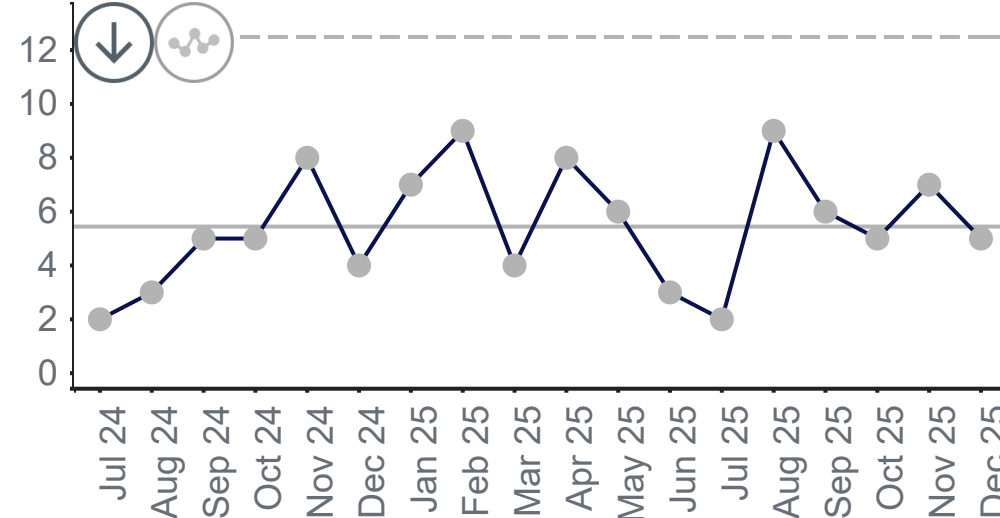


ED: % of very good/good ratings for 'Overall, how was your experience of our service'

Target: Internal

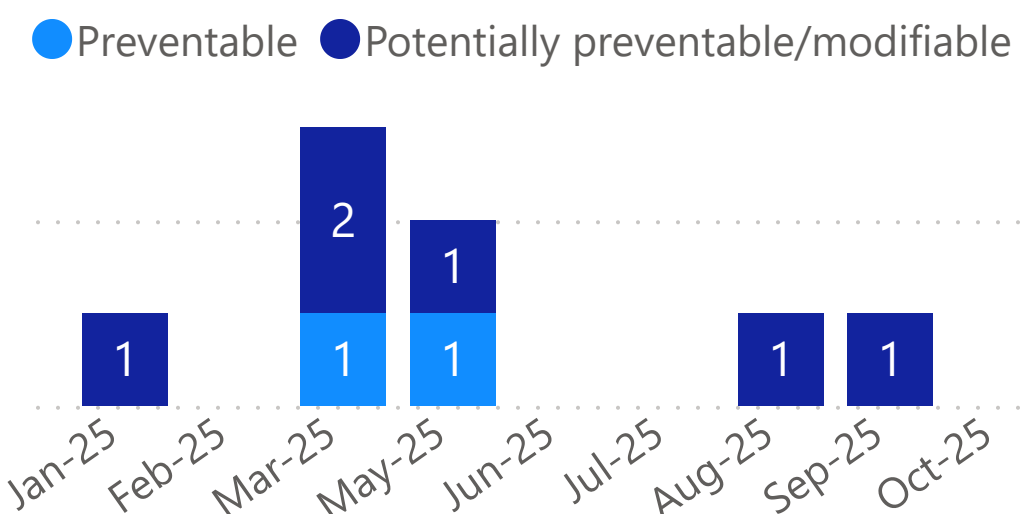


Number of patients deteriorating from HDU admitted to PICU



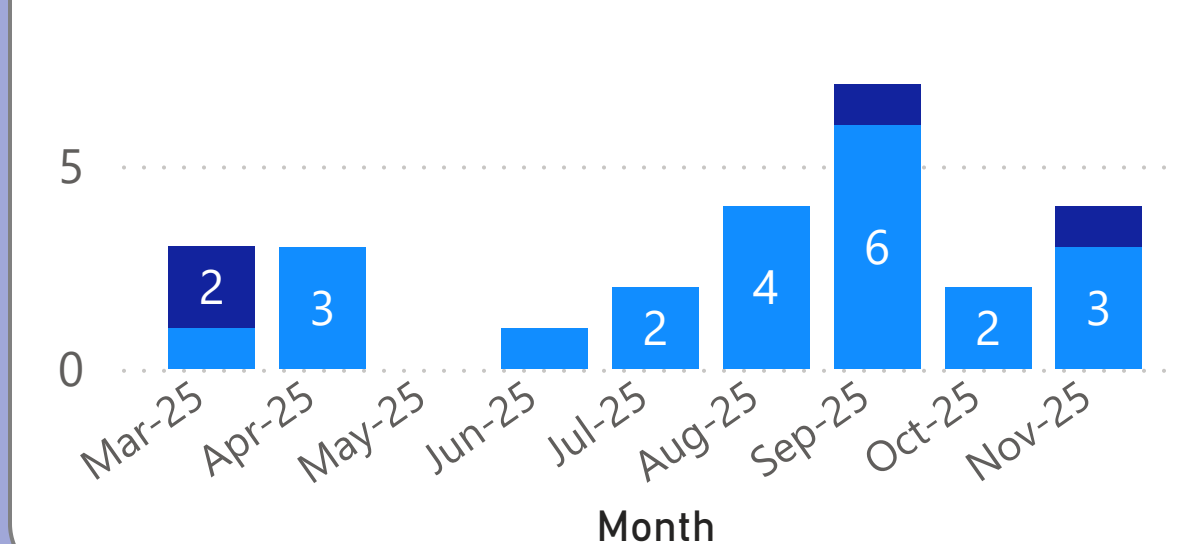
Predictable and preventable deteriorating patients

Not inclusive of all categories



Martha's Rule

● Martha's Rule Requests ● Confirmed deterioration



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:

- Consistent delivery of timely urgent and emergency care: December saw 84.1% of patients treated withing 4 hours • The number of patients being treated within 18 weeks has increased from 61.9% to 62.5% • Theatre utilisation was 83%, the highest YTD • There are zero patients waiting over 52 weeks for community paediatrics.

Areas of Concern:

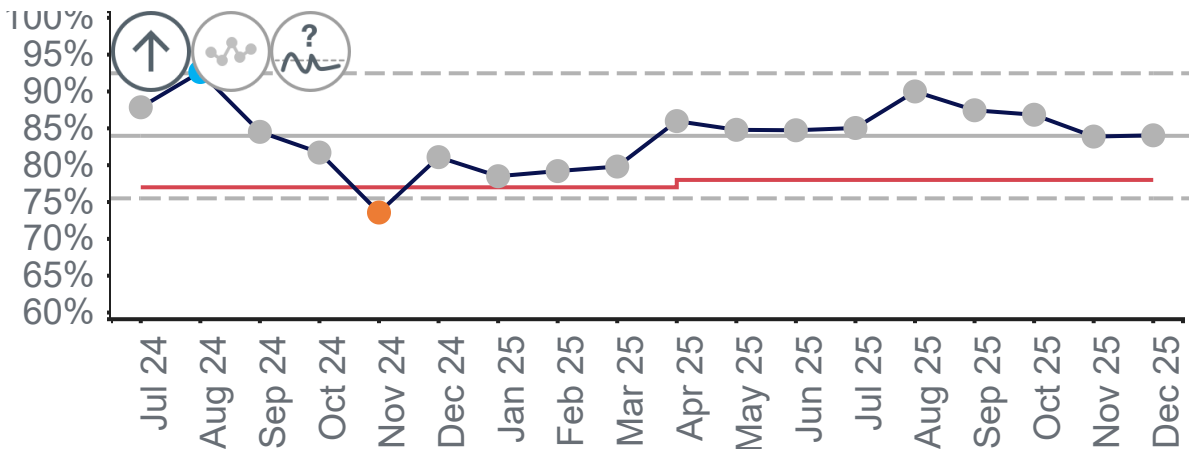
- There was a reduction in DM01 performance, decreasing to 92.9%. This was due to an increase in breaches in gastroscopy & sleep studies • The number of patients waiting over 52 weeks for treatment remains over the 1% threshold and is behind trajectory by 59 breaches • The volume of overdue (2 years) follow-up has increased for a fifth consecutive month.

Forward Look (with actions)

- Improving elective waiting times: Super Saturdays have been arranged in January for dental patients to reduce the number of patients waiting 52 weeks for treatment. Approval for Q4 outpatient sprint has been received, a task and finish group has been set up to oversee implementation.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

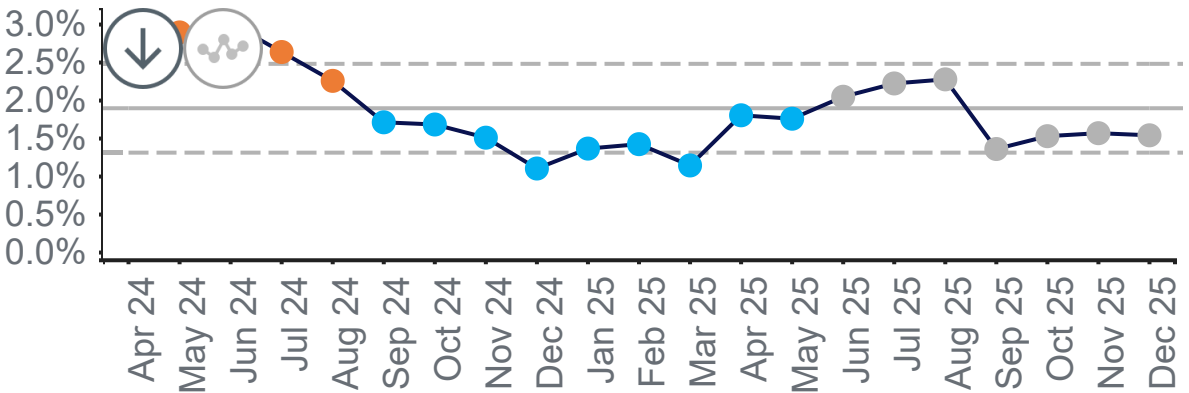
Achieved the national target in December-25 with the 13th consecutive month above target. Common cause variation observed with performance of 84.1% in December, increase from Nov-25 (83.9%). Dec-25 represents performance +3% compared to Dec-24 (81.1%) whilst Dec-25 experienced extra 647 attendances compared to Dec-24.

Actions:

- Enhanced ED escalation plan is in place, with additional specialty in-reach support • Briefings have been rolled out for on-call managers to support with ED pressures • Tactical command structure in place for pre-emptive surge planning for January

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

Target : Statutory



Technical Analysis:

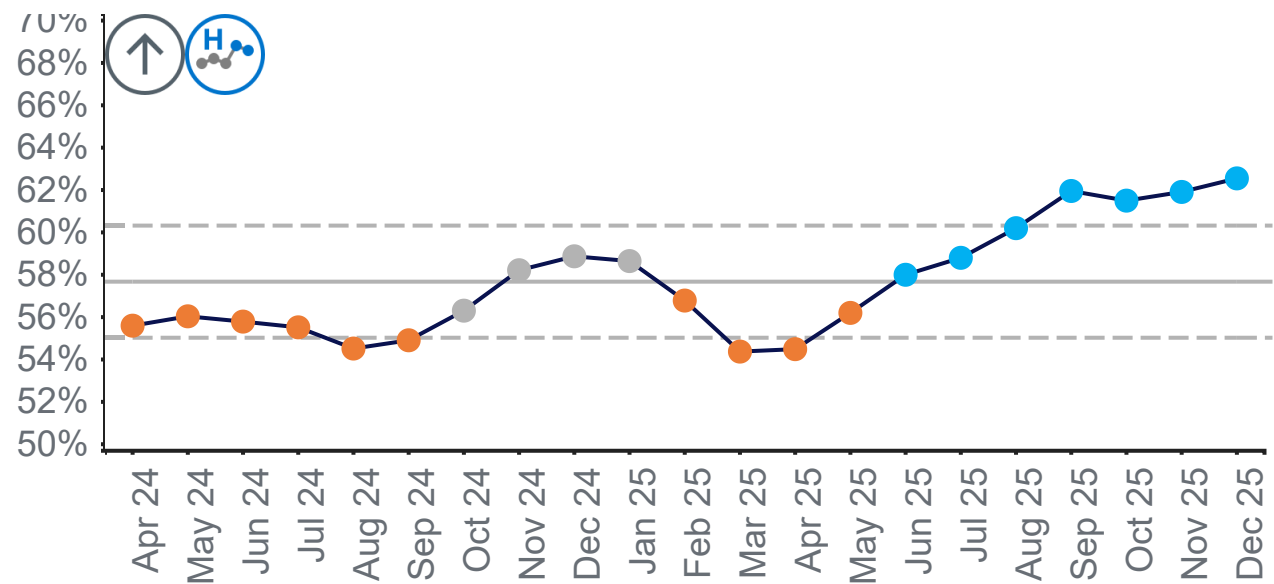
1.54% of our open IP & OP RTT waiting list is waiting >52 weeks against a national target of less than 1% waiting lists waiting >52 weeks by March 2026. This is a decrease from November position of 1.57%. With the total volume now at 258 breaches. 82.5% of current waits >52 weeks within Dentistry service.

Actions:

- Paediatric dentistry is the Trust's most challenged area for 52 weeks. 'Super Saturdays' are continuing throughout Q4, with high volume clinics and allocation of additional theatres where possible. The Trust has also submitted a bid for additional funding to support outpatient and elective activity in Q4.

Revolutionise Care- Effective & Responsive

RTT waiting list within 18 weeks



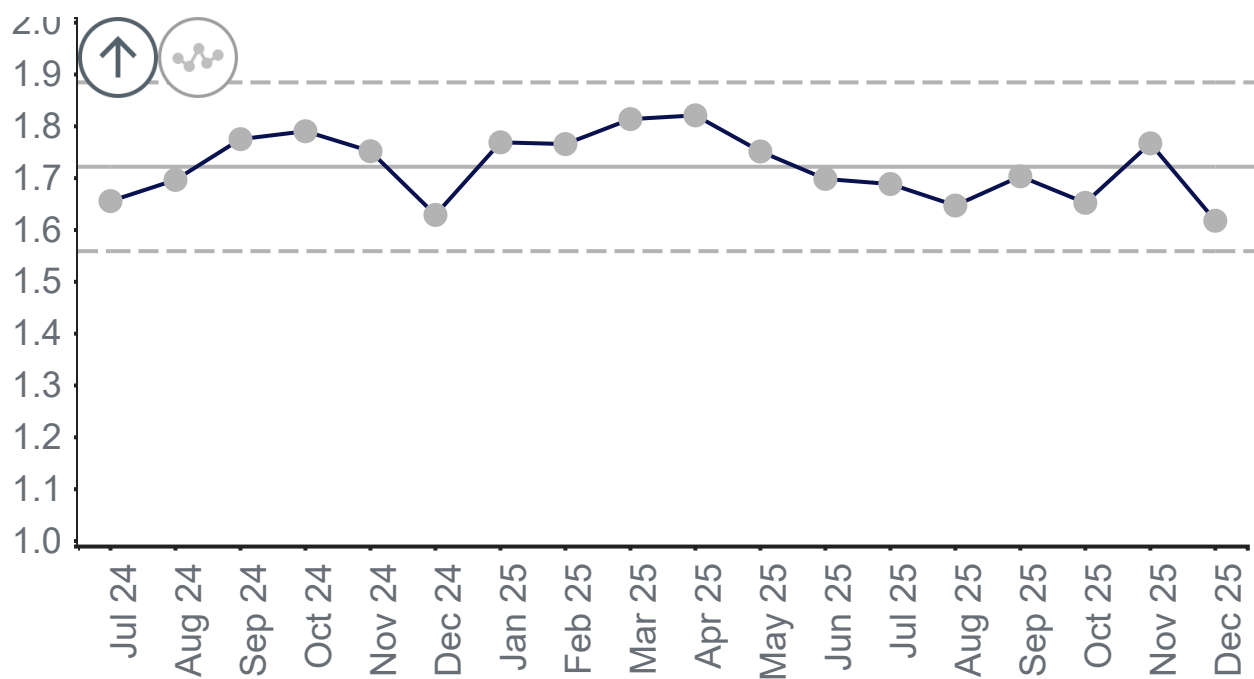
Technical Analysis:

Special cause variation with performance of 62.5% against a year end target of 63.1% by March 2026. This is an increase from November 2025 position of 61.9%. Dentistry, General Paediatrics and Plastic Surgery lowest performing of services with >100 waiters.

Actions:

The Trust was successful in Q4 outpatient bid and has gained funding for additional activity. This will support reducing waiting times for CY&P. Two productivity schemes are underway: optimised booking to compensate for 'Was Not Brought' rates, and Ambient Voice Technology.

Elective admissions (IP & DC) per clinical WTE



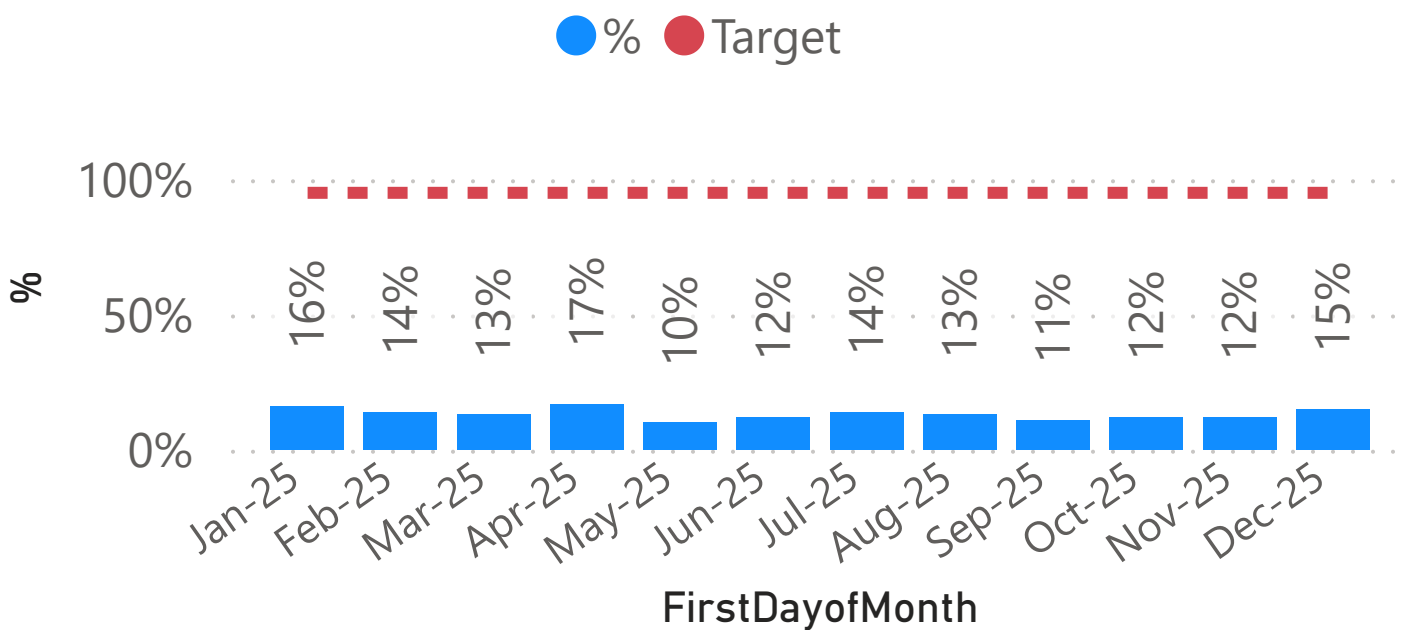
Technical Analysis:

Common cause variation has been observed with performance of 1.62 admissions per Clinical WTE (1608). Slight decrease from December-24 rate at 1.63. Dec-25 experiencing -0.3 admissions per working day compared to Dec-24 however with +15 clinical WTE.

Actions:

Process established to clinically review all patients who unexpectedly converted to a day case, to maximise day surgery rate and minimise cancellations. A pilot programme aimed at maximising the use of daycase ward and reducing the reliance on inpatient beds is set to begin on 12th January.

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



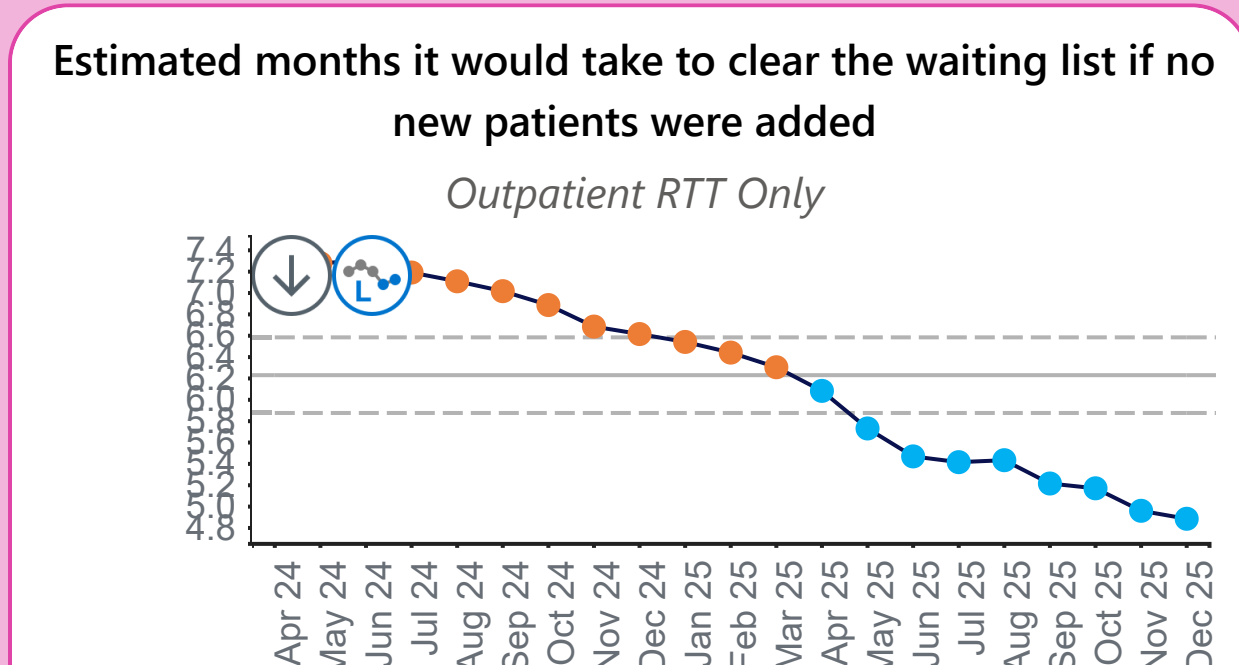
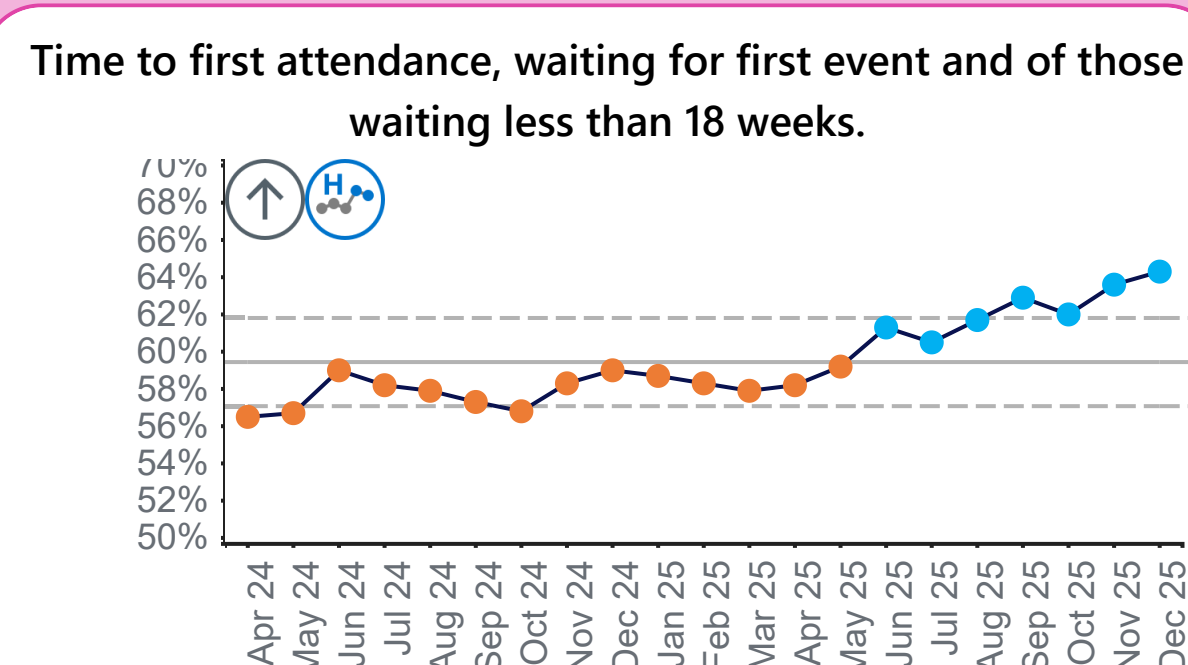
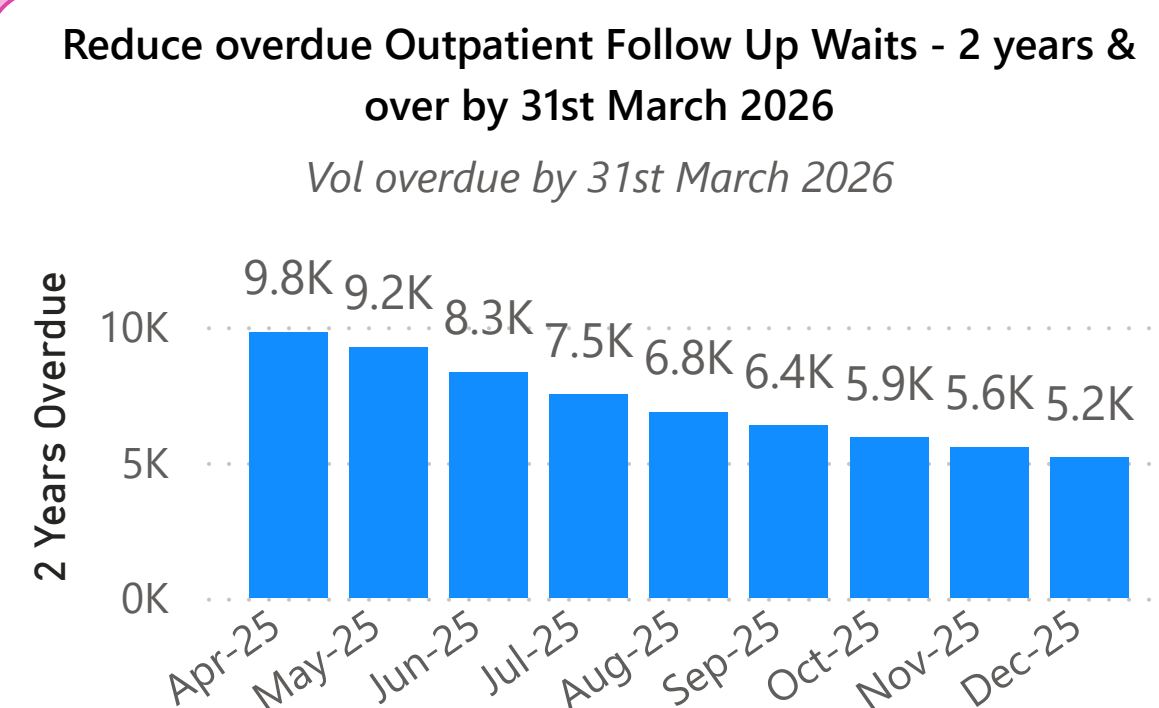
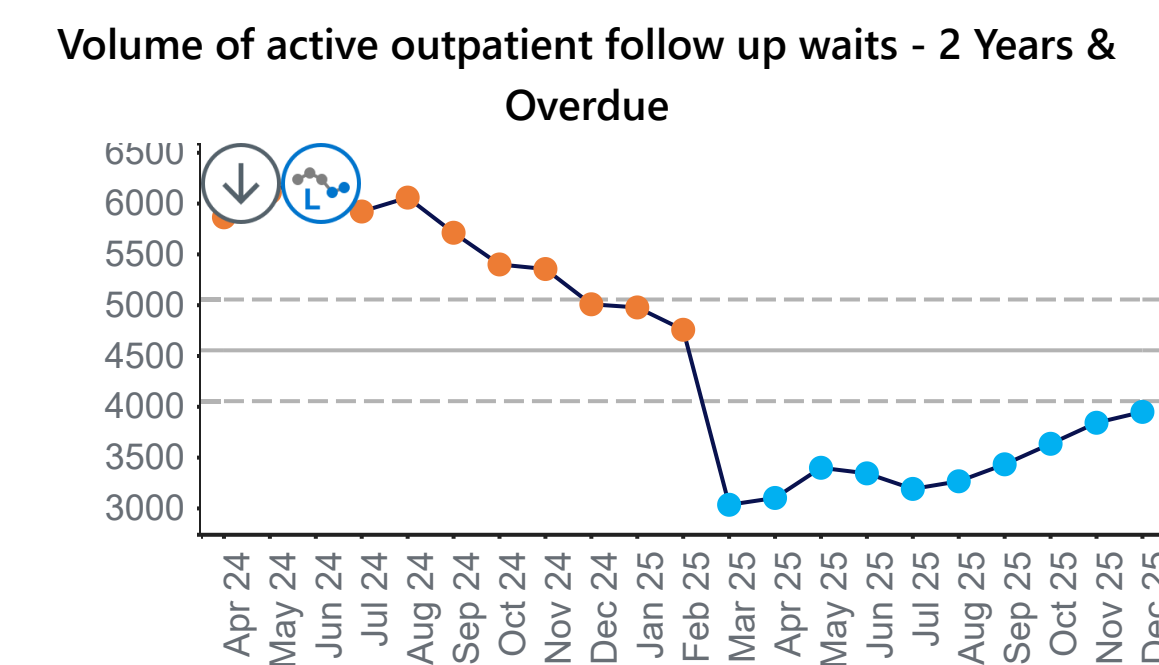
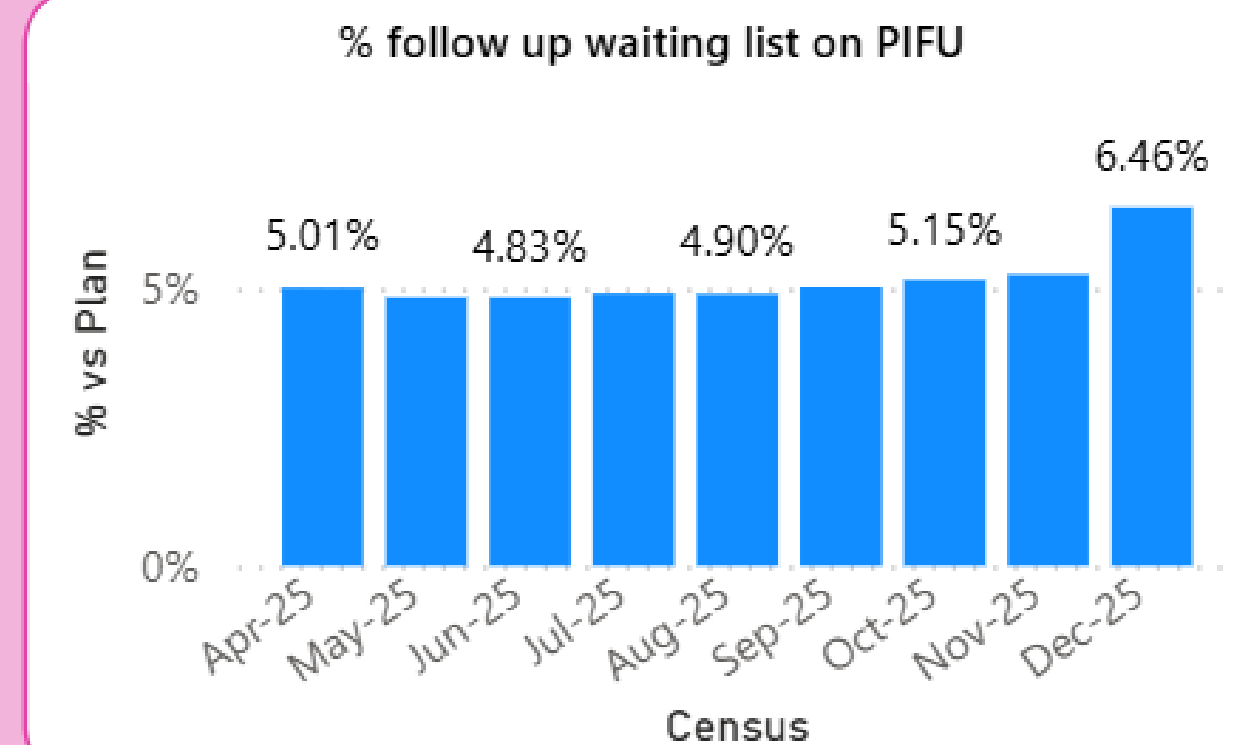
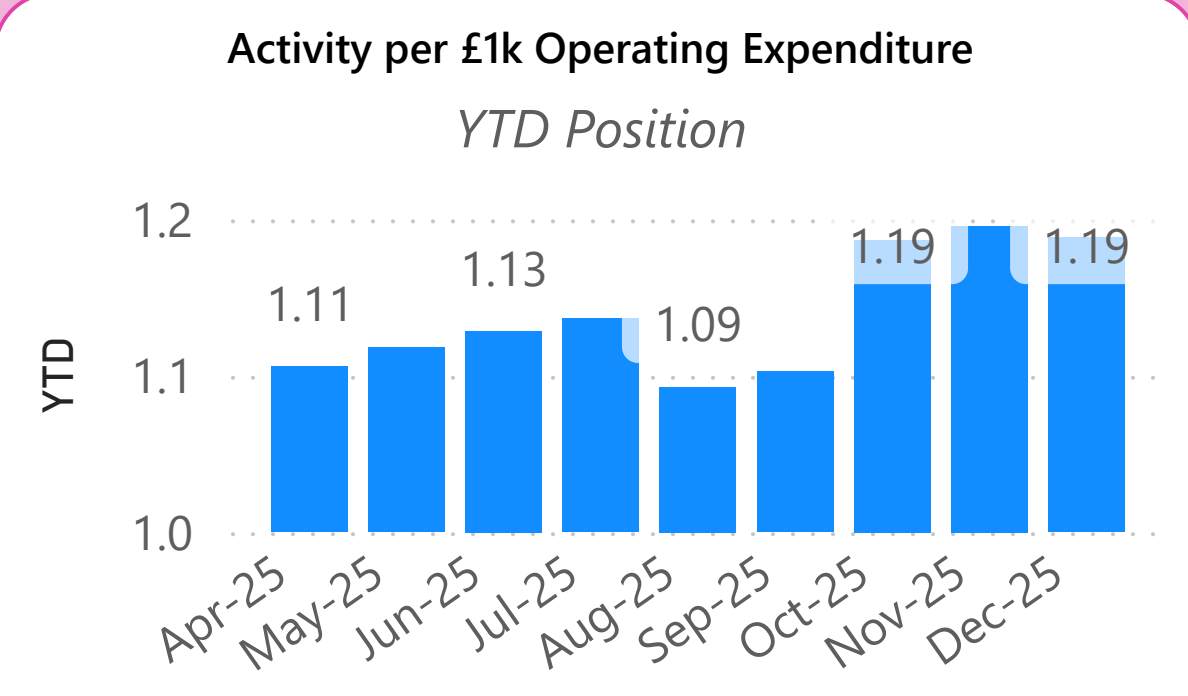
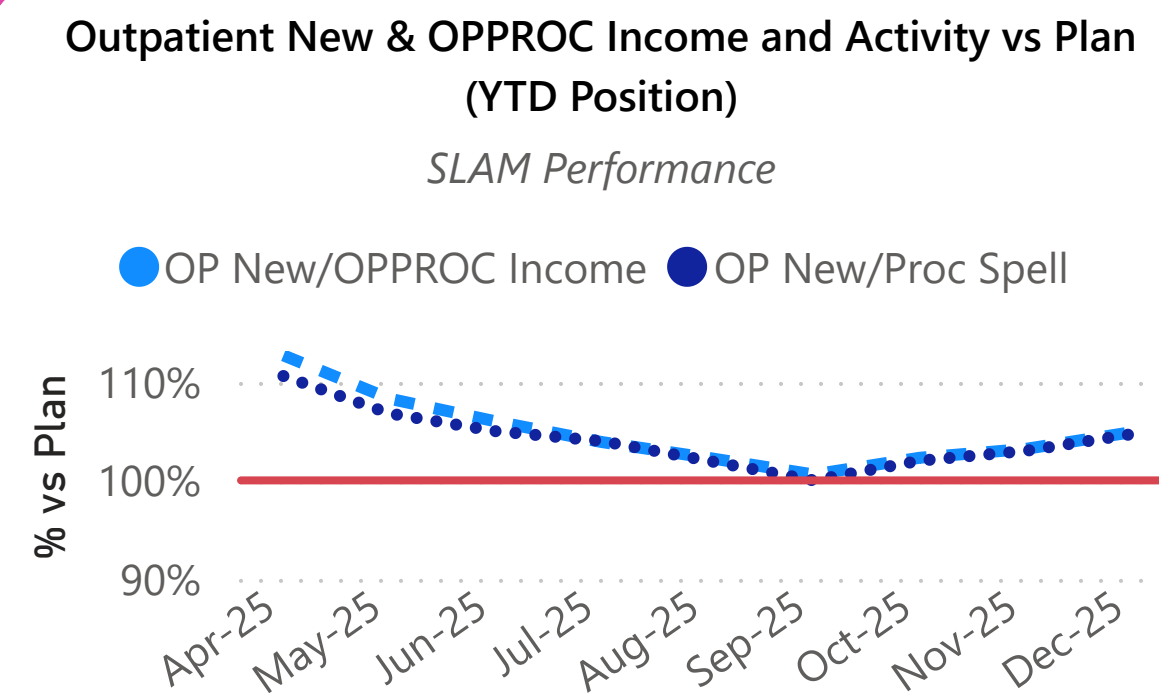
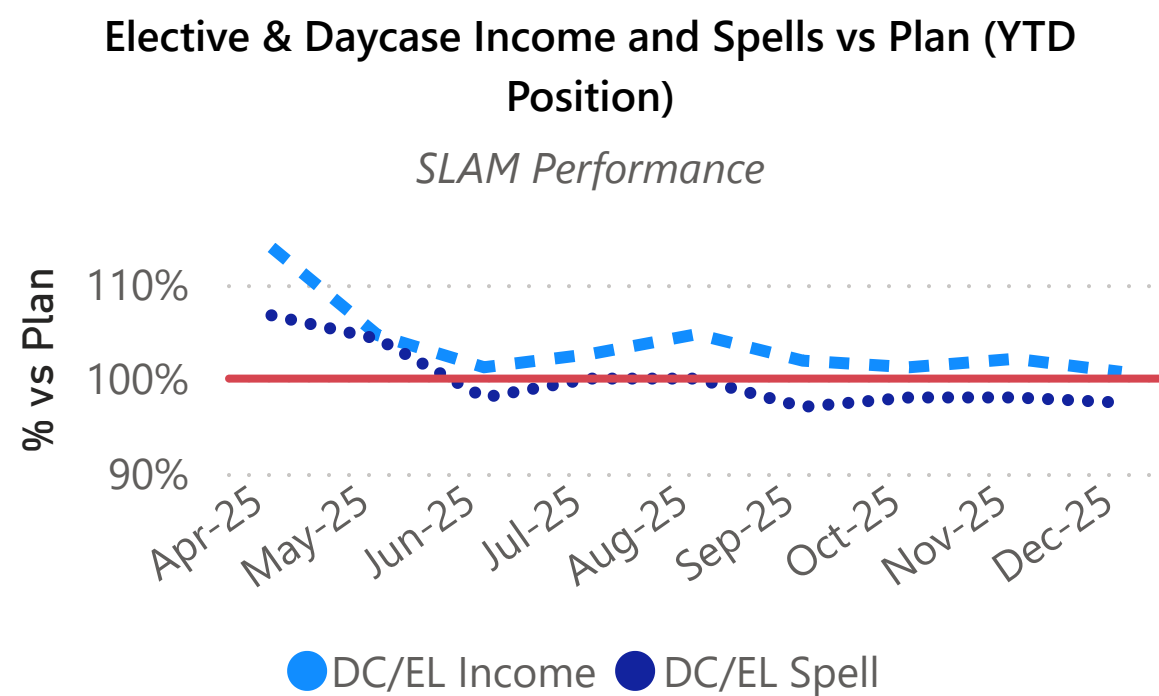
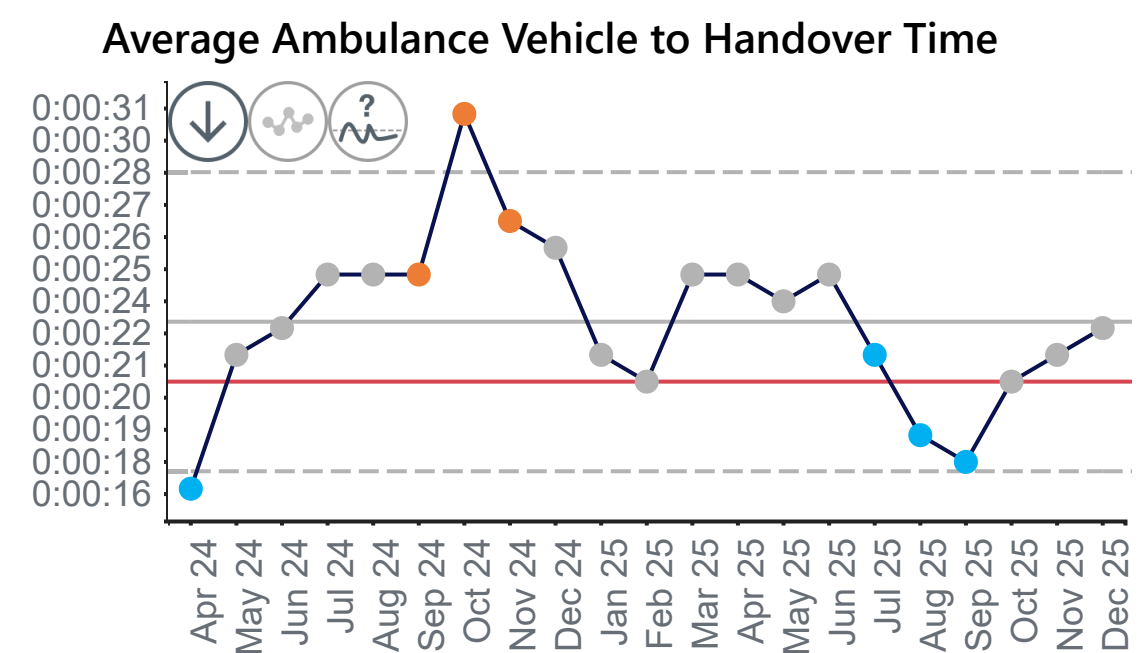
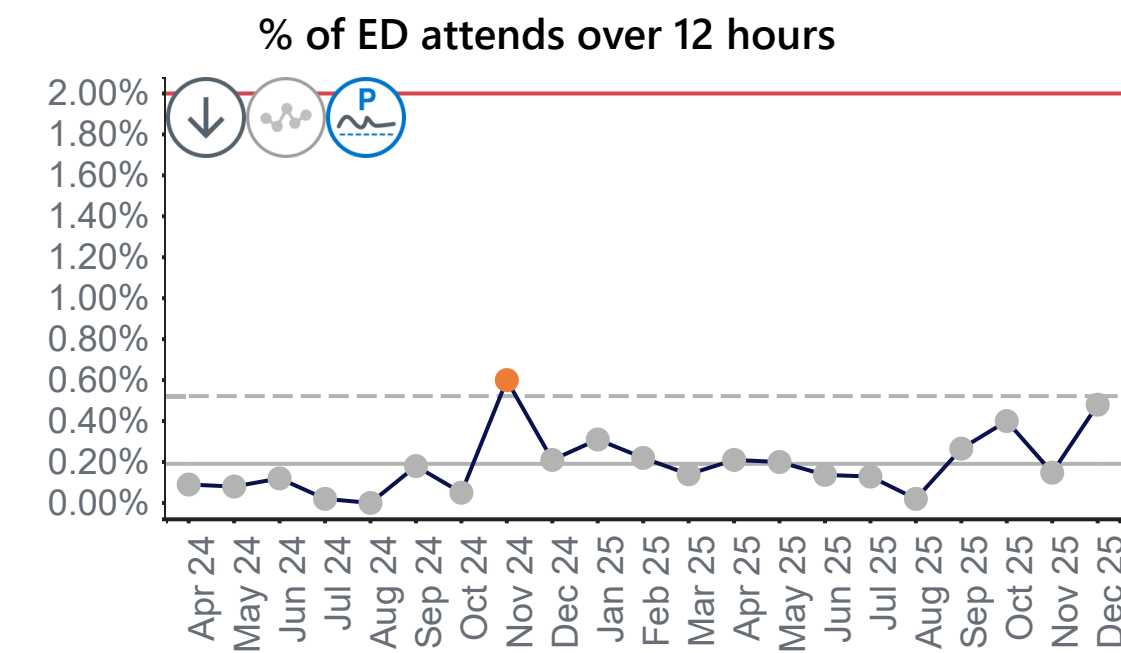
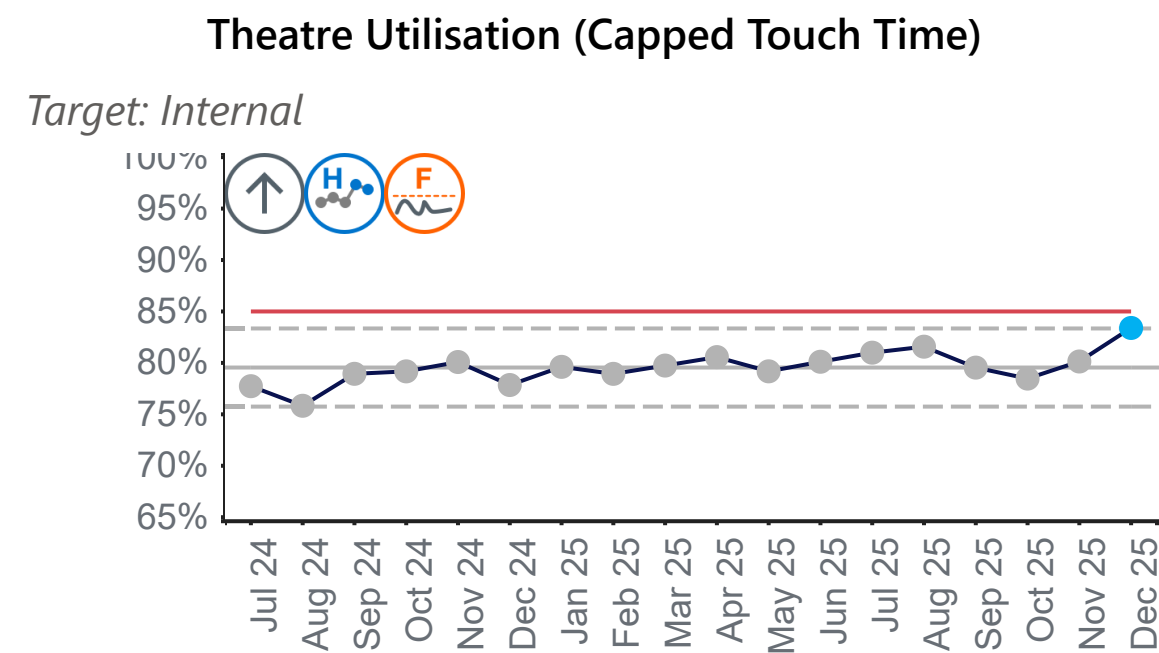
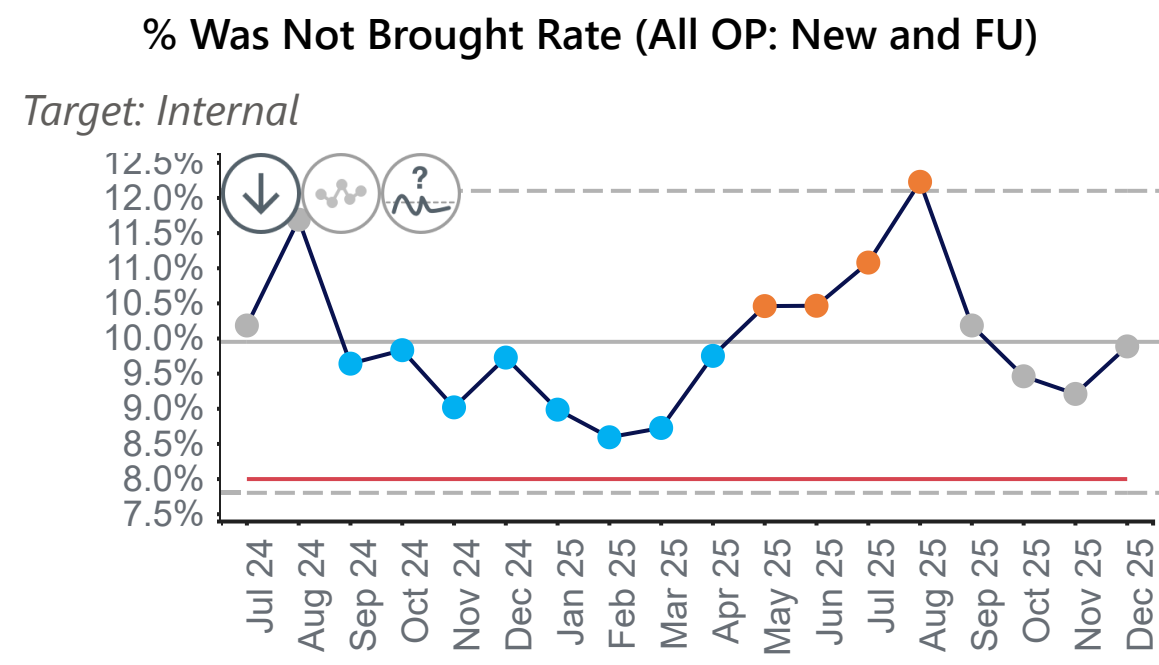
Technical Analysis:

Performance at the end of December 2025 is 15% against a target of 95% which is increased performance from 12% last month and highest since Apr-25.

Actions:

The new single neuro-developmental pathway went live Sept- 25. Evaluation is underway. Review of the referral triage pathway undertaken. Risk documentation to be completed for all CYP open to service - phase 1 commenced. Demand and Capacity work commenced and due to be completed January 2026.

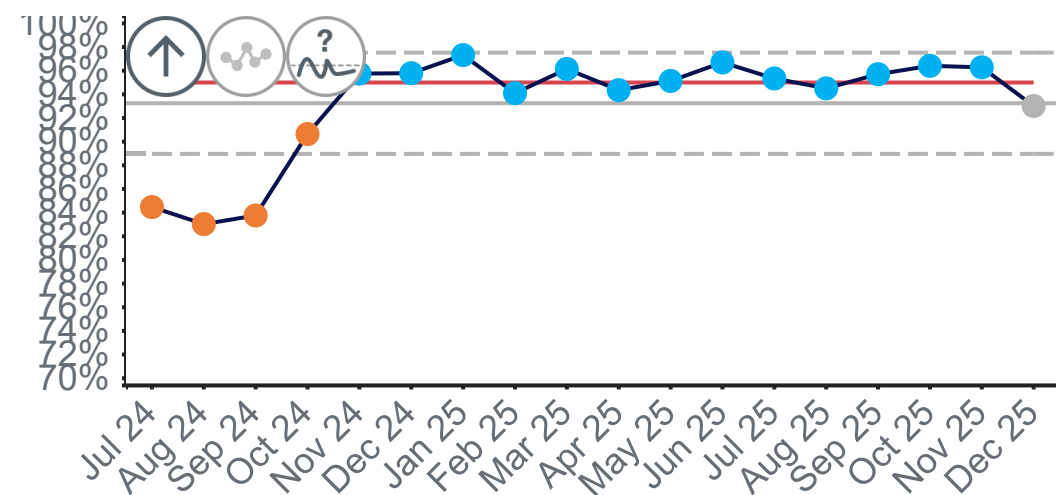
## Revolutionise Care - Effective & Responsive - Watch Metrics



## Revolutionise Care - Effective & Responsive - Watch Metrics

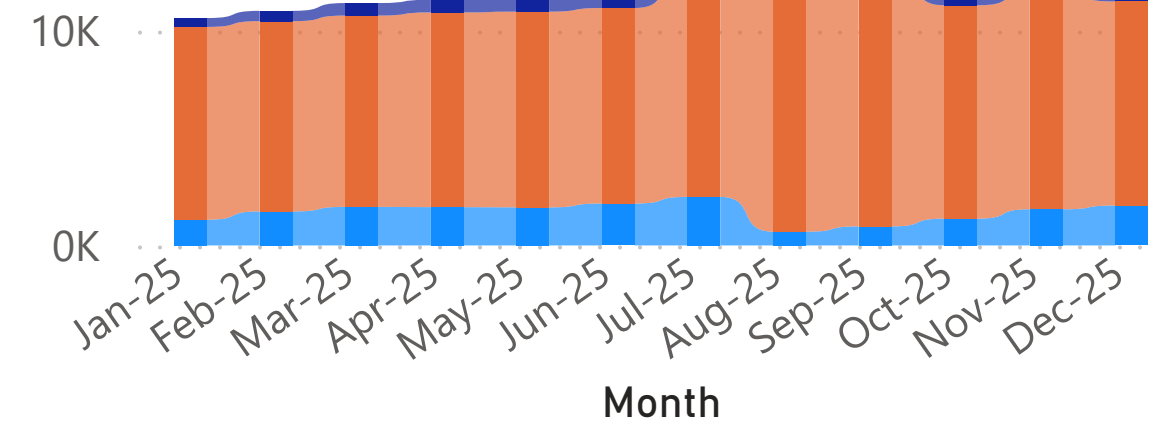
Diagnostics: % Completed Within 6 Weeks of referral

Target: Statutory

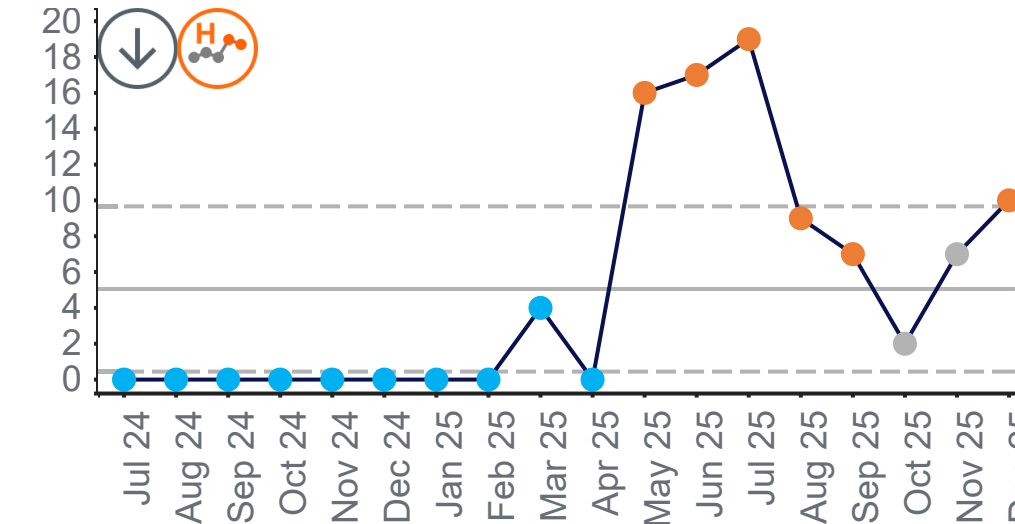


Neurodevelopmental Diagnosis Status

● Awaiting Triage ● Assessment ● Ready to Conclude

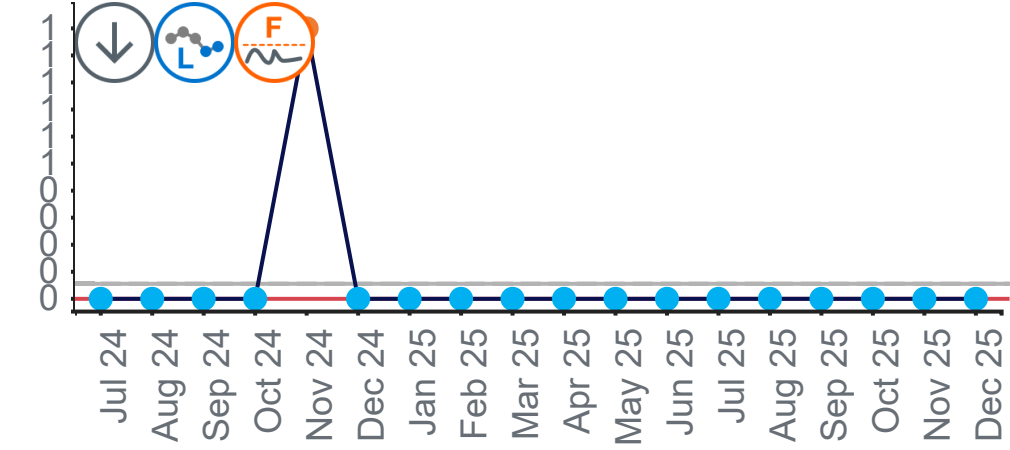


CAMHS: Number of children & young people waiting >52weeks



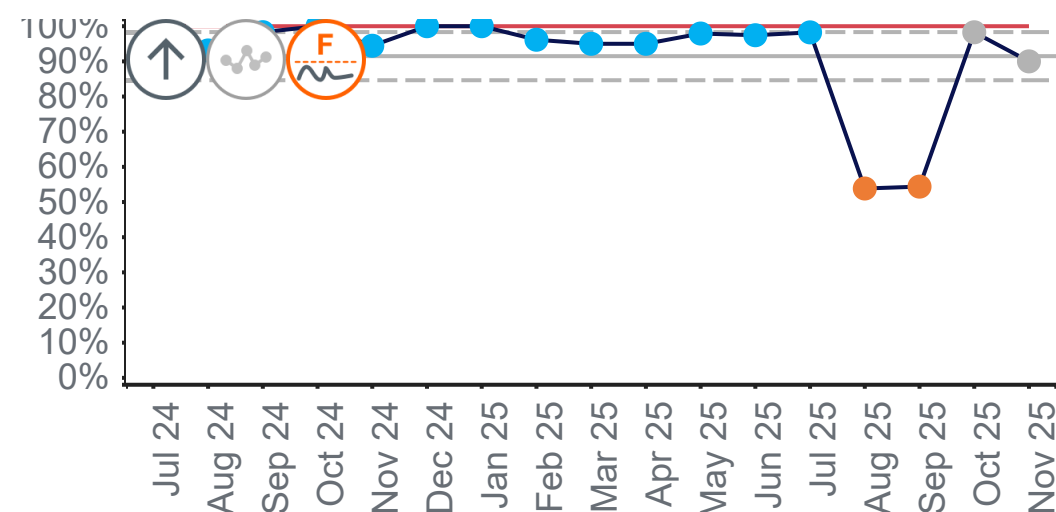
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



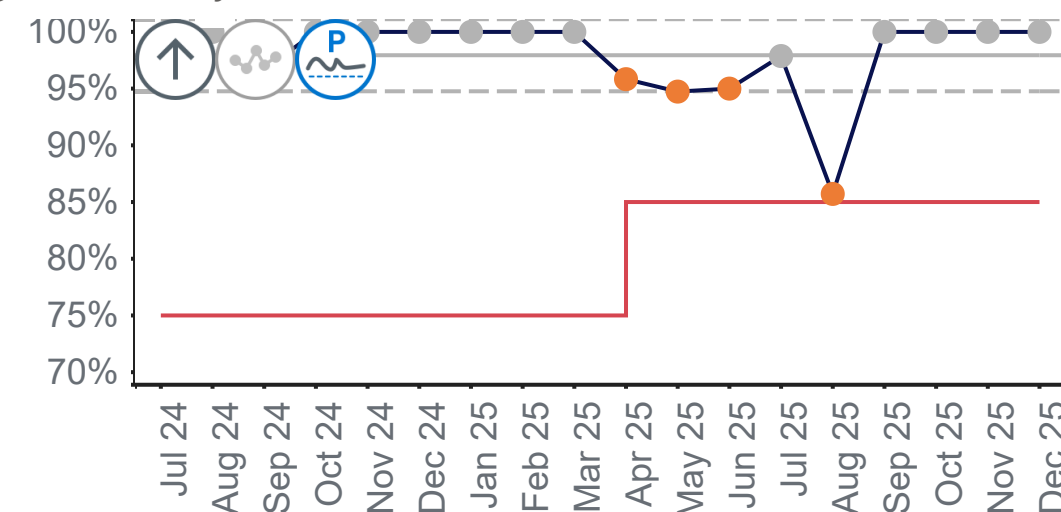
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



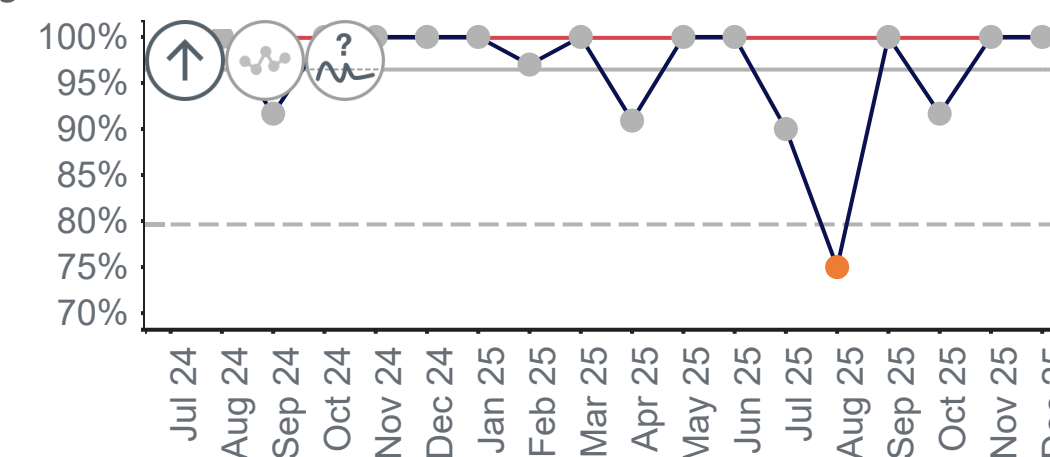
Cancer: Faster Diagnosis within 28 days

Target: Statutory



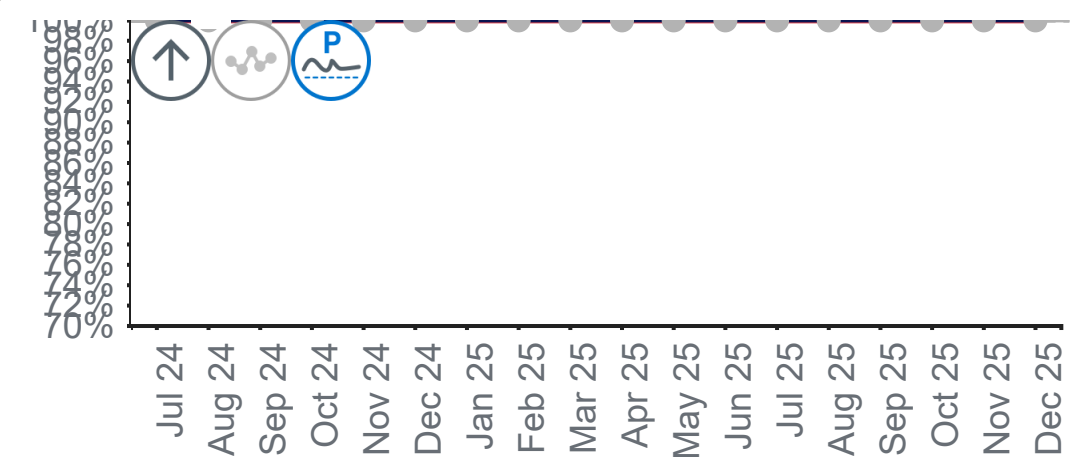
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)

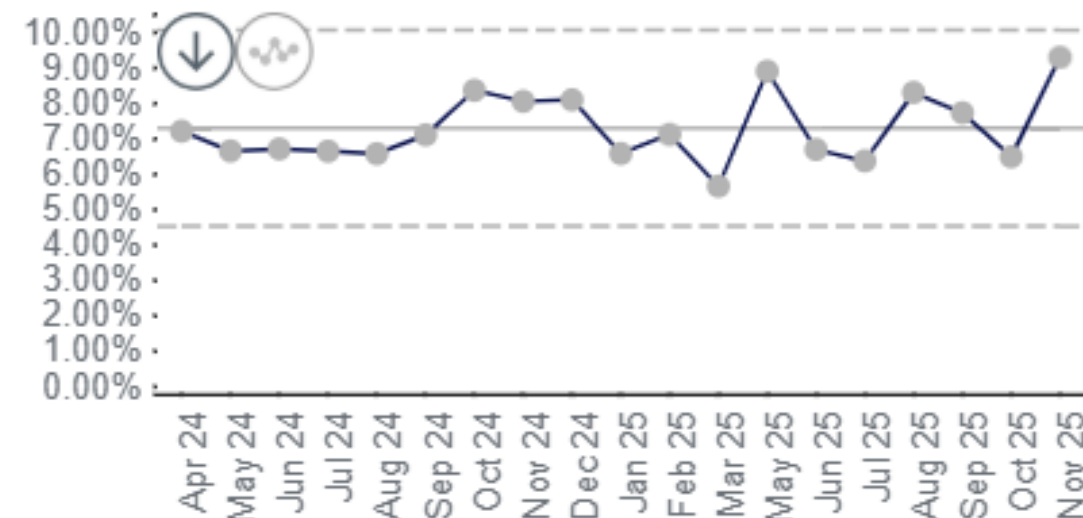


31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

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%. Work is underway reviewing modules with lower compliance levels

Areas of Concern:

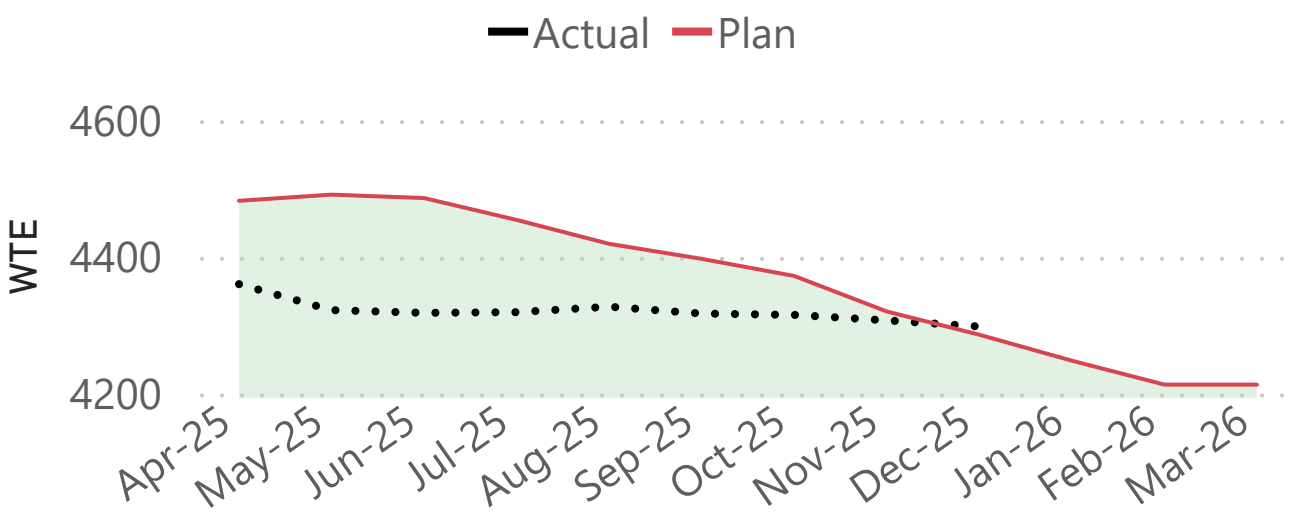
- Total workforce has reduced slightly, with further reductions anticipated in Q4 of 25/26, including the January MARS leavers • While long term sickness absence has slightly reduced, short-term sickness has increased again in month. The refreshed sickness absence support team report to Execs regularly, with additional focus on prevention.

Forward Look (with actions)

- Completion of B7+ PDRs has continued to steadily increase, currently at 85%, with completion of all PDRs at 77%. L&D colleagues continue to support managers to achieve PDR completion.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

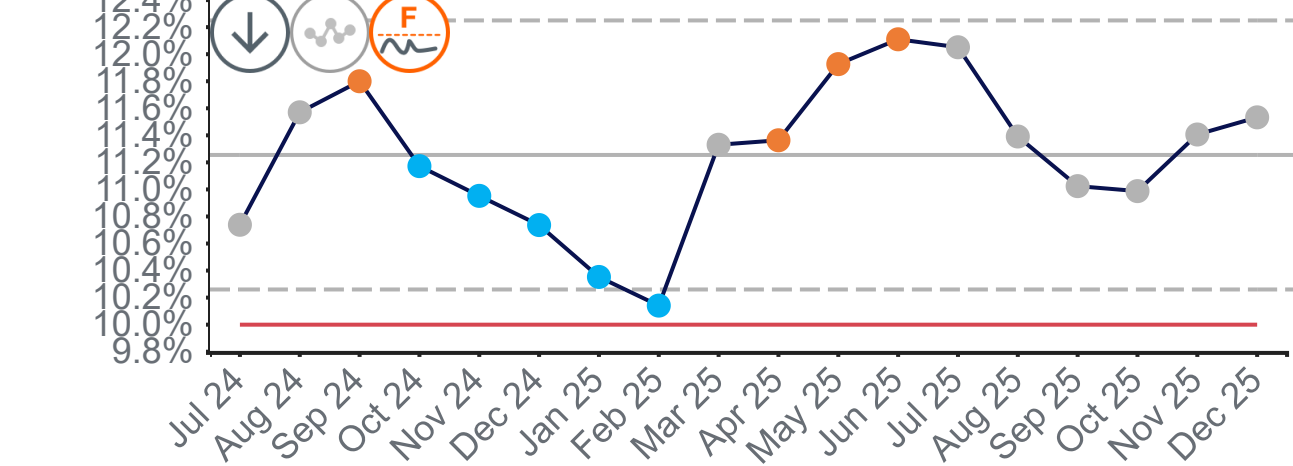
Total workforce for the end of December 2025 was 12.4 WTE above plan. M8 Total workforce was 4298.20, against a plan of 4,285.8.

Actions:

- M8 Total workforce (Inc. Trainees): 4298.20 (M8: 4307.13)
  - Substantive Colleagues (Inc. Trainees): 4214.77 (M8: 4225.80)
  - Bank usage: 79.87 (M8: 78.37)
  - Agency usage: 3.56 (M8: 2.96)
- In addition, overtime spend in month has increased slightly but remains the second lowest month-on-month overtime spend across the previous 12m.

Staff Turnover

Target: Internal



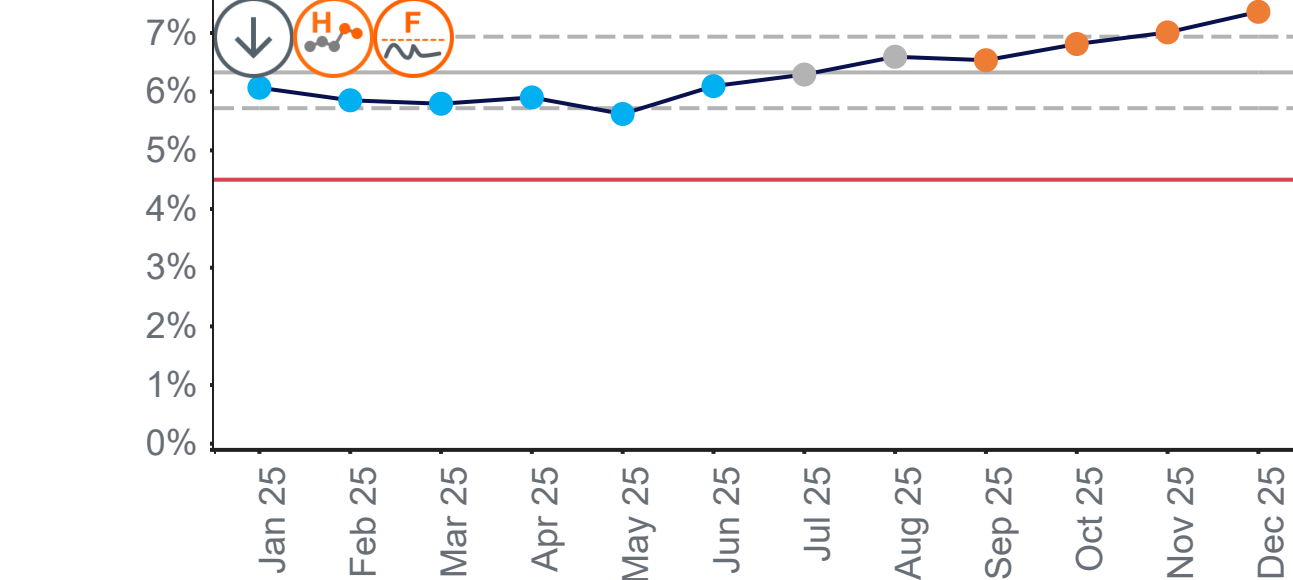
Technical Analysis:

Common cause variation observed with performance of 11.5% in December 2025 against an internal target of 10%. Slight increase from November 25 at 11.4%. Consistently failing metric.

Actions:

Turnover has increased slightly in month due to the end of fixed term contracts, and further colleagues leaving as part of the MARS scheme, with a second group of leavers in mid-January 2026

Sickness Absence Overall



Technical Analysis:

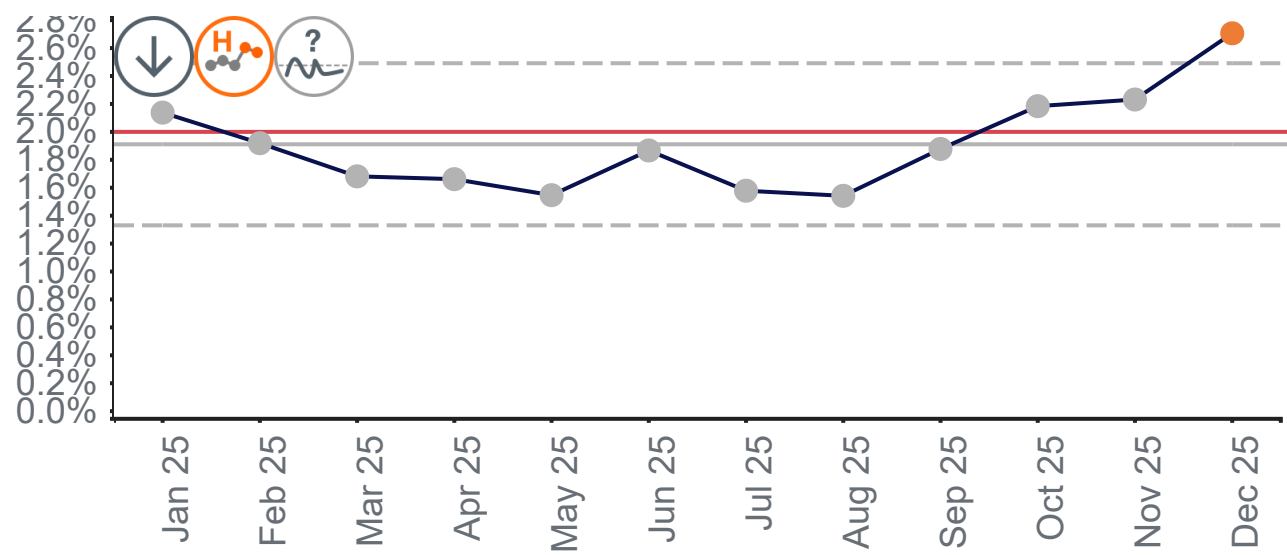
Special cause variation of concerning nature observed. Total sickness absence in December 2025 is 7.36% which is above the 5% target, a 0.35% increase from November 2025 at 7.01%. December 2025 performance comprises STS at 2.71% and LTS at 4.66%. Highest sickness rate in the last 2 years with target being 4.5% in 2025/2026.

Actions:

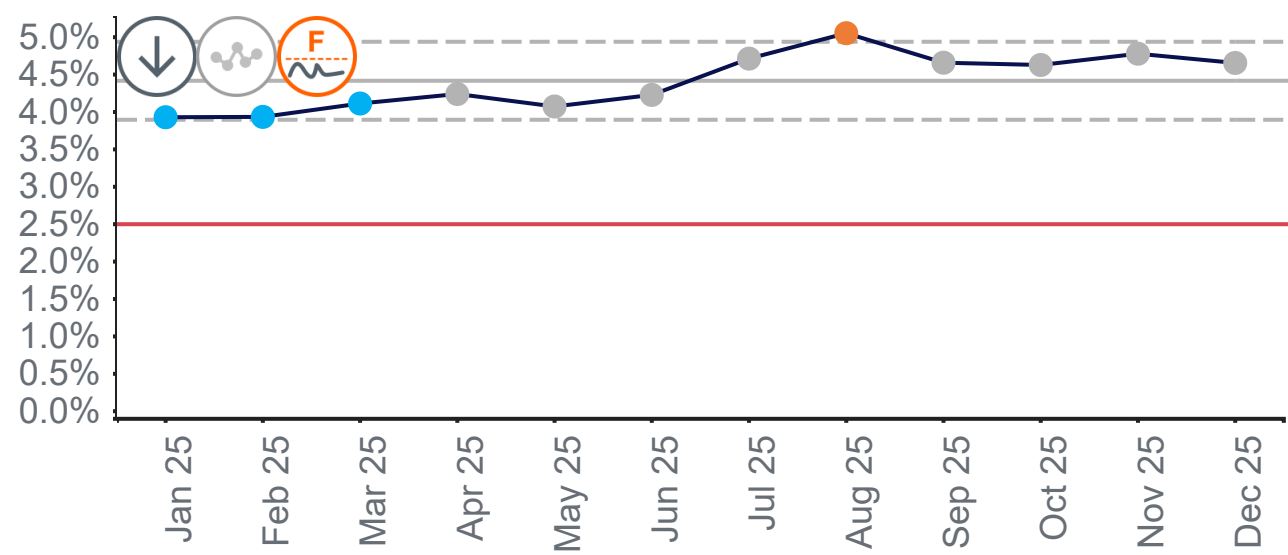
A detailed update is being presented at People Committee in Jan. In addition to absence management, focus is on prevention, with additional support for stress risk assessments, reasonable adjustments, wellbeing sessions, and targeted support for more pressured areas.

Supporting Our People - Watch Metrics

Short Term Sickness

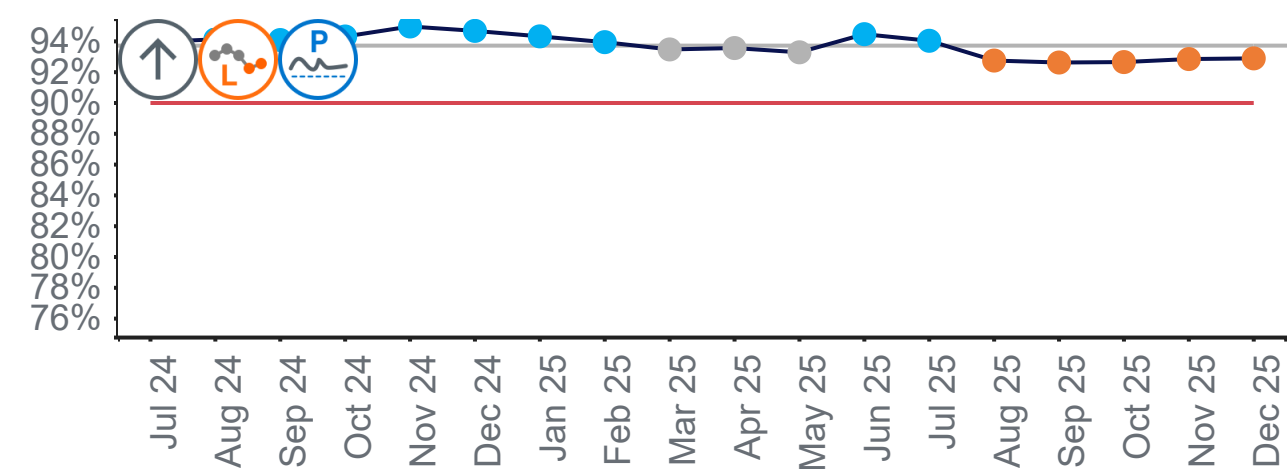


Long Term Sickness

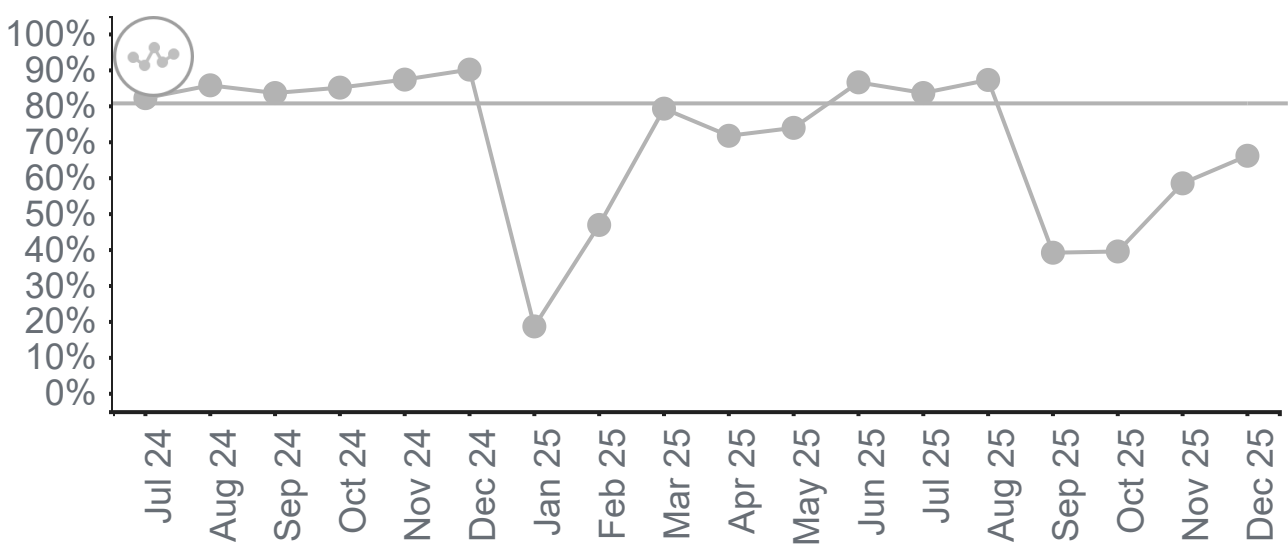


Mandatory Training

Target: Internal

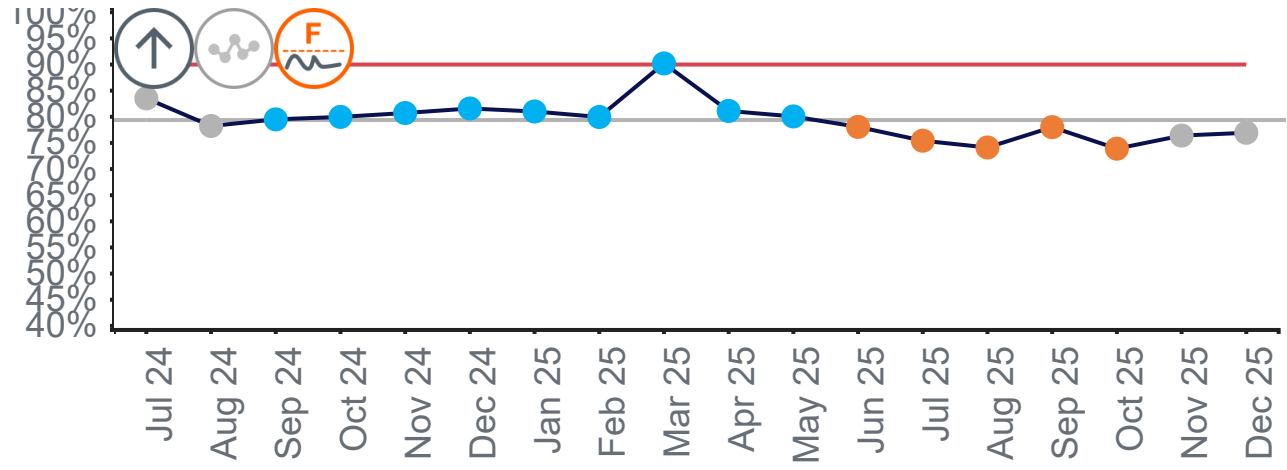


Medical Appraisal

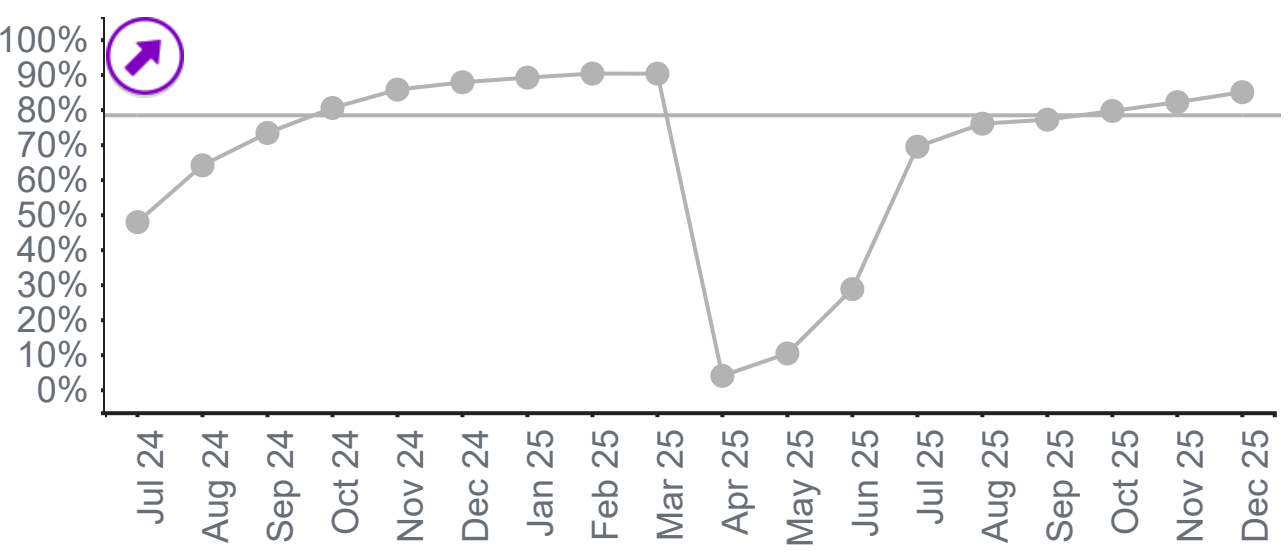


% PDRs Completed (Rolling 12 Months)

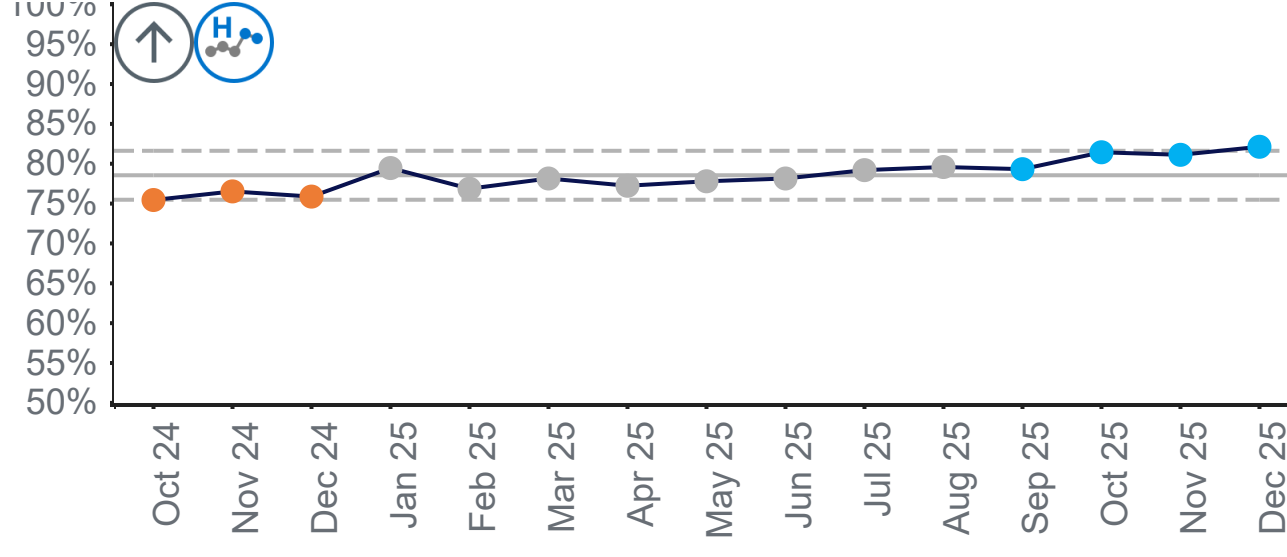
Target: Internal



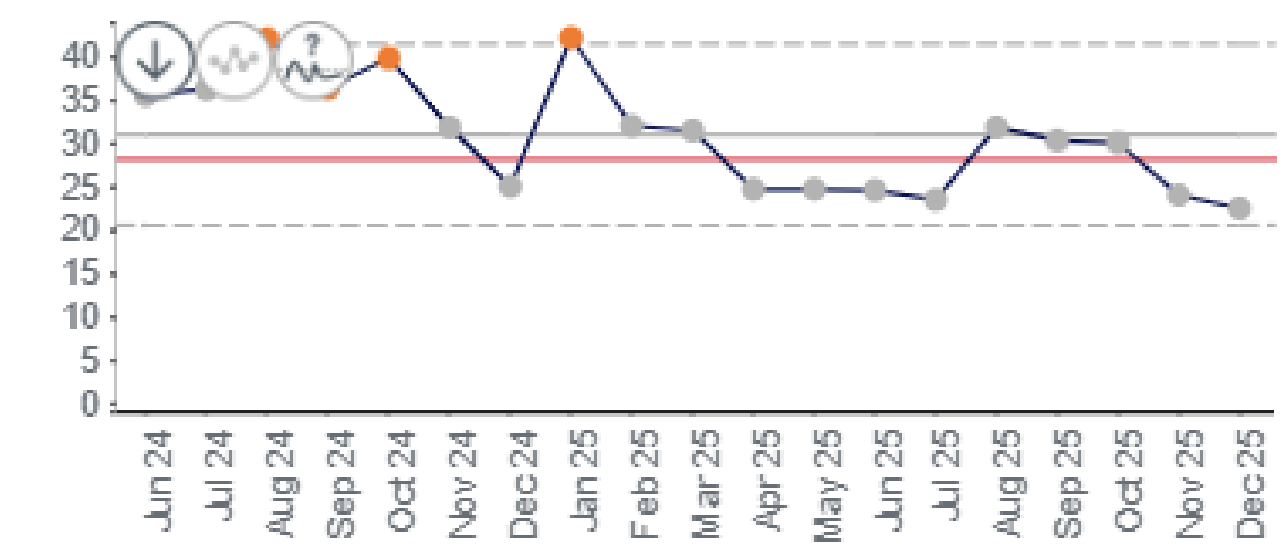
PDR B7+ Completed (Rolling 12 Months)



Workforce Stability



Average Time to Hire





# Pioneering Breakthroughs

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

Highlights:

- Research Performance: • EPIQ ependymoma and FIORE studies achieved major approvals and recruitment milestones, with the FIORE study being the first UK and European site to open and the only UK site to meet the NIHR 150-day target •Significant increase in studies opened in December; 1634 participants recruited since April across the CRD portfolio •No escalations in recruitment to time and target for both hosted and sponsored studies; steady performance excluding rare diseases • Clinical Research Facility (CRF): •36 strategic objectives complete, 23 on track, none delayed. • Main entrance locking system issue resolved. • New PPIE strategy in development; Q3 and annual NIHR reports upcoming. • Paediatric Open Innovation Zone: • Internal job creation on track, robust processes and SOPs implemented • Education, Events, Comms and PPIE: • Career event has taken place in one primary school and five secondary schools • Continued increase in social media engagement • Barclays bank leadership team visited through a Wavelength visit generating approx £13.5k and resulting in ongoing conversations with Barclays Eagle lab to explore potential collaboration • Research PPI/E Officer post (0.6WTE) has been approved by the Exec Vacancy Panel- advert pending

Areas of Concern:

- Research & Delivery: •Drop in commercial Expressions of Interest (EOIs) and participant recruitment in December, attributed to seasonal factors and staff sickness/leave. Deep dives and reviews underway •Some delays in study setup due to lab support capacity, action plan underway. • Innovation & Digital: •Key escalation: SDE (Secure Data Environment) implementation delayed due to digital resource pressures; urgent need for a costed plan •Reduced Data Science capacity and lack of dedicated environment/sandbox are delivery risks for AI strategy •Automation team at minimal viable size, with budget shortfall and no operational lead from end of January. • Partnerships & Funding: •NIHR Capital procurement delays •MRI financial gap (including anxiomics study delay which may impact 26/27 income) •Paediatric Medicines Research Unit sustainability – income does not match expenditure. • Education, Events, Comms and PPIE: •School competition has not reached the level of students anticipated due to school pressures, although activity is taking place.

Forward Look (with actions)

- Focus on delivering against external contracts, national targets and developing a clear and sustainable financial model across Futures disciplines for 26/27.

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

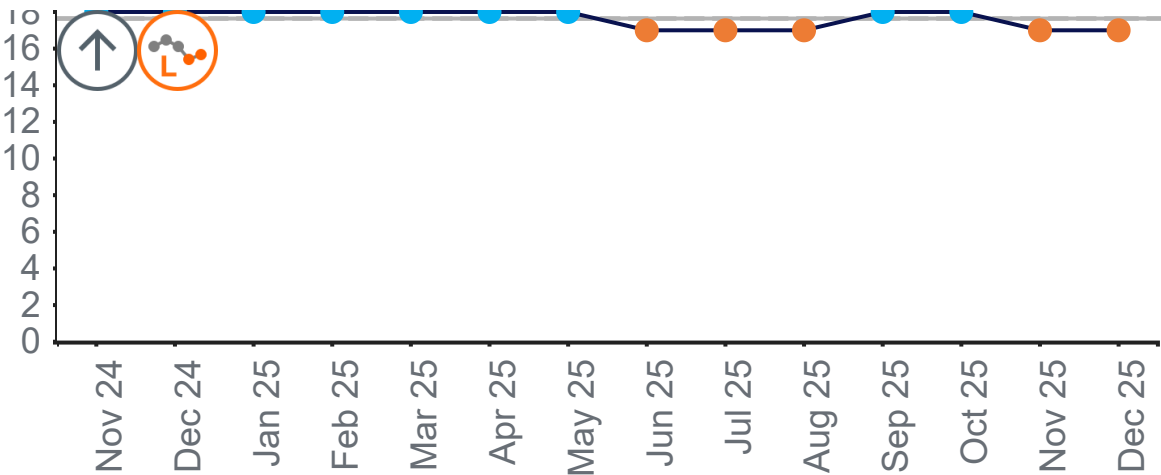
Technical Analysis:

Under Review

Actions:

Under Review

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

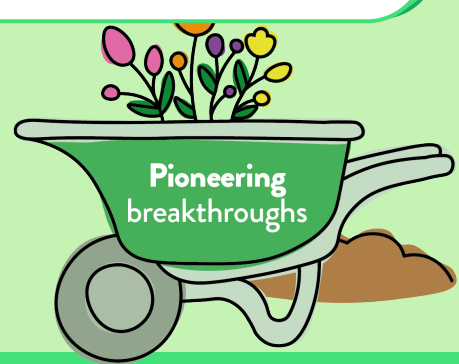


Technical Analysis:

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

Actions:

No action – remains stable. New funding call to support CIs will be released in Feb 2026.

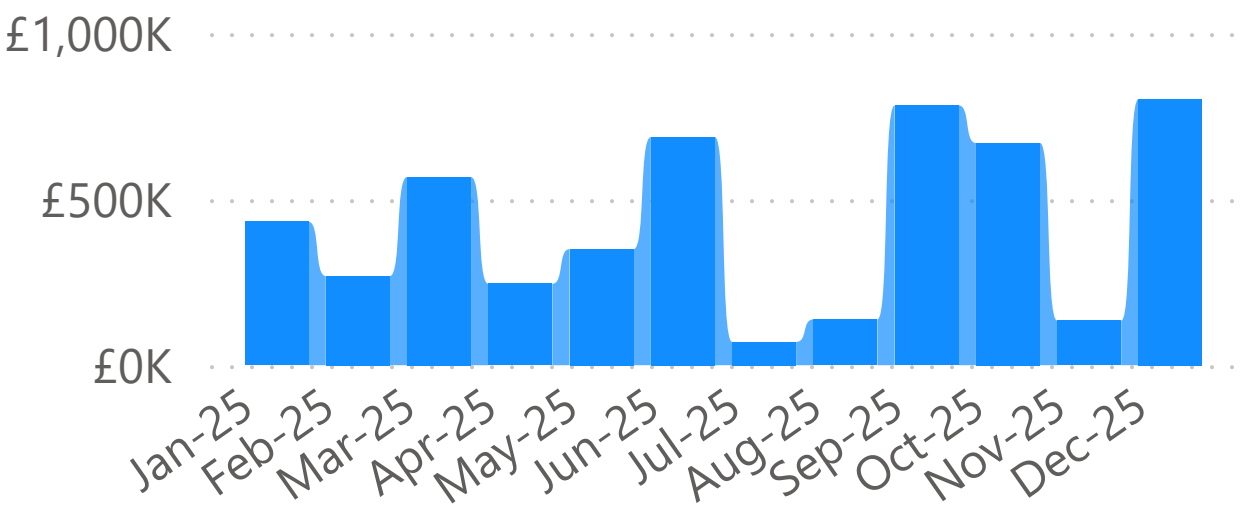


Pioneering Breakthroughs

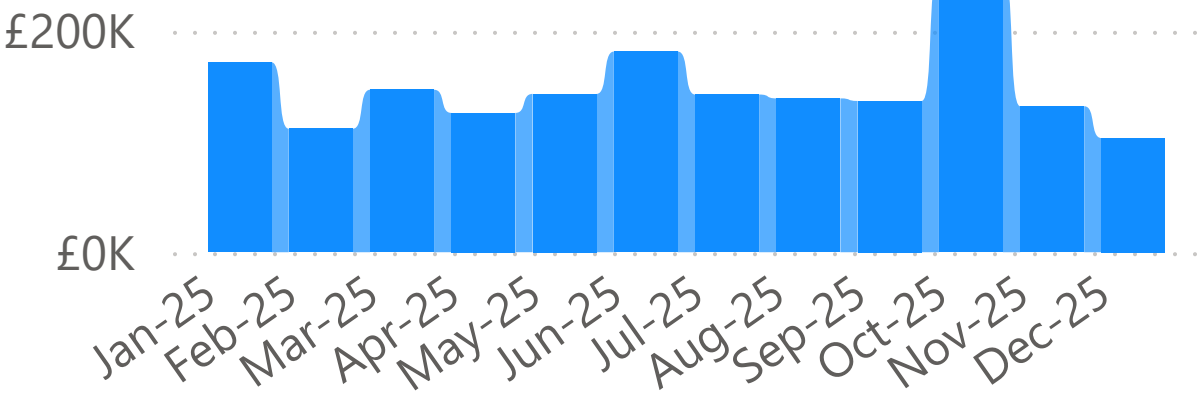
External innovation income received by month (commercial and non-commercial)



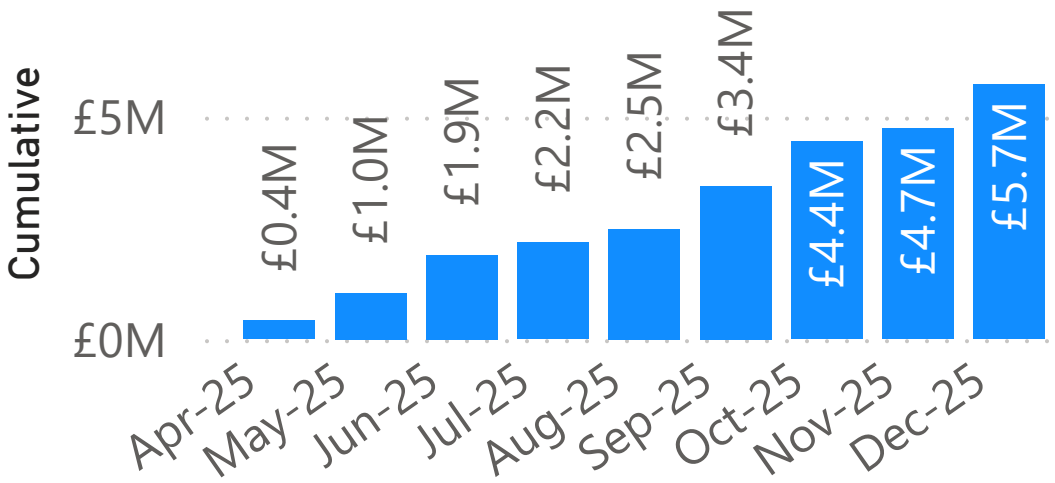
External research income received by month (commercial and non-commercial but excluding NIHR)



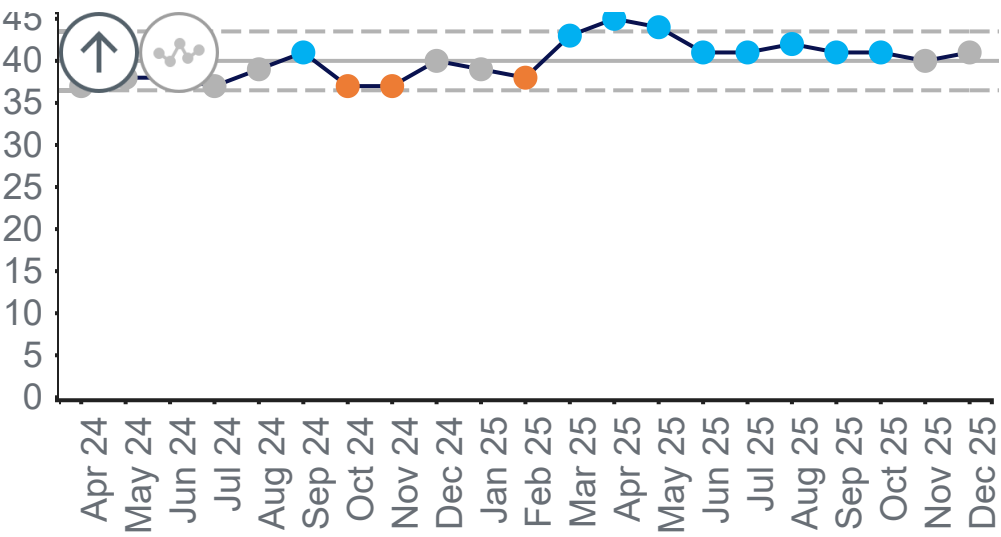
NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)



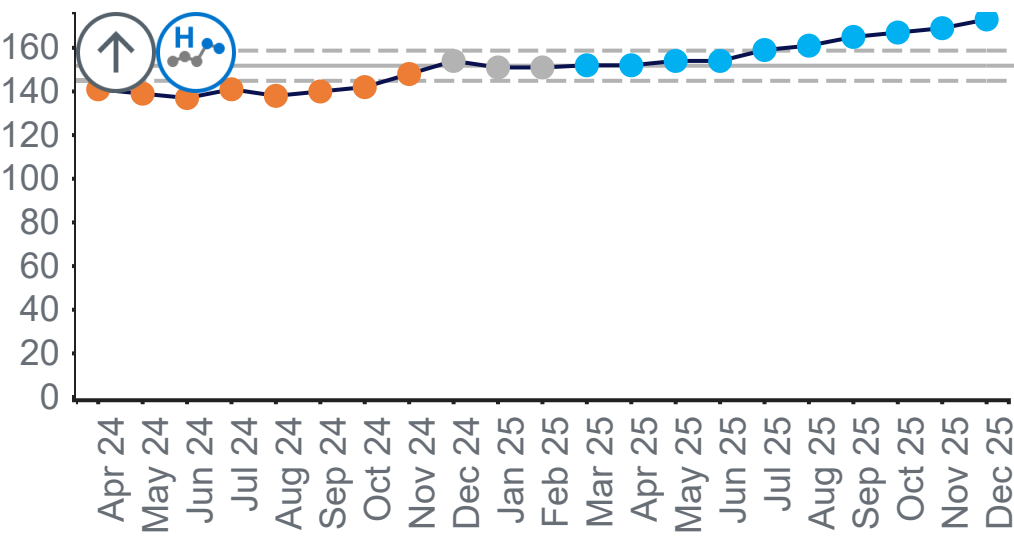
External income received by month across Research and Innovation (YTD Cumulative)



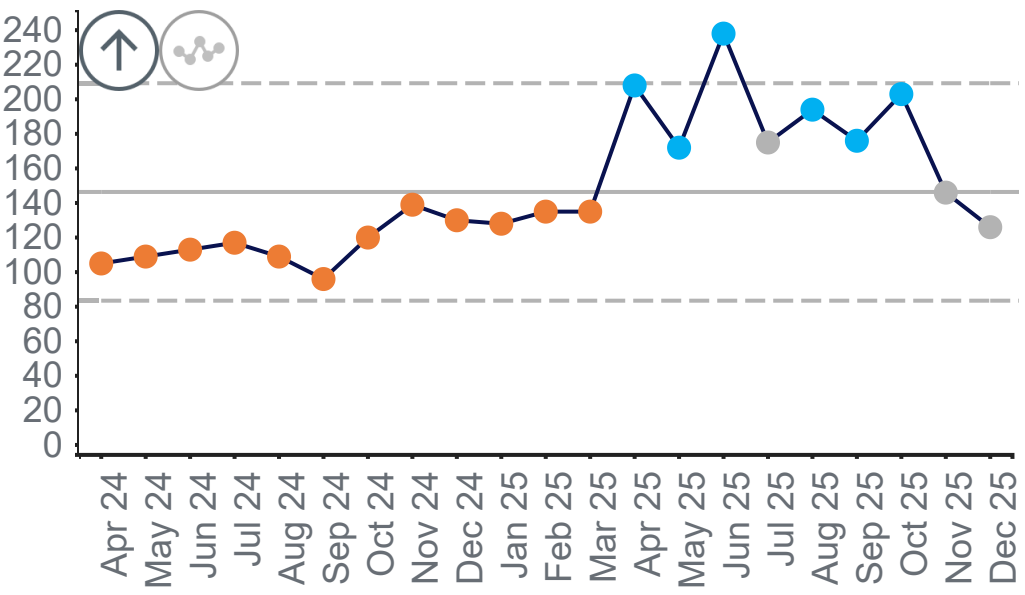
Number of open commercial studies (recruiting and in follow up)



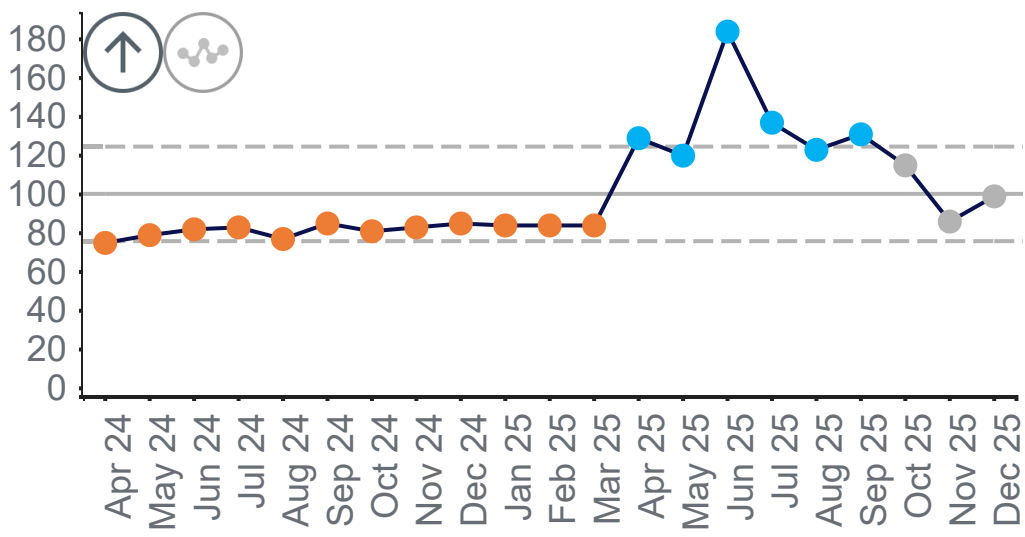
Number of open non-commercial studies (recruiting and in follow up)



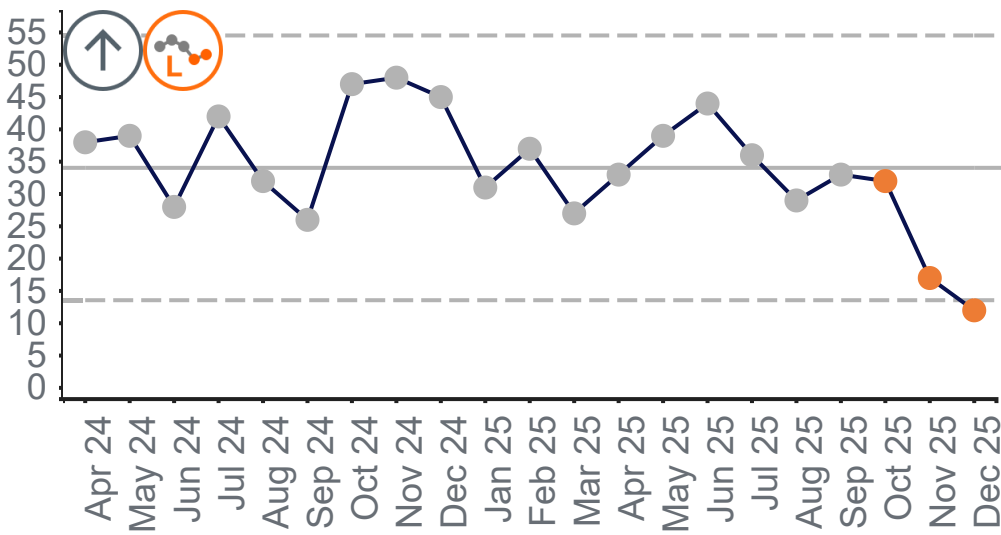
Number of participants recruited to all studies



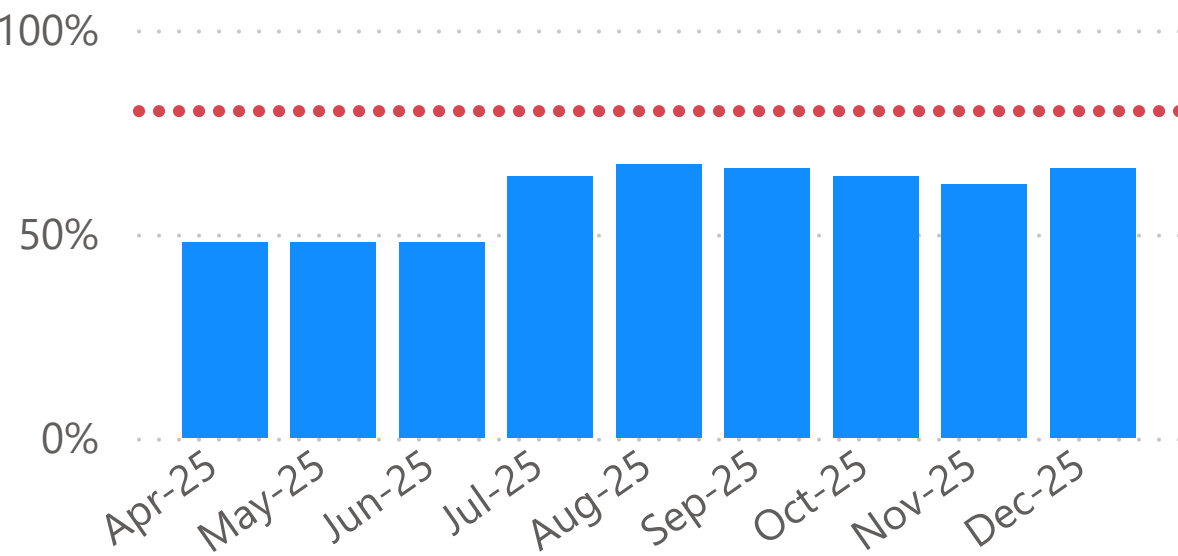
Number of participants recruited to all NIHR portfolio studies



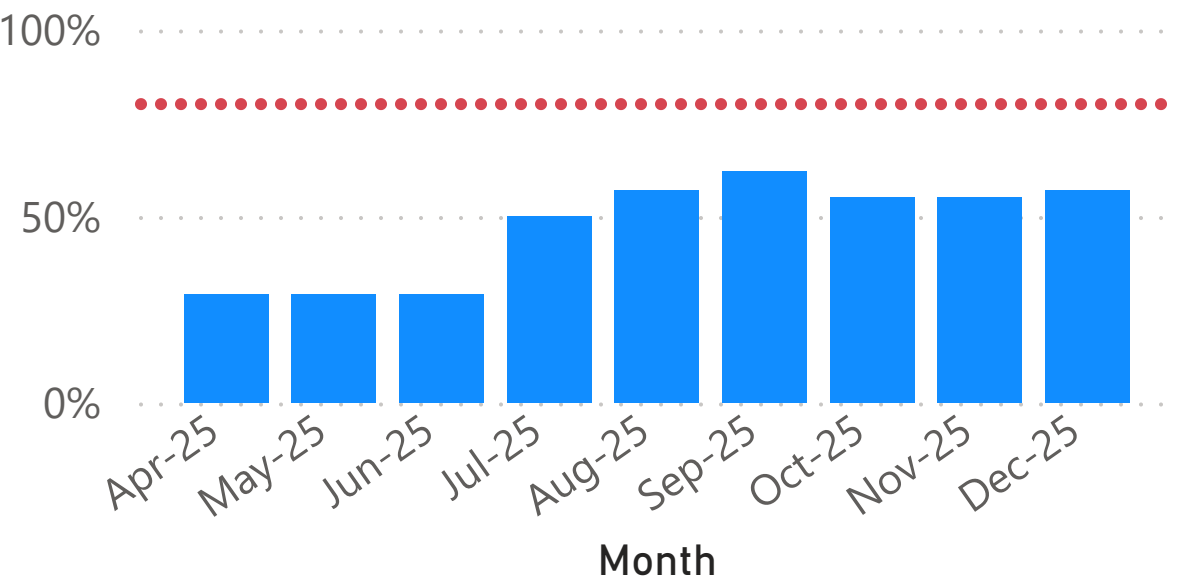
Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



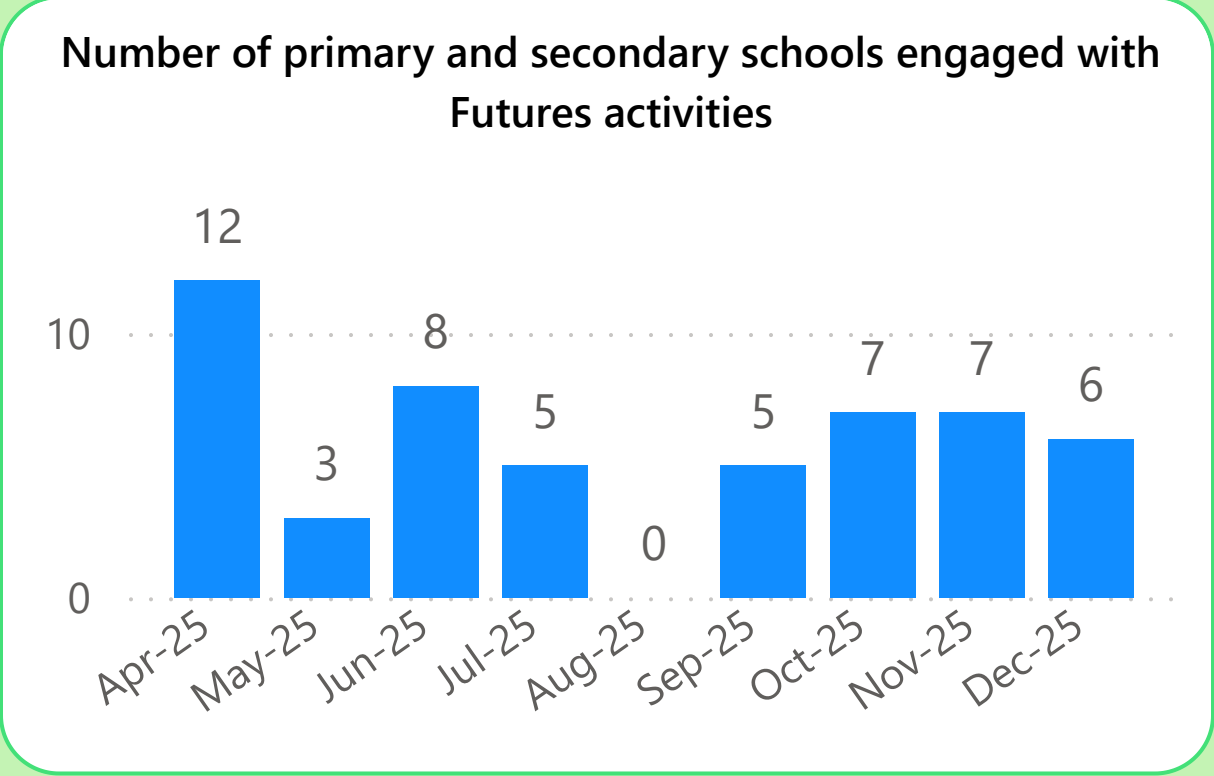
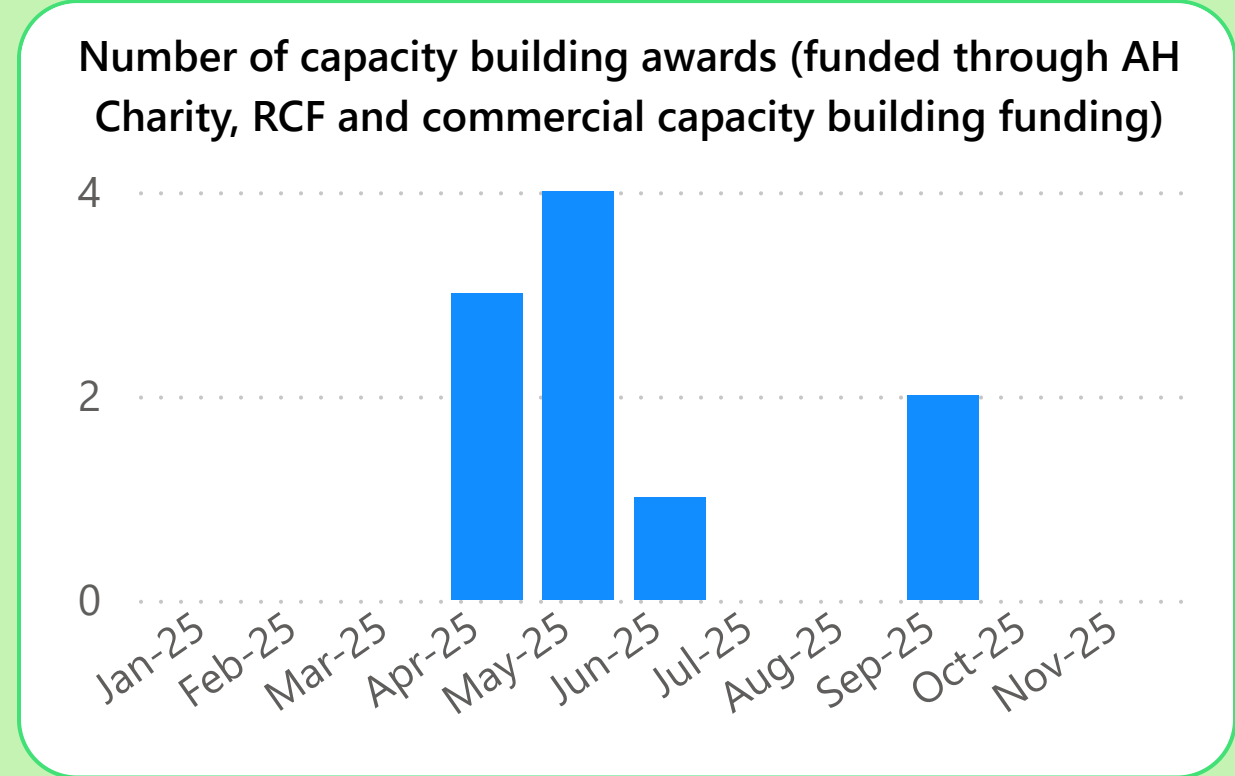
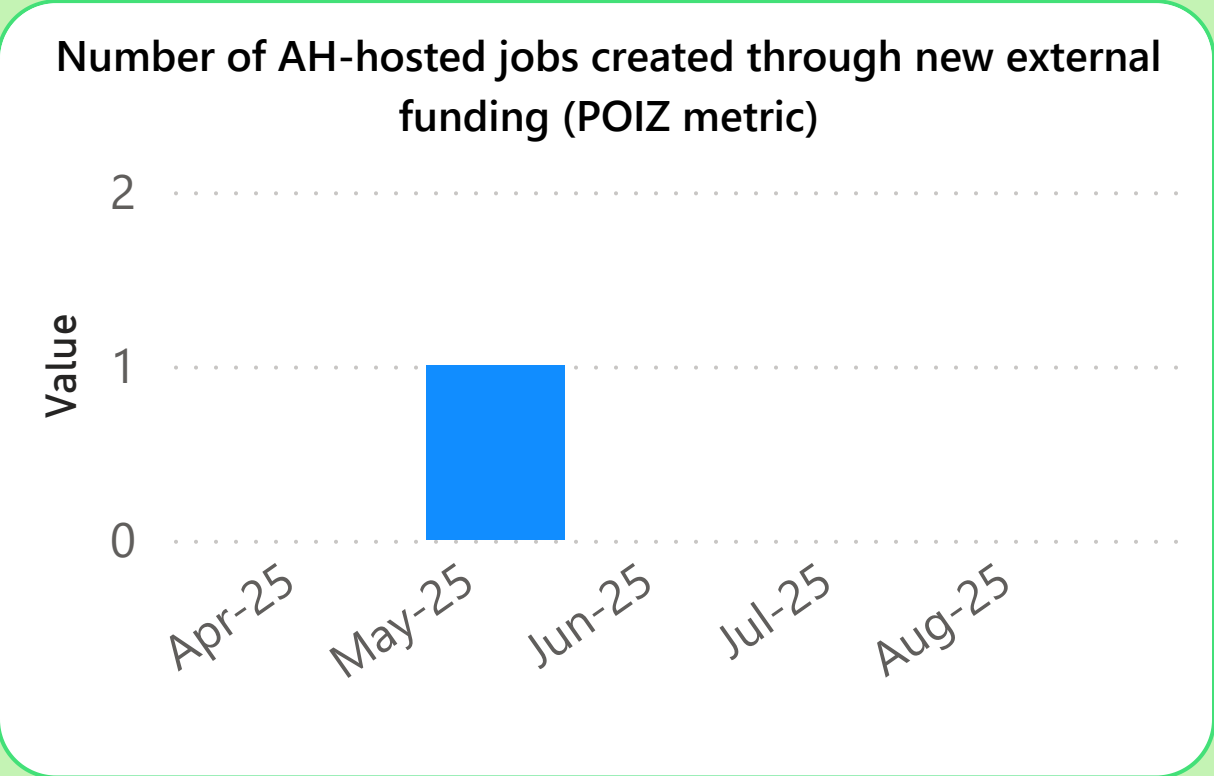
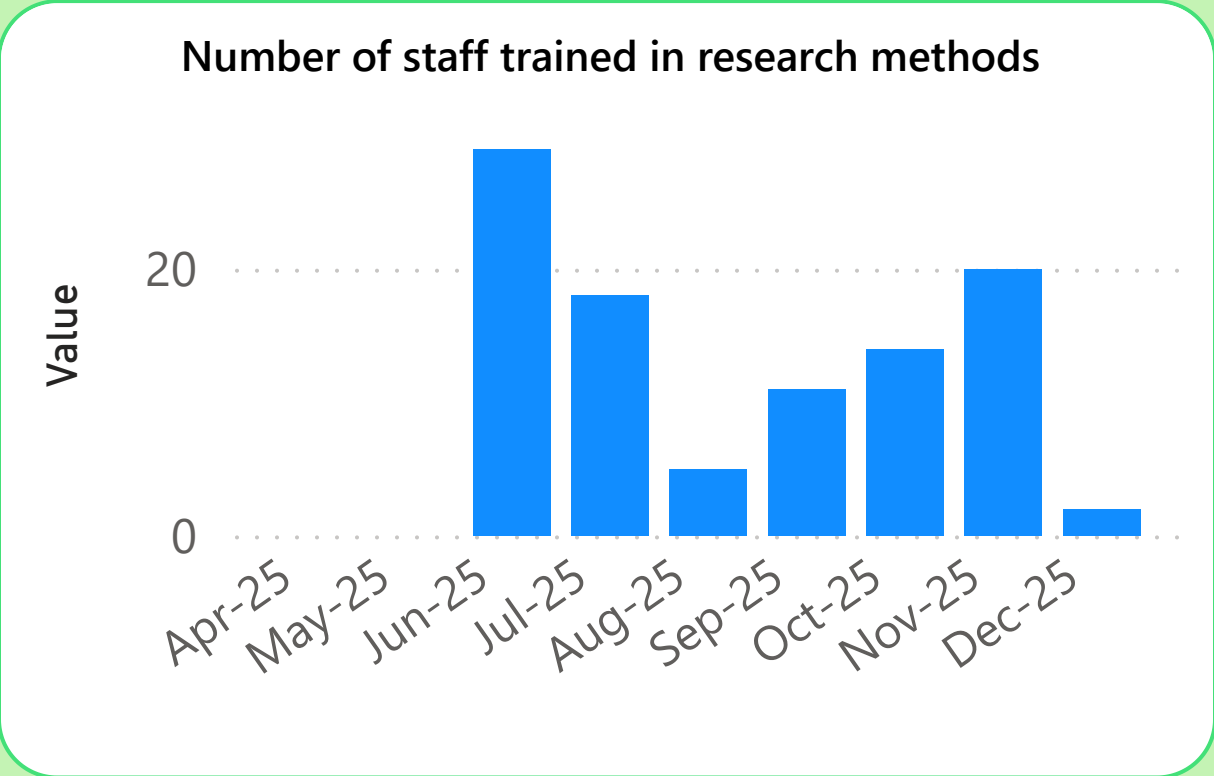
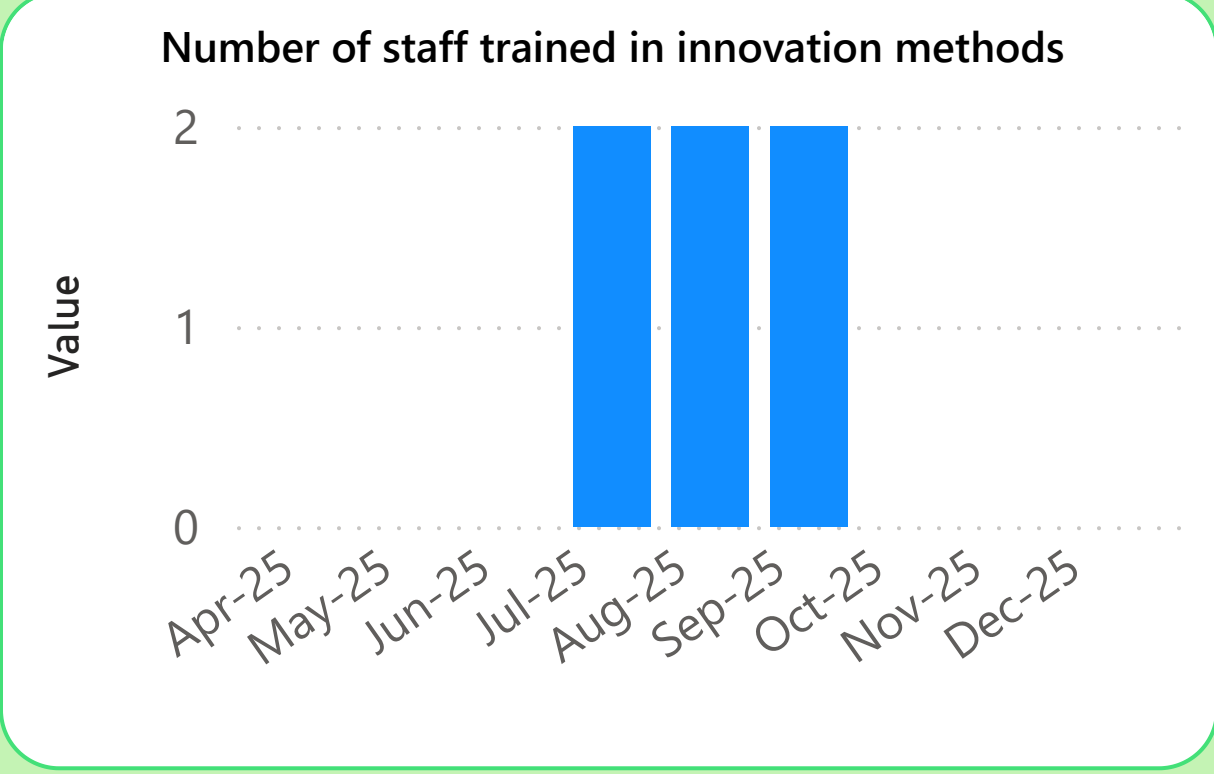
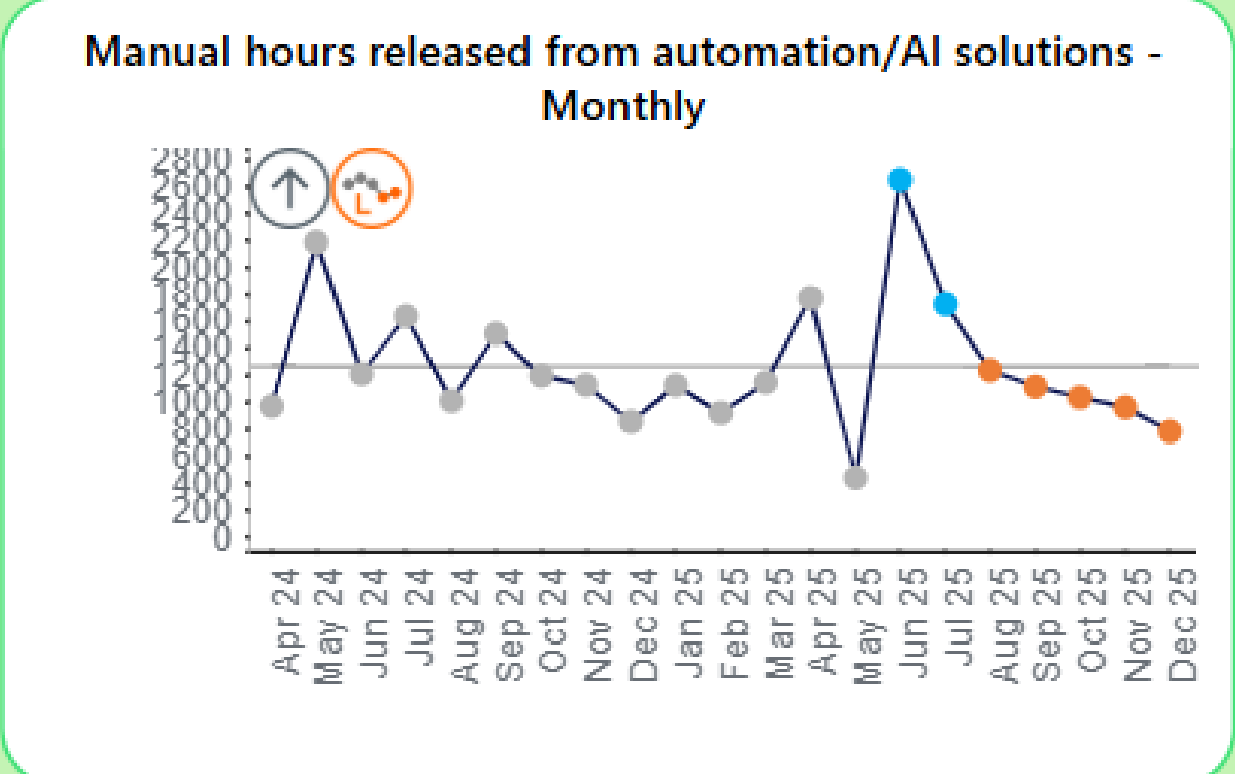
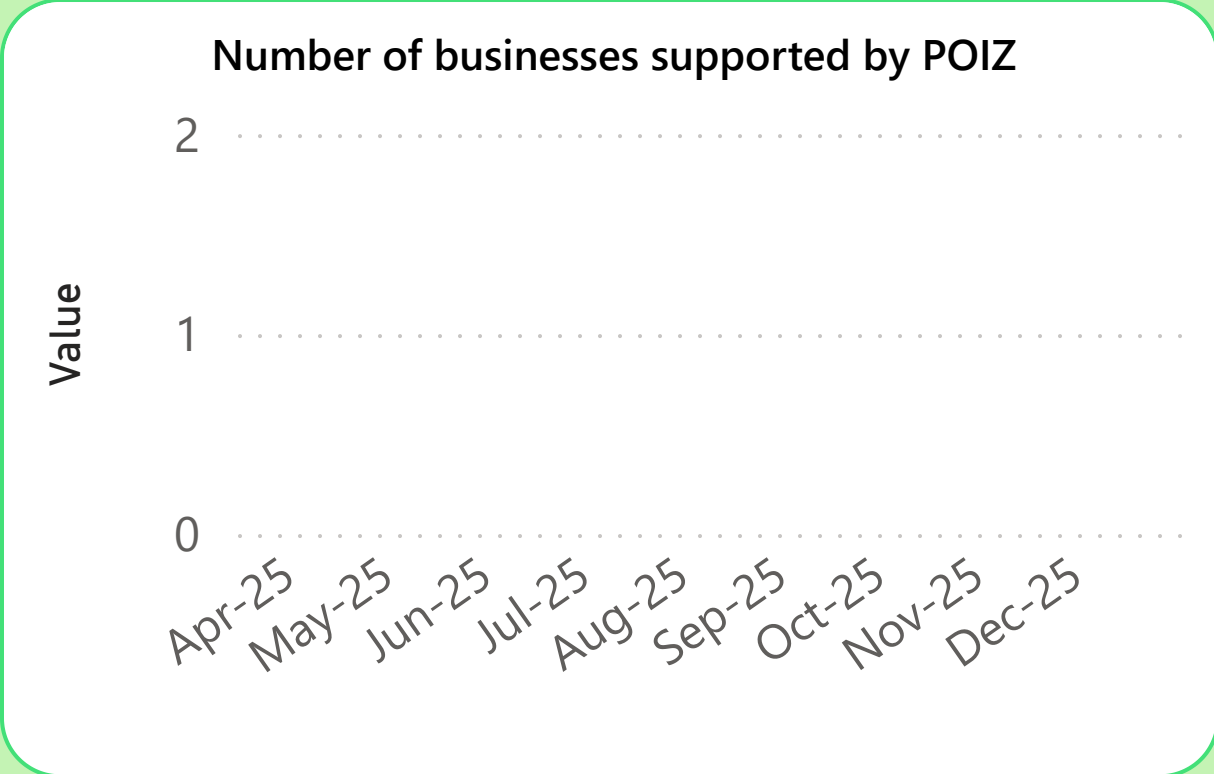
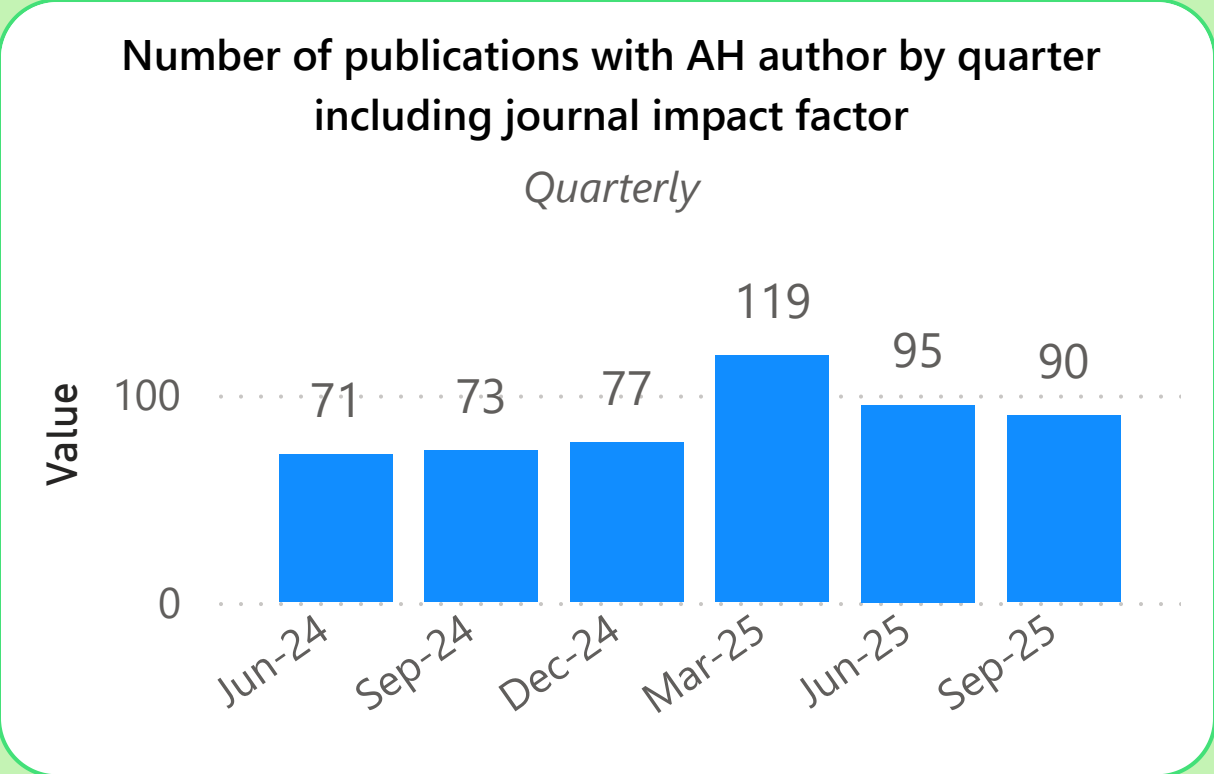
Recruitment to time and target (RTT) for all open studies hosted by AH



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



Pioneering Breakthroughs



Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

£0.3m deficit reported in month, £0.1m surplus YTD which is ahead of plan largely due to IA funding. Externally forecasting £7.160m surplus. Extrapolated forecast remains at £5m surplus in line with M8. £19.6m CIP has been transacted in year (£11.1m recurrently) - £1.9m behind plan YTD. Cash lower than plan due to high levels of non-cash CIP, and capital spend ahead of plan. Capital ahead of plan due to over profiling in line with prioritisation panel based on expected funding, and funding approved after plan set. £2m additional capital awarded due to elective performance to be used over 25/26 and 26/27 and £2.1m SDEC capital funding now confirmed.

Areas of Concern:

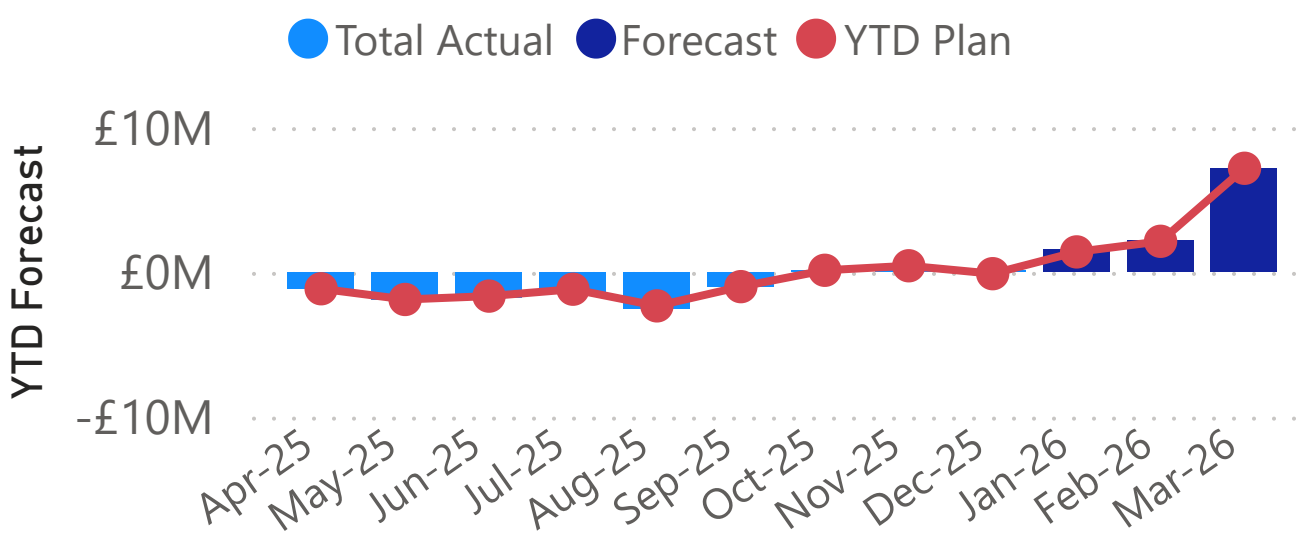
A number of income assumptions in the 25/26 forecast are currently in discussion with the ICB and present a risk to overall delivery of plan if not confirmed. Delivery of recurrent CIP programme continues to present a risk, which, alongside other mitigations, links to deliver of overall plan for the year (including system stretch). Cash is being closely monitored given non-cash CIPs and discussions with commissioners to finalise payments. Discussions also ongoing with commissioner to finalise items with cash impact.

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. Divisional forecasts have improved due to IA funding and pay slippage and other recovery actions being taken by divisions. Cash strategy in development given the gap in forecast to ensure actions do not adversely impact on cash. Work is ongoing to support divisions in achieving recurrent savings, including development of Target Operating Models. 5-year capital plan in development.

I&E Year End Forecast

Target: Statutory



Technical Analysis:

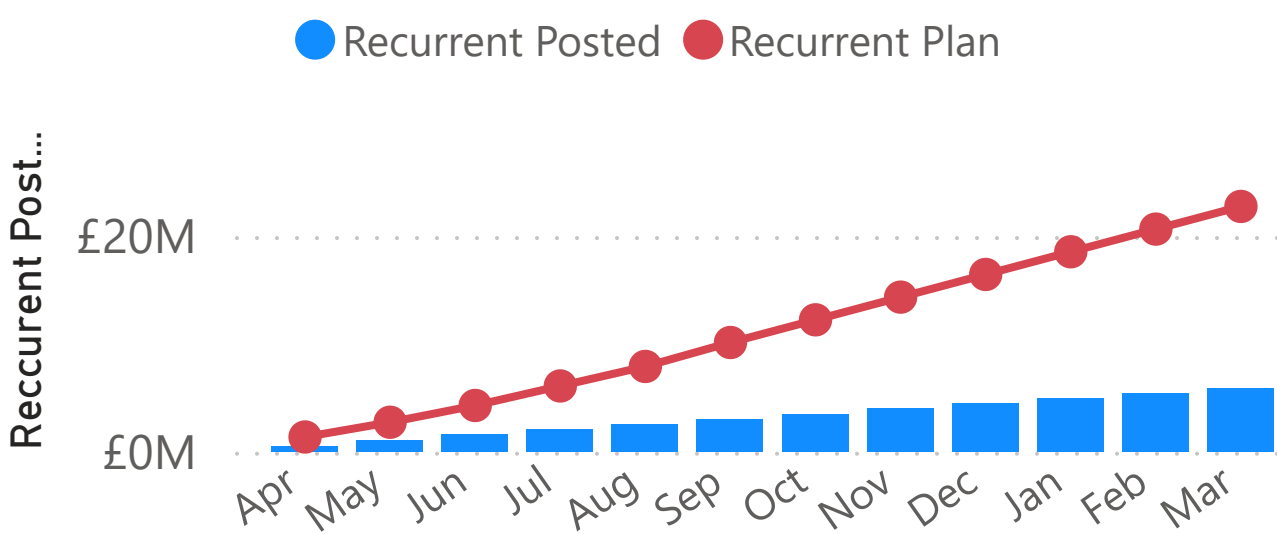
Current plan is £7.160m surplus which we aim to achieve. Risks to delivery of this is linked to achievement of CIP still in progress, identification of system wide schemes to deliver stretch target and management of in year pressures.

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. TOM development ongoing.

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



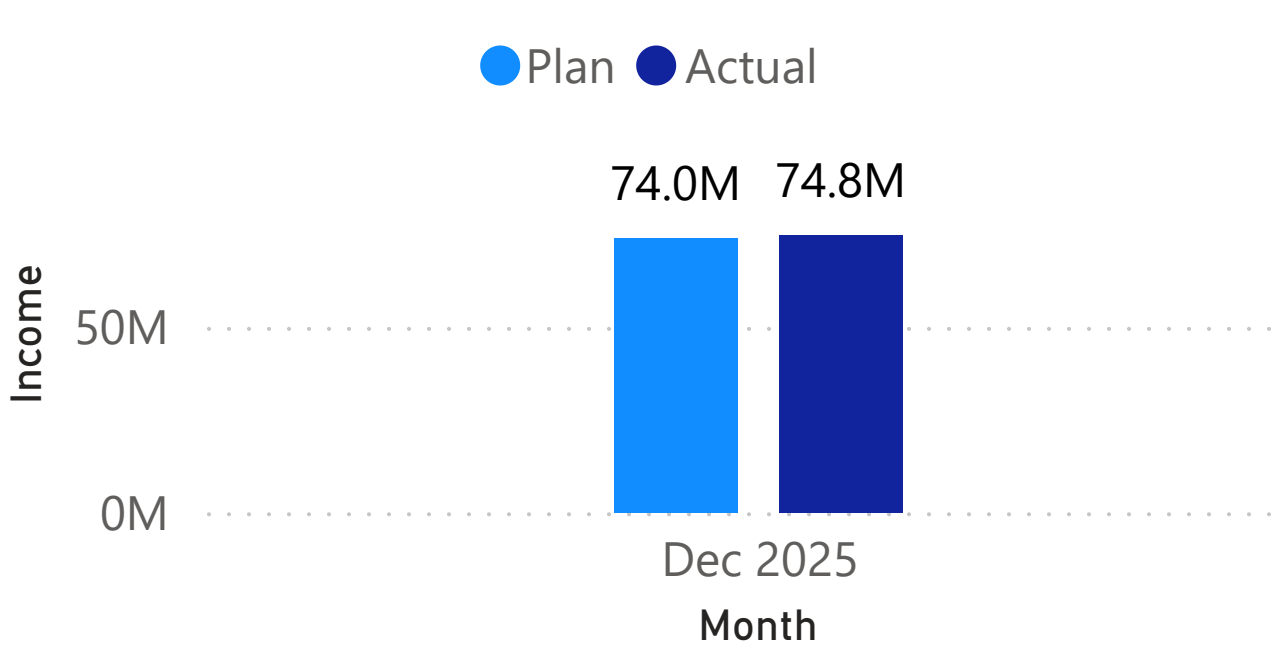
Technical Analysis:

Recurrent CIP identified is £11.1m which leaves a recurrent gap of £11.5m to be carried forward to 26/27.

Actions:

Significant work is ongoing to support the delivery of recurrent efficiency targets across the Trust through the FIP and 'closing the gap' schemes. TOM in development.

YTD ERF Income



Technical Analysis:

December performance estimated at 113%.

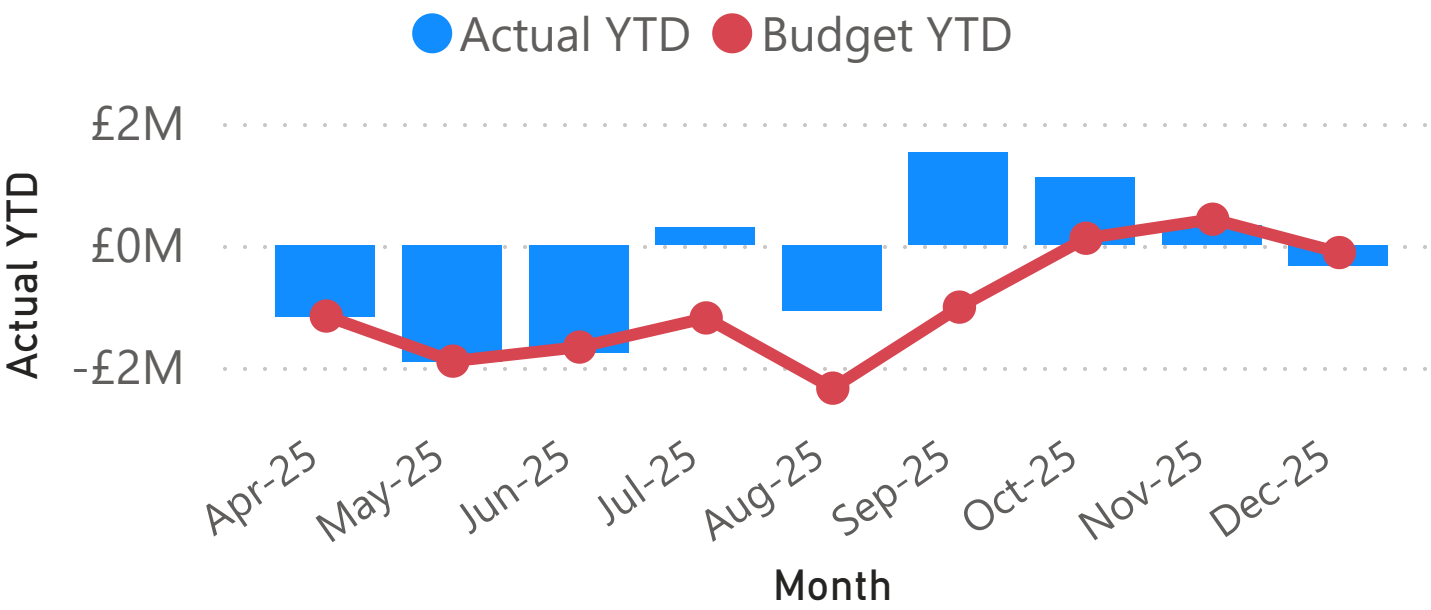
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

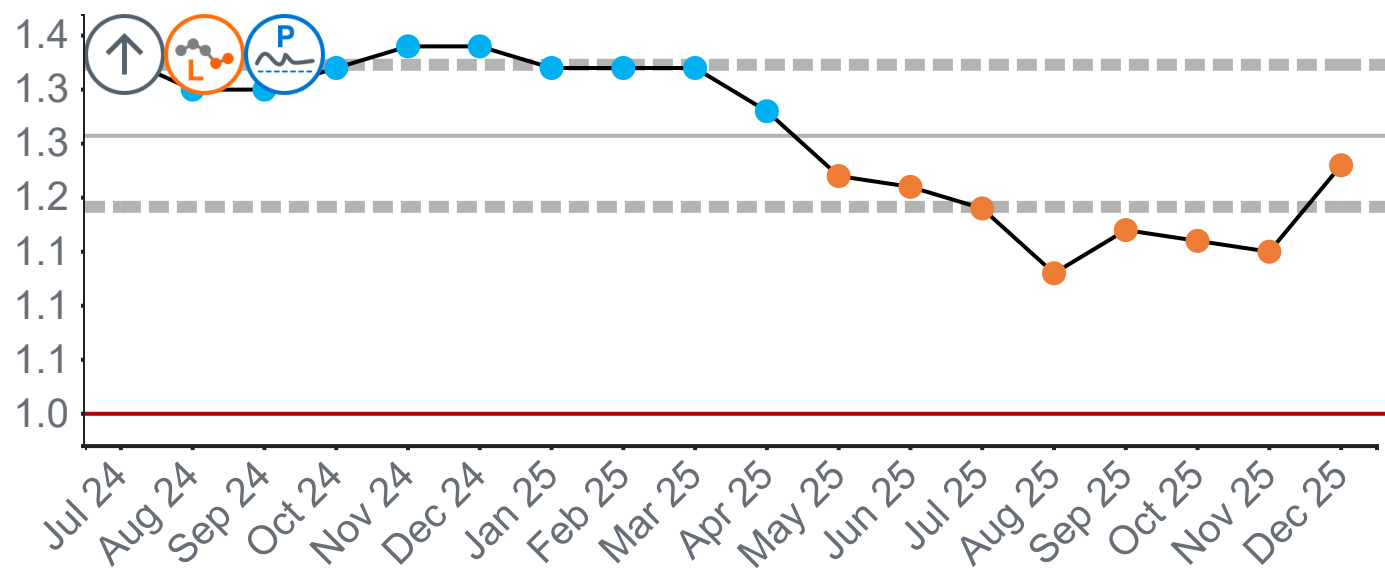
I&E distance from target (cumulative YTD)

Target: Internal

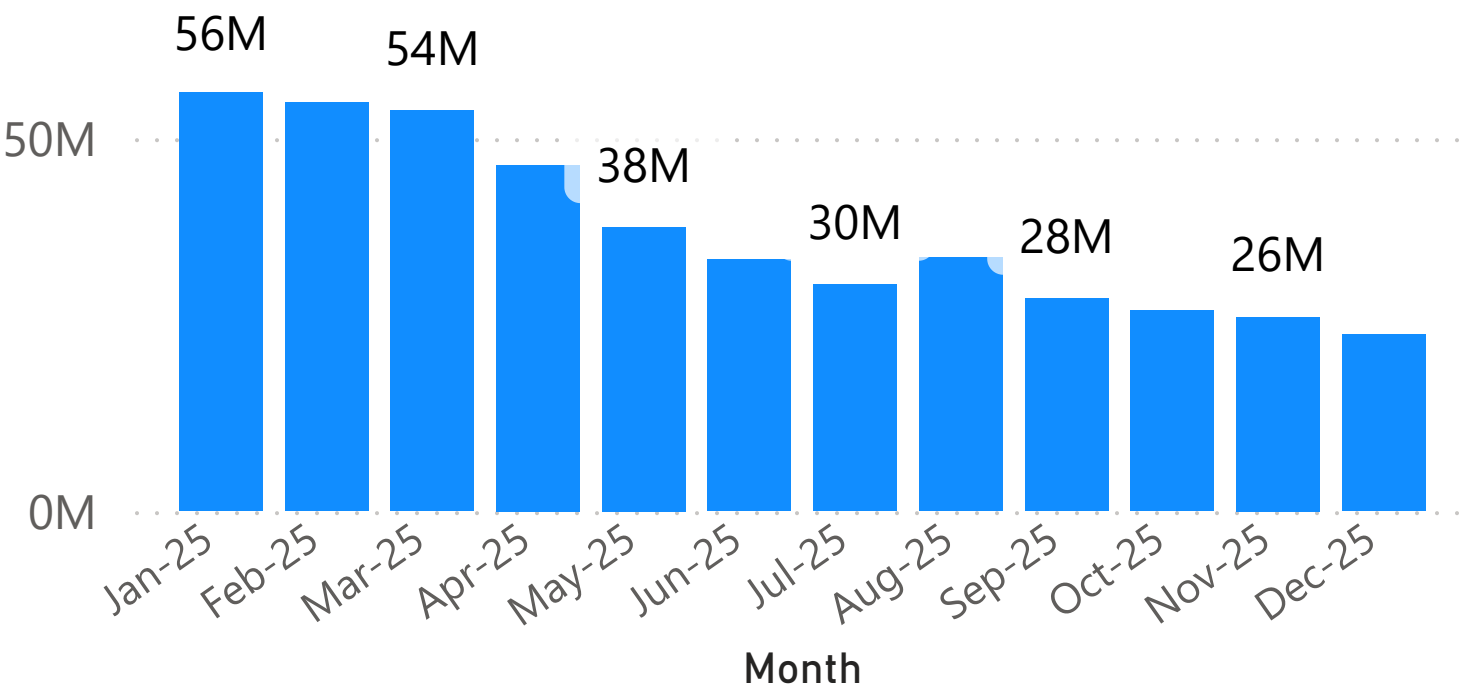


Liquidity

Target: Internal

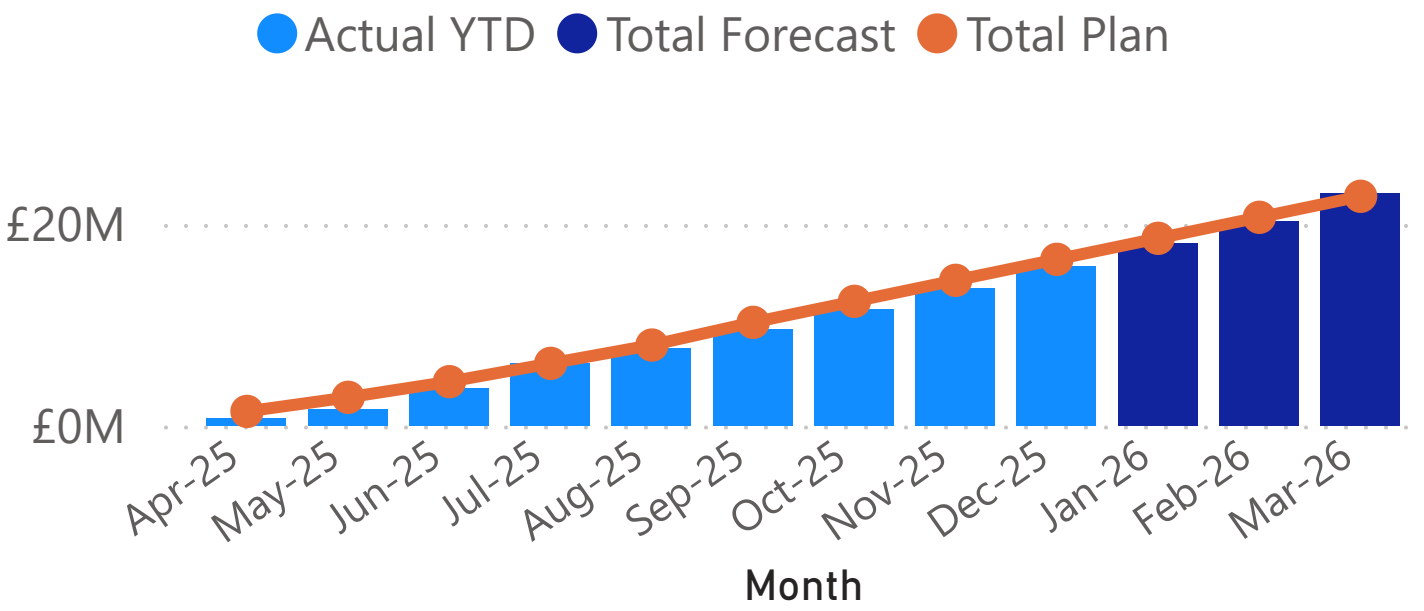


Cash In Bank



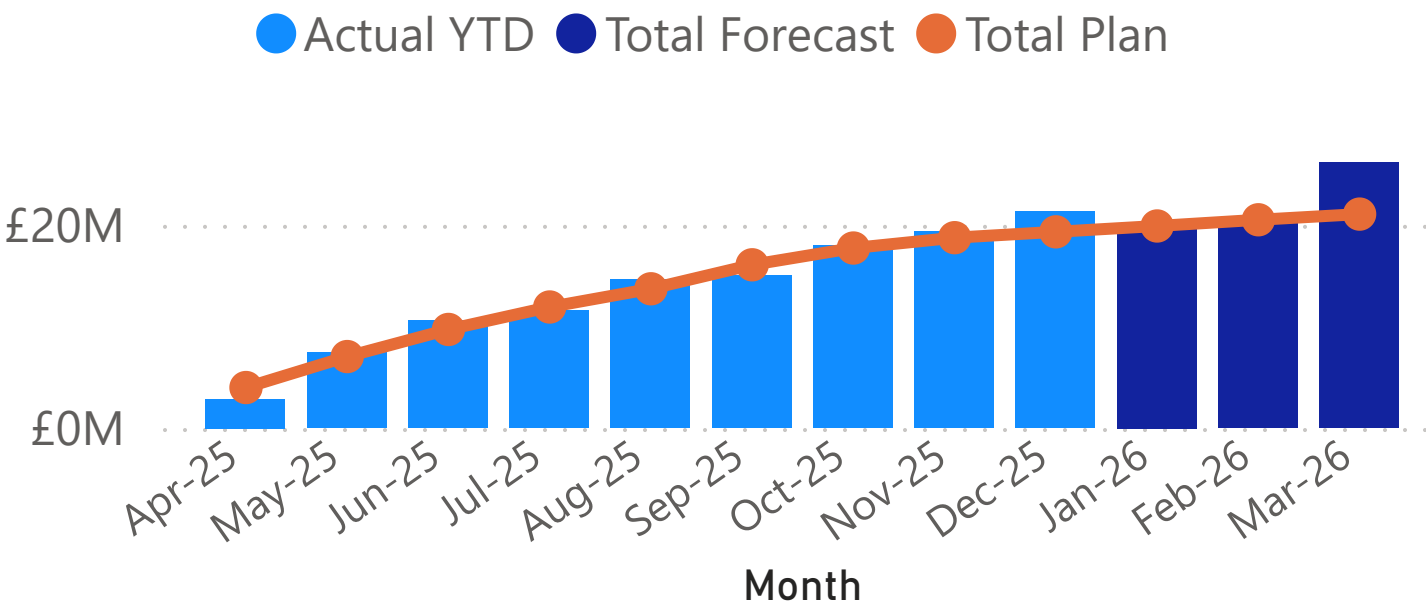
In Year CIP – forecast against plan

Target: Internal



Capital – YTD spend and forecast against plan

Target: Internal



Well Led - Risk Management

SRO: Erica Saunders, Chief Corporate Affairs Officer

Highlights:

• 92% of high risks within review date (2 risks overdue which have now been updated) • Continued positive engagement with risk owners at risk oversight meeting • Standardised Risk Management oversight package developed for use across all Teams • Monthly report presented at monthly Corporate Services Collaborative highlighting overdue actions for corporate services.

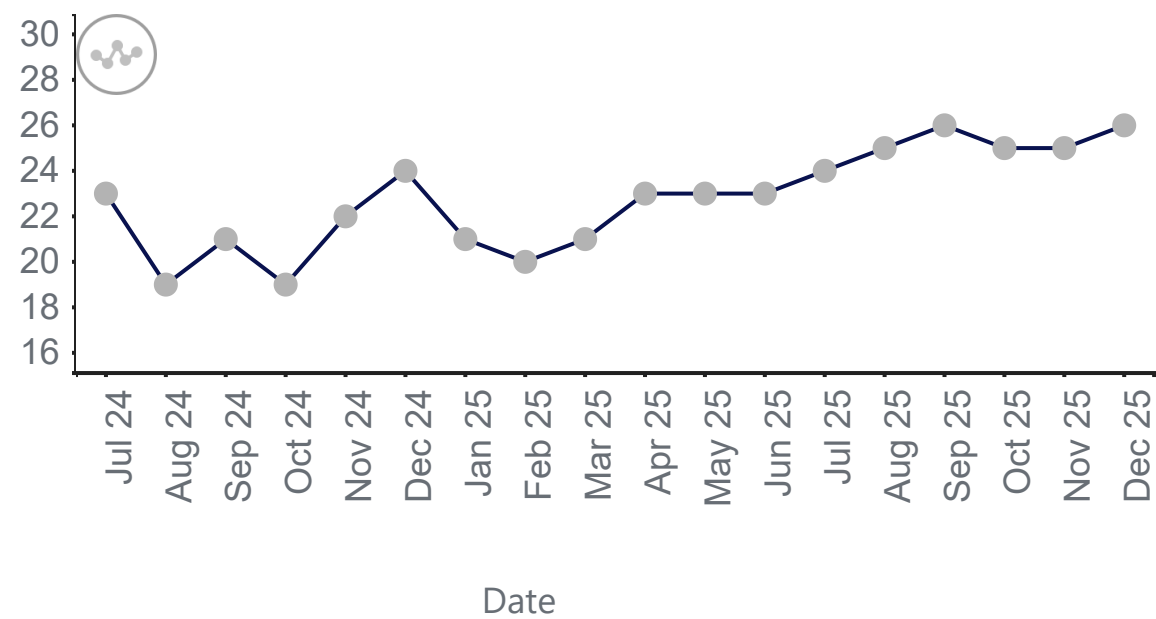
Areas of Concern:

• 19% of high risks without actions (5 / 26) • Roll out of Risk Appetite remains on hold pending further review and approval of risk tolerances by Trust Board

Forward Look (with actions)

• Whilst an improving trend since the last IPR report there will be a continued focus on risks with over actions with risk owners • Risk appetite review by Trust Board ongoing to inform Risk Appetite principles document • Further discussions with Medicine Division to roll out Risk Appetite pending Trust feedback • RMF deep dive focus item going forward to review the ongoing impact of financial decision-making and risk mitigations on high risks • Analysis of risk mitigations and whether they are currently within / outside the Trust control to be added to ARC reports by way of assurance reporting from February 2026.

Number of High Risks (scored 15 and above)



Technical Analysis:

26 high risks on the register as of 31 December 2025. Reporting categories as outlined below:

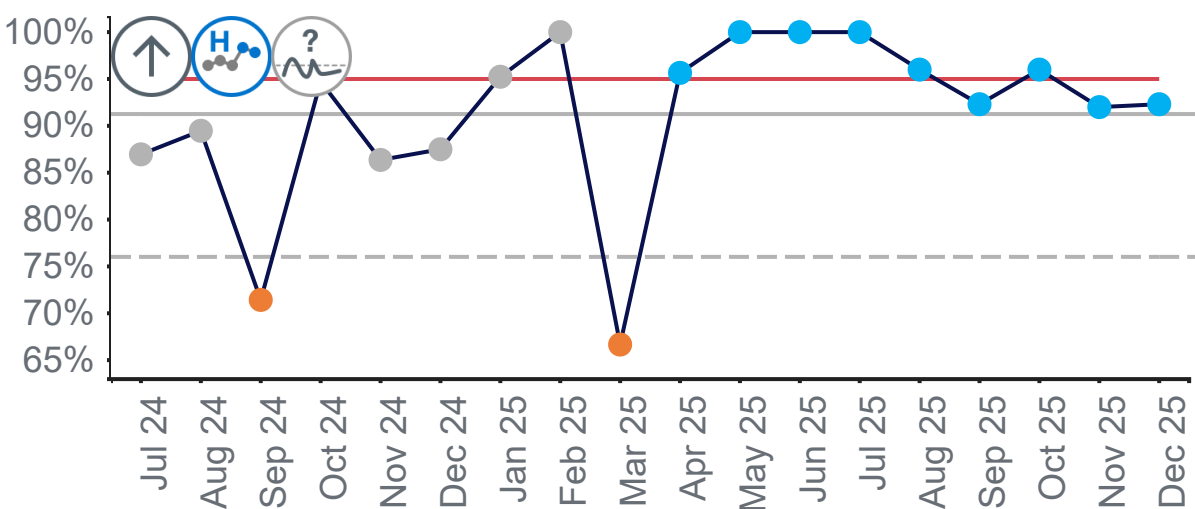
- Quality – Safety = 13 risks •
- Workforce – Sustainability = 5 risks •
- Compliance and Regulatory = 2 risks •
- Financial – Investment = 2 risks •
- Commercial = 2 risks • Financial –
- Compliance = 1 risk • Quality –
- Effectiveness = 1 risk

Actions:

All high risks continued to be reported by way of corporate risk register report and reviewed as a standing agenda item at Risk Management forum. Analysis of risk mitigations for high risks and whether they are currently within / outside the Trust control to be added to ARC reports by way of assurance reporting from February 2026.

% of High Risks within review date

Target: Internal



Technical Analysis:

Special cause variation with performance of 92% for Dec-25 of high risks within review date, same performance as November 2025. 9th consecutive month of performance greater than 90%. Risk watch metric: 19% (5/26) high risks with actions past expected date of completion.

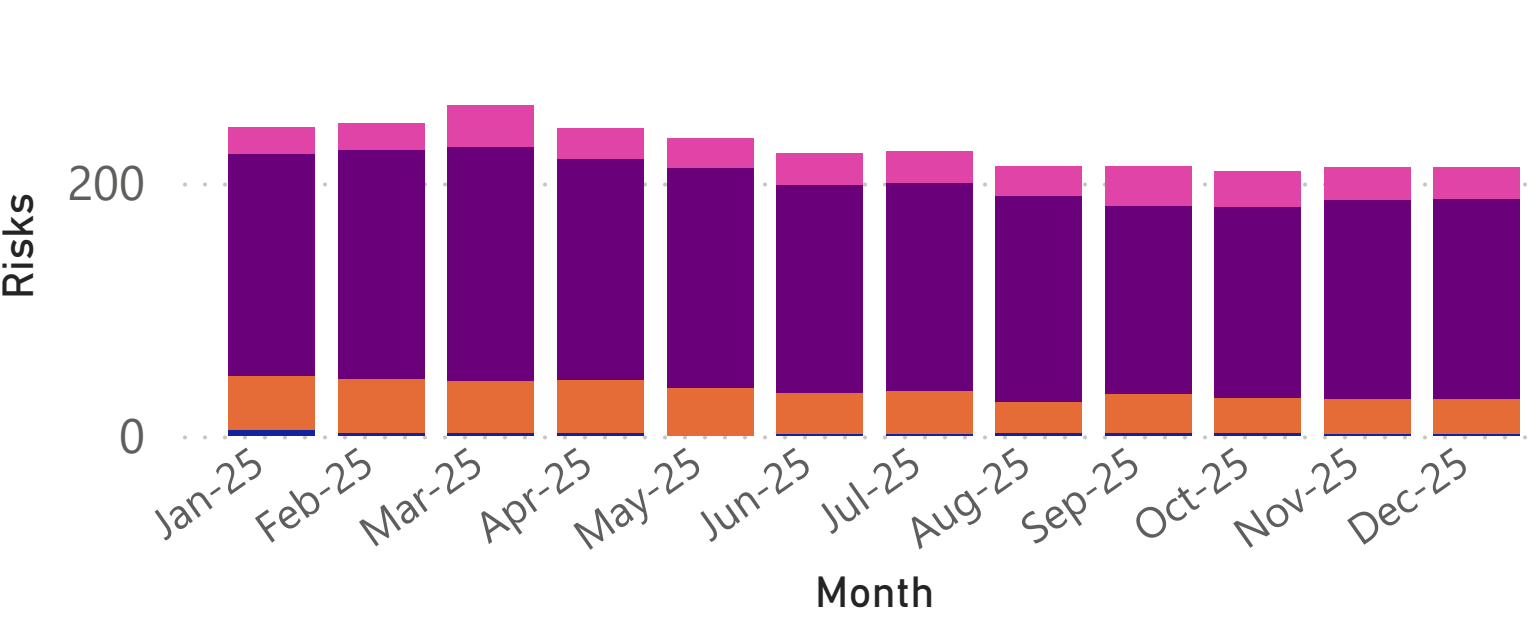
Actions:

92% within review date (2 risks overdue which have now been updated). Whilst an improving trend since the last IPR report there will be a continued focus on risks with over actions with risk owners at the monthly risk oversight meetings

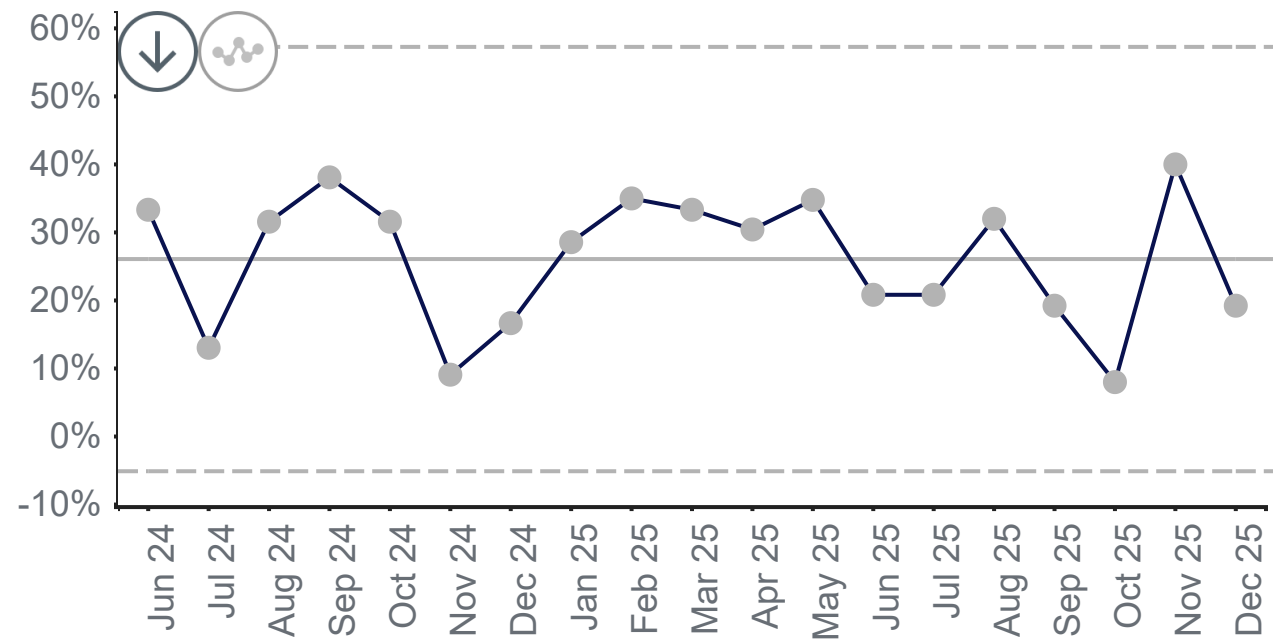
Well Led - Risk Management

Trust Risk Profile

No Rating Very Low Risk Low Risk Moderate Risk High/Extreme Risk



% of high risks with actions past expected date of completion



## Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

### Highlights

- Continued improvement in 18-week RTT for Community Paediatrics (72%) and reduction in waiting list size
- Community Dietetics service continues to meet 18-week RTT target (100%)
- Improvement in Community SALT RTT (97%)
- Mandatory training compliance remains above target (96%)
- Improvement in sickness absence (3.5%)
- Continued reduction in patient safety incidents rated low and no harm
- Increase in number of complaints responded to within 25 days (100% and PALS resolved within 5 days (97%)
- Increase in all FFT measures
- Staff turnover rate has improved (10%)

### Areas of Concern

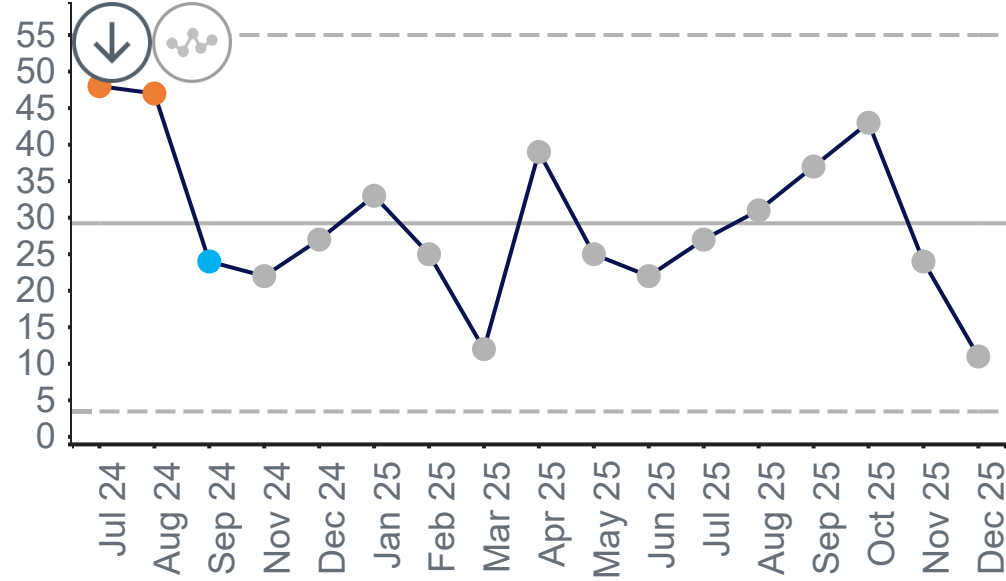
- Venus Centre closed due to unprecedented demand –impacting on referrals and capacity for Sefton Community Mental Health Services. Escalated to ICB.
- Deterioration in timeliness to triage for ND assessments (80%)
- Ten children & young people waiting over 52 weeks for treatment to start in Community Mental Health Services (Liverpool), this was due to delays with recruitment. Improvement plan in place.
- Ongoing concerns regarding the number of clinical letters, with a deterioration in number of clinical letters completed within 10 days (8%) due to delays in transcription process
- Ongoing challenges with ADHD medication shortages which is impacting on waiting times for the treatment pathway

### Forward Look (with actions)

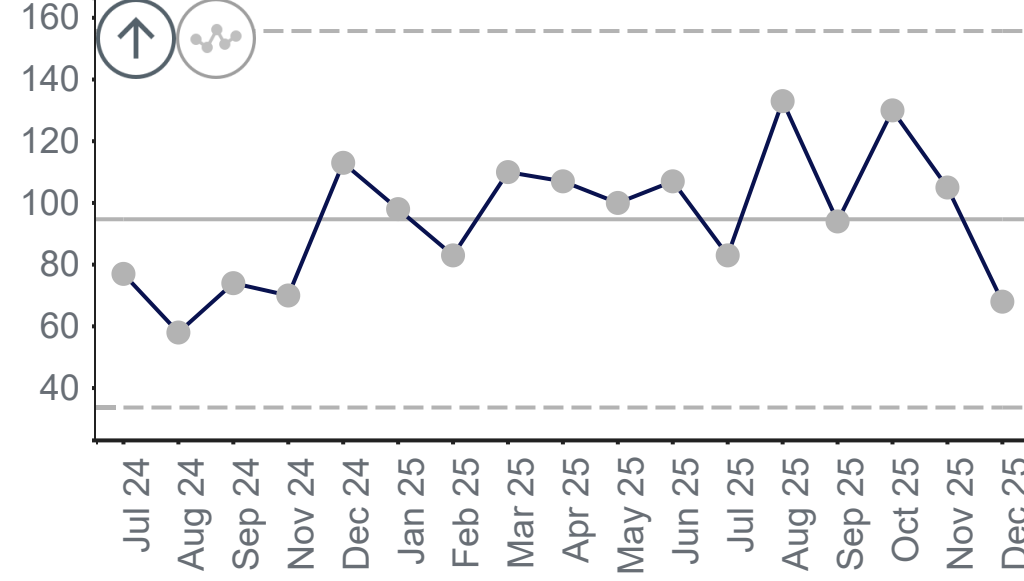
- ND transformation programme:
  - Work ongoing to streamline and validate data
  - Review of the referral triage pathway to be undertaken
  - New risk documentation to be completed for all children & young people open to service. A phased approach has been agreed.
  - Demand & capacity work commenced to identify resource needed to meet maximum 52 week wait to conclude (January 2026).
- Liverpool Community Mental Health Services performance improvement plan in place using A3 brilliant basics methodology
  - Waiting times managed against improvement trajectory. Increase in 52+ weeks due to maternity and vacancies. Additional hours requested to improve position, trajectory to be reviewed.
  - WNB rate remains high. Improvement within new assessment appointment type, deep dive into group appointments ongoing. Reminder calls using WNB predictor ongoing and action plan under review.
- Mental Health data reporting – work ongoing
  - Paper being developed to revise access and performance KPIs in line with NHSE proposal of standards for access and waiting times for Children and Young People Mental Health Services.
  - MHSDS Phase 2 (Crisis Care) commenced, with Meditech developments completed in October 2025, testing ongoing during November & December 2025 – go live currently planned for January 2026.
  - Waiting times, access and productivity review ongoing: Operational and Clinical Team contributing to NHS England "indirect contact task and finish group"
  - IT and Operational Team working with IAPTUS to review scope of IAPTUS to Meditech data migration – options appraisal in development
- Community Paediatrics - No child or young person waiting longer than 2 years for follow up. Significant reduction in children waiting 1+ year (<50 compared to 569 in January 2025)
- Work ongoing to provide psychological support to children impacted by the Southport critical incident. PIFU discharge pathway agreed to enable follow up until CYP turn 18. Ongoing discussions with ICB regarding funding for this resource.

## Divisional Performance Summary - Community & Mental Health

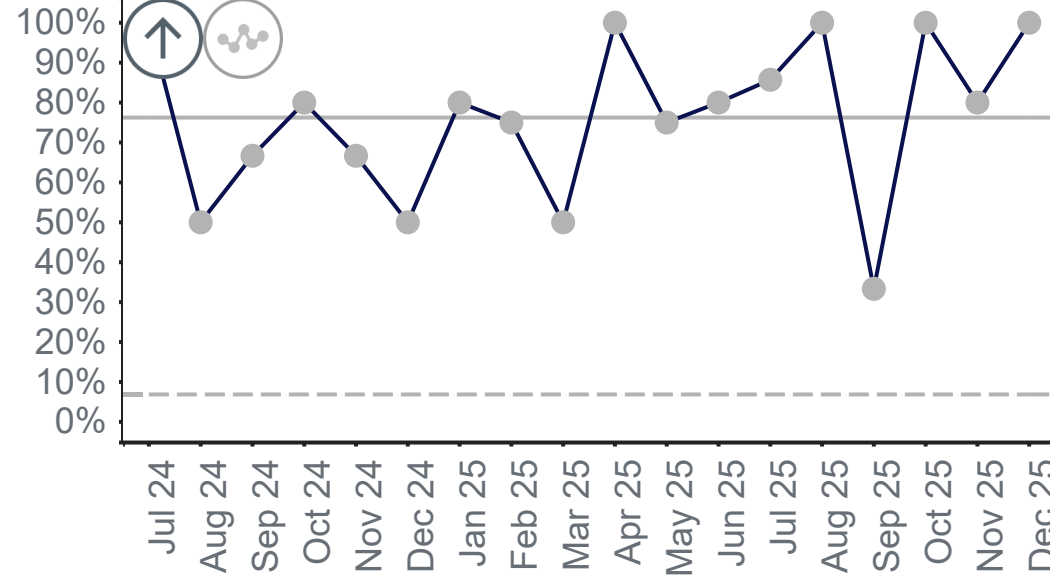
Patient Safety Incidents rated Low Harm & Above



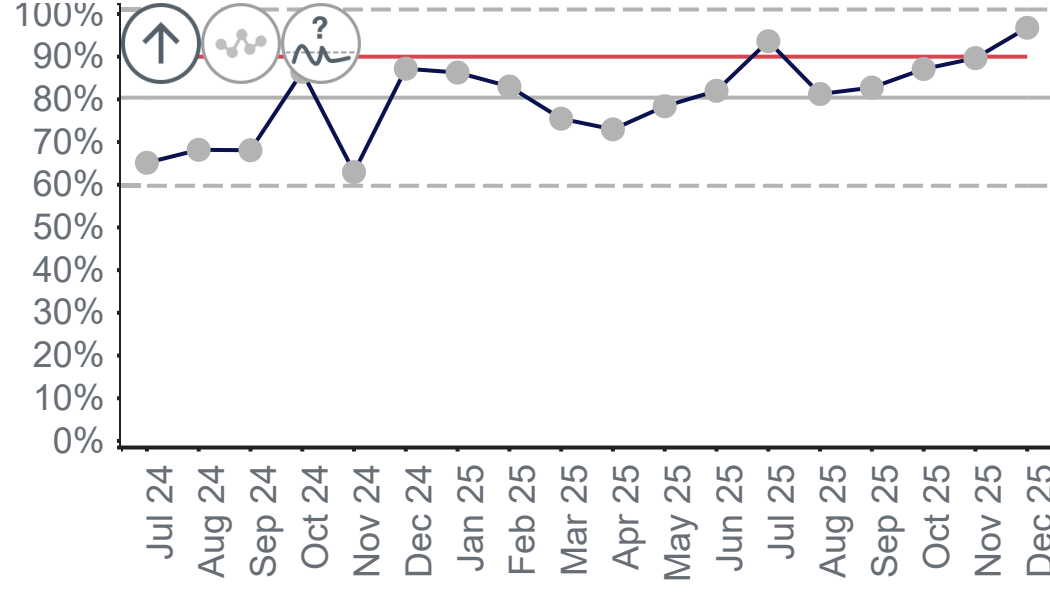
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

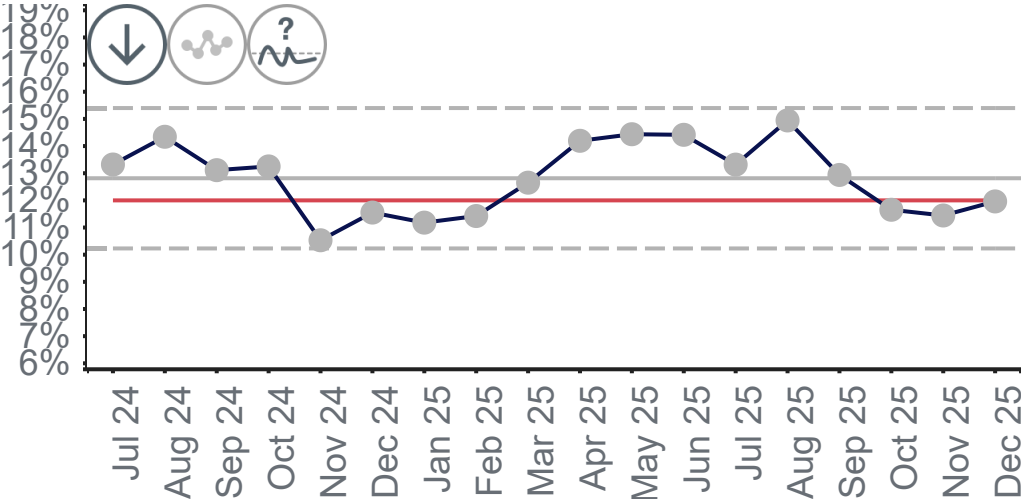


% PALS Resolved within 5 Days

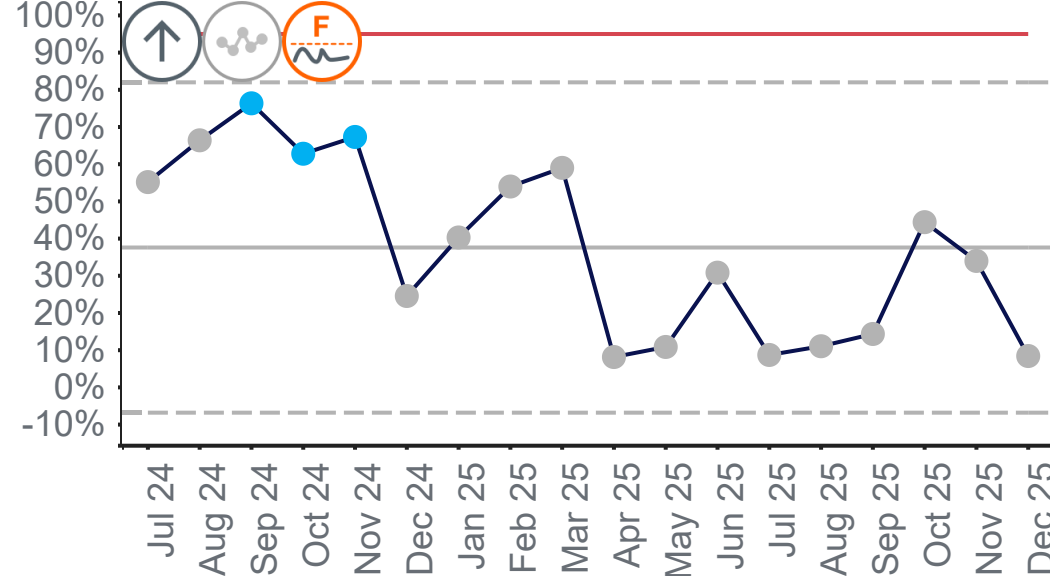


% Was Not Brought Rate (All OP: New and FU)

Target: Internal



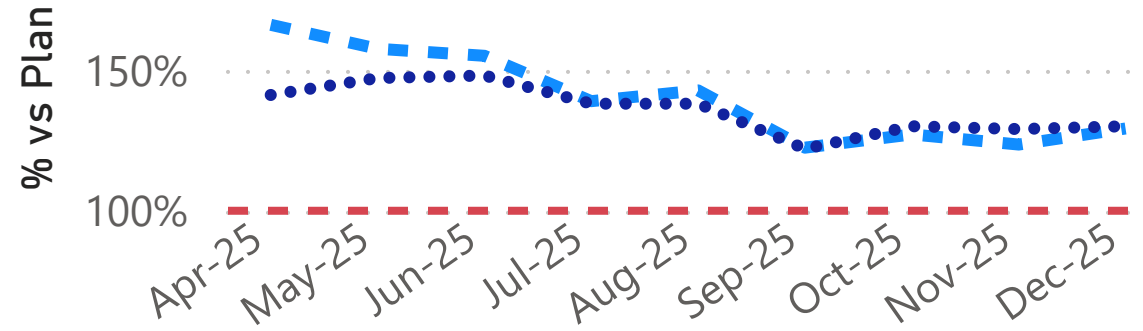
% of Clinical Letters completed within 10 Days



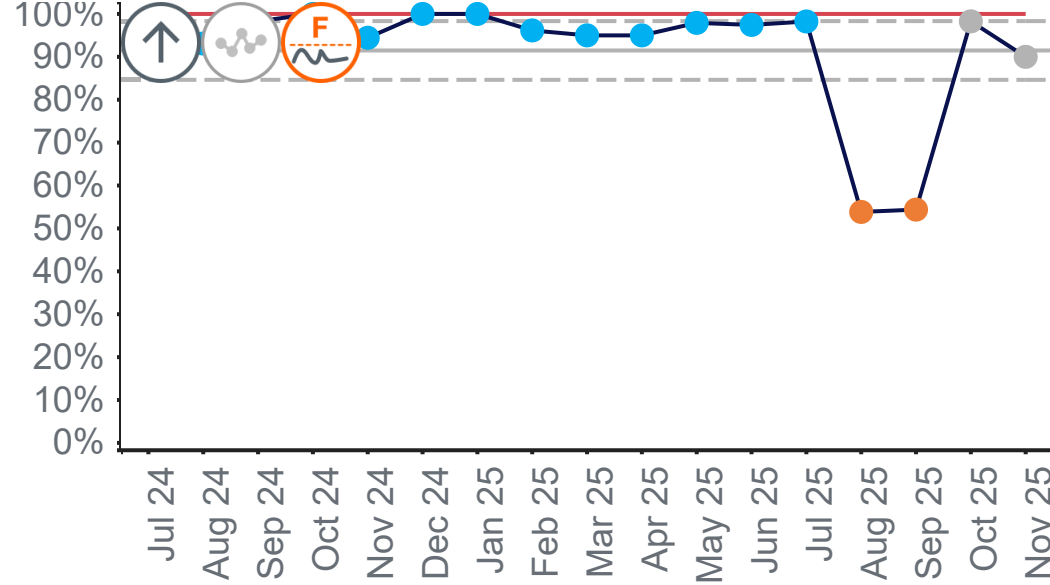
Outpatient New & OPPROC Income and Activity vs Plan  
(YTD Position)

SLAM Performance

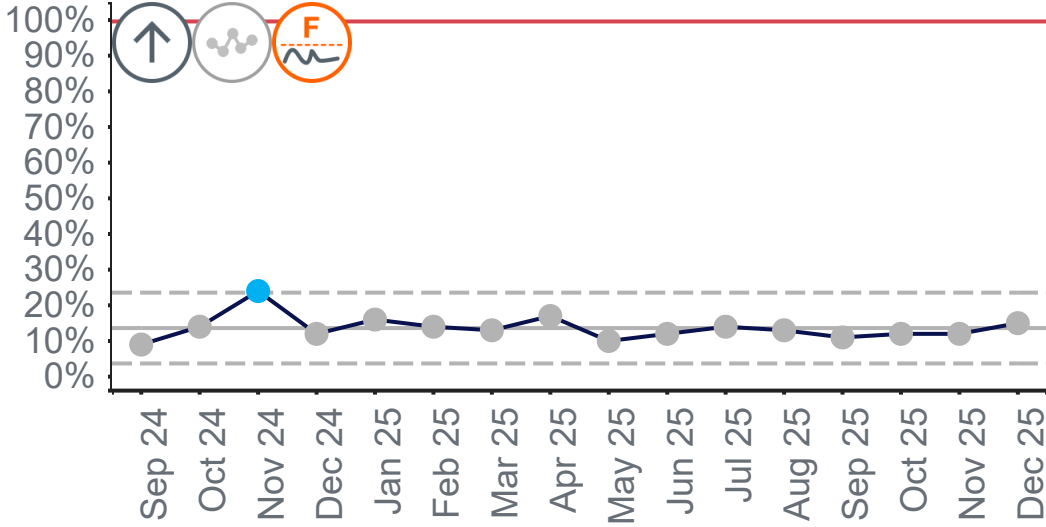
OP New/OPPROC Income OP New/Proc Spell



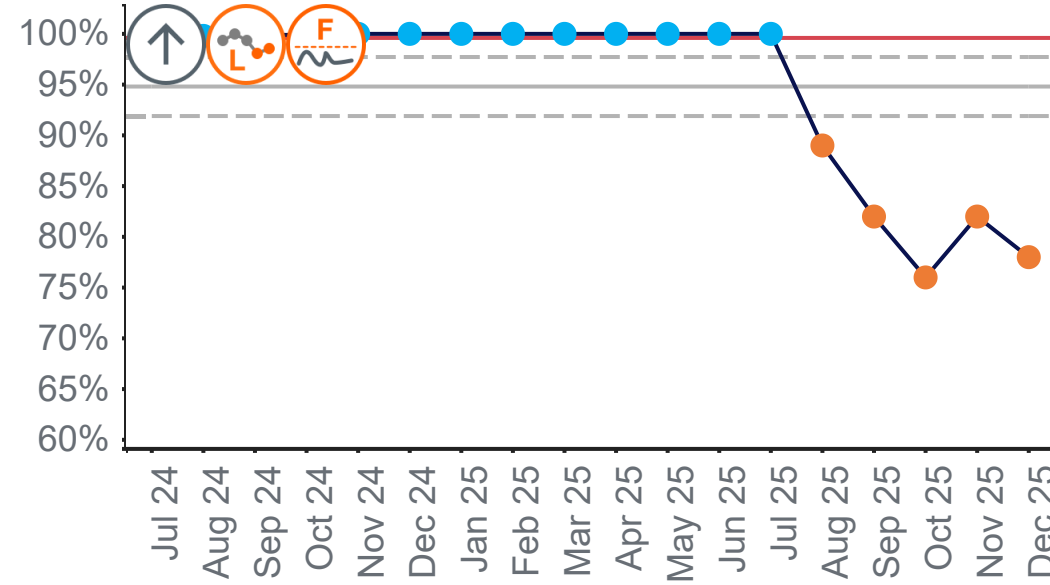
IHA: % complete within 20 days of referral to Alder Hey



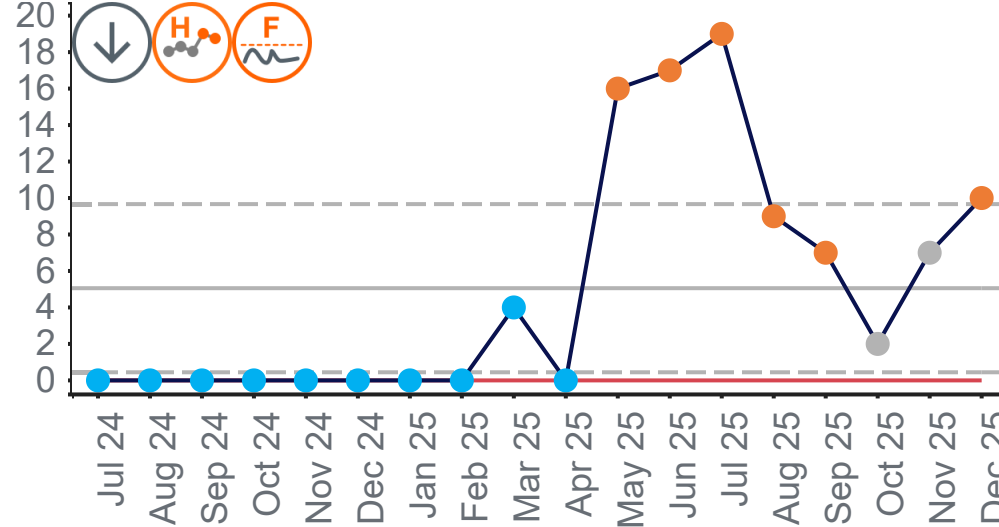
ND Assessment: % waiting <65 weeks for concluded diagnosis



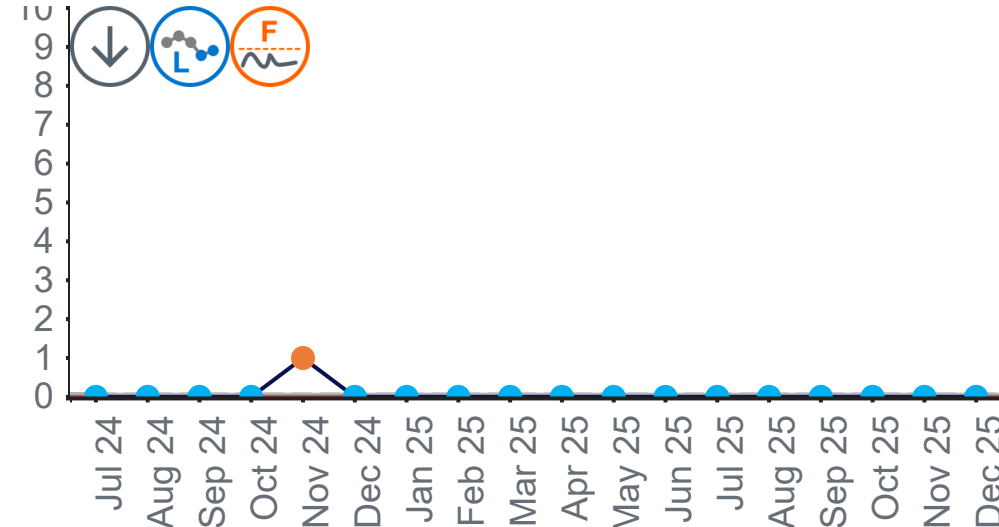
ND Assessment: % triage within 12 weeks



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

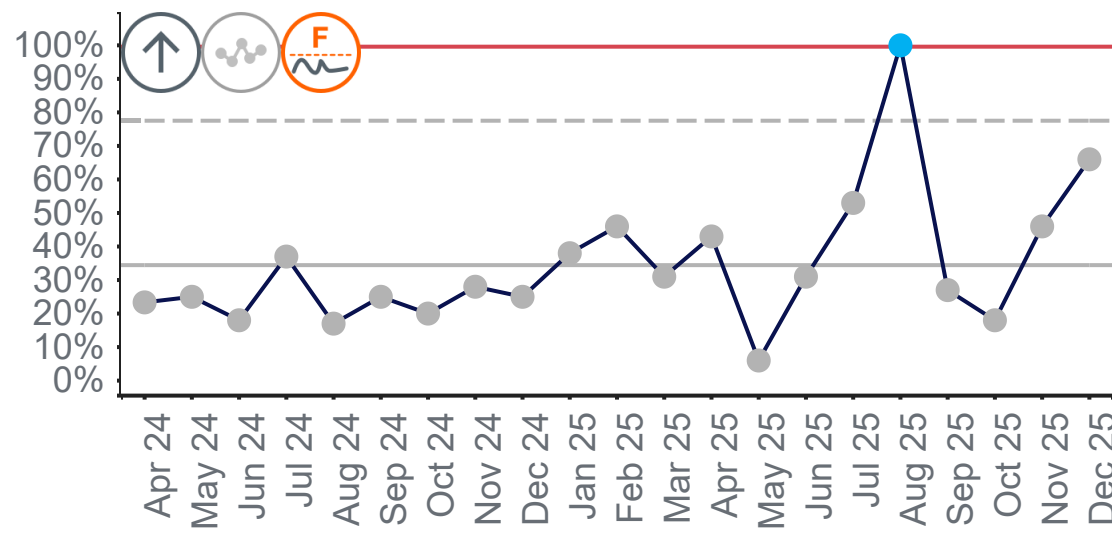


Community Paediatrics: Number of children and young people waiting >52 weeks

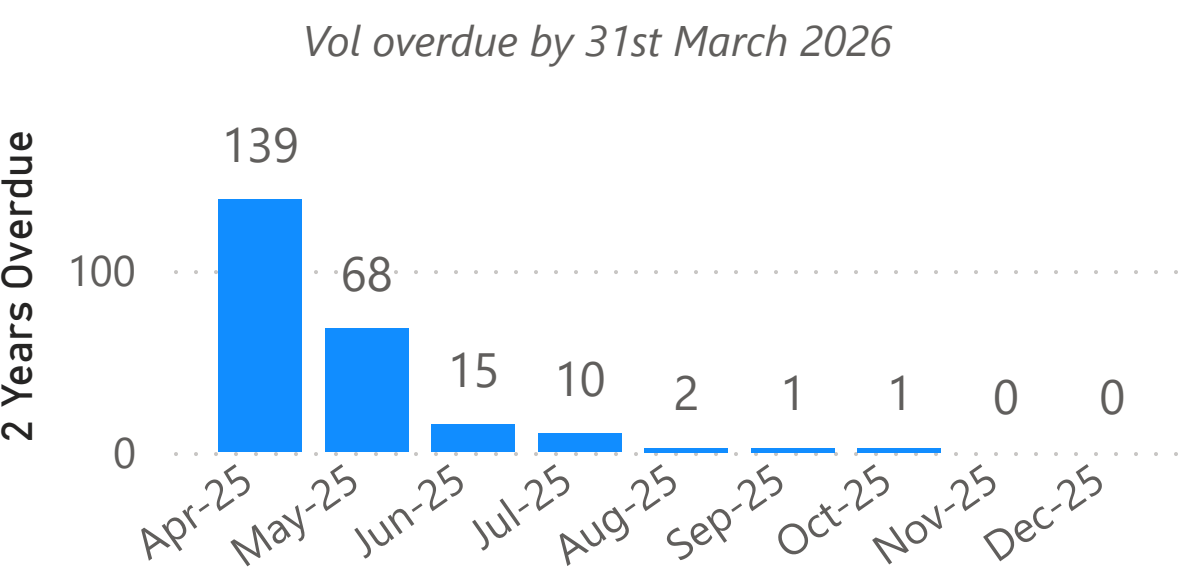


## Divisional Performance Summary - Community & Mental Health

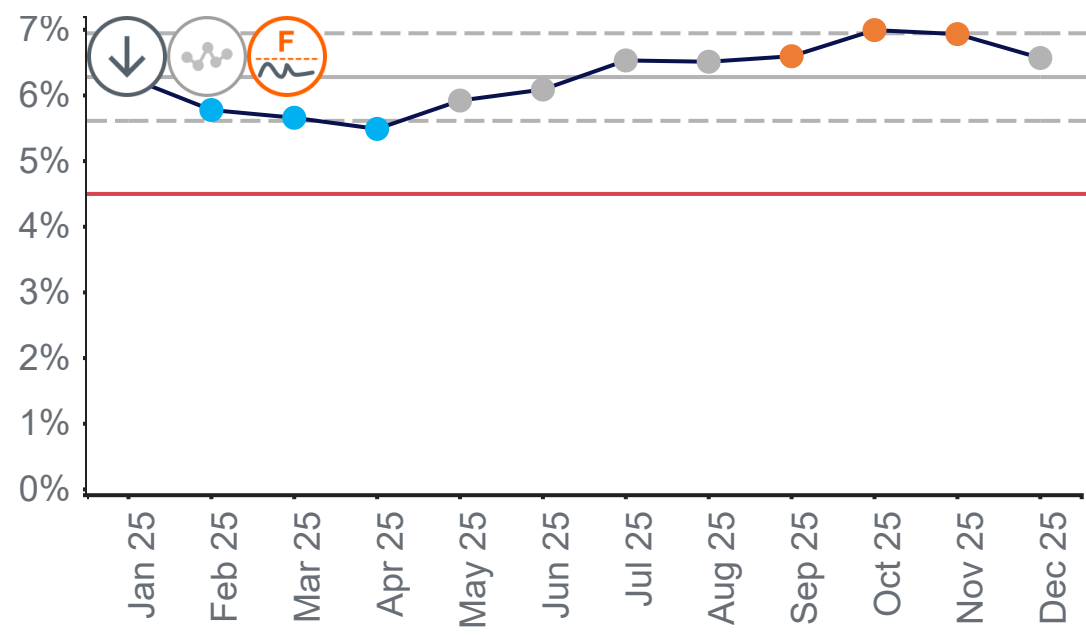
Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours



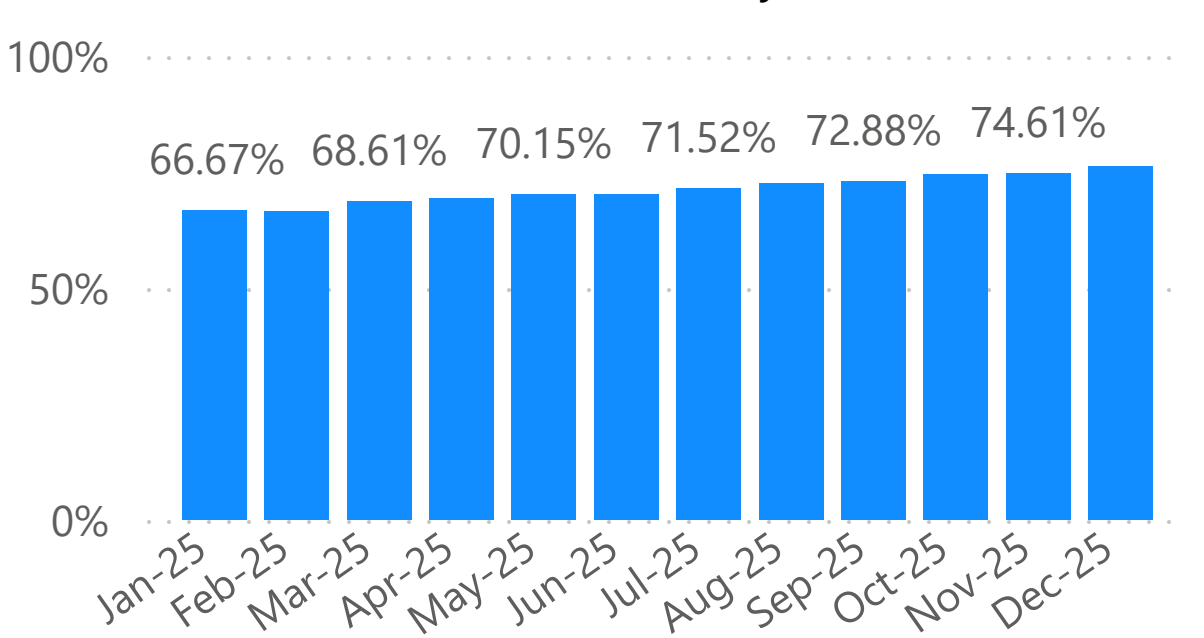
Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026



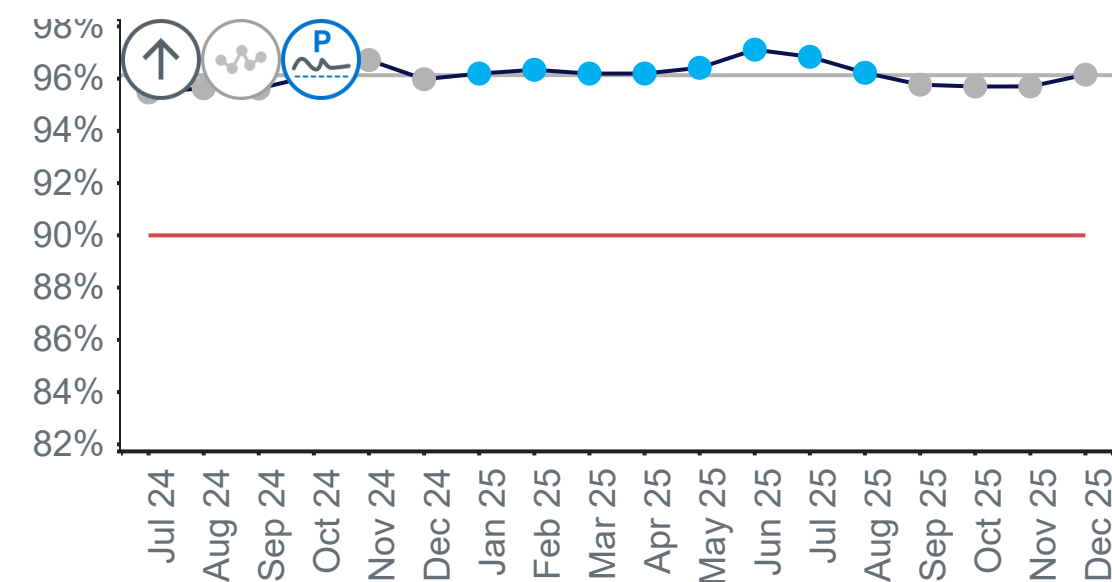
Sickness Absence Overall



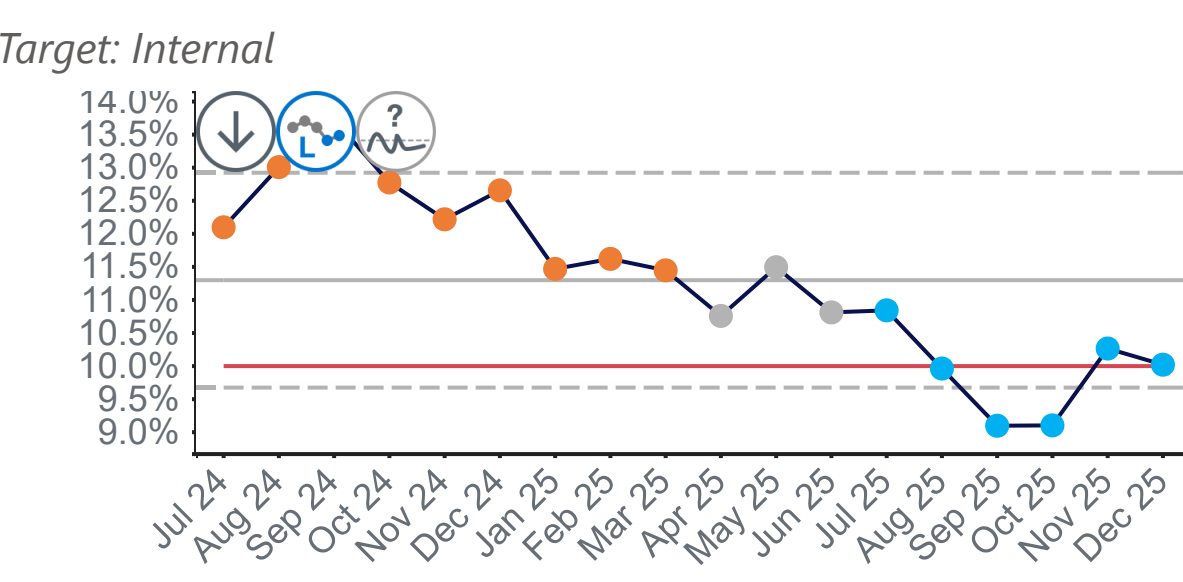
Workforce Stability



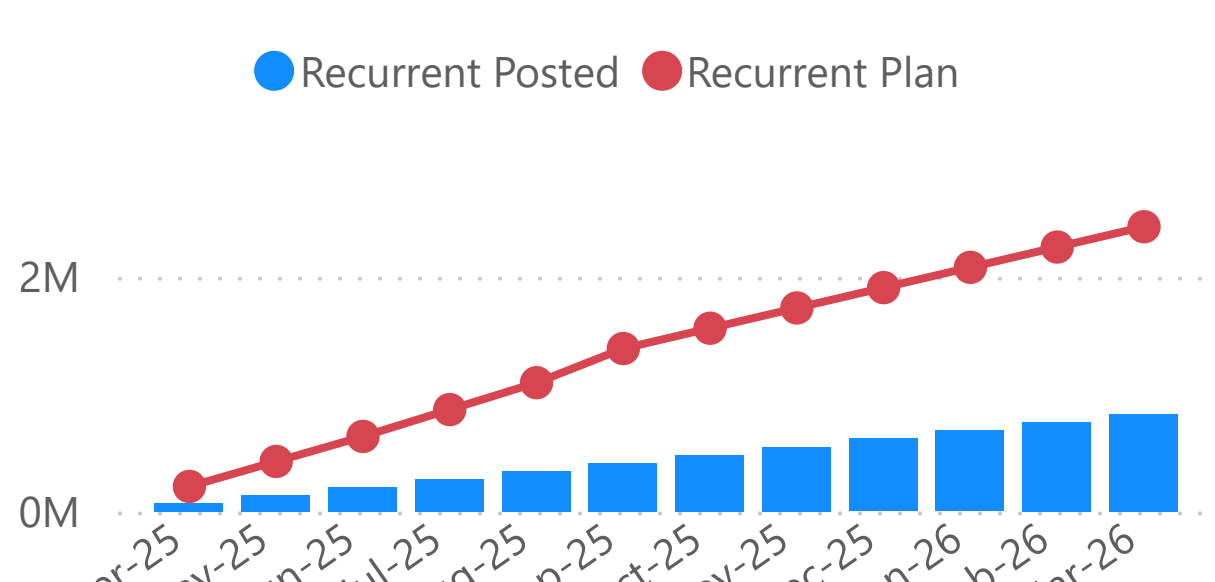
Mandatory Training



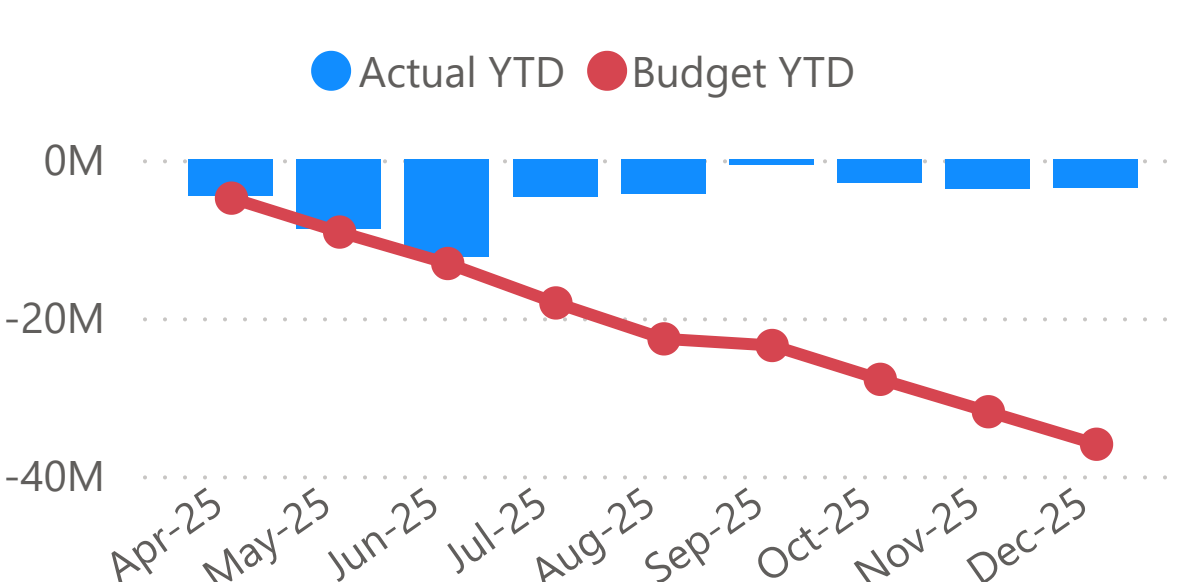
Staff Turnover



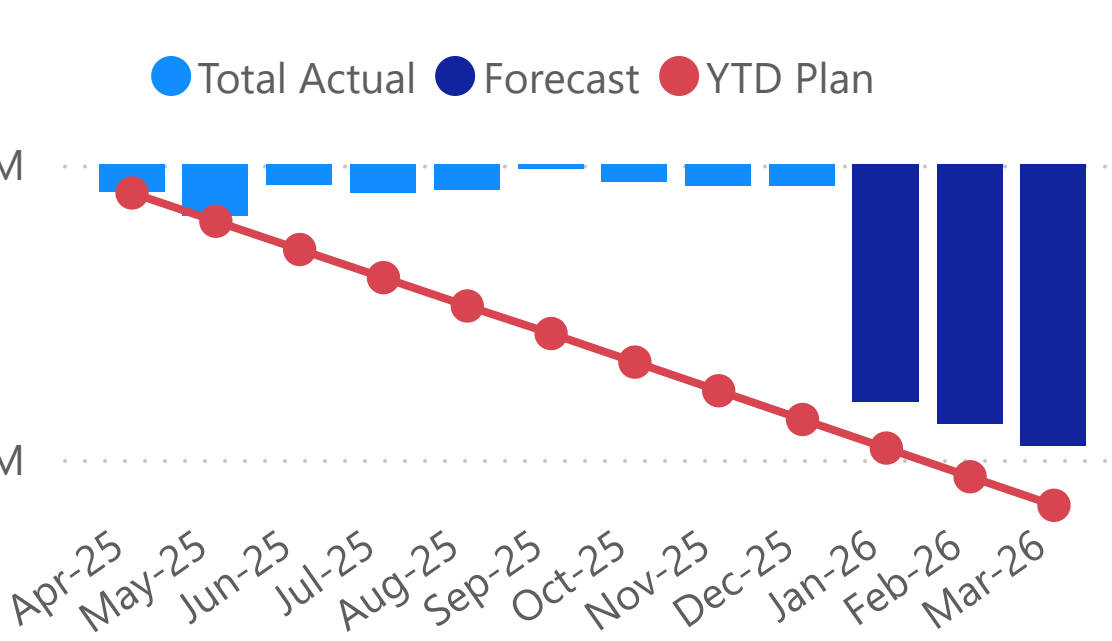
Recurrent Efficiency Plans Delivered (Forecast)



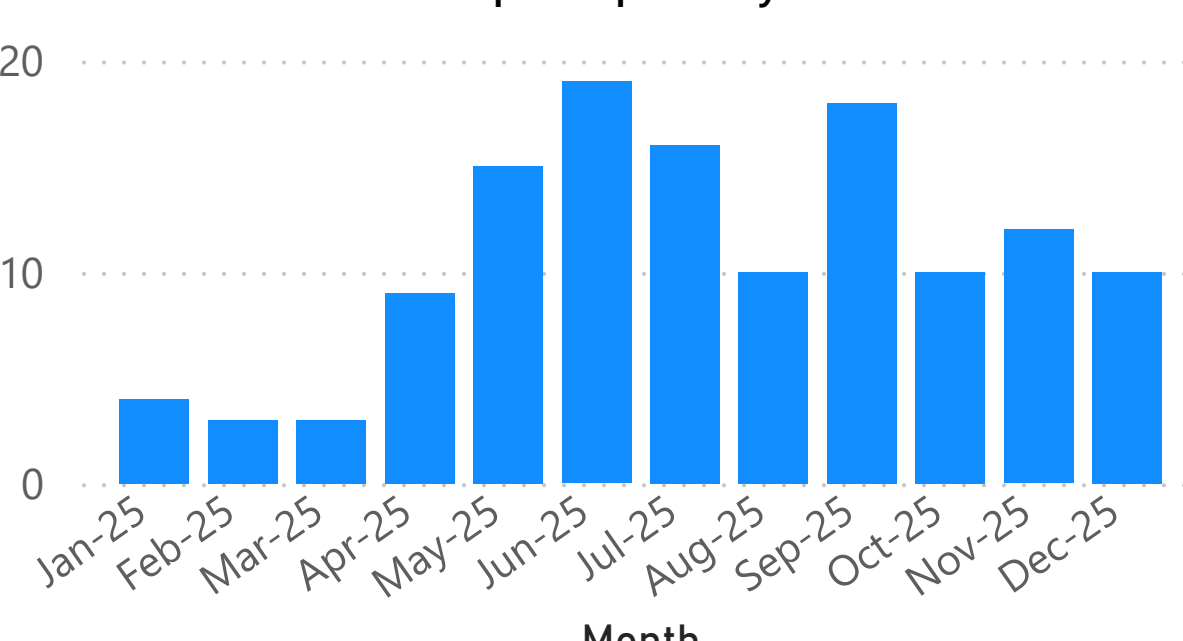
I&E distance from target (cumulative YTD)



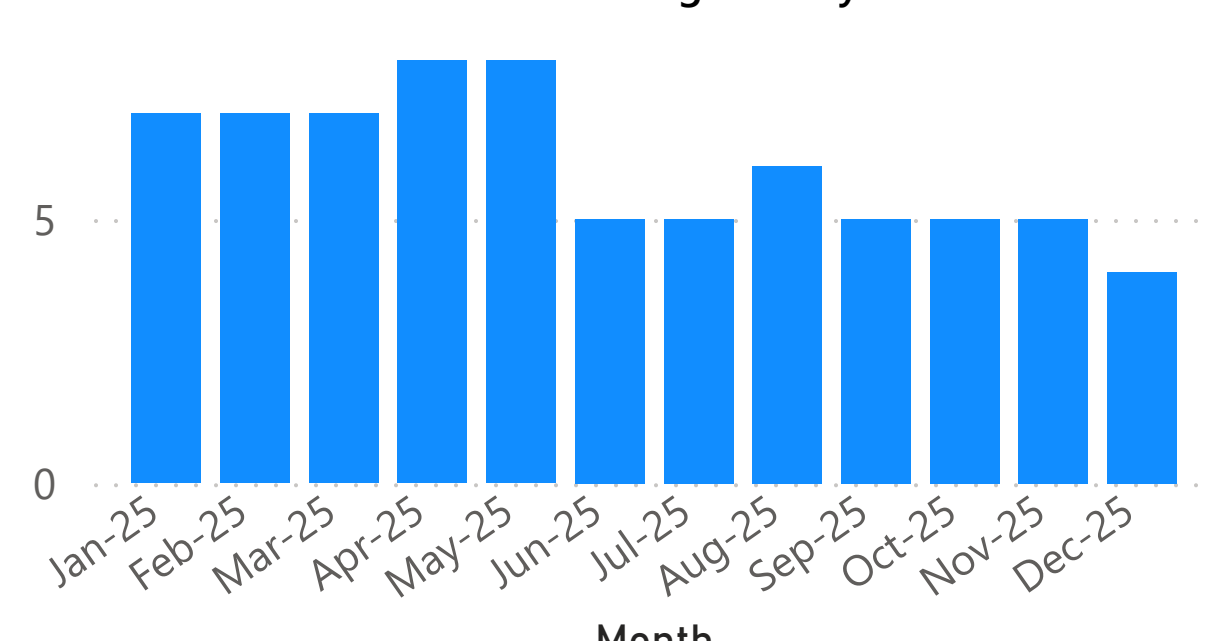
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



## Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

### Highlights

- Whilst there was a high volume of ED attendances, ED performance maintained above national targets at 84.1%. 12 Hour waits in ED maintained at 0.17%.
- PALs responded to within 5 days remains at 100% and Complaints responded to within 25 days has improved from 88% in November to 100% in December.
- Activity and Income for Medicine was above plan across all ERF PODS. This resulted in an overall position at 115% of plan.
- Patients waiting over 52 weeks to be seen has maintained at 0 in December.

### Areas of Concern

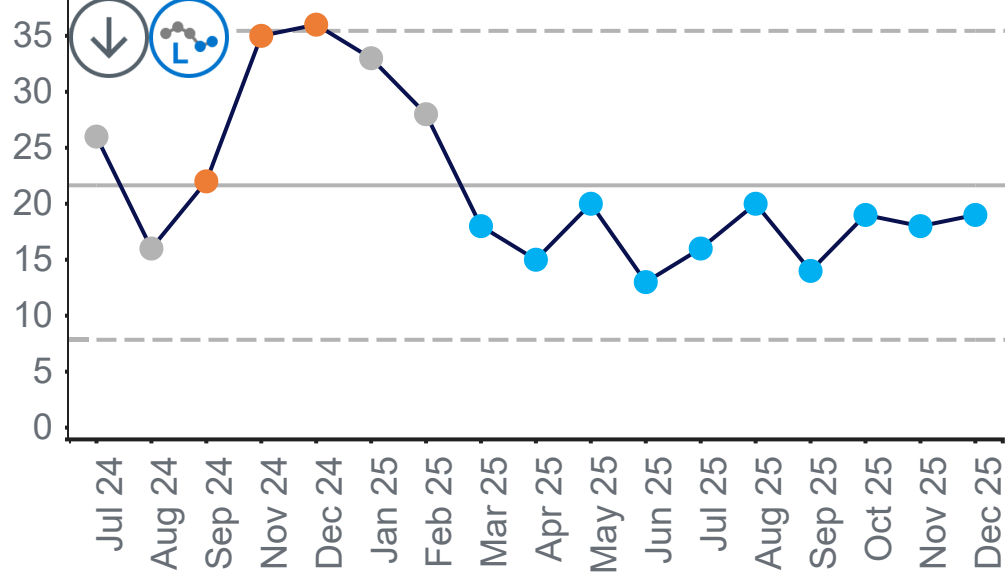
- WNB remains above the Trust target at 8% for December. Work is undergoing at speciality level to instigate overbooking to mitigate where able.
- Inpatient discharges per working day has declined each month over Q3. There is a seasonal trend with this metric, acknowledging increased acuity in the winter months compared to summer however discharges per day were lower in December 2025 compared to December 2024.
- DM01 has declined in December to 93% due to challenges in Respiratory and Gastroenterology.

### Forward Look (with actions)

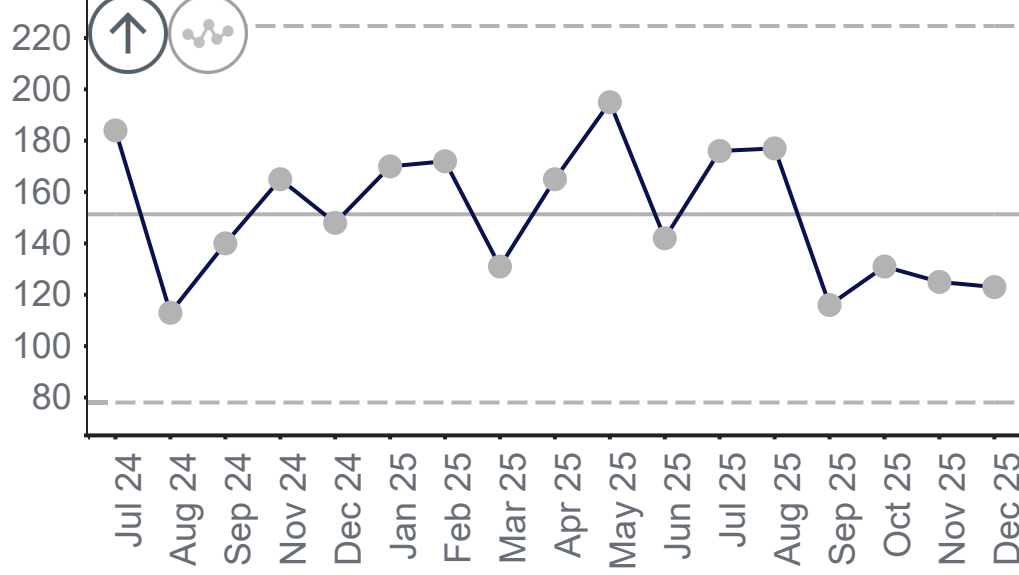
- We are expecting a second surge in ED attends in January/February 2026 and as such have instigated a tactical command response to manage this.
- We are reviewing plans to be able to address challenges in Respiratory and Gastroenterology to improve the DMO1 position.
- We have increased the General Paediatric capacity for Jan-Mar to see OPD News with a view to reducing the overall waiting list size and improve the RTT position.
- We are working to review opportunities to deliver additional activity through the OPD Sprint that has been approved.

## Divisional Performance Summary - Medicine

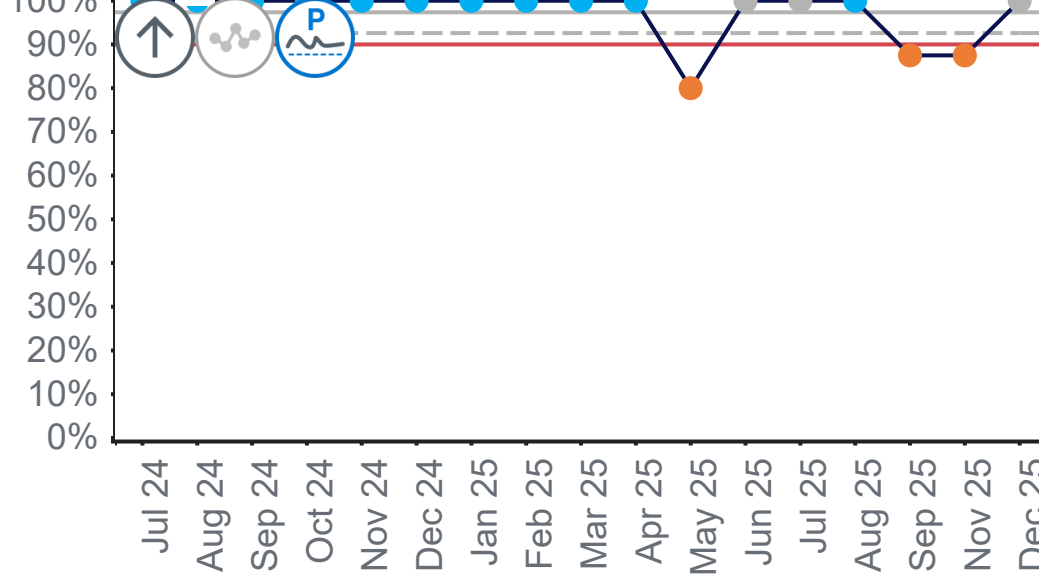
Patient Safety Incidents rated Low Harm & Above



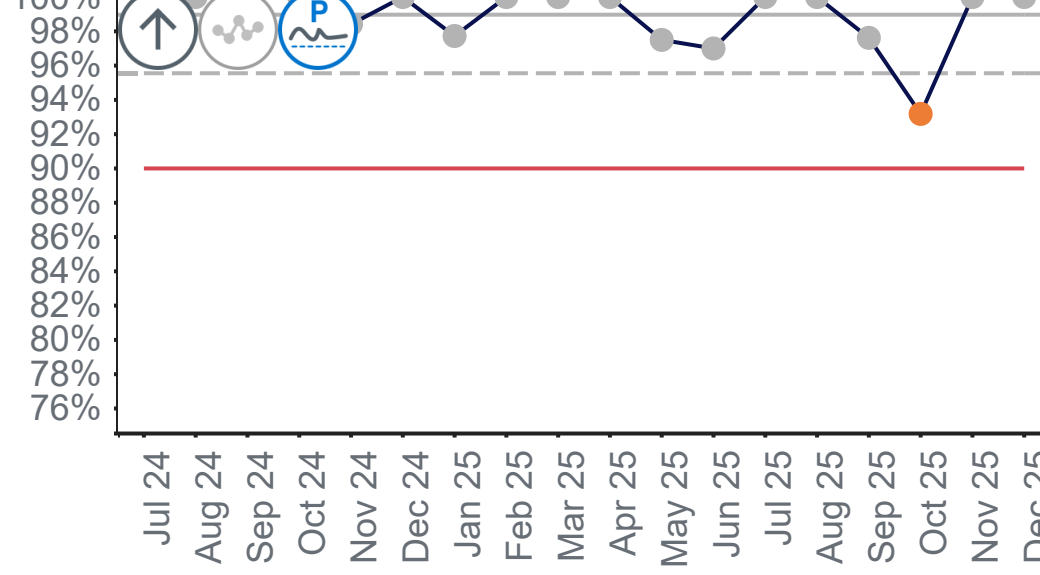
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

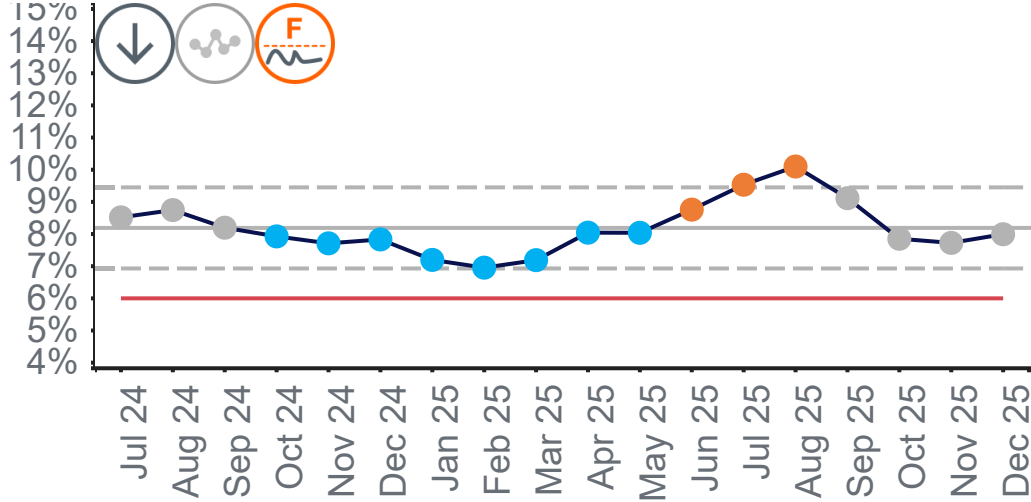


% PALS Resolved within 5 Days

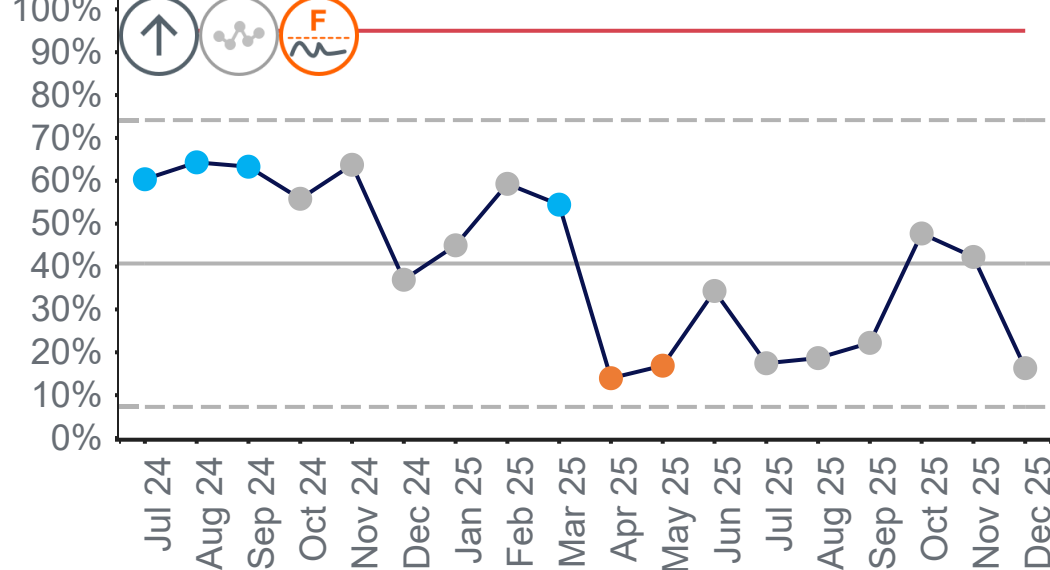


% Was Not Brought Rate (All OP: New and FU)

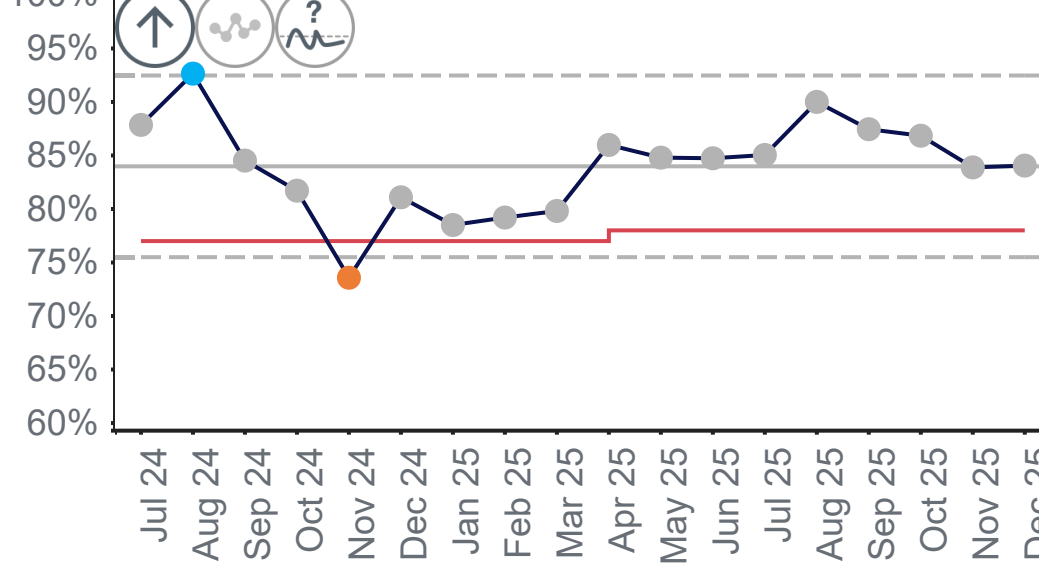
Target: Internal



% of Clinical Letters completed within 10 Days



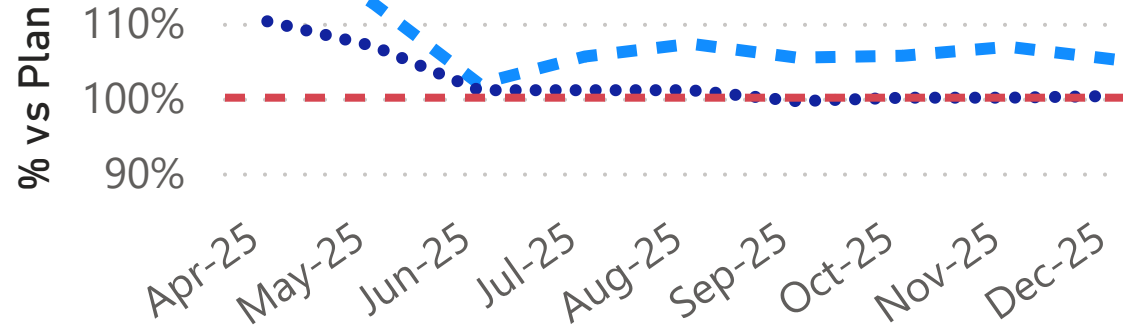
ED: % treated within 4 Hours



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

SLAM Performance

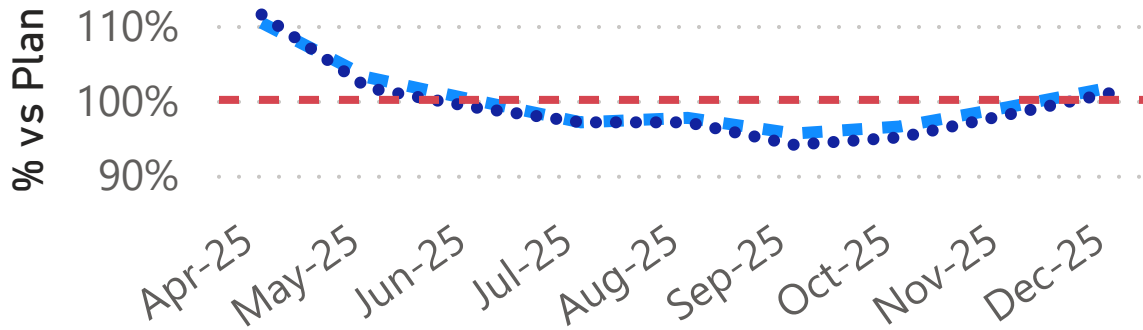
DC/EL Income DC/EL Spell



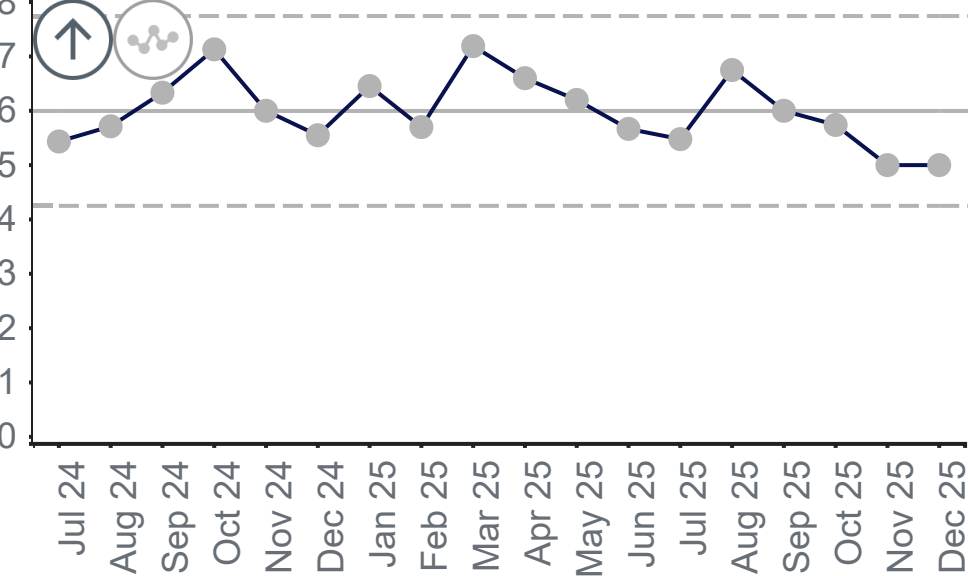
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

SLAM Performance

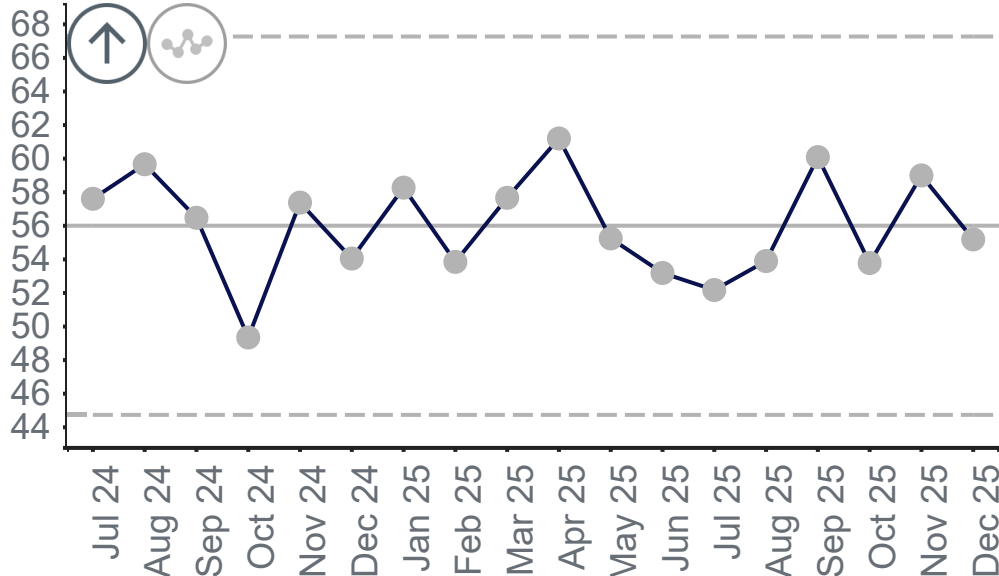
OP New/OPPROC Income OP New/Proc Spell



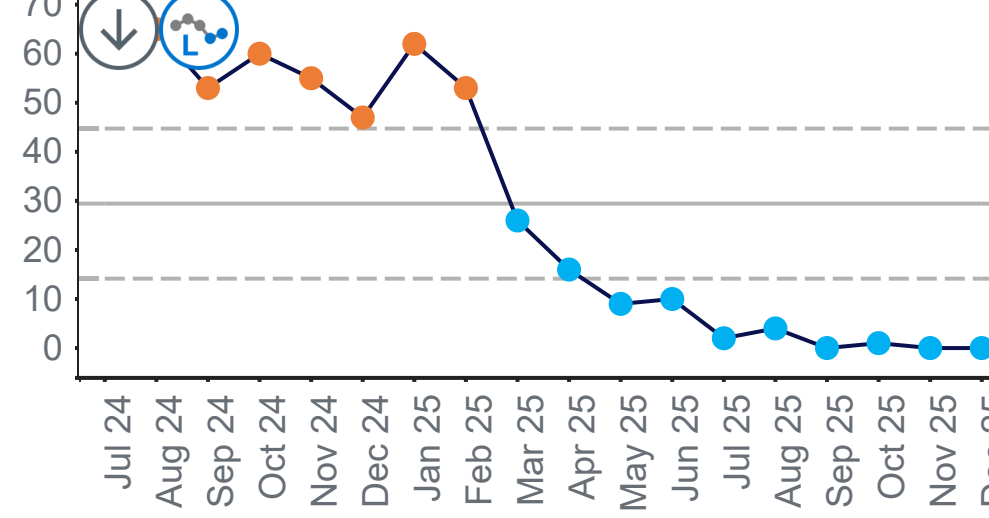
Inpatient Discharges per working day



Day Cases per working day

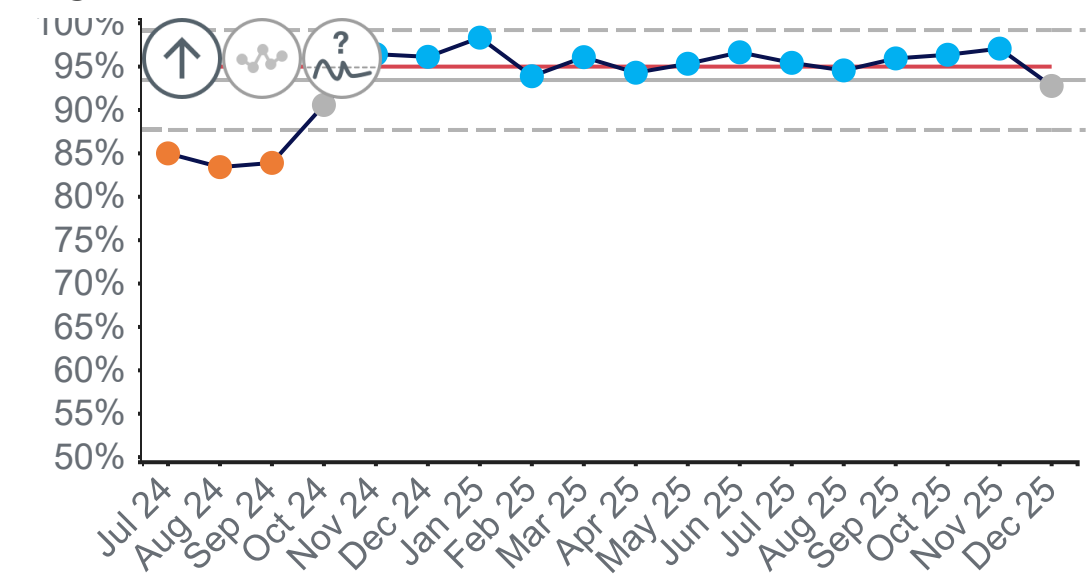


Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



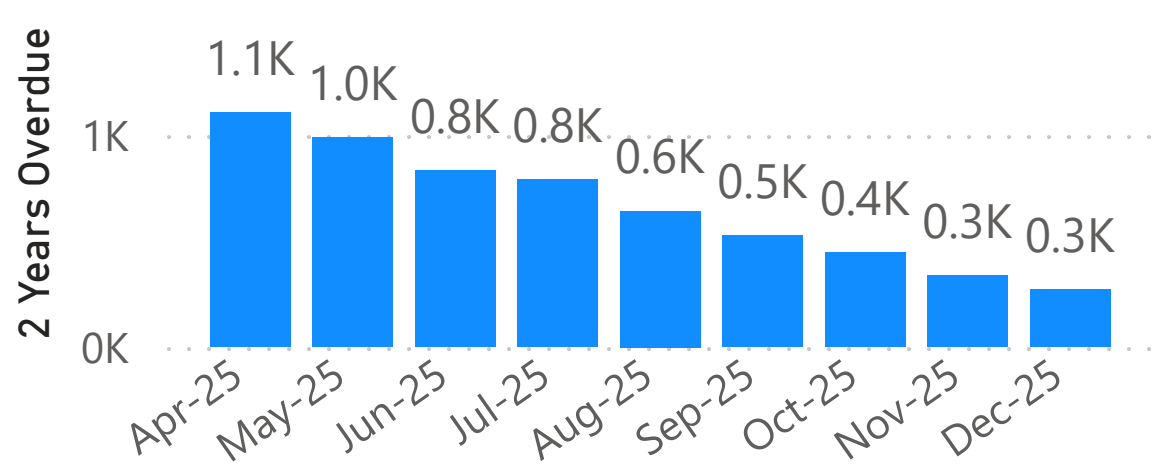
Divisional Performance Summary - Medicine

Diagnostics: % Completed Within 6 Weeks of referral

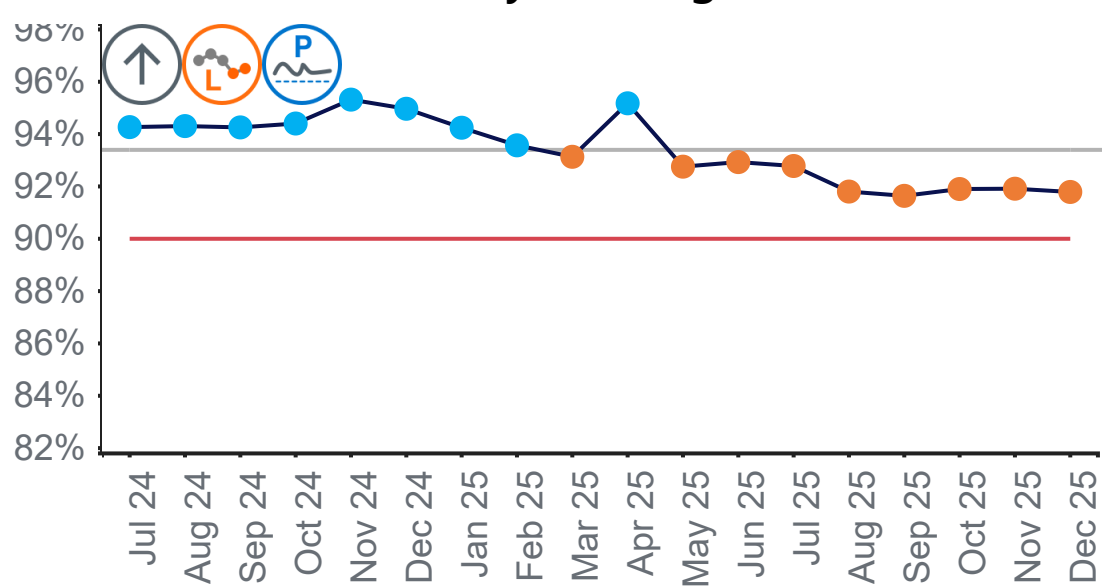


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

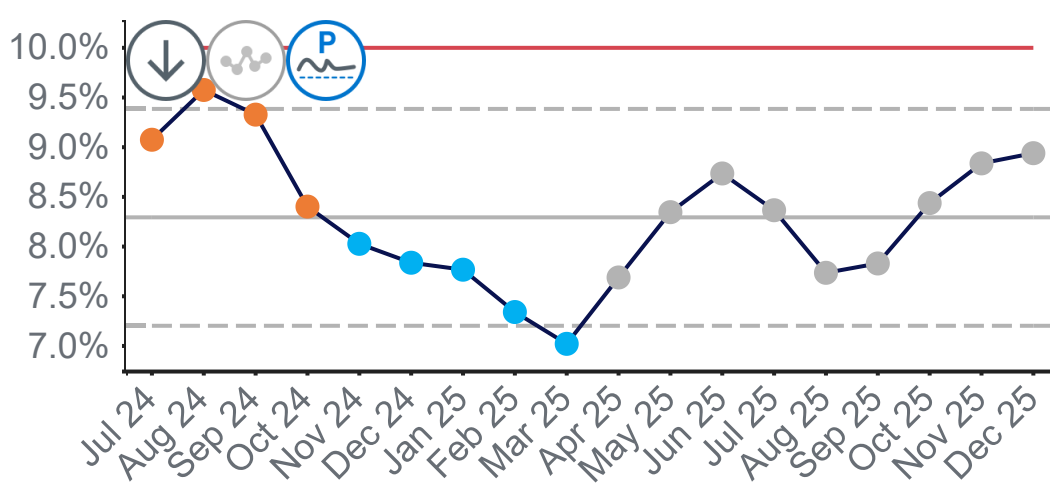


Mandatory Training

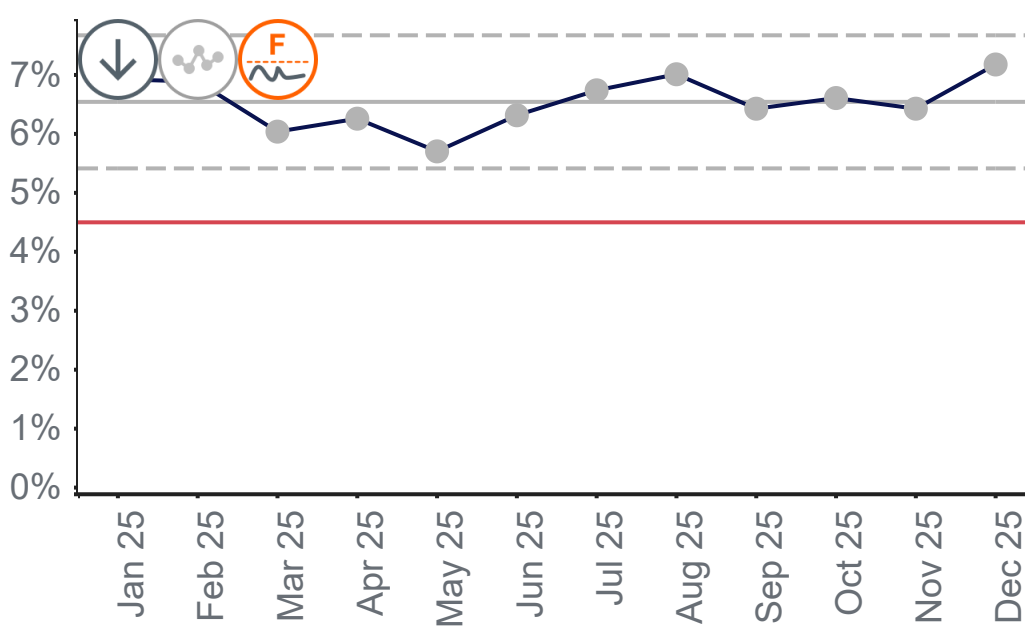


Staff Turnover

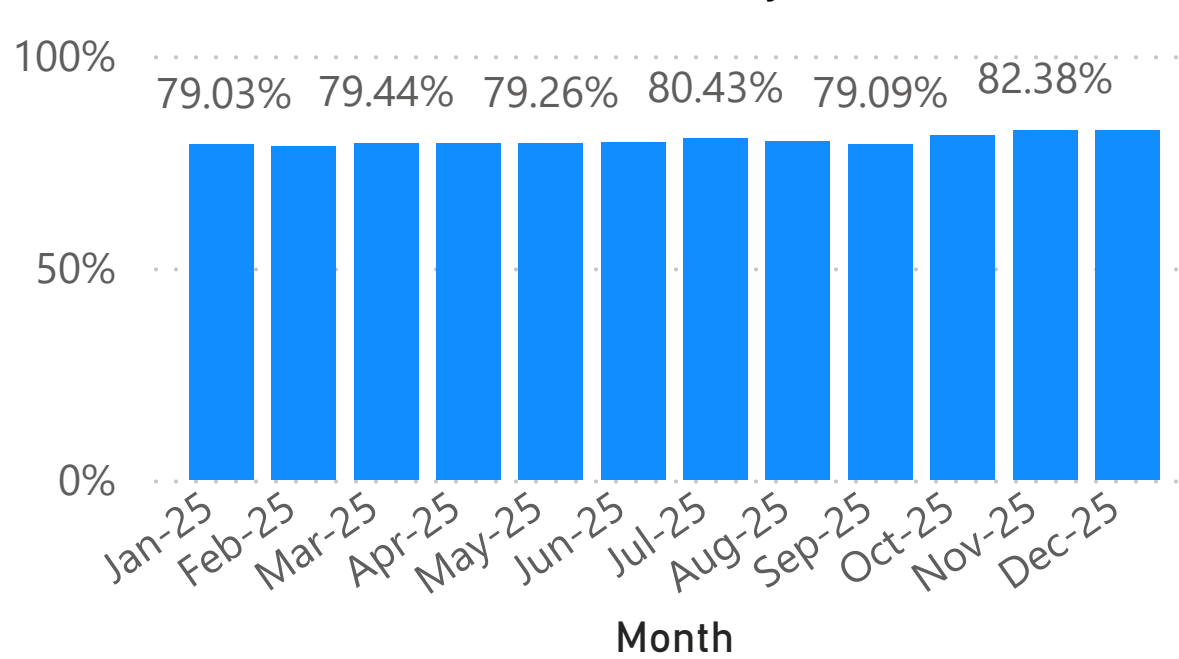
Target: Internal



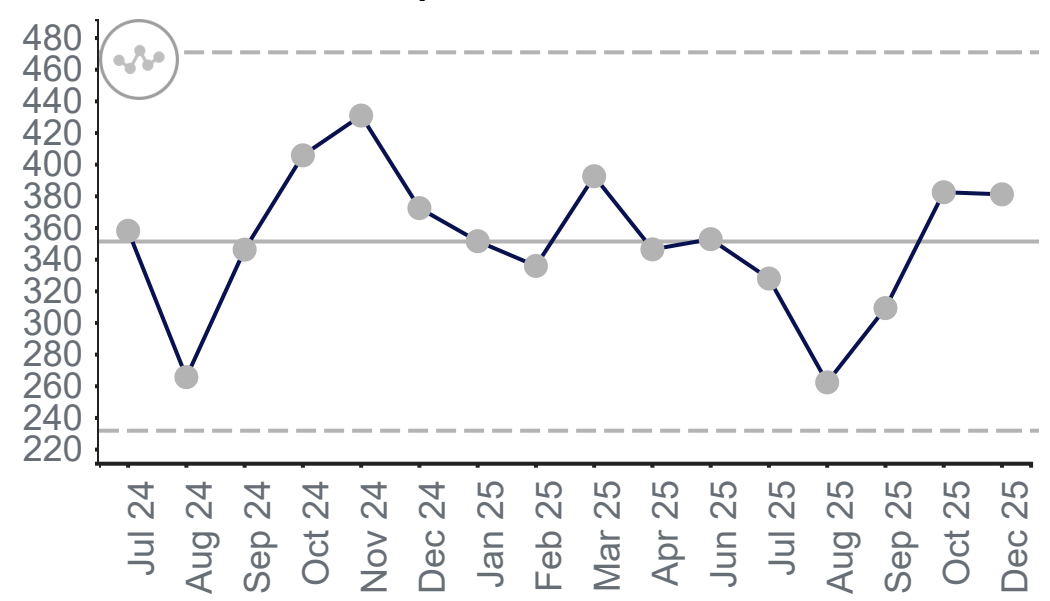
Sickness Absence Overall



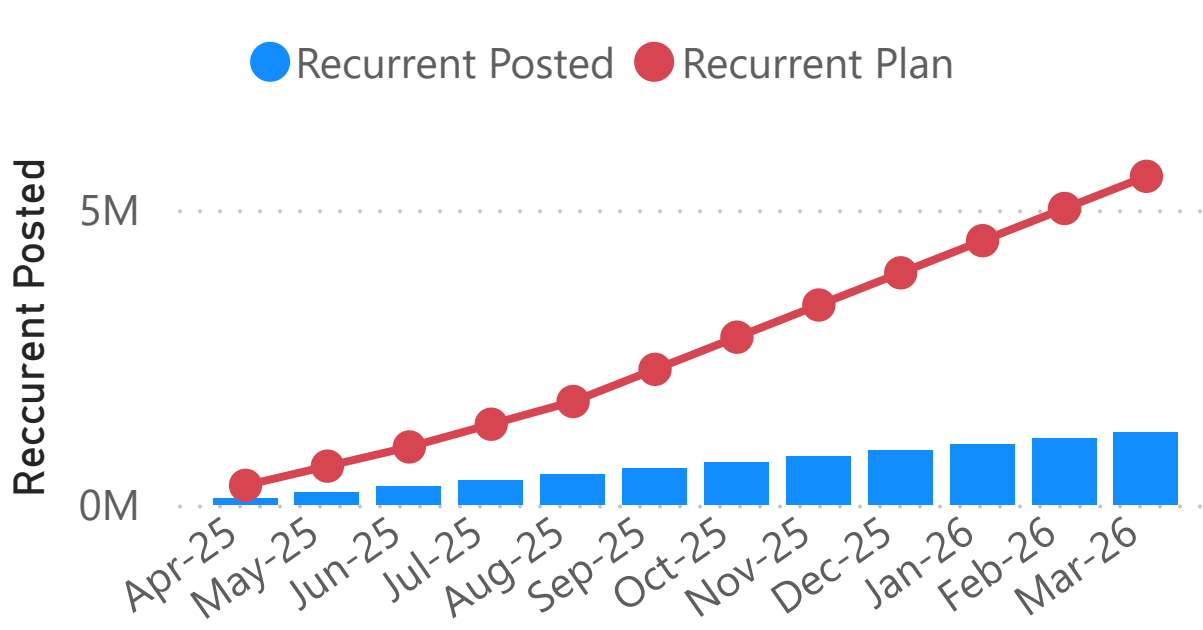
Workforce Stability



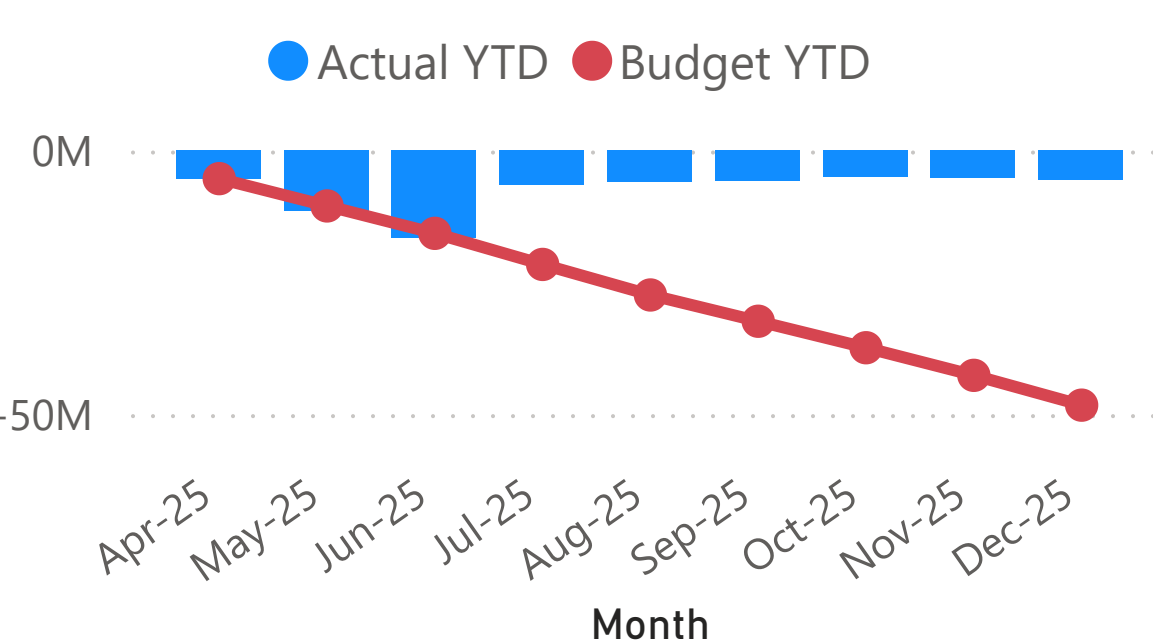
A&E Attendances per ED Consultant WTE



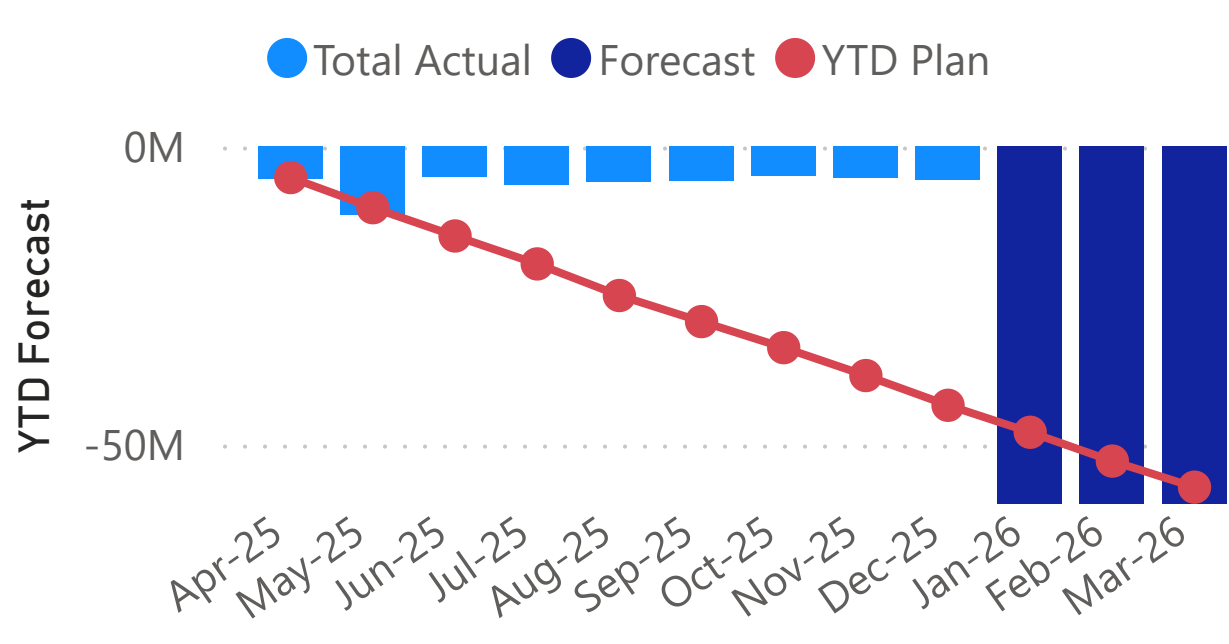
Recurrent Efficiency Plans Delivered (Forecast)



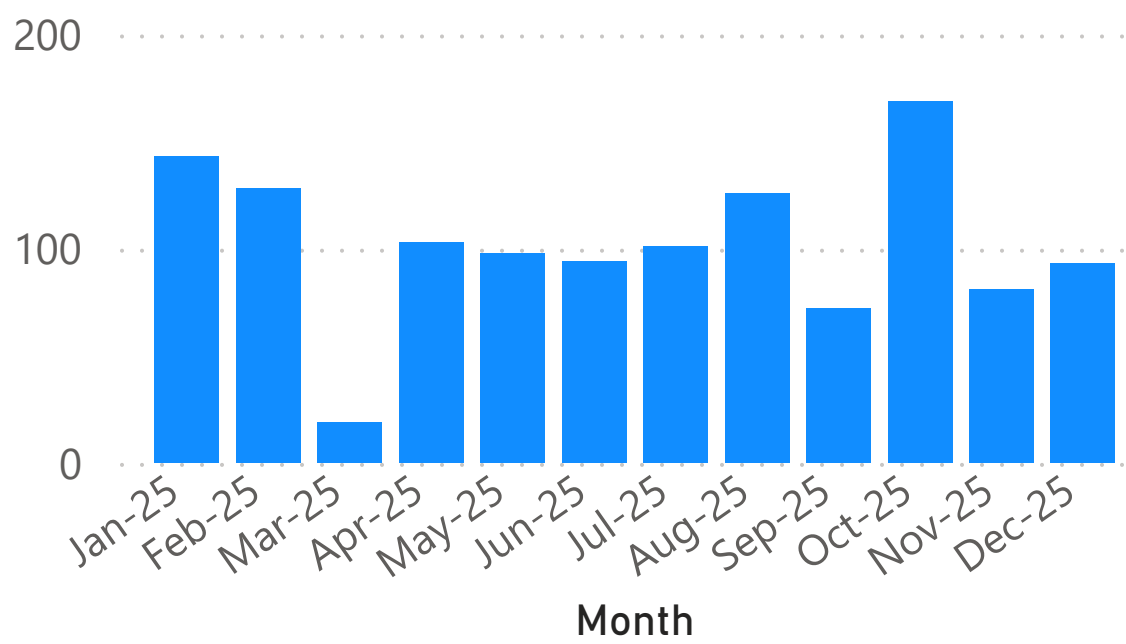
I&E distance from target (cumulative YTD)



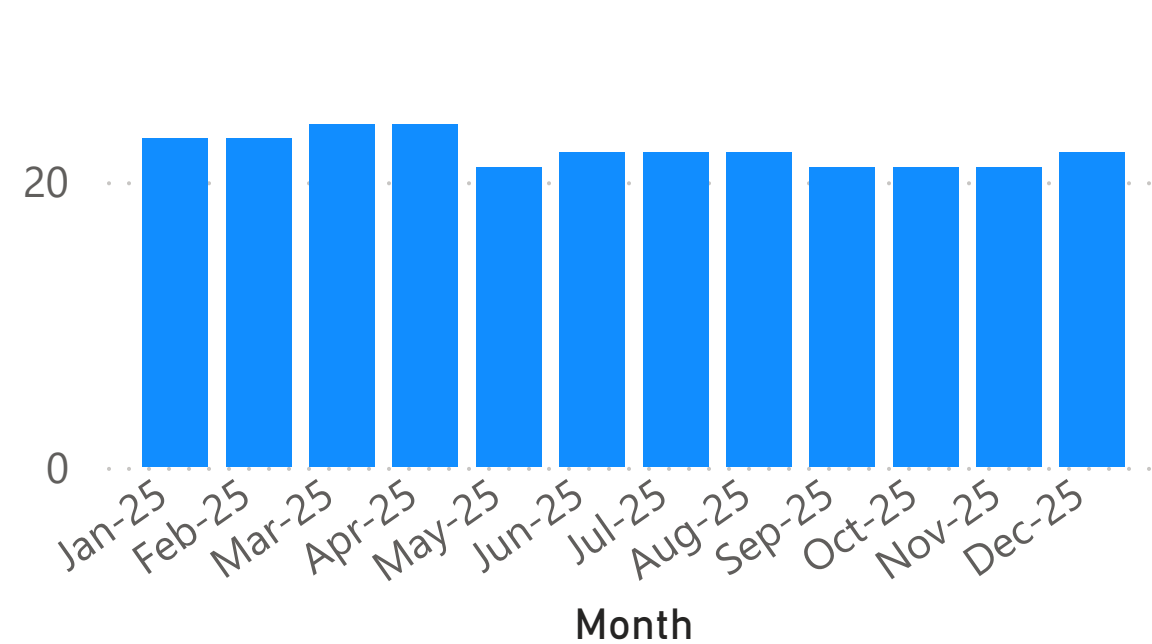
I&E Year End Forecast



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

- Mandatory training remained above trust compliance at 92%
- Outpatient activity continues to overperform in month on activity (103%) & income (103.9%)
- Division reporting to achieve year end income plans inclusive of a planned surplus
- Impact of optimised booking in Surgery has led to an improvement of 6.7% planned utilisation & 3.9% actual utilisation
- Maintaining strong position in majority of specialities in terms of RTT compliance improvement- challenge remains in Dentistry
- DM01 compliance above target at 96%

### Areas of Concern

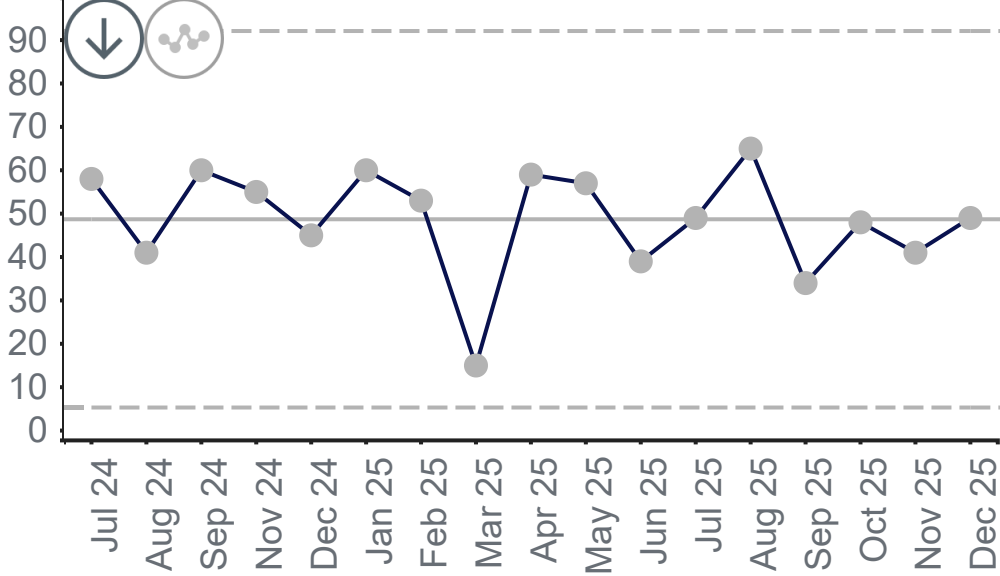
- Although decline in % PALS response noted, actual compliance in December was 96%. Only 1 case was a genuine delay based on Christmas period (received 24th Dec). 2 cases were formally put on pause. 1 formal complaint breach in month (1 day), cross divisional response required.
- Elective activity was slightly under plan in month, contributing factors: industrial action cancellations, trust emergency surge period, high volume of uncoded procedures.
- Day cases per working day declined but expected over Christmas period.

### Forward Look (with actions)

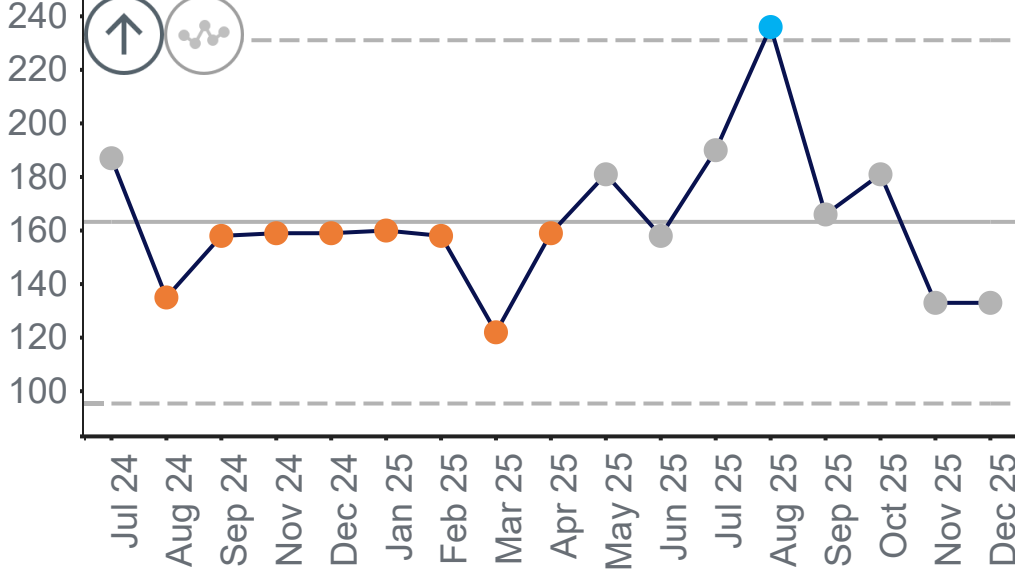
- Full rollout of optimised booking for all surgical specialities (requires B & S resource)
- Full engagement with Q4 Outpatient sprint to increase activity run rates to impact on overall RTT position
- Continued maximised capacity planned for Dentistry where the majority of 52-week waits are held
- Day case pilot to expand volume of cases per day- reduce LOS & support increase in cases
- Rollout of consultant connect in ENT to reduce front end outpatient demand

## Divisional Performance Summary - Surgery

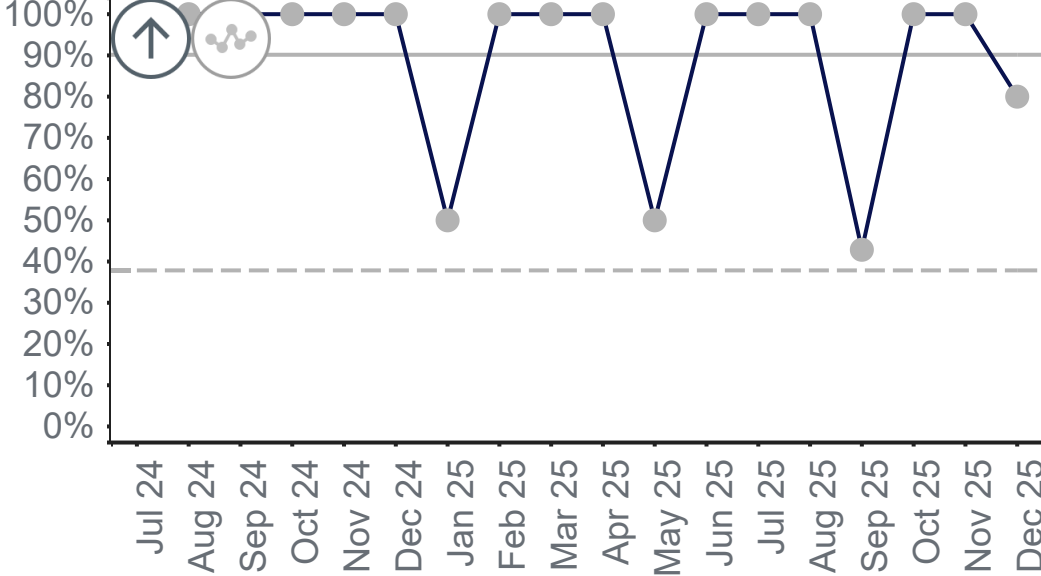
Patient Safety Incidents rated Low Harm & Above



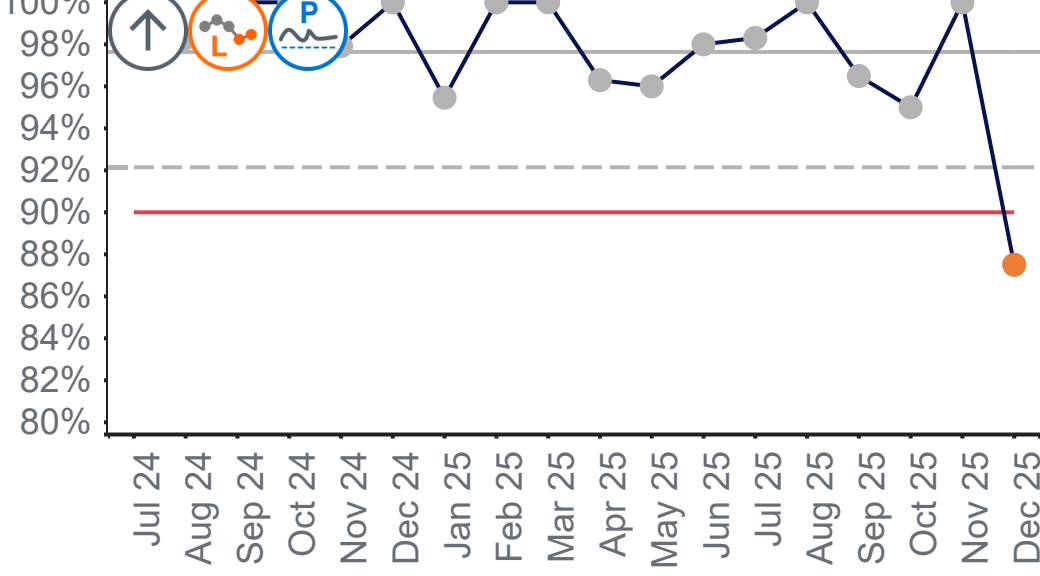
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

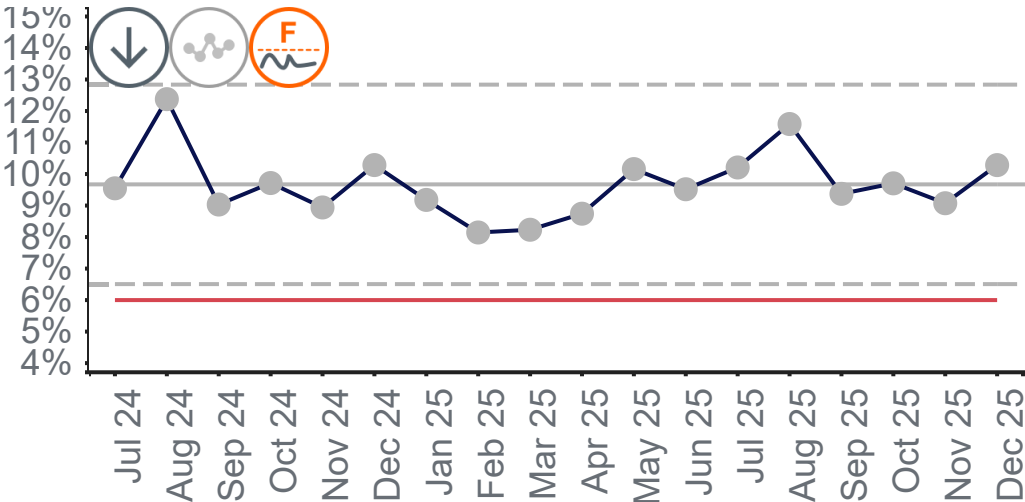


% PALS Resolved within 5 Days

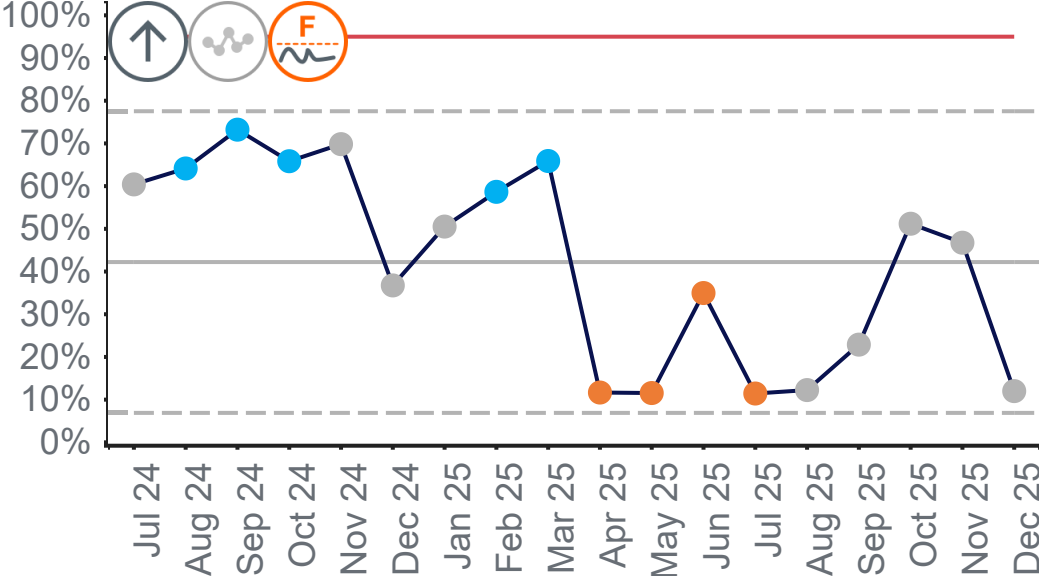


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

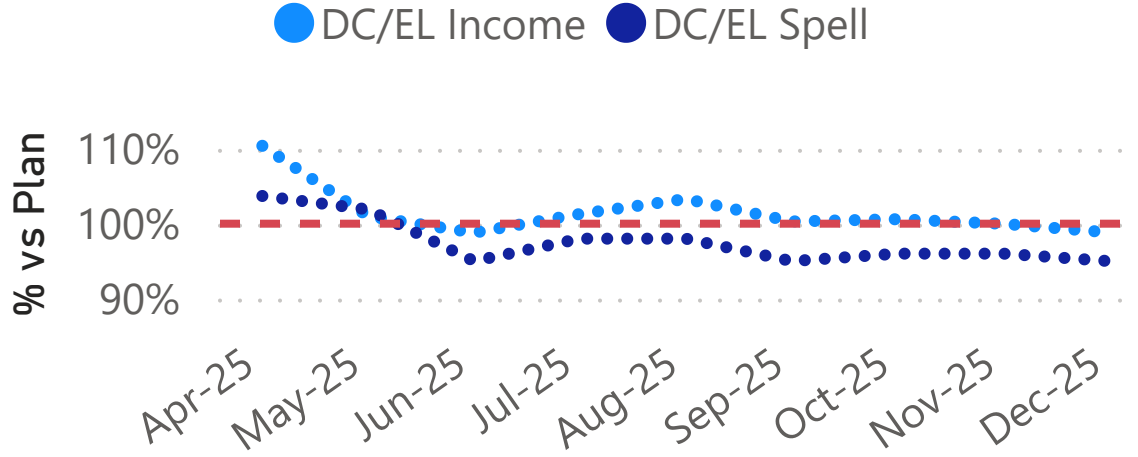


% of Clinical Letters completed within 10 Days



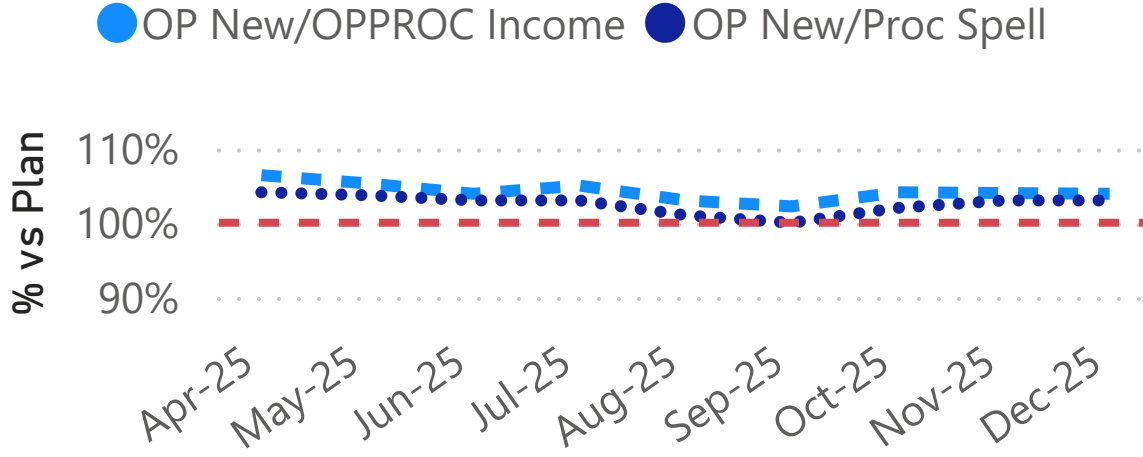
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

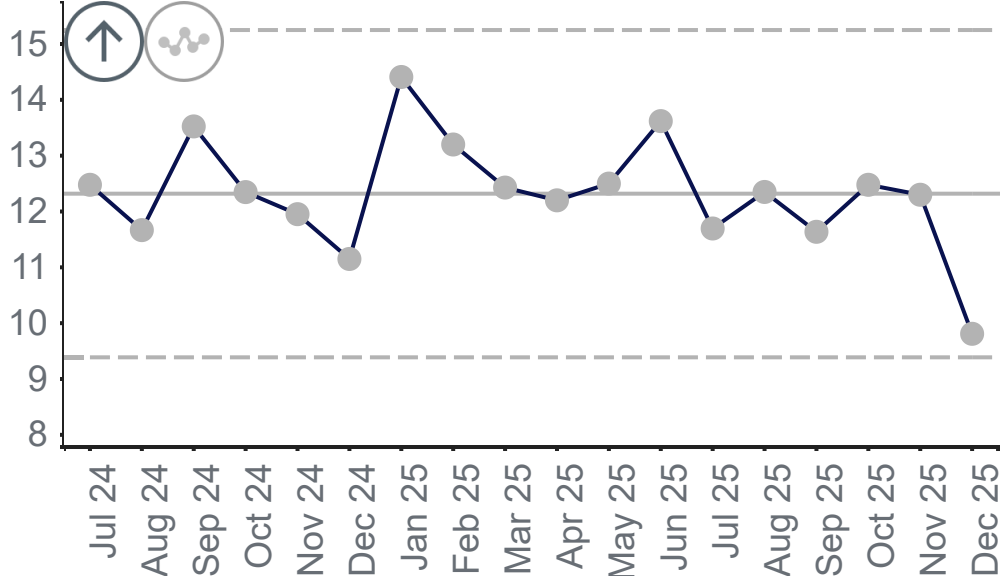


Outpatient New & OP/PROC Income and Activity vs Plan (YTD Position)

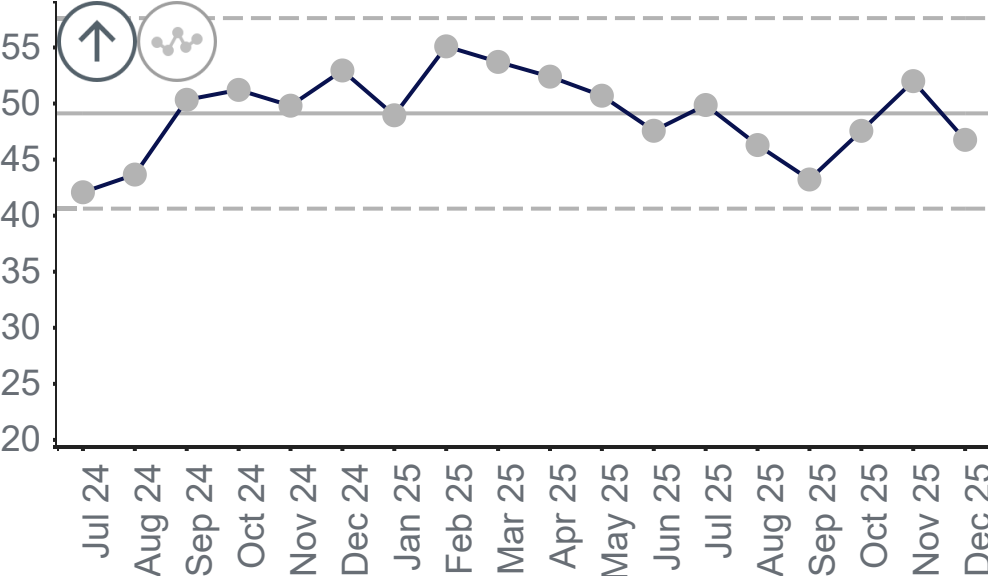
SLAM Performance



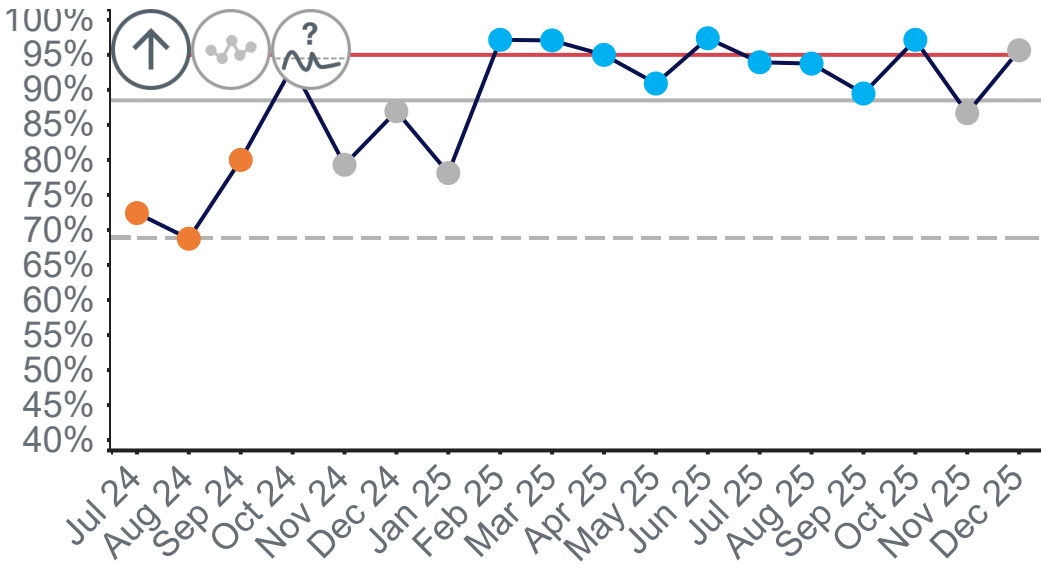
Inpatient Discharges per working day



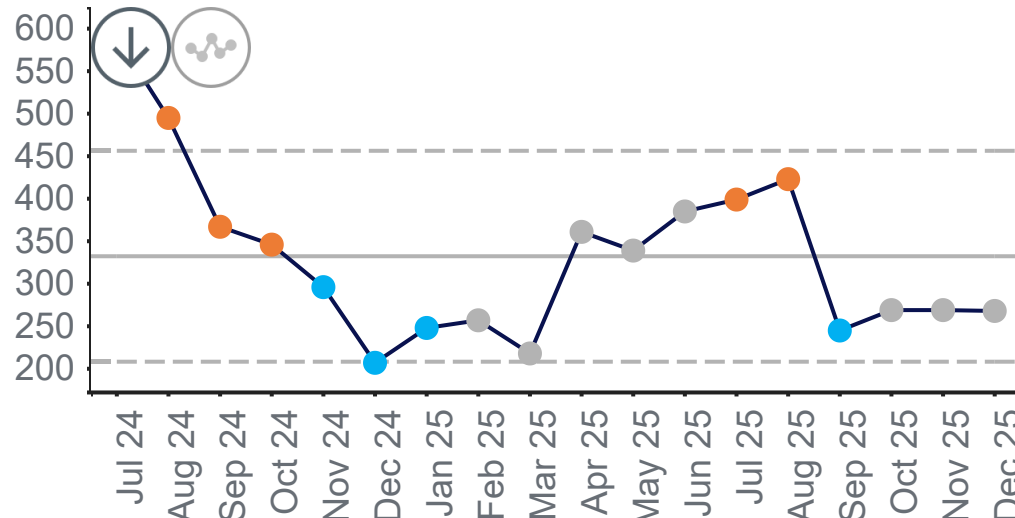
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



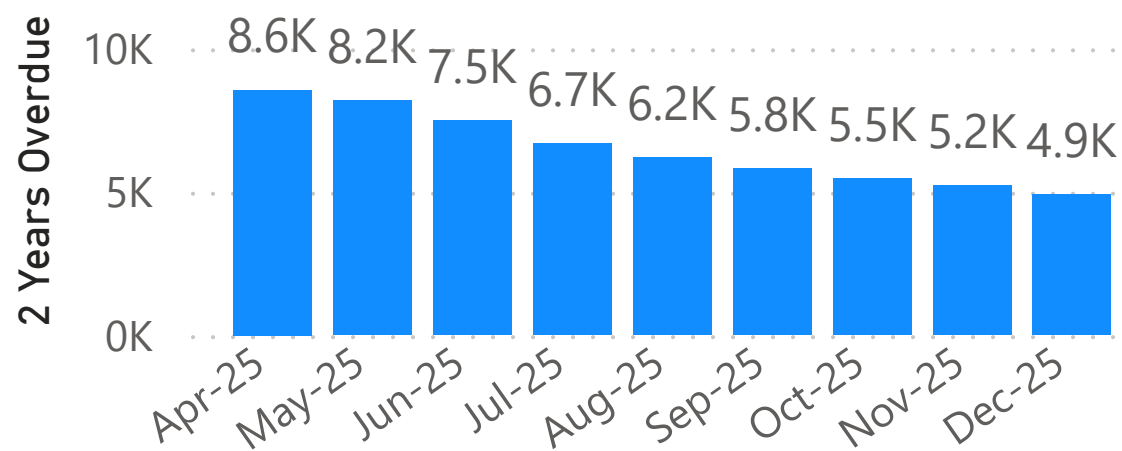
Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



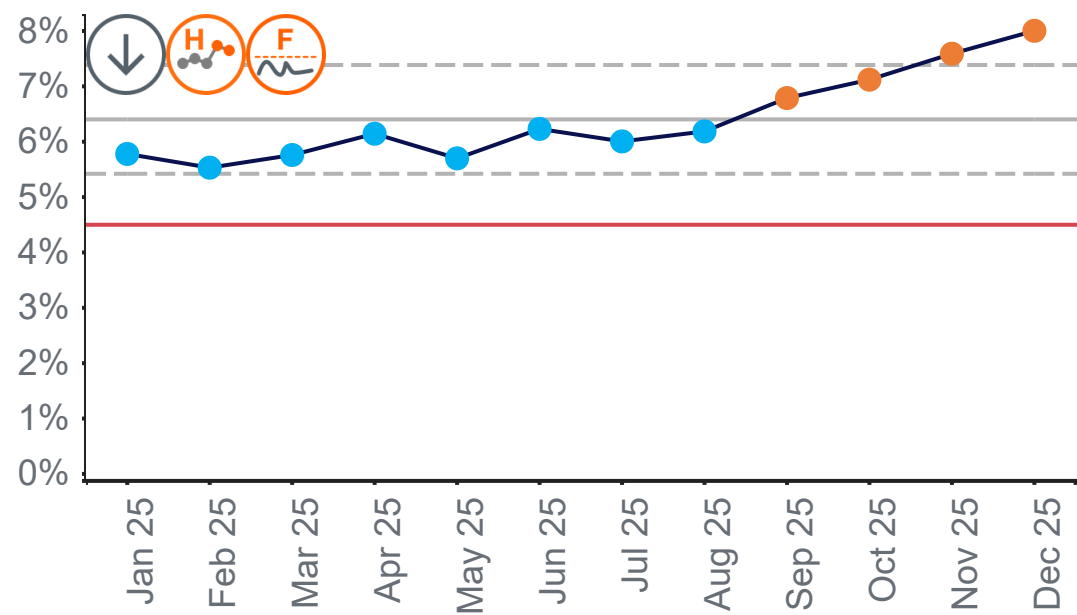
## Divisional Performance Summary - Surgery

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

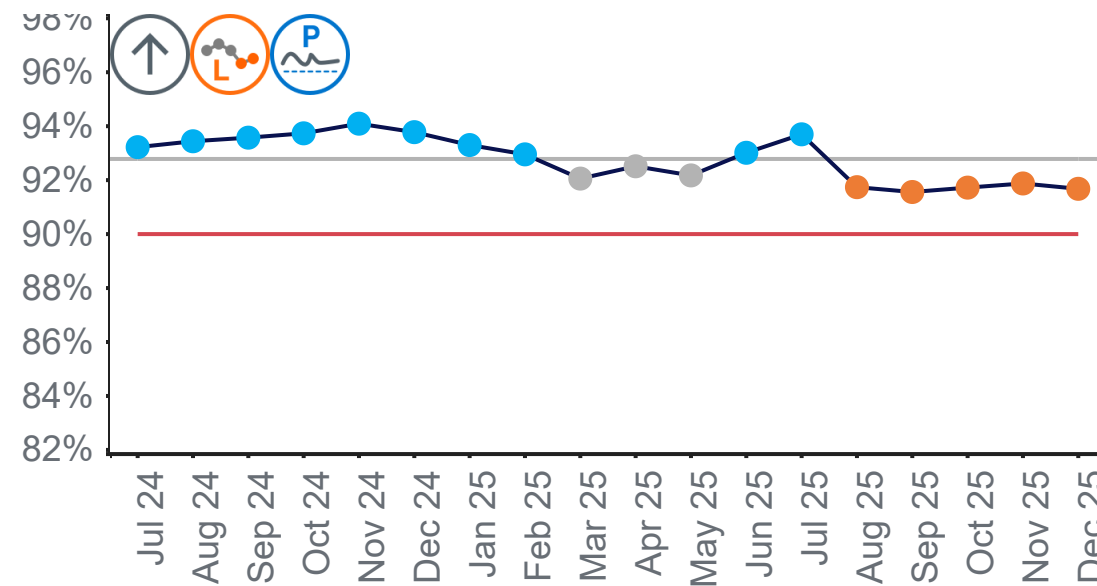
Vol overdue by 31st March 2026



### Sickness Absence Overall

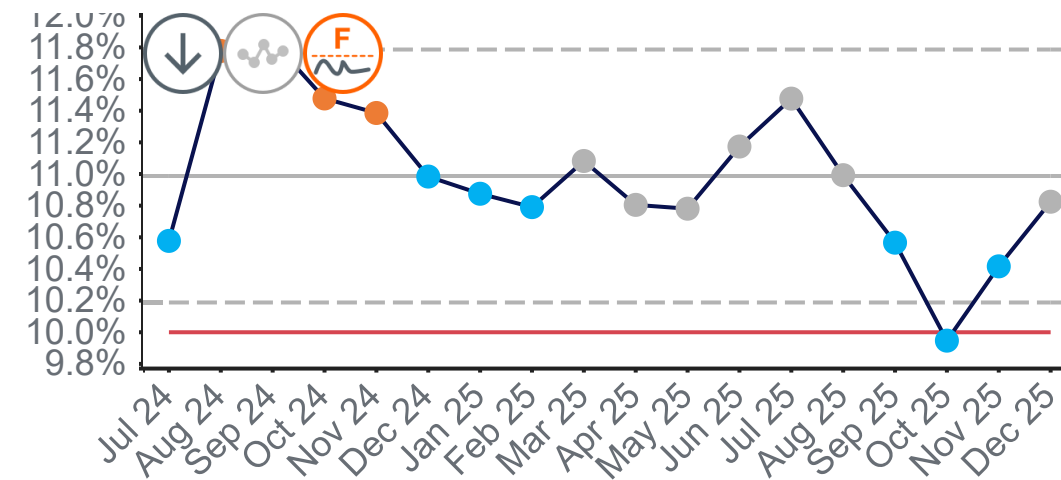


### Mandatory Training

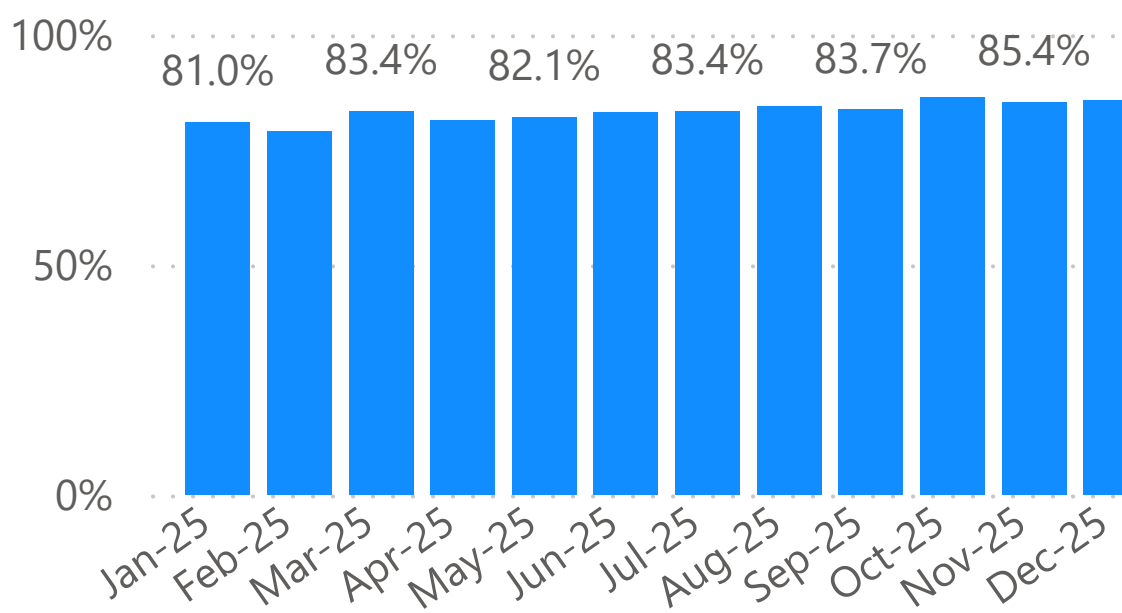


### Staff Turnover

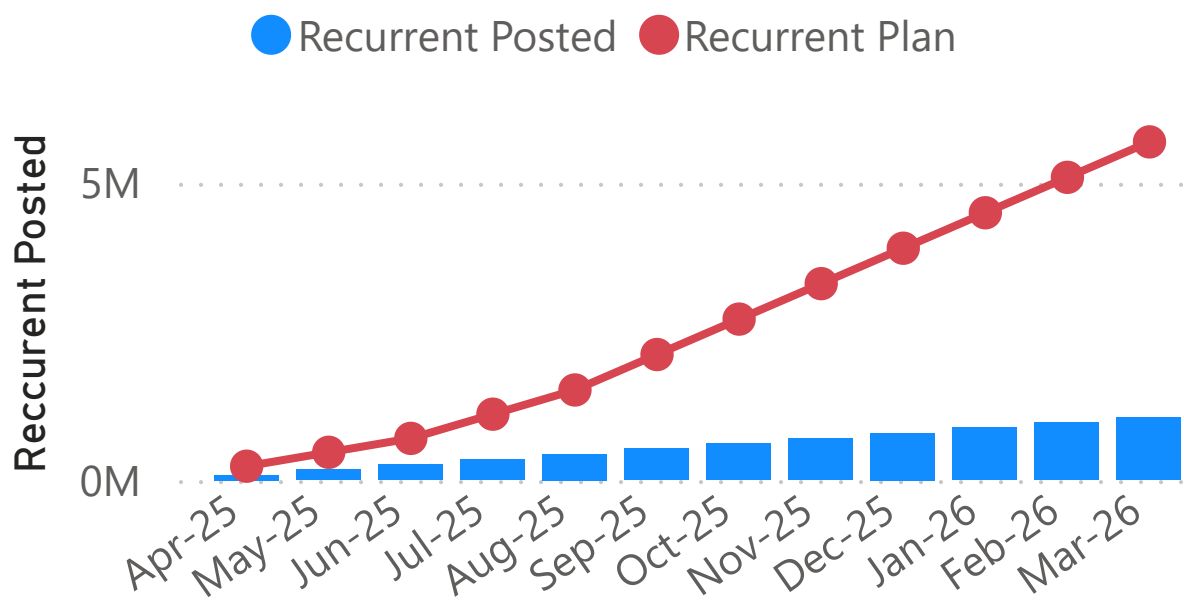
Target: Internal



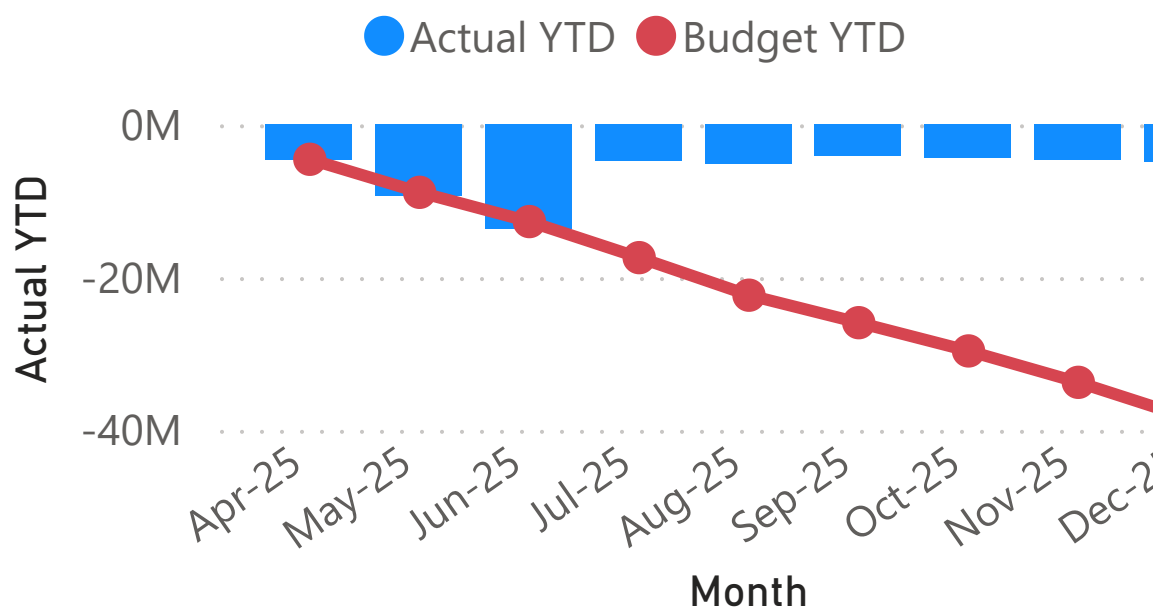
### Workforce Stability



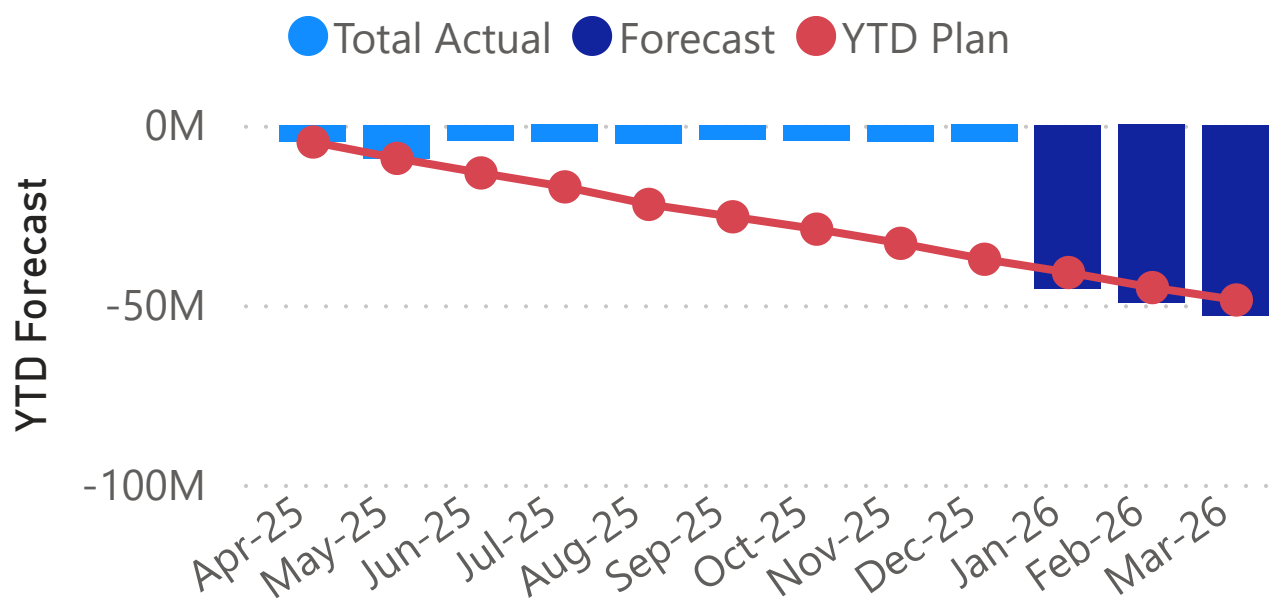
### Recurrent Efficiency Plans Delivered (Forecast)



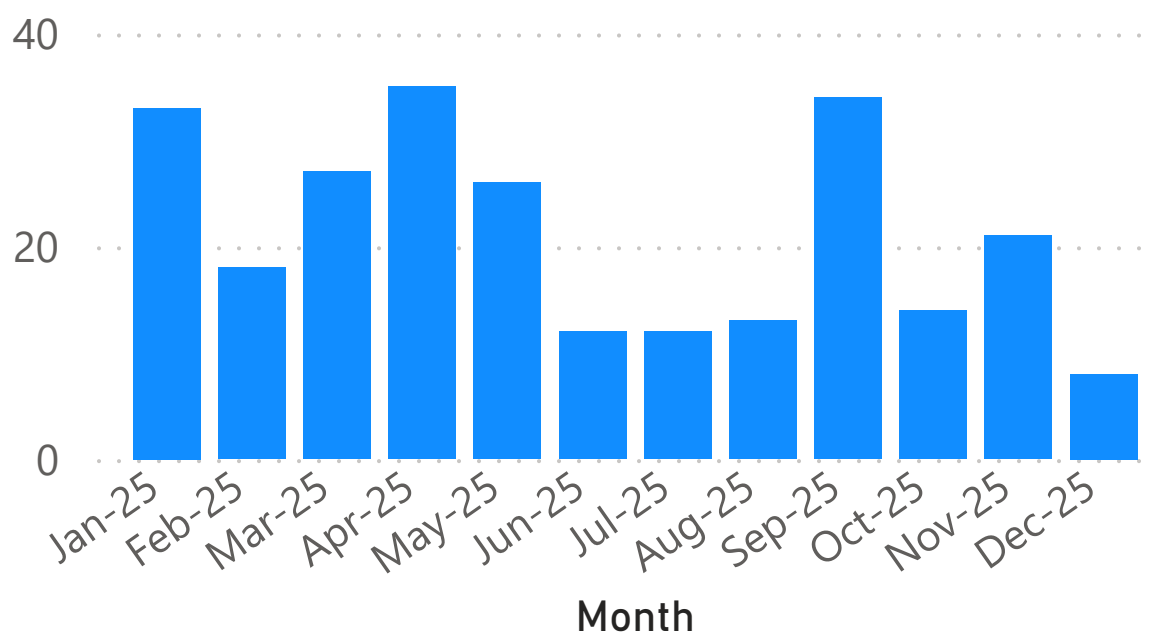
### I&E distance from target (cumulative YTD)



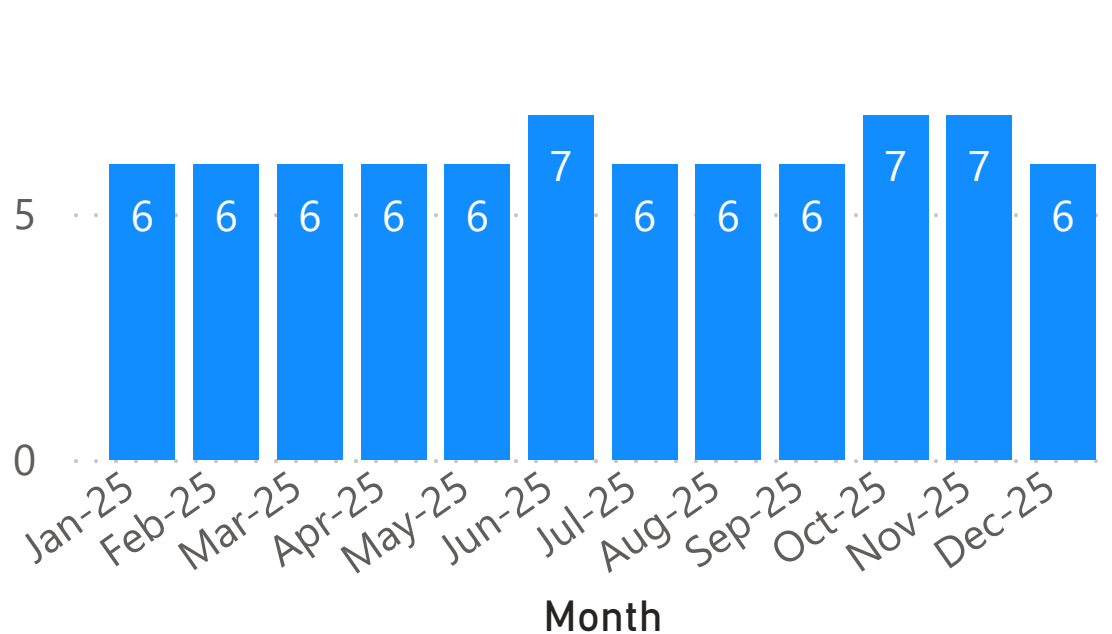
### I&E Year End Forecast



### 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

- Majority of people metrics on track – sickness slightly higher than target but expected over winter months
- See pioneering breakthrough section for research highlights

### Areas of Concern

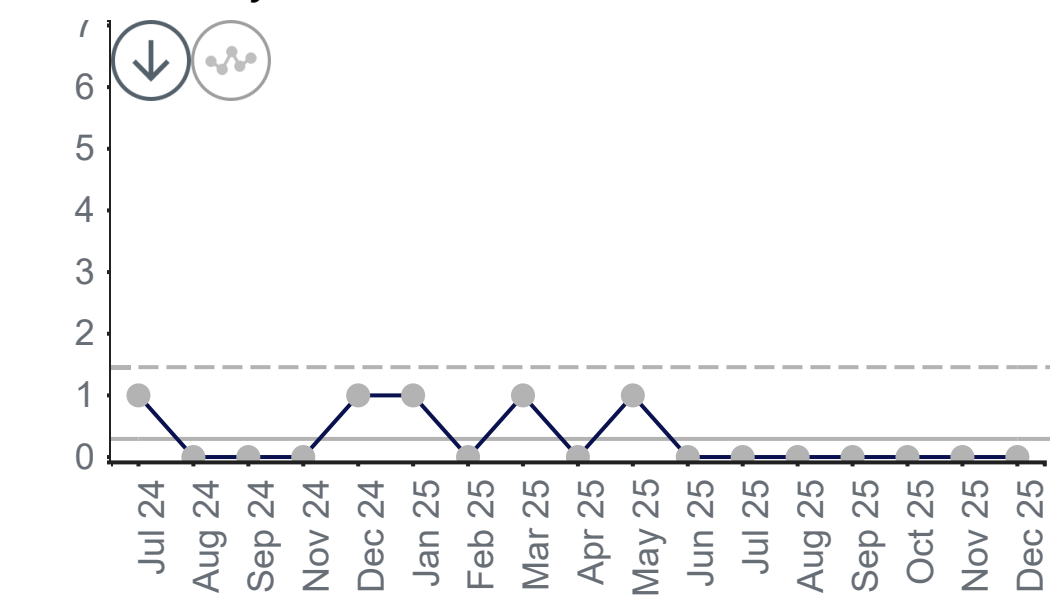
- See pioneering breakthrough section for research areas of concern

### Forward Look (with actions)

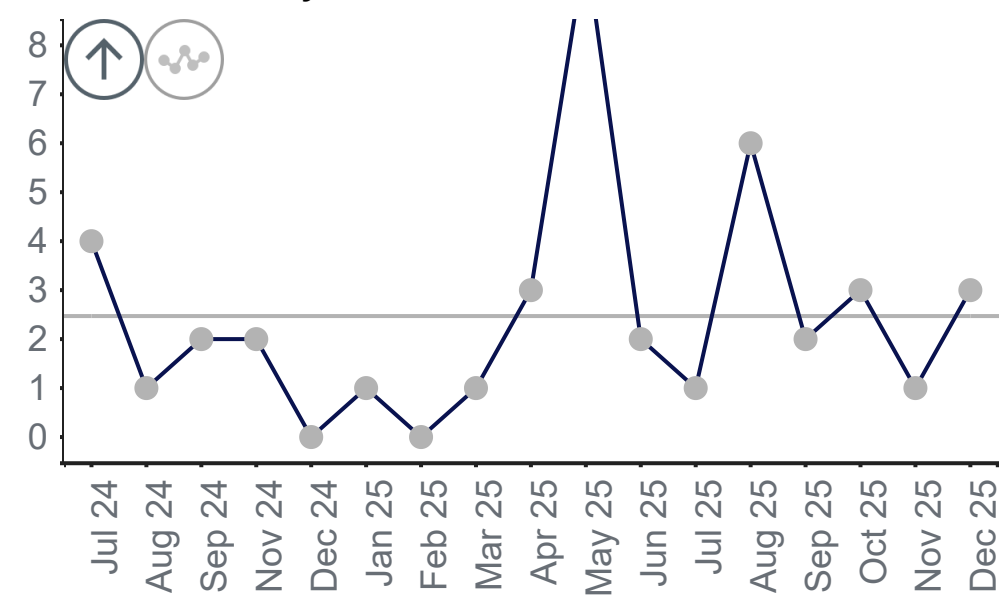
- See pioneering breakthrough section for research forward look

Divisional Performance Summary - Clinical Research

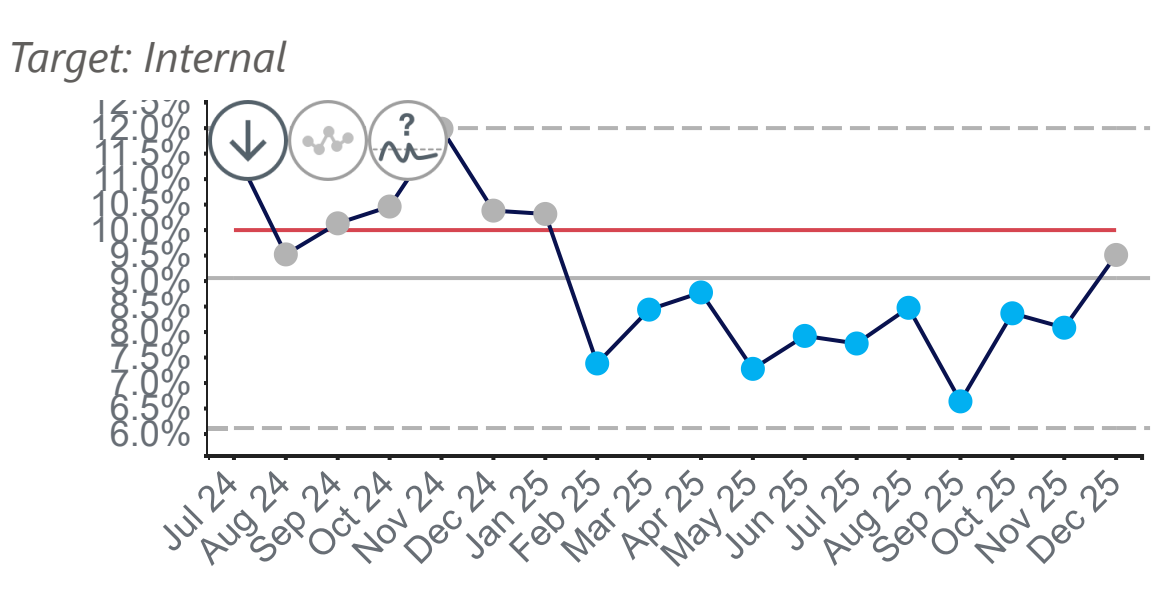
Patient Safety Incidents rated Low Harm & Above



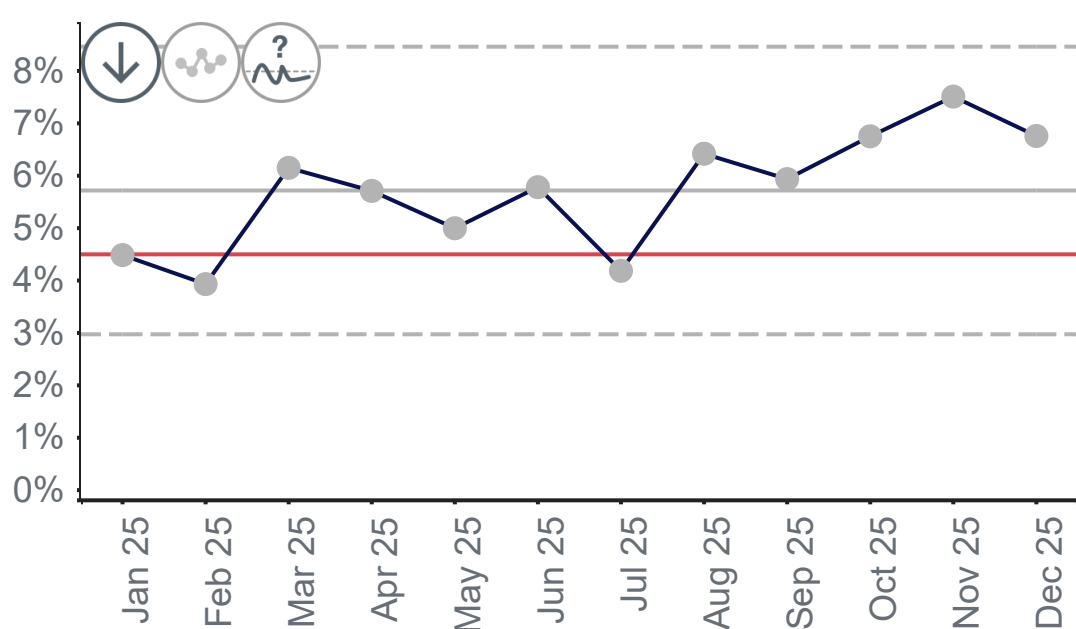
Patient Safety Incidents rated No Harm



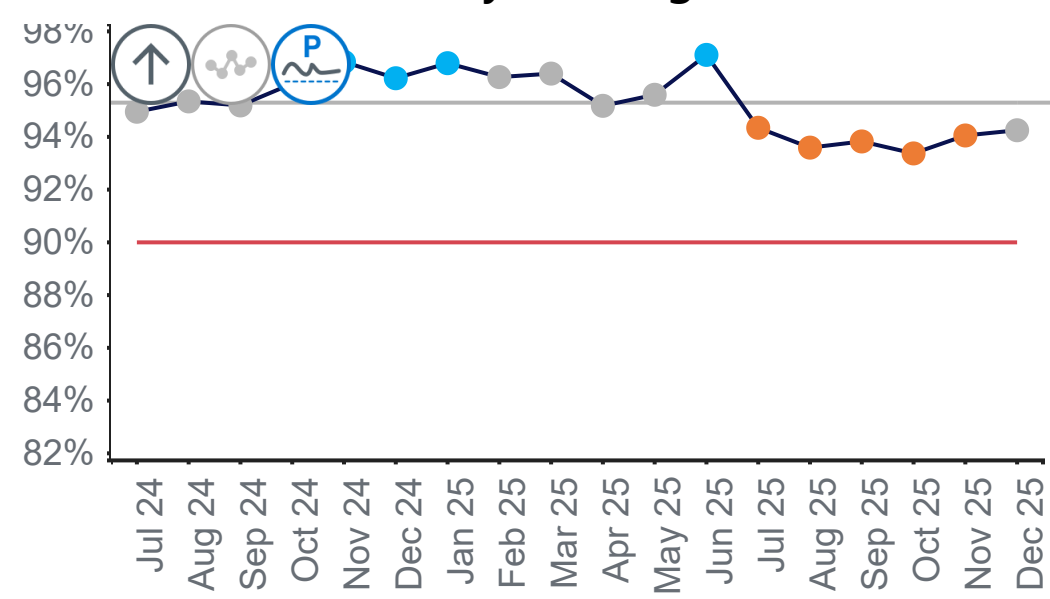
Staff Turnover



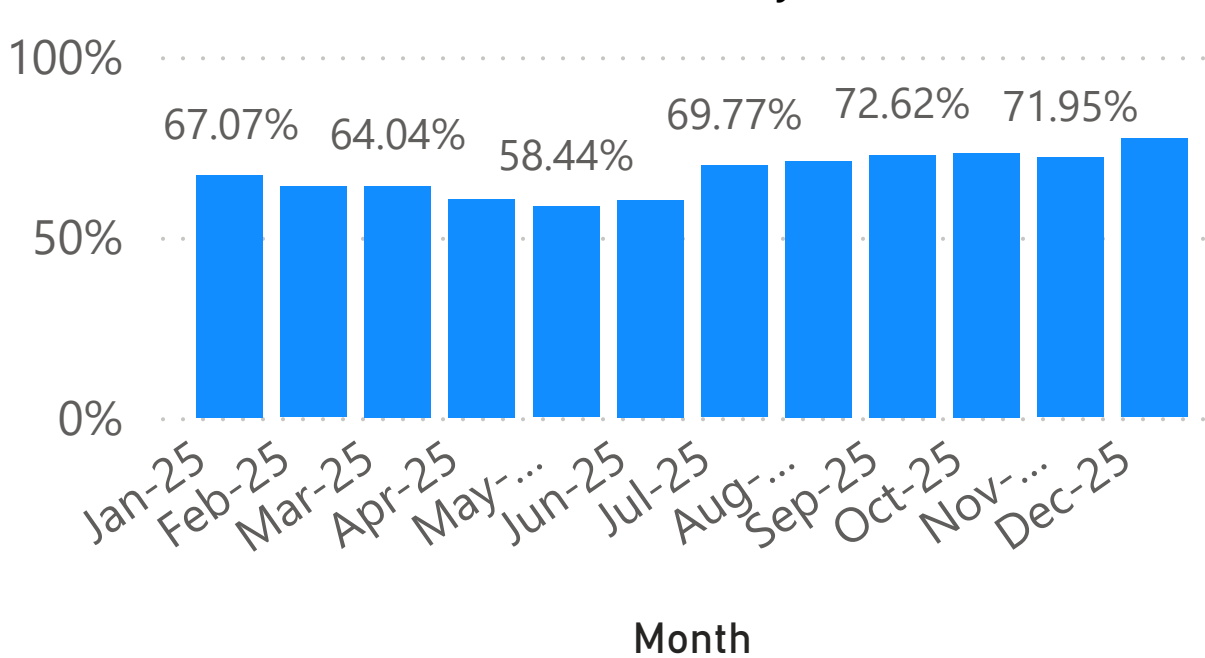
Sickness Absence Overall



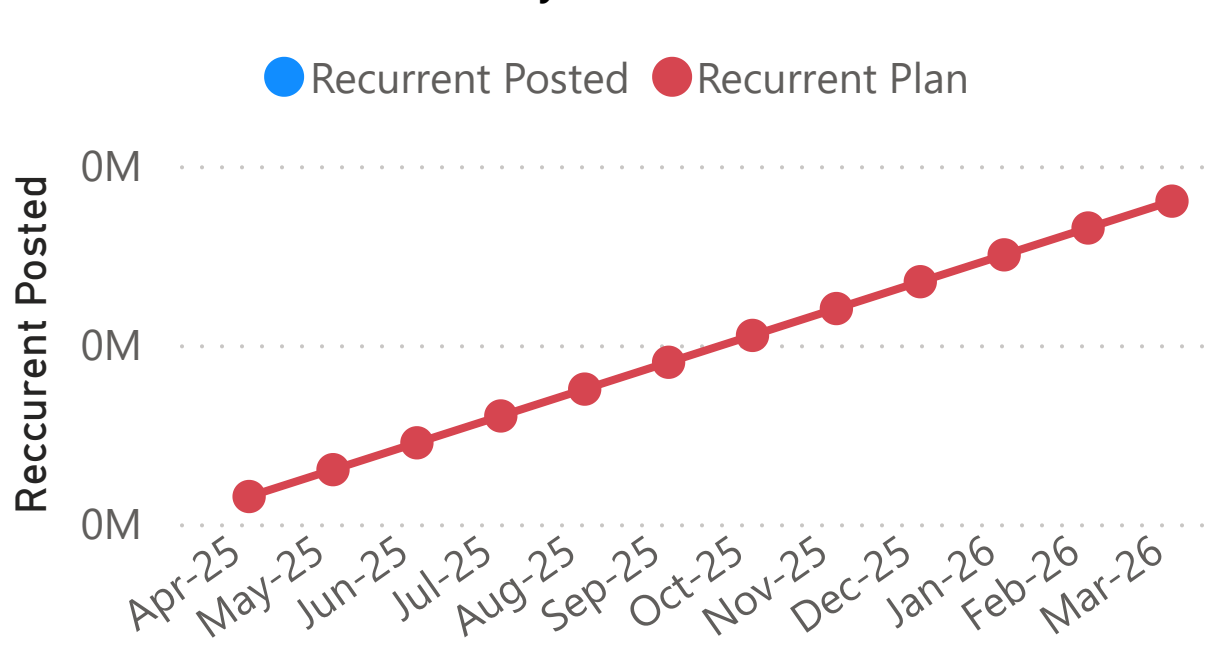
Mandatory Training



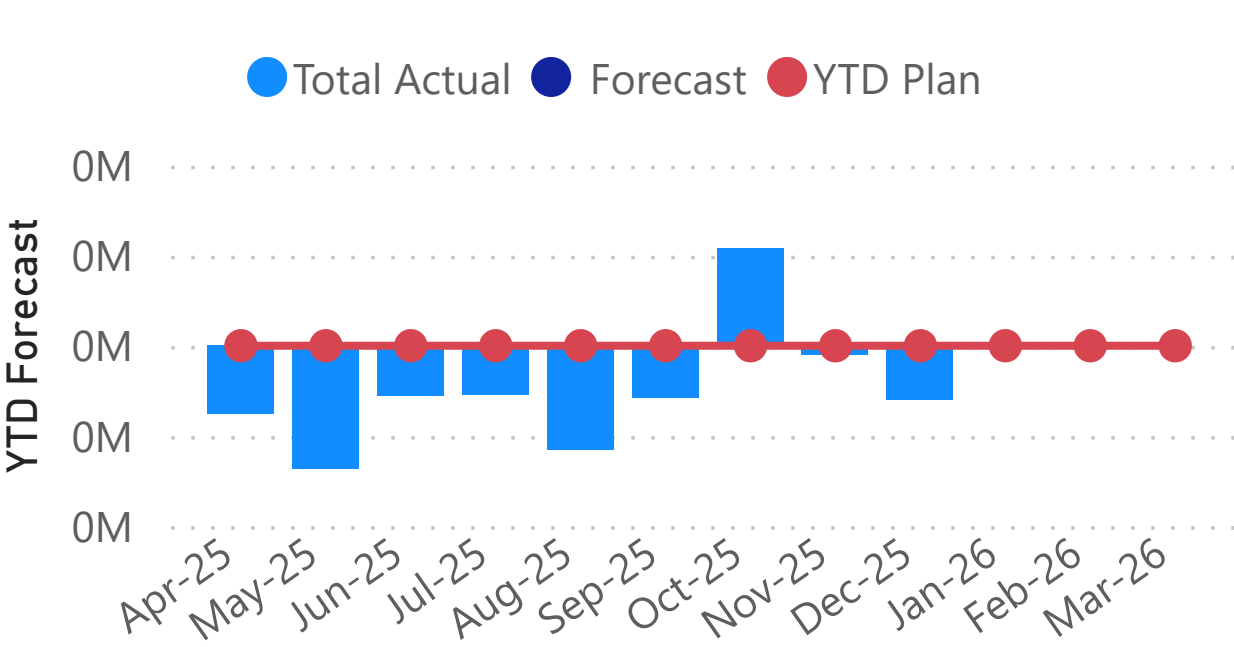
Workforce Stability



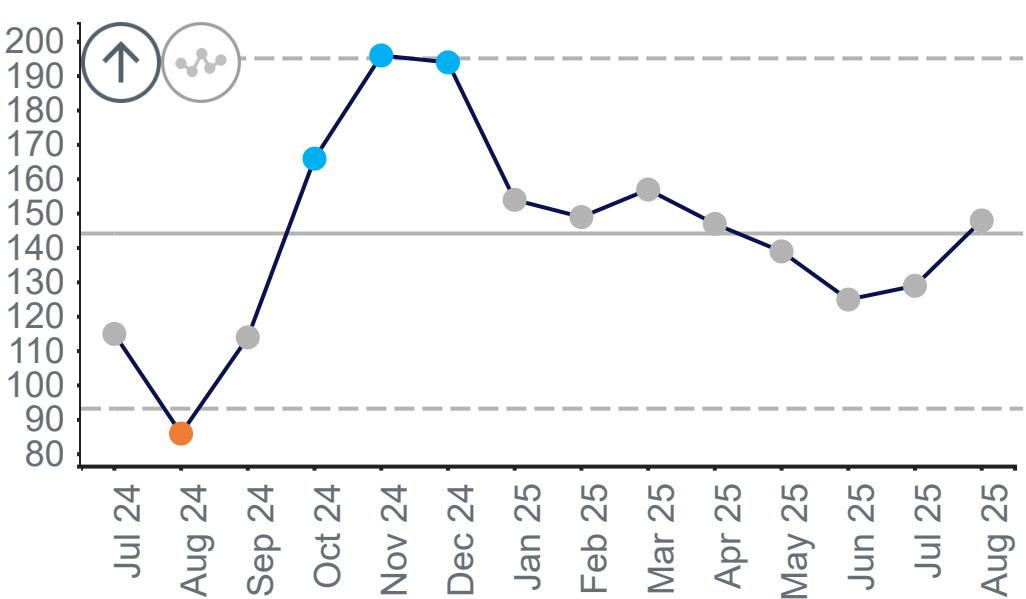
Recurrent Efficiency Plans Delivered (Forecast)



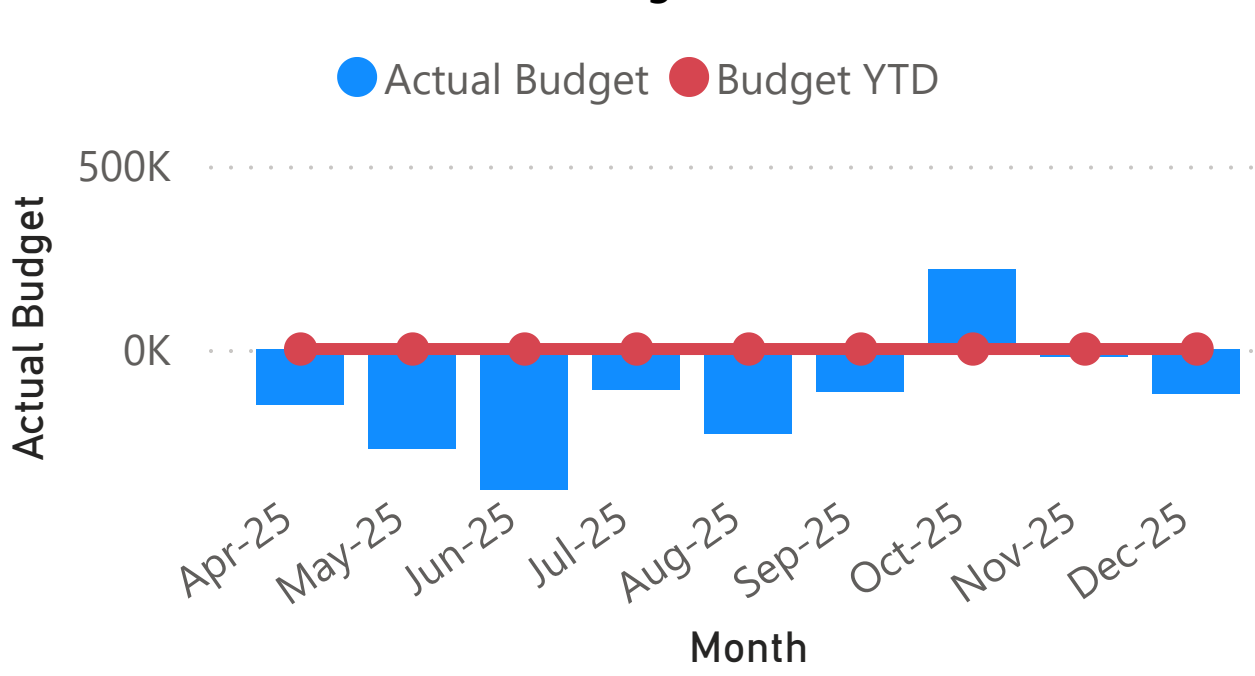
I&E Year End Forecast



Number of Patients Recruited into Research Studies



I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Chief Corporate Affairs Officer

Highlights

The Corporate Services Collaborative met on 12th January 2026; highlights from the December data include:

- PDR compliance for B7+ is above Trust target at 92%.
- Mandatory training currently at 93%.
- Overall compliance targets for corporate documents have been met since April 2025, with further improvements noted since September. Just 13 documents have become overdue from December 2025; plans are in place to review this documentation in the coming period.
- Delivery of nearly £5.8m in CIP (exceeding the in-year target by £0.4m).

Areas of Concern

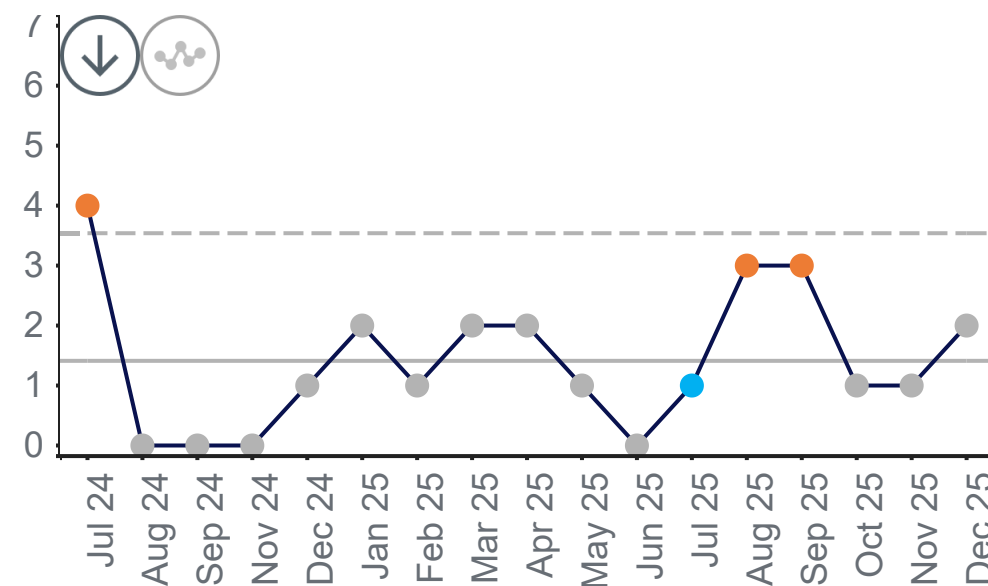
- Overall sickness absence remains above target at 6.96% for the month of December 2025.
- Long term sickness absence is sitting at 4.61% and is outside of Trust target of 2.5%.
- Short term sickness increased slightly to 2.3%.
- PDRs for all staff within corporate services is sitting at 83% against a 90% target.
- Despite mandatory training being above Trust target, 50 areas were flagged as red with urgent action needed to address these.
- YTD overspend of £1.7m
- Recurrent CIP gap of £0.2m in-year, likely to roll into 2026/27 if not addressed by March 2026.

Forward Look (with actions)

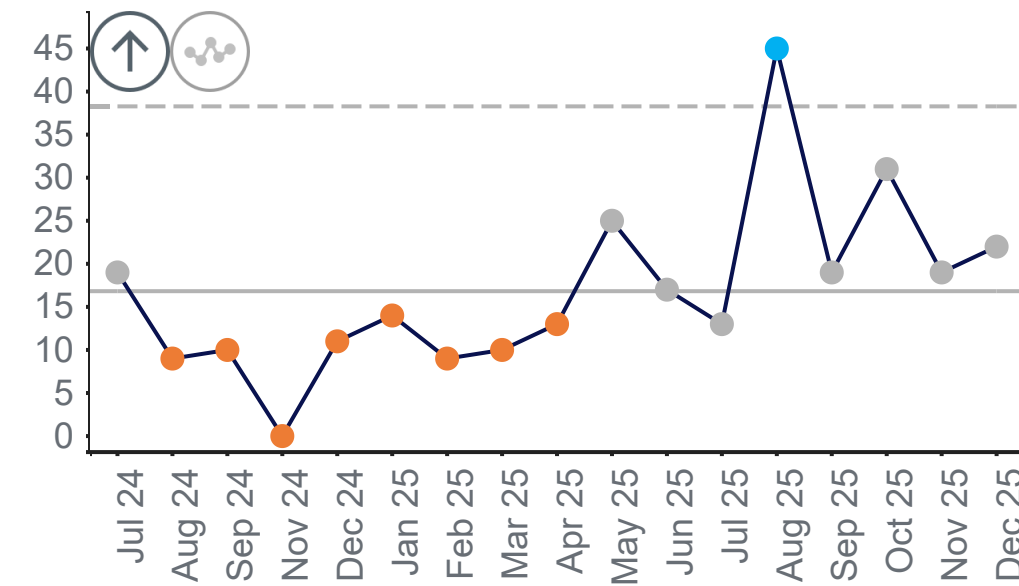
- Further analysis to distinguish between work-related and non-work-related stress absences.
- Focus on financial position, system finance and opportunities.
- Forward look for the collaborative in terms of how we interface with Fit for the Future.

## Divisional Performance Summary - Corporate

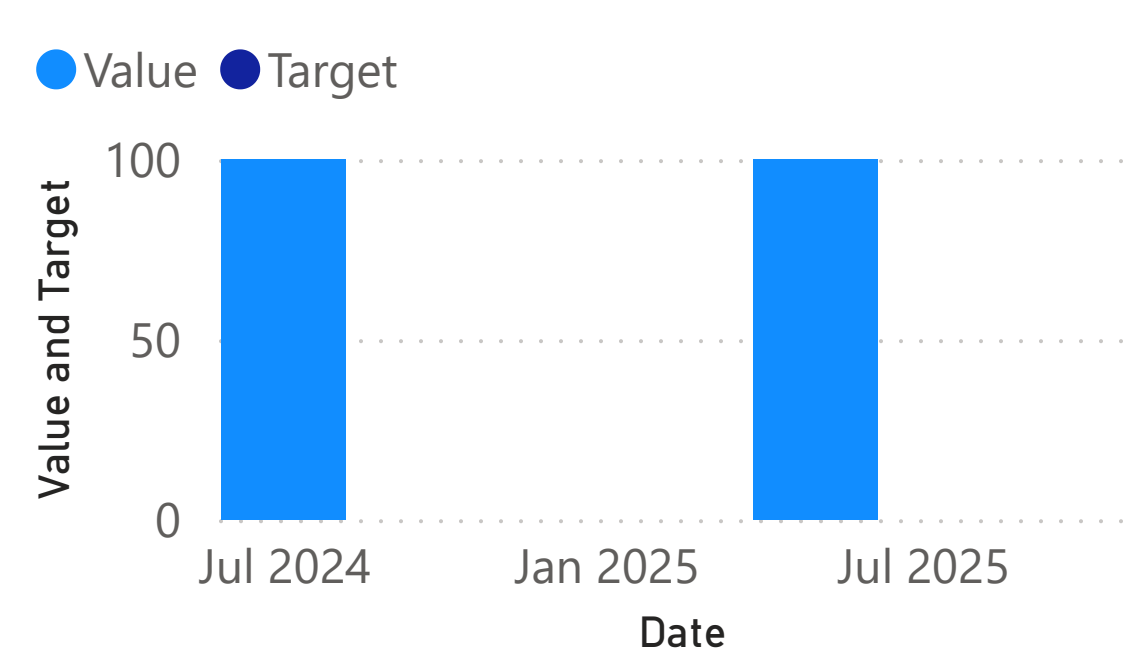
Patient Safety Incidents rated Low Harm & Above



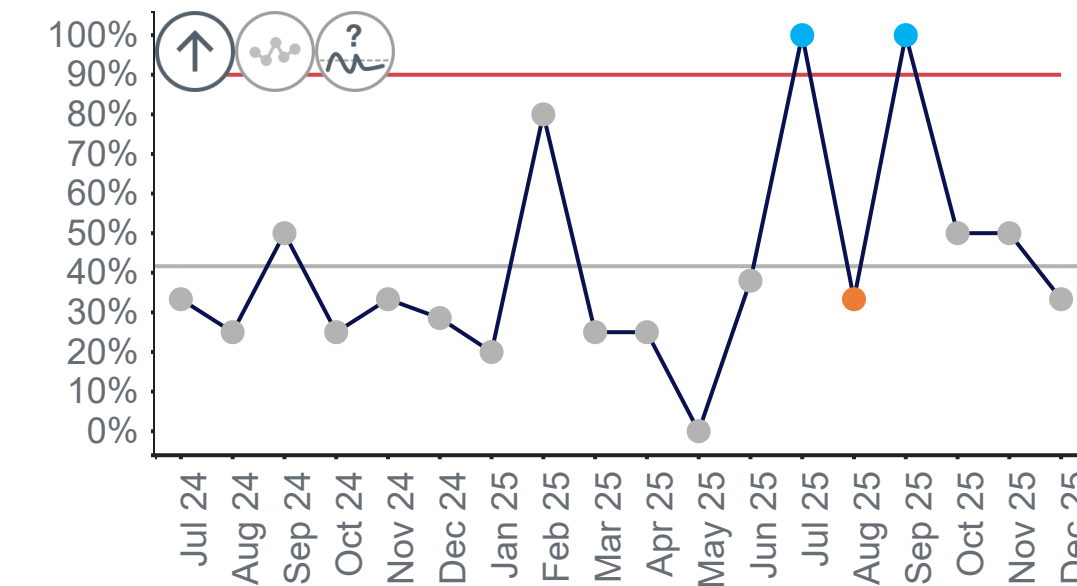
Patient Safety Incidents rated No Harm



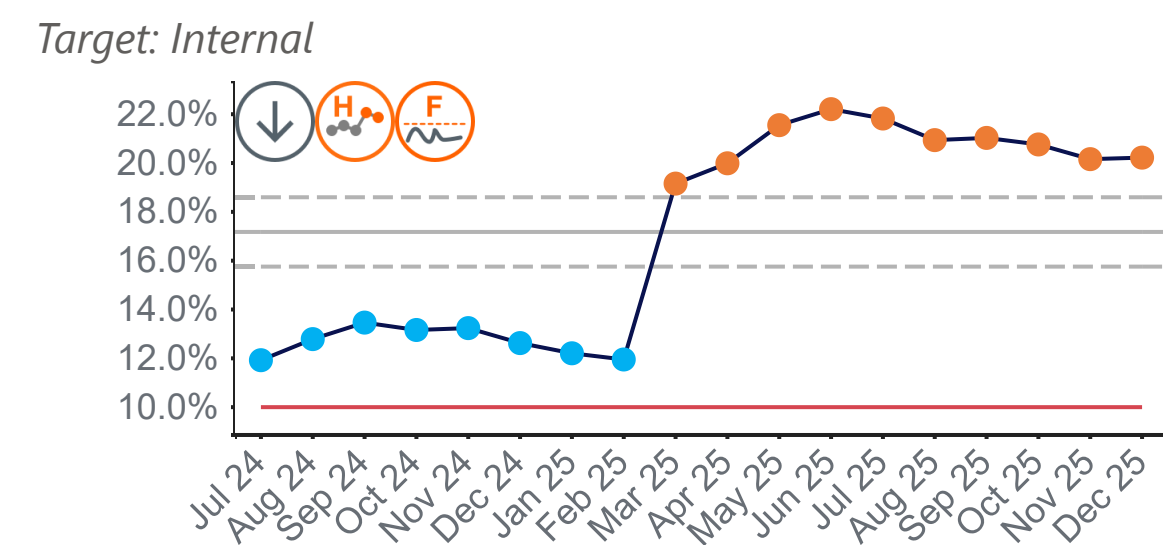
% Complaints Responded to within 25 working days



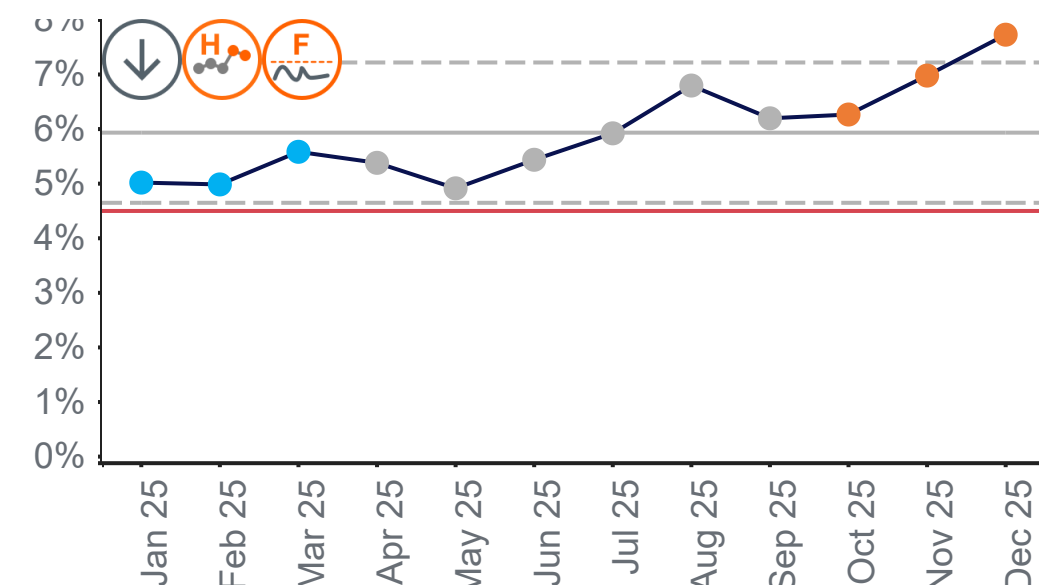
% PALS Resolved within 5 Days



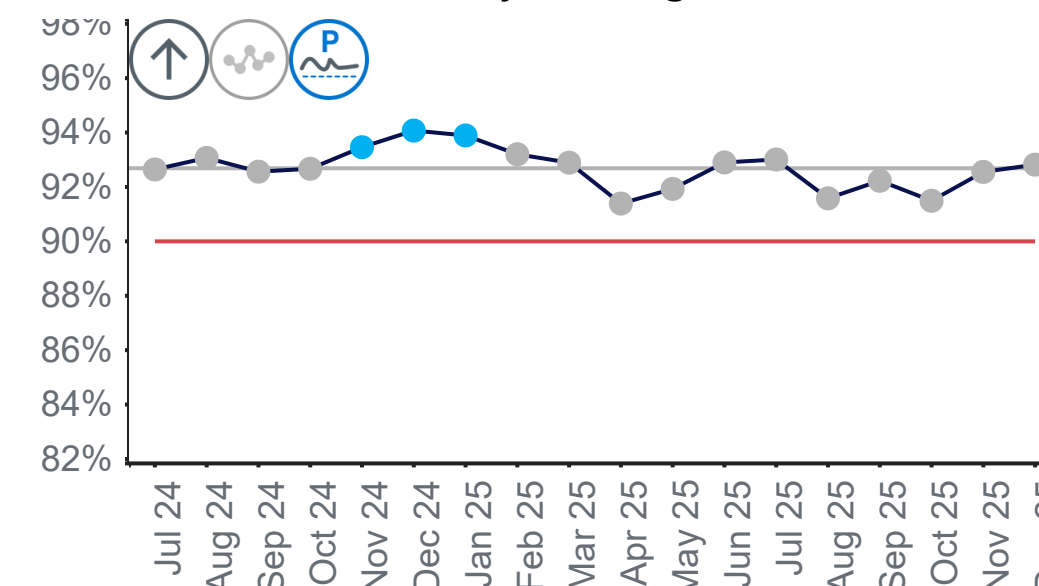
Staff Turnover



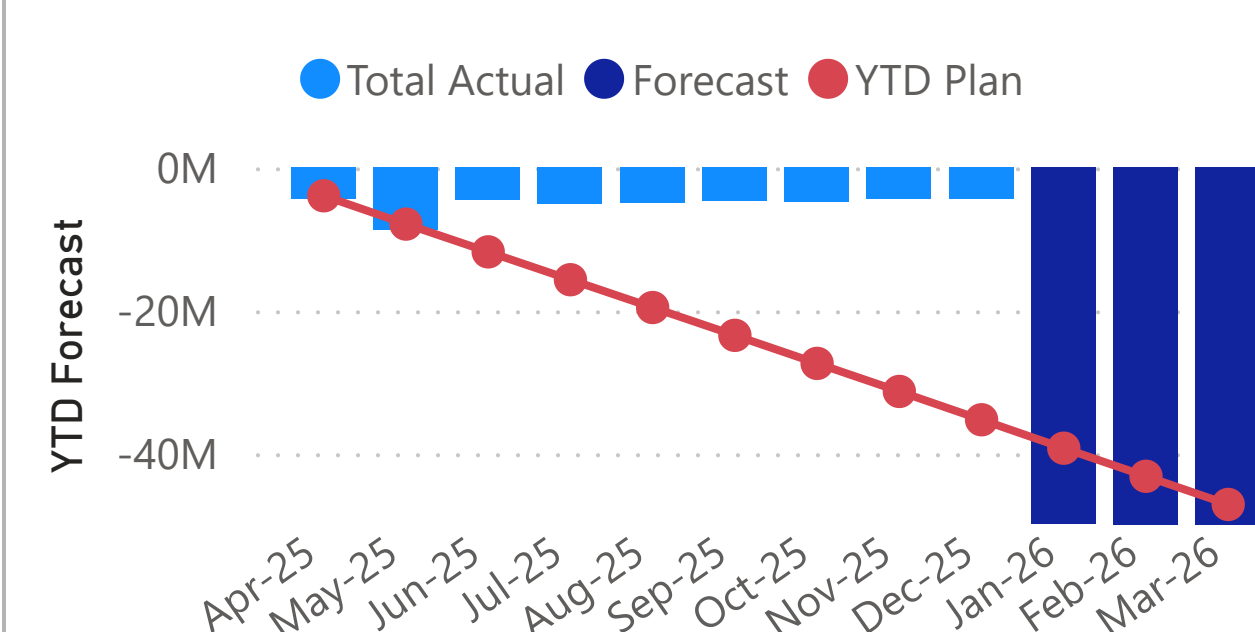
Sickness Absence Overall



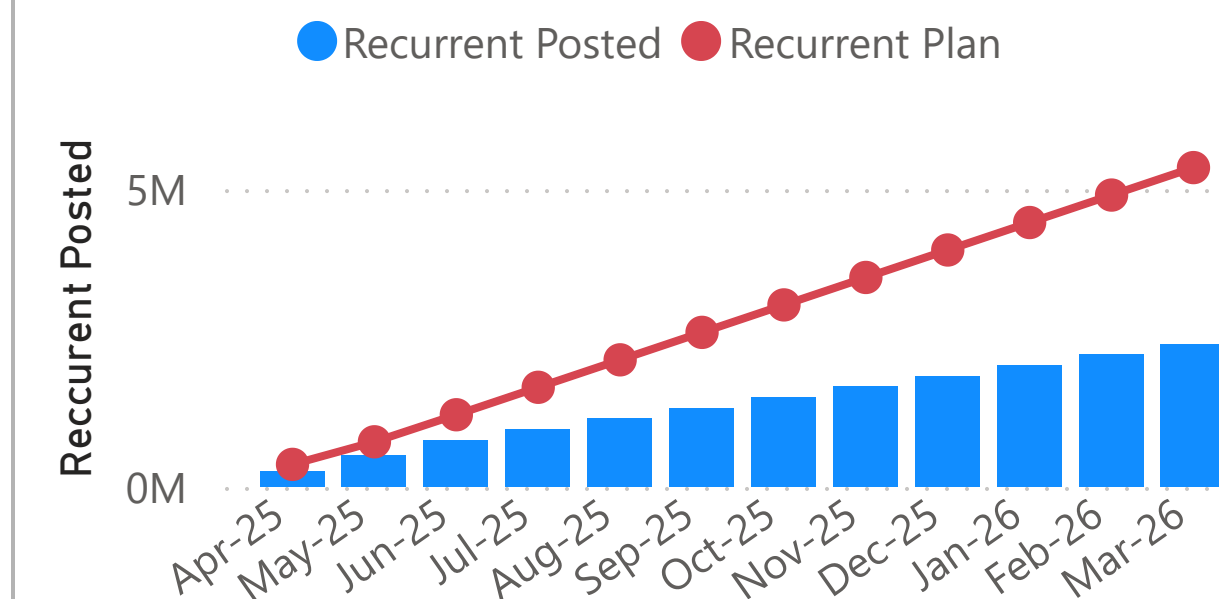
Mandatory Training



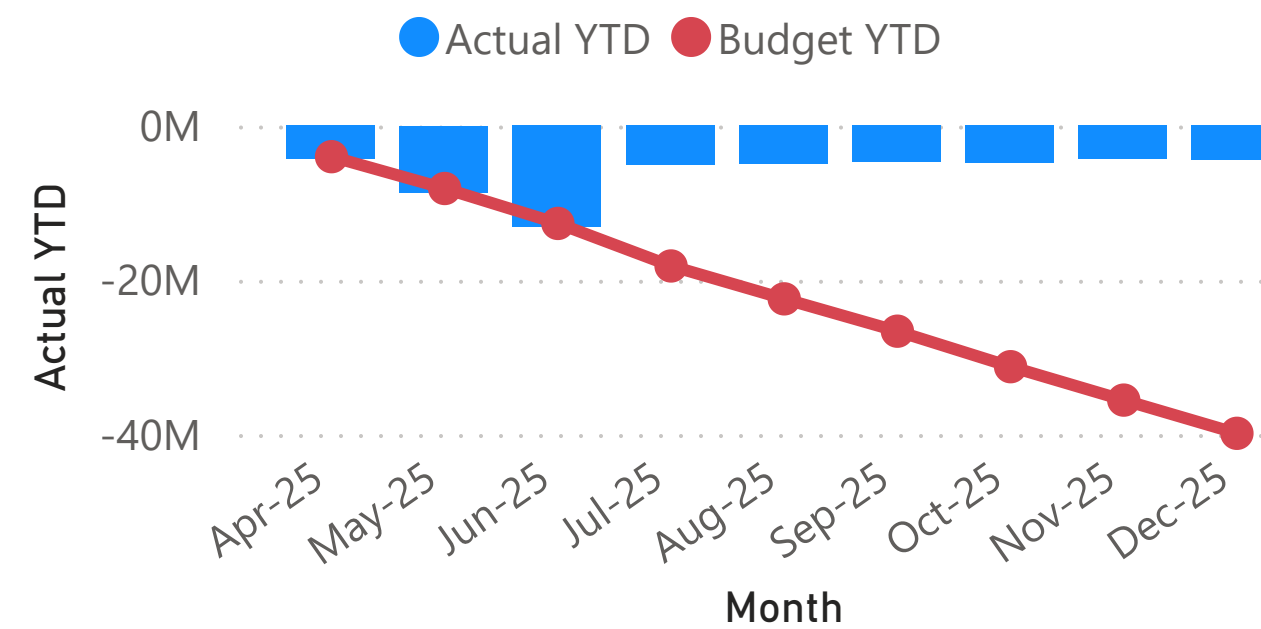
I&E Year End Forecast



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 December 2025 Staffing, CHPPD and Benchmark

|            | Day                            |                                | Night                         |                                | Patients | CHPPD      | National benchmark | Availability |           | Vacancy  |        |           |         | Turnover (Leavers) |        |           |         | Sickness |        |           |         | Medication incidents |     | Staffing Incidents |     | FFT                |                      |      | Complaints |
|------------|--------------------------------|--------------------------------|-------------------------------|--------------------------------|----------|------------|--------------------|--------------|-----------|----------|--------|-----------|---------|--------------------|--------|-----------|---------|----------|--------|-----------|---------|----------------------|-----|--------------------|-----|--------------------|----------------------|------|------------|
|            | Average fill rate - registered | Average fill rate - care staff | Average fill rate - registere | Average fill rate - care staff |          | CHPPD Rate | Sep-25             | RN - FTE     | HCA - FTE | RN - FTE | RN - % | HCA - FTE | HCA - % | RN - FTE           | RN - % | HCA - FTE | HCA - % | RN - FTE | RN - % | HCA - FTE | HCA - % | Month                | YTD | Month              | YTD | Number of response | % Very good and good | Pals |            |
| Burns Unit | 86%                            |                                | 100%                          |                                | 98       | 18.90      | 18.87              | 530.51       | 31        | -0.8     |        | 0         |         | 0.00               | 0.00%  | 0.00      | 0.00%   | 4.07     | 0.77%  | 0         | 0.00%   | 0                    | 12  | 0                  | 2   | 5                  | 100%                 | 0    | 0          |
| HDU        | 76%                            | 55%                            | 71%                           | 42%                            | 286      | 26.80      | 26.08              | 2,139.16     | 58.28     | -6.09    |        | 3.23      |         | 0.00               | 0.00%  | 0.00      | 0.00%   | 103.91   | 4.86%  | 0         | 0.00%   | 8                    | 82  | 6                  | 13  | 1                  | 100%                 | 0    | 0          |
| ICU        | 86%                            | 90%                            | 87%                           | 55%                            | 483      | 36.60      | 36.07              | 5,002.56     | 124       | -4.81    |        | 0.00      |         | 0.00               | 0.00%  | 0.00      | 0.00%   | 276.31   | 5.52%  | 11        | 8.87%   | 7                    | 119 | 0                  | 0   | 0                  | 0%                   | 0    | 1          |
| Ward 1cC   | 82%                            | 85%                            | 80%                           | 43%                            | 481      | 13.50      | 11.5               | 1,854.21     | 155.83    | -2.2     |        | 0.08      |         | 0.00               | 0.00%  | 0.00      | 0.00%   | 236.77   | 12.77% | 3.76      | 2.41%   | 4                    | 61  | 9                  | 57  | 7                  | 100.00%              | 1    | 1          |
| Ward 1cN   | 96%                            | 49%                            | 108%                          |                                | 246      | 16.40      | 18.12              | 1,249.95     | 24.8      | -4.34    |        | 1.63      |         | 2.30               | 2.50%  | 0.00      | 0.00%   | 71.32    | 5.71%  | 0         | 0.00%   | 5                    | 43  | 0                  | 0   | 1                  | 100%                 | 0    | 0          |
| Ward 3A    | 89%                            | 57%                            | 88%                           | 95%                            | 625      | 11.20      | 8.39               | 1,636.76     | 401.13    | -5.17    |        | 2.46      |         | 0.00               | 0.00%  | 6.06      | 5.79%   | 208.25   | 12.72% | 101.36    | 25.27%  | 5                    | 50  | 1                  | 19  | 20                 | 100.00%              | 0    | 0          |
| Ward 3B    | 92%                            | 93%                            | 93%                           |                                | 382      | 13.10      | 13.83              | 1,212.86     | 177.4     | 2.79     |        | 2.09      |         | 0.00               | 0.00%  | 0.00      | 0.00%   | 80.23    | 6.61%  | 19.69     | 11.10%  | 7                    | 36  | 0                  | 1   | 3                  | 100%                 | 1    | 0          |
| Ward 3C    | 77%                            | 62%                            | 76%                           | 61%                            | 686      | 10.30      | 9.87               | 1,815.35     | 501.37    | 0.71     |        | 2.65      |         | 1.50               | 1.71%  | 0.00      | 0.00%   | 139.81   | 7.70%  | 87.15     | 17.38%  | 5                    | 112 | 0                  | 2   | 7                  | 100.00%              | 0    | 0          |
| Ward 4A    | 72%                            | 51%                            | 76%                           | 84%                            | 592      | 12.10      | 9.33               | 2,025.96     | 160.37    | -0.8     |        | 2.99      |         | 0.00               | 0.00%  | 0.00      | 0.00%   | 312.93   | 15.26% | 31.28     | 19.50%  | 5                    | 69  | 1                  | 6   | 0                  | 0%                   | 2    | 0          |
| Ward 4B    | 94%                            | 85%                            | 75%                           | 93%                            | 484      | 17.70      | 4.72               | 1,188.50     | 1280.84   | -8.35    |        | 2.00      |         | 0.00               | 0.00%  | 0.00      | 0.00%   | 109.69   | 9.23%  | 150.37    | 11.74%  | 4                    | 85  | 0                  | 10  | 7                  | 86%                  | 0    | 0          |
| Ward 4C    | 72%                            | 53%                            | 76%                           | 50%                            | 577      | 10.30      | 9.32               | 1,754.10     | 221.13    | -5.32    |        | 4.08      |         | 0.00               | 0.00%  | 0.00      | 0.00%   | 235.43   | 13.42% | 56.77     | 25.67%  | 5                    | 80  | 0                  | 1   | 16                 | 100.00%              | 0    | 1          |

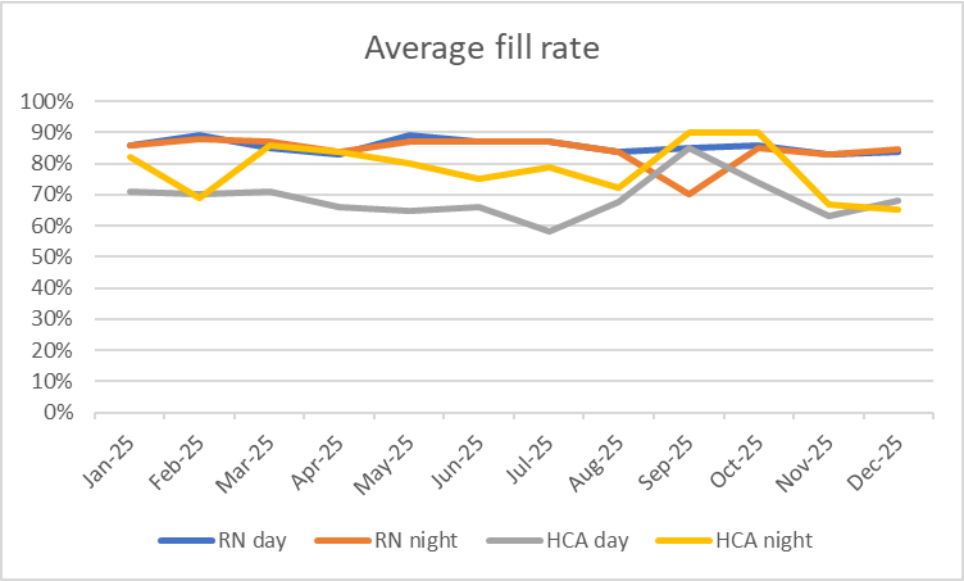
The purpose of the Safe Staffing and Patient Quality Indicator Report is to provide a summary of overall Registered Nurse (RN) and Health Care Assistant (HCA) staffing fill rates, alongside Care Hours per Patient Day (CHPPD), across all inpatient areas. The report highlights areas where staffing fill rates have fallen below the 80% threshold and considers the potential impact on patient safety, outcomes, and experience. Fill rates are calculated by comparing the planned number of RN and HCA hours for days and nights with the actual hours worked over the month. Planned hours are set through the electronic roster and captured daily. The system automatically generates the monthly percentage fill rate, which includes all hours provided by both substantive and bank staff, ensuring an accurate reflection of total staffing delivered against the plan CHPPD benchmarks in this report are based on the most recent Model Hospital data available (September 2025). These figures may not be directly comparable due to differences in activity, acuity, or seasonal demand. All areas, apart from Ward 3B (which is marginally below), are above the national CHPPD benchmark. This is primarily driven by sustained low occupancy across the Trust, which increases CHPPD even when staffing levels are appropriate to maintain safe cover. Informal bed closures remain active to reflect reduced demand:

- 3A: 4 beds closed
- 4A: 4 beds closed
- 3C: 8 beds closed

In addition, HDU capacity has been reduced to 13 commissioned beds. These measures align with current low occupancy levels and support the safe deployment of staffing resources. A Standard Operating Procedure (SOP) is now in place to enable the rapid reopening of these closed beds within four hours should clinically demand increase.

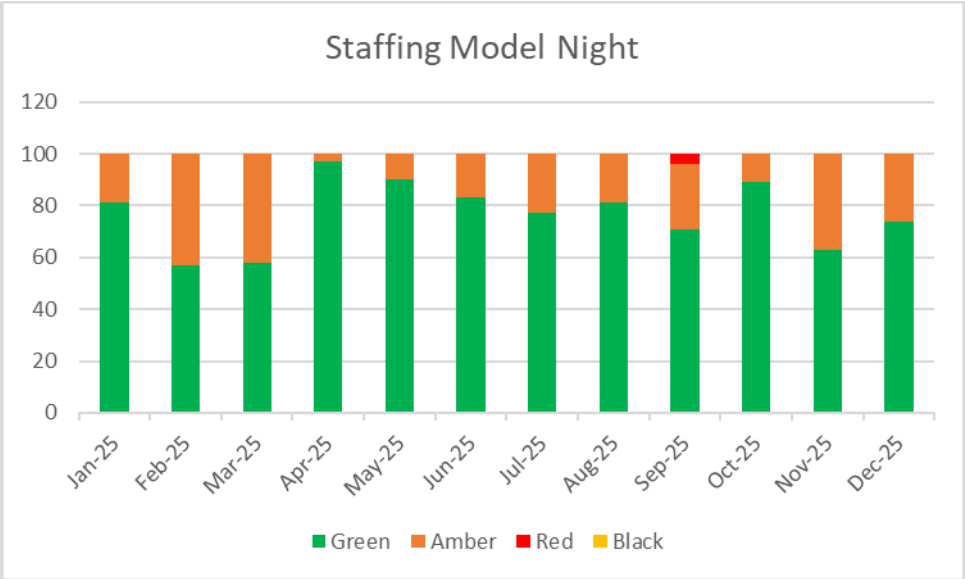
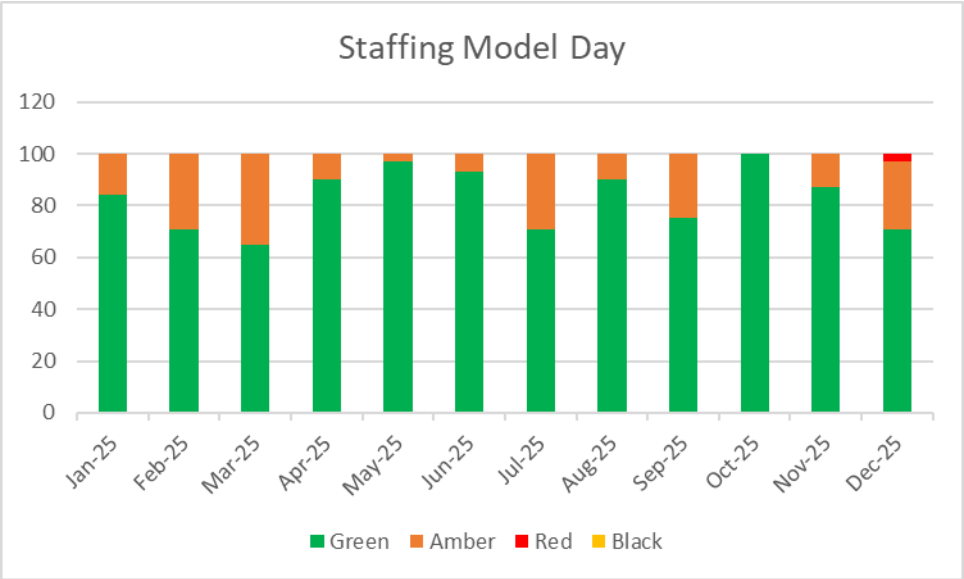
| Nursing and care staff average fill rate December 2025                                  |                                                                                       | Nursing and care staff average fill rate December 2025                                    |                                                                                           |
|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Day average fill rate                                                                   |                                                                                       | Night average fill rate                                                                   |                                                                                           |
| Registered (%)                                                                          | Care Staff (%)                                                                        | Registered (%)                                                                            | Care Staff (%)                                                                            |
| 83.8%  | 68%  | 84.5%  | 65.4%  |

RN fill rate has increased slightly since previous month. There is a decrease in HCA fill rate in night shifts which can be explained by high level of sickness and vacancies.



**Summary of Staffing models January 2025 – December 2025 Registered Nurses**

*To Note only red, amber, and green staffing status is now reported via the staffing template.*  
December staffing status has seen a decrease in green staffing model on days but an increase on nights with one reported red shift on days.



### **Registered Nurse and Unregistered Bank Spend December 2025**

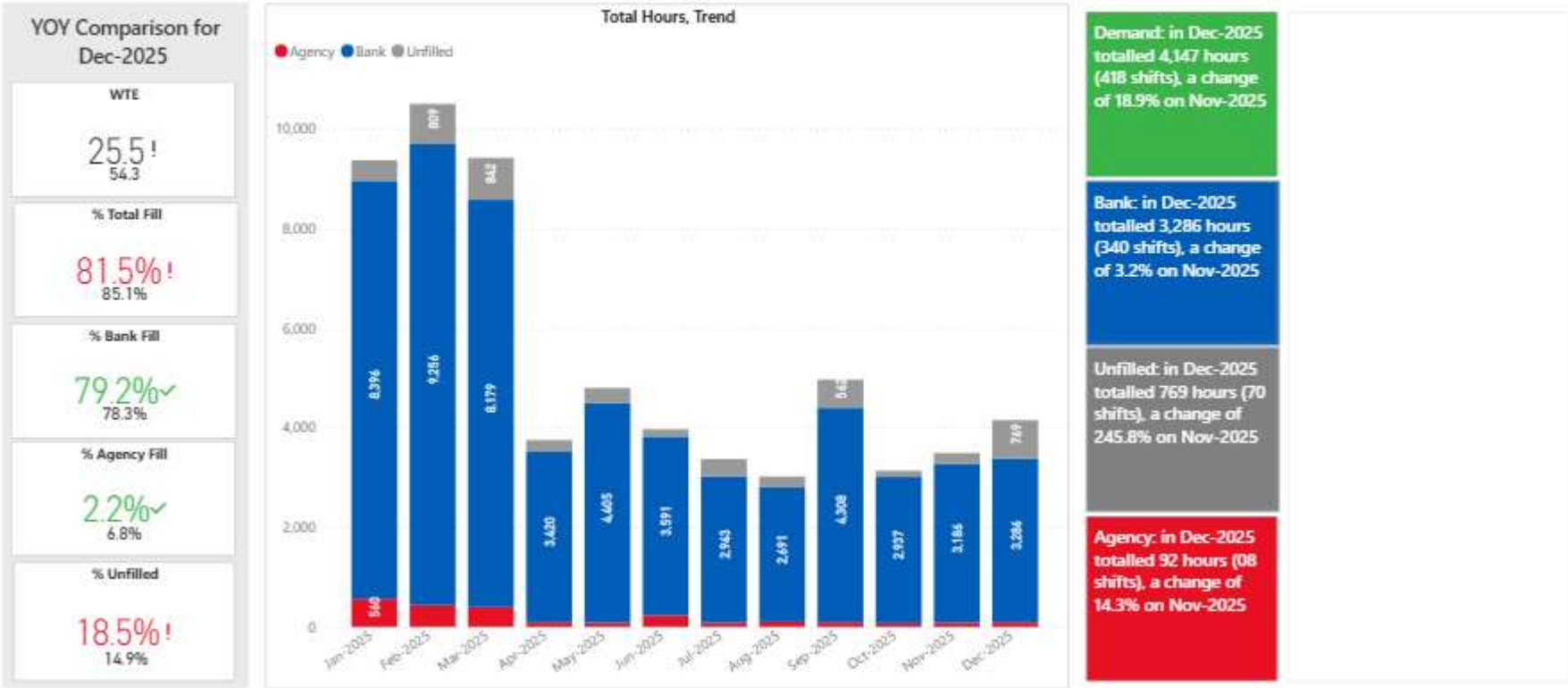
The Divisions has demonstrated strong governance and sustained progress in reducing temporary staffing costs, improving workforce efficiency and strengthening assurance processes. Temporary staffing is monitored closely with oversight from Workforce Efficiencies group attended and represented by senior 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. Over the past 12 months bank and agency usage has significantly reduced. Registered Nurse Bank usage did increase by 3.2% in December 2025 compared to November. This slight increase is primarily attributed to sustained high levels of sickness across all wards and departments alongside increased bed capacity, higher patient acuity and a surge in emergency attendees. In line with the SOP for Closing and Rapid Reopening of beds, Nurse Bank utilisation is an essential part of the process to ensure safe staffing when beds are reopened, and temporary workforce is required. The areas with notable high bank spend are within critical care HDU & ICU as well as Sunflower House 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. 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 December, 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 to go through the strengthened approval process requiring Chief Nurse sign-off.

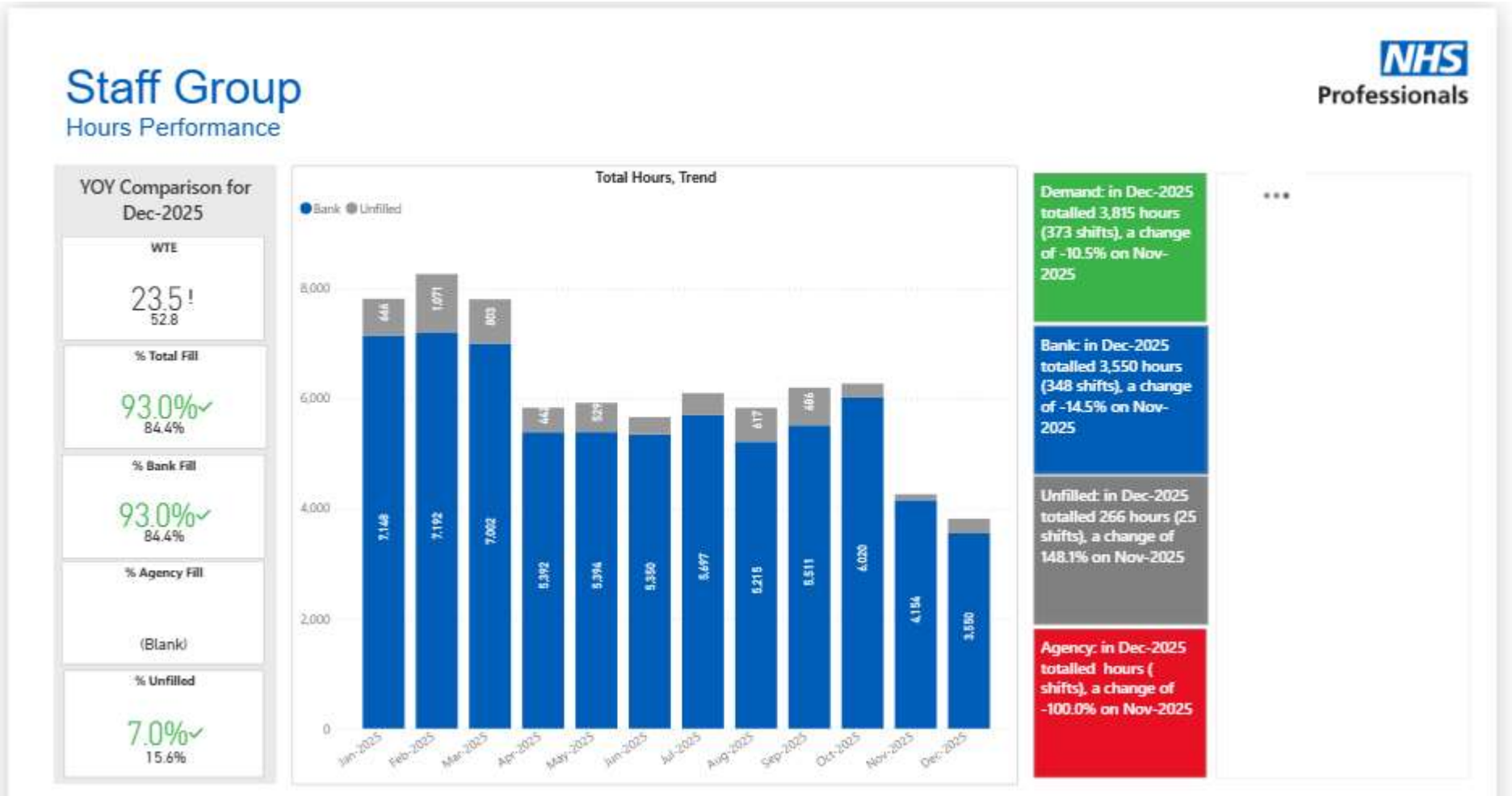
Unregistered Nurse Bank spend decreased by 14.5% in November 2025, continuing to remain low compared with the same period last year. This reduction is particularly positive given on-going substantive workforce gaps and higher than usual sickness levels across the Trust. Ward 3C, which had long standing substantive HCA vacancies, has strengthened its establishment with 3 new starters in June and a further 6 redeployed staff who commenced in September. In addition, 12 NHSP trainees have recently completed their competencies and have all been appointed to permanent HCA roles within the Trust, further reducing historic gaps. Substantive recruitment continues at pace, with prioritisation of high demand wards to maintain staffing resilience. These collective actions demonstrate strong grip, effective controls and sustained improvement in workforce efficiency, contributing to reduced reliance on temporary staffing.

Registered Nurse Bank Spend December 2025

Staff Group  
Hours Performance



Unregistered Nurse Bank Spend December 2025



## KPI E-Roster December 2025

| RosterPerform 11 Overview                |                                                                              |                                                 |                                                                                          |           |                                              |                                                     |                                                         |                                                        |                                    |                                   |                                   |                                  |                                                 |                                                          |
|------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------|-----------|----------------------------------------------|-----------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------|------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|-------------------------------------------------|----------------------------------------------------------|
| KPI Description                          | The minimum no of days notice teams need to be given for shifts to be worked | % of changes made in roster since full approval | The number of contracted hours people owe or are owed (Negative = owed, positive = owes) |           | The % of shifts filled by temporary staffing | The total number of hours filled by temporary staff | The number of shifts created ontop of the establishment | The % of shits in the roster that have not been filled | % of staff in post on Annual Leave | % of staff in post on Study Leave | % of staff in post on other leave | % of staff in post on sick leave | % of staff in post on parenting leave (Mat/Pat) | Total % of staff in post booked off as an unavailability |
| KPI Metric                               | 42 Days                                                                      | <25%                                            | Unit Level KPI (Column D)                                                                |           | <10%                                         | NA                                                  | 0                                                       | <15%                                                   | Between 11% & 17%                  | <2%                               | <5%                               | <5%                              | <7%                                             | <30%                                                     |
| Org.Units/Metrics                        | Roster Approval (Full) Lead Time Days (10 November - 7th December 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)     | 47                                                                           | 31.93%                                          | 80.00                                                                                    | -75.6     | 0.00%                                        | 0                                                   | 1                                                       | 31.42%                                                 | 9.94%                              | 13.50%                            | 0.40%                             | 2.31%                            | 0.00%                                           | 26.16%                                                   |
| Accident & Emergency - Nursing (912201)  | 46                                                                           | 22.71%                                          | 720.00                                                                                   | 111.48    | 0.67%                                        | 63.25                                               | 1                                                       | 23.03%                                                 | 11.94%                             | 1.80%                             | 1.44%                             | 9.51%                            | 5.82%                                           | 31.17%                                                   |
| Burns Unit (915208)                      | 44                                                                           | 31.35%                                          | 140.00                                                                                   | 98.82     | 8.58%                                        | 165.5                                               | 1                                                       | 10.90%                                                 | 12.30%                             | 1.63%                             | 0.87%                             | 3.51%                            | 16.63%                                          | 34.94%                                                   |
| Critical Care Ward (913208)              | 44                                                                           | 19.73%                                          | 1200.00                                                                                  | 1141.03   | 3.50%                                        | 667                                                 | 0                                                       | 18.93%                                                 | 10.36%                             | 2.82%                             | 0.30%                             | 6.71%                            | 6.70%                                           | 26.94%                                                   |
| High Dependency Unit (HDU) (913210)      | 44                                                                           | 30.22%                                          | 640.00                                                                                   | 239.7     | 10.86%                                       | 803                                                 | 0                                                       | 31.49%                                                 | 12.65%                             | 3.74%                             | 2.30%                             | 6.63%                            | 11.20%                                          | 36.53%                                                   |
| Medical Daycase Unit (911314)            | 48                                                                           | 11.58%                                          | 50.00                                                                                    | -6        | 0.00%                                        | 0                                                   | 1                                                       | 16.30%                                                 | 5.96%                              | 0.00%                             | 1.51%                             | 2.61%                            | 0.00%                                           | 23.90%                                                   |
| Outpatients (916503)                     | 41                                                                           | 21.72%                                          | 420.00                                                                                   | -205.05   | 2.63%                                        | 122                                                 | 0                                                       | 22.82%                                                 | 10.32%                             | 0.49%                             | 1.74%                             | 14.67%                           | 2.25%                                           | 32.48%                                                   |
| Sunflower House (912310)                 | 41                                                                           | 39.87%                                          | 190.00                                                                                   | 98.62     | 25.86%                                       | 1153                                                | 68                                                      | 5.15%                                                  | 9.71%                              | 4.75%                             | 0.45%                             | 10.87%                           | 2.88%                                           | 35.74%                                                   |
| Surgical Daycase Unit (915418)           | 44                                                                           | 33.33%                                          | 85.00                                                                                    | -66.11    | 13.96%                                       | 422.75                                              | 0                                                       | 21.20%                                                 | 12.41%                             | 0.05%                             | 3.28%                             | 14.29%                           | 3.88%                                           | 33.90%                                                   |
| Theatres - Cardiac & Cardiology (915405) | 44                                                                           | 27.27%                                          | 130.00                                                                                   | -13.5     | 0.00%                                        | 0                                                   | 0                                                       | 14.58%                                                 | 12.00%                             | 2.26%                             | 0.40%                             | 4.72%                            | 0.00%                                           | 19.38%                                                   |
| Theatres - Emergency (915420)            | 44                                                                           | 28.71%                                          | 230.00                                                                                   | -16.75    | 1.14%                                        | 26.75                                               | 0                                                       | 4.86%                                                  | 11.68%                             | 1.73%                             | 0.00%                             | 4.60%                            | 0.00%                                           | 18.01%                                                   |
| Theatres - IP Anaesthetics (915423)      | 44                                                                           | 25.87%                                          | 82.00                                                                                    | -80.67    | 2.05%                                        | 68.25                                               | 0                                                       | 10.18%                                                 | 11.33%                             | 0.93%                             | 2.03%                             | 13.06%                           | 0.00%                                           | 27.35%                                                   |
| Theatres - IP Porters (915435)           | 44                                                                           | 50.72%                                          | 101.00                                                                                   | 32.5      | 9.94%                                        | 118                                                 | 0                                                       | 22.69%                                                 | 6.95%                              | 0.00%                             | 0.00%                             | 37.33%                           | 0.00%                                           | 44.28%                                                   |
| Theatres - IP Recovery (915422)          | 44                                                                           | 48.34%                                          | 103.00                                                                                   | 35.6      | 10.59%                                       | 159                                                 | 0                                                       | 25.34%                                                 | 3.61%                              | 0.90%                             | 5.56%                             | 28.57%                           | 0.00%                                           | 38.64%                                                   |
| Theatres - IP Scrub (915424)             | 44                                                                           | 36.11%                                          | 128.00                                                                                   | -10.5     | 5.96%                                        | 102.5                                               | 0                                                       | 13.35%                                                 | 8.79%                              | 1.02%                             | 3.21%                             | 12.16%                           | 14.73%                                          | 48.18%                                                   |
| Theatres - Ortho & Neuro Scrub (915436)  | 44                                                                           | 34.29%                                          | 37.80                                                                                    | -0.5      | 1.85%                                        | 45                                                  | 1                                                       | 16.78%                                                 | 12.28%                             | 0.97%                             | 2.19%                             | 9.94%                            | 7.12%                                           | 32.50%                                                   |
| Theatres - SDC Anaesthetics (915429)     | 44                                                                           | 66.97%                                          | 58.40                                                                                    | -1.5      | 35.47%                                       | 344.33                                              | 0                                                       | 24.55%                                                 | 11.11%                             | 0.00%                             | 3.10%                             | 21.31%                           | 7.63%                                           | 43.16%                                                   |
| Theatres - SDC Recovery (915430)         | 40                                                                           | 38.06%                                          | 177.30                                                                                   | -6.02     | 8.33%                                        | 103                                                 | 0                                                       | 15.70%                                                 | 8.96%                              | 1.76%                             | 0.89%                             | 12.35%                           | 7.06%                                           | 31.02%                                                   |
| Theatres - SDC Scrub (915421)            | 44                                                                           | 30.77%                                          | 532.00                                                                                   | -4.68     | 2.50%                                        | 52                                                  | 0                                                       | 20.81%                                                 | 8.24%                              | 1.25%                             | 2.59%                             | 21.45%                           | 4.70%                                           | 38.25%                                                   |
| Ward 1C Cardiac (913307)                 | 38                                                                           | 26.66%                                          | 361.00                                                                                   | 207.2     | 3.44%                                        | 209                                                 | 0                                                       | 20.48%                                                 | 11.68%                             | 1.80%                             | 4.11%                             | 15.44%                           | 5.48%                                           | 39.67%                                                   |
| Ward 1C Neonatal (913310)                | 45                                                                           | 50.34%                                          | 556.00                                                                                   | 1745.25   | 0.00%                                        | 0                                                   | 11                                                      | 16.27%                                                 | 11.14%                             | 6.44%                             | 0.75%                             | 7.26%                            | 7.57%                                           | 36.79%                                                   |
| Ward 3A (915309)                         | 44                                                                           | 23.93%                                          | 371.00                                                                                   | 78.81     | 3.69%                                        | 218.5                                               | 5                                                       | 25.06%                                                 | 14.57%                             | 1.49%                             | 3.15%                             | 16.19%                           | 5.32%                                           | 40.72%                                                   |
| Ward 3B - Oncology (911208)              | 48                                                                           | 22.59%                                          | 555.00                                                                                   | 220.55    | 2.88%                                        | 138                                                 | 1                                                       | 17.51%                                                 | 14.91%                             | 2.68%                             | 1.91%                             | 10.11%                           | 3.61%                                           | 33.21%                                                   |
| Ward 3C (911313)                         | 45                                                                           | 27.96%                                          | 607.00                                                                                   | 205.52    | 3.80%                                        | 287.5                                               | 8                                                       | 31.37%                                                 | 15.18%                             | 1.44%                             | 2.32%                             | 10.20%                           | 6.17%                                           | 35.77%                                                   |
| Ward 4A (914210)                         | 44                                                                           | 28.14%                                          | 634.00                                                                                   | 121.62    | 3.97%                                        | 276                                                 | 1                                                       | 25.83%                                                 | 10.04%                             | 3.09%                             | 1.41%                             | 13.92%                           | 6.80%                                           | 36.25%                                                   |
| Ward 4B (914211)                         | 45                                                                           | 27.38%                                          | 533.00                                                                                   | 228.07    | 5.62%                                        | 494.5                                               | 27                                                      | 15.08%                                                 | 11.24%                             | 0.94%                             | 1.82%                             | 10.87%                           | 5.01%                                           | 30.08%                                                   |
| Ward 4C (912207)                         | 46                                                                           | 16.44%                                          | 280.00                                                                                   | 19.7      | 0.00%                                        | 0                                                   | 0                                                       | 25.47%                                                 | 11.34%                             | 2.38%                             | 2.78%                             | 12.92%                           | 4.53%                                           | 34.82%                                                   |

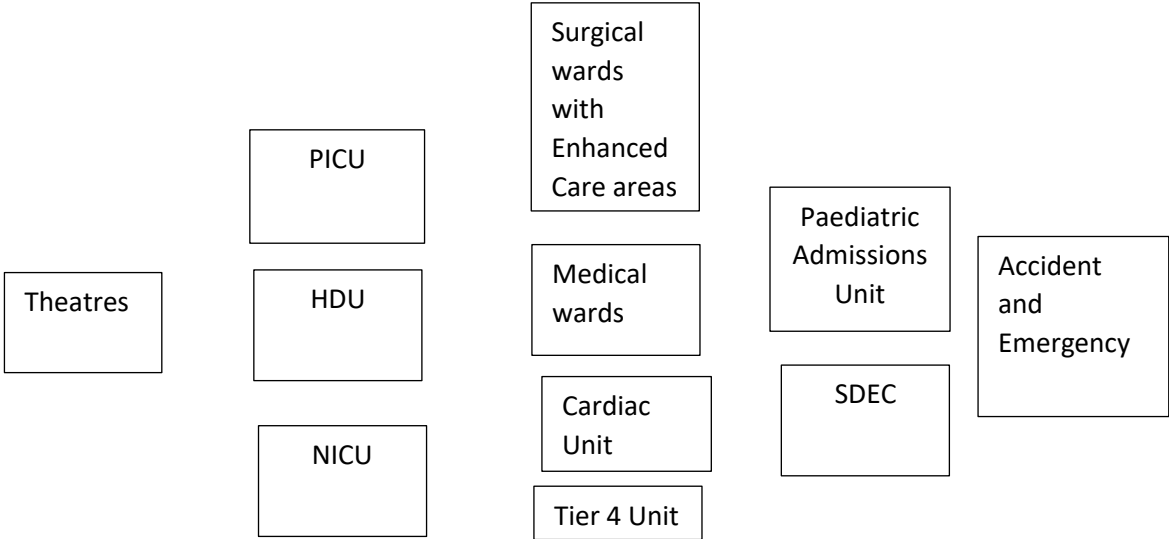
## Trust Summary

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

- Lead time 44 days (KPI 42 Days)
- Net hours have decreased from 4452 to 4098 (KPI 9001 to allow for up to a day to owe or be owed)
- Bank/Agency has increased from 5665 hours to 6039 hours
- Sickness continues to remain high at 12.4% (KPI<5%)
- Annual leave 10.8% just below KPI (11%-17%) & other Leave 1.9% within the agreed ( KPI<5%)
- Study leave outside KPI at 2.2% (KPI 2%)
- Additional duties have decreased 189 shifts to 126 shifts

## BOARD OF DIRECTORS

Thursday, 5<sup>th</sup> February 2026

|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Title</b>                            | Deteriorating Patient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exec Sponsor</b>                     | Alfie Bass, Medical Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Divisional Lead</b>                  | Benedetta Pettorini, Division of Surgery Clinical Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Author</b>                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exec Summary</b>                     | <p>This paper is submitted to Trust Board for noting.</p> <p>It outlines themes identified from a review into the current management of deteriorating patients and the surrounding governance framework and the progress made to date.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Alignment to Strategic Objective</b> | Patient Safety Priority 2025/2026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Problem Statement</b>                | <p>Previous workstreams were established to address issues in relation to the management of deteriorating patients, however, there has been a lack of overarching strategy, resource allocation and governance framework to obtain full oversight and enact impactful change.</p> <p>The impact of this is that patients may experience preventable deterioration that could have been managed more effectively leading to delays in treatment and potentially resulting in harm.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Background and Current State</b>     | <p><b>Background</b></p> <p>A Patient Safety Learning Response was undertaken in 2024 following the death of a patient of ward 4A following craniofacial surgery. The terms of reference for this learning response identify the work required to comprehensively map the system of work relating to the deteriorating patient, so work as prescribed, understood and done, is more deeply and holistically understood.</p> <p>As part of our patient safety plan informed by intelligence gathering and triangulation of data The Deteriorating patient was identified as one of the 3 key themes impacting patient safety across the trust.</p> <p>It is also recognized that Alder Hey is an increasingly complex acute trust attracting patients with an increasingly complex set of conditions requiring high risk interventions.</p> <div style="text-align: center; margin-top: 20px;">  </div> |

This document outlines the work that has been undertaken to address the operational systems that prevent, identify, escalate and respond (PIER) to deteriorating patients. It also outlines the program attending to culture that are required to enact and maintain meaningful change.

## Governance

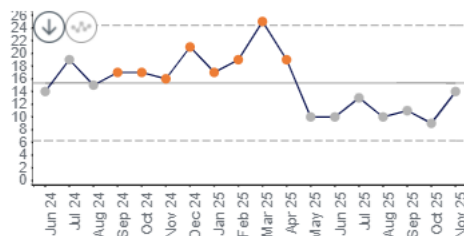
A stakeholder group has been established to oversee delivery of the key workstreams . This reports into the Patient Safety Board which in turn reports to SQAC which reports into the trust board:-



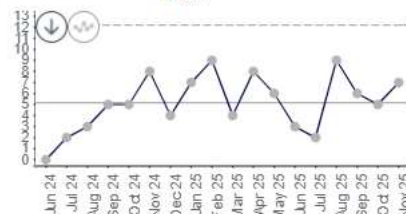
## Outcome Data

Two watch metrics are currently tracked in the Integrated Performance Report (screenshot taken 22/12/25). These metrics are reported to and discussed by the Patient Safety Board every month.

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



Number of patients deteriorating from HDU admitted to PICU



These graphs show – statistical significance and improvement. These numbers totals and do next contextualise the numbers of deteriorations with the overall patinets numbers. Therefore as for harm statistics per 1000 bed days has been requested to asses proportionality.

Each month the preventability and predictability framework is applied to unplanned admissions from in-patient wards into HDU and from HDU into PICU. This provides clinical narrative against the data to assess if deteriorations requiring transfer were predictable, preventable or modifiable. See table 1 below for the assessment criteria.

Table 1: Assessment criteria for predictability / preventability of deteriorating patients.

Framework for reviewing the potential for preventability of Critical Deterioration Episode: Unplanned transfer to PICU or HDU

| Deterioration   | Domains                                                              | Contributory factors to Critical Deterioration Episodes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Evident on retrospective review of data                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Action                                                                                                                                                        |
|-----------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Predictable     | 1. Preventable                                                       | a) Documented signs of multi organ failure (shock), either not recognised OR not escalated OR not treated adequately (signs persist).<br>b) Documented signs of single organ failure, either not recognised OR not escalated OR not treated adequately (signs persist).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | a) MOSF not stabilised; PEWS ≥5 OR CRIS ≥4 OR cardiac arrest OR peri-arrest<br>b) Organ failure not stabilised; PEWS ≥4 despite organ support OR any activation of the resuscitation team OR CRIS ≥3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Guidelines<br>Education<br>Supervision<br>Feedback                                                                                                            |
|                 | 2. Not preventable                                                   | Documented signs of organ dysfunction (PEWS) OR HCP concern of deterioration OR parent concern of deterioration<br>a) Deterioration was recognised, and escalated but progressed to become critical despite adequate management                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | a) Deterioration progressed despite adequate care e.g. fulminant disease process                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Positive feedback                                                                                                                                             |
|                 | 3. Potentially modifiable factors, with potential to improve outcome | Documented signs of organ dysfunction (PEWS) OR HCP concern of deterioration OR parent concern of deterioration<br>a) Poor monitoring of clinical state OR poor adherence to the escalation process; Chain of Prevention<br>b) Delay in clinician response to the deteriorating patient<br>c) Failure of the responder to recognise clinical deterioration<br>d) Antecedent risk factor for critical deterioration not acknowledged<br>e) "Deterioration Management Plan": Non responder to 1 <sup>st</sup> and 2 <sup>nd</sup> line treatment, but not escalated to senior clinician (Min ST3 OR Consultant) OR not escalated for HDU or PICU review<br>f) "Deterioration Management Plan": Non responder to 1 <sup>st</sup> and 2 <sup>nd</sup> line, but treatments were not optimised<br>g) Documented New Sepsis concern, poor bundle adherence<br>h) Seriously unwell at ward admission, possible inappropriate patient placement which contributed to delay in escalation to HDU or PICU<br>i) Delay in transfer to HDU or PICU (once accepted), deterioration progressed while waiting<br>j) Delay in clinical response OR in transfer to HDU or PICU (once accepted), but the patient did not get any worse while waiting | a) Monitoring or escalation not delivered as per the agreed standard, but no exemption documented<br>b) Delay beyond the standard for response time; within 30 minutes, or immediate for PEWS 10+ or activation of the resuscitation team<br>c) Failure of the responder to recognise deterioration; mis-diagnosis<br>d) Previous PICU or HDU, age < 1 year, premature birth (< 32/40 or ventilated), oncology or cyanotic heart<br>e) Evidence of ongoing organ failure with transient/no improvement following intervention, but no evidence of senior clinician involvement (min ST3 AND Consultant) OR not escalated to PICU or HDU<br>f) Intervention delivered, no improvement or transient improvement, but treatments were not optimised OR plan unclear<br>g) Review timeliness and completeness of modified NICE sepsis bundle<br>h) PEWS ≥5, on maximal treatment at ward admission, evidence of delay in escalation or response to the patient<br>i) Delay > 1 hr, evidence of deterioration progression and higher intensity organ support required<br>j) Delay of > 1 hr, no deterioration progression. [Quality issue] | Feedback<br>Education<br>CQI<br>Supervision<br>& Support<br>Staffing<br>review<br>Contingency<br>plan review<br>Bed<br>management<br>Safe transfer<br>process |
| Not predictable | 4. Not preventable                                                   | No documented signs of organ dysfunction (PEWS) beyond usual state OR no HCP concern of deterioration OR no parent concern of deterioration<br>b) Sudden deterioration<br>c) Typical signs of deterioration not evident                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | b) Arrhythmia, spontaneous bleed, blocked tracheostomy<br>c) PEWS < 3, no HCP OR parent concern of deterioration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Learning about antecedent risk factors                                                                                                                        |

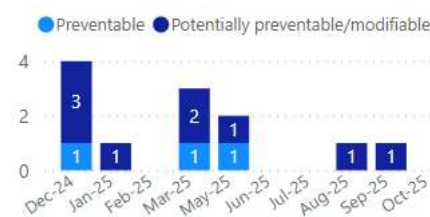
Chain of Prevention (Smith 2010); CRIS Children's Resuscitation Intensity Scale (Parshuram 2011); HCP Healthcare Professionals; HDU High Dependency Unit; HFVCO High Flow Nasal Cannulae Oxygen; hr hour; MOSF Multi-organ system failure; PEWS: Paediatric Early Warning Score; PICU Paediatric Intensive Care Unit; < less than; > more than; ≥ more than or equal to

DETECT study August 2021

The framework assessment for all deteriorations from an in-patient bed to HDU is illustrated in graph 1 below.

#### Predictable and preventable deteriorating patients

Not inclusive of all categories



## Deteriorating Patient Workstreams

1. Hospital Observation Policy
2. Introduction National PEWS
3. Digital Integration of Observation devices into the electronic patient record (EPR)
4. Review of Airvo policy (High Flow Oxygen)
5. Martha's Rule implementation
6. Workforce realignment across General Paediatric/HDU
7. Education framework for deterioration
8. Safety culture.

### 1. Observation Policy

A new observation policy has been instituted across the trust and with the device integration it allows us to monitor compliance across the trust in real time to allow for constant improvement.

The screenshot below demonstrates how observations are recorded :-

Metrics and Analysis: Trend and Current Data vs Target Driver and watch metrics



PEWS document usage dashboard.

83.92% via monitors (reduction of 3% since last reporting period)  
16.08% manual PEWS (increase of 3% since last reporting period)

## 2.National PEWS

We have now adopted the National Paediatric Early Warning Score(PEWS) and are producing data which is allowing us to adapt our escalation plans.

The DETECT study provided a significant step forward in digital management and safety for children admitted to Alder Hey using mobile devices to record vital signs at the bedside and whole hospital situational awareness about deteriorating patients. The iPod Touch devices used are end of life, and therefore are no longer fit for purpose. In addition, the contract with System C is scheduled to end in June 2025, which will leave a gap in providing safe monitoring for our sick and deteriorating patients. Given these factors, the Observation Integration Project was initiated to explore the opportunity to integrate the bedside monitors with EPR to reduce the risk of transcription errors and to provide another solution to support early warning and escalation processes for deteriorating patients.

The Observation Integration Project is also managing the adoption of national PEWS requirements; developing capabilities of frontline teams to understand and use NPEWS alongside observation integration into the EPR.

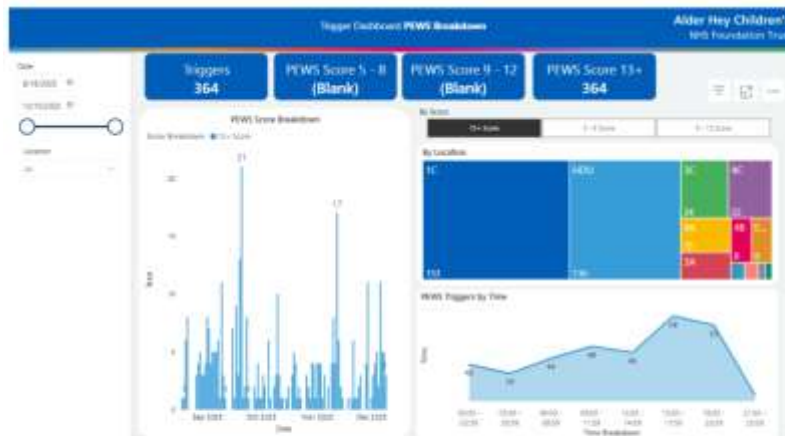
This project has an existing plan, key metrics and governance managed through Digital committees. The project clinical lead provided a presentation to the stakeholder group to support review of the work system and design requirements.

Score 5-8 escalated to Senior nurse in charge on ward

Score 9-12 escalated to nurse in charge on ward and acute response team.

Score above 13 Arrest call but this data is being analysed to inform appropriate escalation.





PEWS Trigger Dashboard filtered by score 13+

From 18/08/25 to 10/12/25

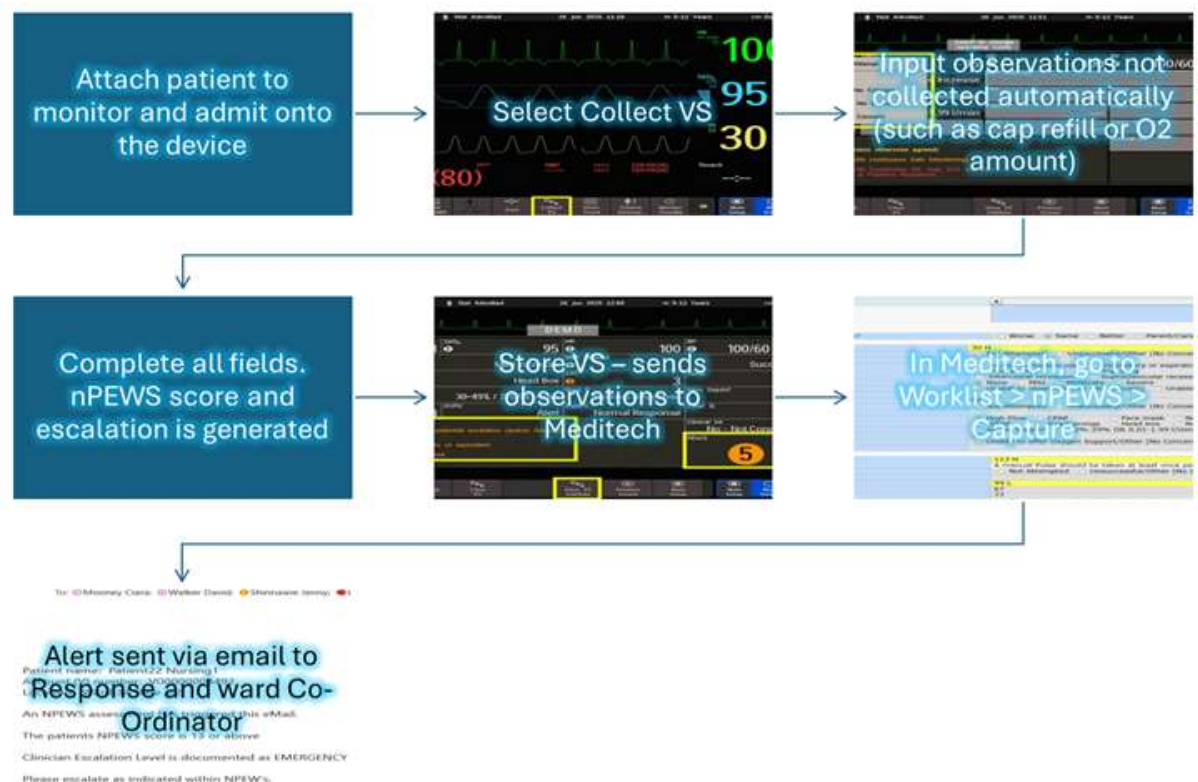
Breaks down by:

- Location – most in 1C > HDU > 3C > 4C > 4A
- Time of day – majority occurring between 3pm and 8pm

Analysis of Resus calls and >13 triggers is being undertaken to assess the response level being provided to this patient group.

### 3. Digital Integration of Observation devices

Both Welch Allyn and Phillips devices now allow staff to input observations directly into the EPR which will generate a PEWS score and alert nurse in charge and the acute response team by email.



### 4. Review of Airvo policy

The policy that supports the use of humidified oxygen and high flow oxygen and the educational package in relation to its prescription/use and escalation have been reviewed and training has been enhanced. (see appendix 1)

### 5. Martha Rule implementation

Martha's Rule was introduced to strengthen the Trust's approach to recognising and responding to patient deterioration by ensuring patients, families, carers, and staff have a clear and timely route to escalate concerns. To support effective implementation, a set of driver metrics has been developed to provide oversight of activity, accessibility, and outcomes associated with the system. Alder hey was selected as one of the pilot sites to introduce this initiative.

A Whats App innovation was developed allowing communication between staff and our Response team with an educational and promotional package alongside it.

The number of triggered Martha's Rule requests will be monitored to understand levels of utilisation across the organisation and to identify any emerging patterns by ward, specialty, or time of day. Alongside this, patient and family feedback will be gathered through a short "effort score" to assess how easy the escalation process was to access and whether individuals felt listened to and supported. This will help the Trust ensure the pathway remains visible, understood, and responsive.

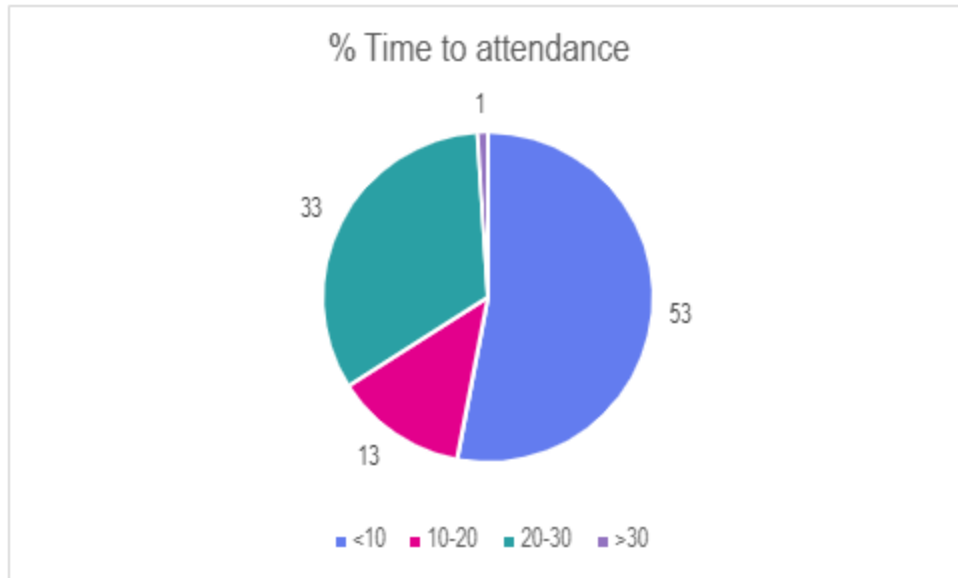
In addition, the Trust will capture the number of inappropriate requests, recognising that while all concerns are valid, some escalations may indicate a need for clearer communication or targeted staff training. Response times will also be scrutinised, with current expectations set at a 30 minute attendance window. Monitoring adherence to this timeframe will enable early identification of operational pressures or bottlenecks that may affect the timeliness of reviews.

A key outcome measure will be whether the review resulted in escalation of care, such as transfer to a higher acuity area, changes to the care plan, or involvement of a senior decision maker. This will provide assurance that the process is influencing clinical decision making and supporting early intervention for patients at risk of deterioration.

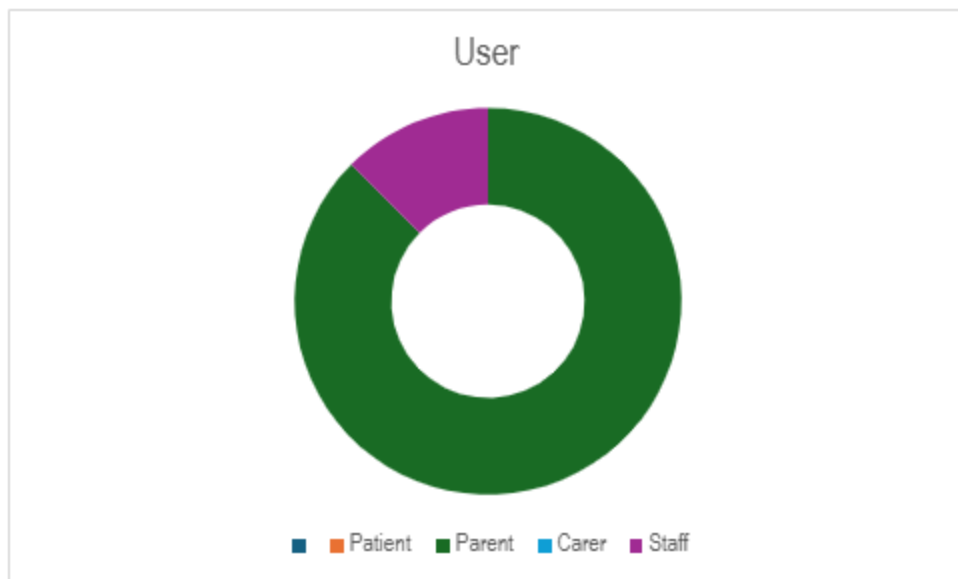
Martha's Rule has now been rolled out to all inpatient areas excluding Sunflower House. 1C neonatal last to roll out in November 2025. Roll out started in November 2024 as part of phased approach. Training continues regularly for all nursing staff on ward study days, and it is also included in the Dr's induction training.

Next steps: Including AHP workforce in training plan. Assessing next area ED, OPD or Sunflower house. Awaiting feedback form other Trusts who have piloted. Also, introducing languages within What's App Chat bot.

Majority of calls are communication issues. No deteriorations noted requiring transfer to critical care.



Attendance at all calls is aimed for 20 minutes, in comparison to other Trusts who aim to be there between 60 minutes and 2 hours.



Predominant user is parent, have had 1 nurse requesting support this period.

## **6.General Paeds /HDU Investment**

Funding has been obtained and recruitment has been completed which now means we have a consultant paediatrician present on PAU 12 hours per day 7 days per week as well as the on call paediatric consultant for the wider hospital. This is a key feature of compliance with RCPCH guidance.

Ongoing project is looking to facilitate a resident/ANP rota on HDU to support with the 24/7 HDU consultant rota. This will allow removal of the third general paediatric registrar slot improving time in specialty and work life balance. Due for completion September 2026.

PICU/NICU and Cardiac now have their own standalone resident and consultant on call rotas .

## **7.Education & Training**

A full scoping review of existing organisational education and training provision in relation to the care of the deteriorating patient has been completed. The outcomes of this demonstrated multiple opportunities available via other existing training, for staff to receive the 15 core components of deteriorating patient education that the working group identified.

There was recognition that those staff within the critical care areas, who undertake advanced training, have increased opportunities. There may be consideration for wider delivery to those working outside of these environments, to help with 'early recognition' of the deteriorating patient.

To aid with this it was agreed that further exploration of the Acute Illness Management (AIMs) education programme delivered in Greater Manchester may also be beneficial. This is particularly timely given the paediatric AIMs has just undergone review and update.

For all future training and education in regards to the deteriorating patient, there is also the need for regular and reliable data collection, to provide organisational assurance of compliance. Currently training records are maintained across a number of systems held at organisational, or ward/area level. Exploration of possible current system functionality, or wider options for greater oversight to support this is also to be undertaken.

To support with all of these ongoing objectives, the working group will continue to meet monthly and consider possibilities. Vikki Hughes (Head of Nurse Education) will attend Manchester Childrens Hospital, to observe delivery of paediatric AIMs programme, and will also link with Peter White to consider digital support for compliance reporting. This will enable the working group to provide increased information for the stakeholder group at future meetings allowing further decisions to be made in relation to ongoing staff education and training in relation to care of the deteriorating patient.

## **8.Safety culture**

A trust wide safety culture program has been developed, however, specifically for the deteriorating patient work we have initiated a Deteriorating Patient Learning Forum(DPLF) meeting. The TOR(appendix 2) has been developed, and it will be chaired by our patient safety lead and head of OD.

The objectives of the DPLF are to foster an environment in which staff feel safe to speak openly and honestly about their experiences, decisions, and challenges when managing deteriorating patients. The central aim of the forum is to intentionally bring teams together across professional, departmental, and hierarchical boundaries to strengthen teamworking, shared understanding, and communication during episodes of patient deterioration. Through collective reflection, the forum

aims to build a shared understanding of how care is delivered in real-world conditions, including the pressures, constraints, and competing priorities that influence clinical work.

The forum seeks to identify system strengths, adaptive behaviours, and enablers of success, as well as to explore any gaps between what was expected to occur and what happened. Where such gaps exist, the focus is on understanding why they occurred, rather than attributing fault. Learning generated through the forum is intended to be translated into practical, system-level improvements that enhance patient safety, support staff, and reinforce a just and learning culture across the organisation.

#### Vision and Goals

To support the delivery of a **quality** service for the **prevention, identification, escalation** and **response** to deterioration underpinned by **robust clinical governance** and **continuous improvement**.

#### Goals:

1. A comprehensive data set that is used to drive continuous improvement by December 2025. **ACHIEVED.**
2. Consistent and systematically applied processes for the prevention, escalation, identification and response to deterioration by December 2025. **ACHIEVED.**
3. Trust wide education and training to develop and maintain the knowledge, skills and competence required to support the PIER framework by September 2025. **ONGOING.**
4. A comprehensive clinical governance process in place that supports learning, continuous improvement and assurance at all levels of the organisation by December 2025. **ONGOING.**

#### Financial Analysis

At present a financial analysis for the overall programme has not been undertaken as there are considerations within some of the separate workstreams that are being progressed through operational routes.

#### Risks

At the time of writing this paper there are no identified risks for delivery of the programme of work.

#### EIA / QIA

An EIA / QIA is not required at this stage.

#### Governance Arrangements

The stakeholder group agreed the terms of reference for the stakeholder meeting and the oversight group.

The stakeholder group agreed the project assurance reporting structure:

The stakeholder group agreed the decision making structure:



|                       |                                                                                                                                                                                                                                                                  |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                       | The next stakeholder meeting will be scheduled for February 2026 where updates from the workstreams will be presented and opportunities for subsequent improvements will be agreed plus the ongoing management of this work through BAU routines will be agreed. |
| <b>Recommendation</b> | <b>It is recommended that Trust Board:</b> <ul style="list-style-type: none"> <li>- <b>notes the progress of the programme of work to date</b></li> </ul>                                                                                                        |

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. Title</b>                                                        | <b>Airvo update</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>2. Exec sponsor</b><br>Operational lead<br>Clinical Leads<br>Author | Nathan Askew Chief Nurse, Alfie Bass, Chief Medical Officer<br>N/A<br><br>Vanessa Compton, Clinical Specialist Physiotherapist<br>Jennie Williams, Head of Improvement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>3. Exec summary</b>                                                 | <p>The purpose of this paper is to provide an update to the Chief Medical Officer and the Chief Nurse on the review of humidified / high flow oxygen within Alder Hey.</p> <p>The work reviewed in this paper was initiated following an incident in which Airvo high flow oxygen was a component.</p> <p>This paper synthesizes the action within the investigation and evaluates the operational practices related to Airvo.</p> <p>The readers are asked to note the content of the paper and consider if any further assurance on safe practice related to Airvo is needed.</p>                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>4. Alignment to strategic objective</b>                             | Safety                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>5. Problem statement</b>                                            | <p>An incident happened in October 2023 where Airvo / high flow oxygen was involved. At the time an action plan was developed, completed and closed. Executive leads requested further assurance on the use of Airvo in the organisation.</p> <p>This is important to address to ensure that the systems and processes for utilising Airvo in clinical practice are fully embedded in practice and reporting can provide assurance that these are fully embedded in practice.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>6. Background and current state</b>                                 | <p><b><u>Background</u></b></p> <p>An action from the incident specifically relating to oxygen prescribing and the use of Airvo was documented as:<br/> <i>RCA4. Action: A review is required of existing hospital wide policies relating to the prescribing and application of oxygen including high flow oxygen, including training needs to ensure that policies are embedded in all clinical areas, are fully understood and adhered to consistently.</i></p> <p>As a result of this action the work undertaken included:</p> <ul style="list-style-type: none"> <li>- Working group met during 2024 and reviewed the existing hospital wide policies relating to the prescribing and application of oxygen.</li> <li>- The Trust Medicines Management Code incorporates the 'Guidelines for the Prescribing and Administration of Oxygen in Hospital' which comprises: Oxygen Prescribing and Administration in Hospital; Humidified High Flow Nasal Cannula</li> </ul> |

(HHFNC) Algorithm - Critical Care; and Humidified High Flow Nasal Cannula (HHFNC) Algorithm for Wards.

- The guidance clearly sets out that oxygen therapy should not be delayed in the treatment of life-threatening hypoxia and in an emergency, oxygen should always be given immediately and documented later.
- The guidance includes setting up high flow oxygen including Airvo.
- Algorithms for high flow oxygen in critical care areas and wards now include clear information about escalation of care and algorithms are being included in update training for use of Airvo machines around the Trust
- A training plan, Training Needs Analysis, and trajectory for training was devised led by the Head of Nurse Education to address any changes in the guidance and facilitate Trust wide implementation.

This action closed on October 2024.

#### **Current state**

As part of the whole system review of deteriorating patients the action was reviewed and greater insight into the use of Airvo was gained.

#### **Use of Airvo at Alder Hey**

Alder Hey have been using Airvo as the method for delivering oxygen since 2005.

Before Airvo, several devices were trialled with a robust evaluation completed across a multidisciplinary team consisting of Physiotherapy specialists, Pharmacists and BME colleagues.

In summary, devices that have been trialled and subsequently not recommended was due to a combination of the following:

- not sufficient for humidification
- growth of pseudomonas in tubing
- requirement to remove the oxygen safety valve in the wall
- lack of control of flow rate for paediatrics
- Exposed hot plates on humidifiers creating patient risk.
- piped air not being available at all bedspaces
- costs due to parts being misplaced
- additional training needs
- difficult for staff to use and trouble shoot.

If a patient requires more than 2L of oxygen for a prolonged period, they will require heated humidification. This can only be delivered by the Airvo

The algorithm for HHFNC clearly sets out the parameters for placing patients on to Airvo, indication, cautions, documentation, who to inform and escalation and de-escalation of treatment. It has been disseminated to all Clinical Educators within the Trust and highlighted in training sessions. It has been updated since the adoption of NPEWS to include the escalation triggers.

There is a live tracker for all Airvo devices that can identify the wards they are in use in at any one time.

### **Training compliance**

An audit of training compliance of oxygen prescribing for resident doctors and Airvo for nursing staff and physiotherapy on-call staff has been completed.

### **Resident Doctors**

The Education Pharmacist delivers prescribing oxygen training at each resident doctor induction which is Aug, Sept, Dec, Feb, March & April at their rotation. This includes how to prescribe oxygen on AlderCare, demonstrating the order set which outlines the target saturations. Data on the compliance rates for induction completion for resident doctors is held by the trusts Medical Education team.

### **Nursing Staff**

The table below is provided by the Head of Nurse Education. It illustrates the compliance rates for nursing staff across relevant in-patient areas up to end of September 2025.

| Area  | Total nursing staff | Airvo trained nursing staff | % compliance | Additional information                                                                                                     |
|-------|---------------------|-----------------------------|--------------|----------------------------------------------------------------------------------------------------------------------------|
| 3a    | 74                  | 60                          | 81           | training plan in place - working with Vanessa                                                                              |
| 3b    | 50                  | 15                          | 30           | training plan in place - working with Vanessa                                                                              |
| 3c    | 66                  | 53                          | 80           | training plan in place - working with Vanessa                                                                              |
| 4a    | 79                  | 55                          | 70           | 3 staff currently unavailable - Airvo is included in area study day, but cancellations of this have impacted on compliance |
| 4b    | 83                  | 71                          | 85           |                                                                                                                            |
| 4c    | 52                  | 52                          | 100          |                                                                                                                            |
| AED   |                     |                             |              |                                                                                                                            |
| ICU   | 176                 | 176                         | 100          |                                                                                                                            |
| HDU   | 74                  | 74                          | 100          |                                                                                                                            |
| Burns | 19                  | 14                          | 74           | not a frequently used skill in this area, refresher needed when patient requires this treatment                            |
| 1CC   | 66                  | 64                          | 97           |                                                                                                                            |
| 1CN   |                     |                             |              |                                                                                                                            |

### **Physiotherapists who undertake on-call.**

The Physiotherapy lead reports this is 100% compliance.

A yearly training session is offered to all Physio's and OT, including therapy assistants who work on the wards.

The compliance of training is planned to be included in the education and training workstream of the deteriorating patient work and will report as part of the suit of

|                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                   | <p>metrics for deteriorating patients into patient safety board on a frequency that is to be determined.</p> <p><b><u>Future developments</u></b></p> <p>A charitable funds bid for the provision of the latest model - Airvo 3 – has been successful. This is a newer version of the machine. All machines come with a battery so patients can be mobilised and transferred on Airvo in a safer and effective way. This model will be easier for staff to use and safer for patient transfers due to the in-built battery being able to provide a clear display on battery life once unplugged. It also provides more scope for different sizes of nasal cannula than the Airvo 2. Training will be updated and rolled out once they are purchased. An Airvo 3 SOP will be written but it will follow the same algorithm.</p> <p>There is also a potential cost saving with the latest version of the machine as the circuit updates are less frequent than the current model and an additional machine and circuit are not required for transfer.</p> <p>As it will be possible to mobilise the patients on these machines there will be added benefit of potential reduction in length of stay</p> |
| <b>7. Financial analysis</b>      | No financial requirements have been identified.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>8. EIA / QIA</b>               | N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>9. Governance arrangements</b> | Governance of education and training for the complete suite of deteriorating patients' topics will be enhanced through the education and training workstream of deteriorating patients. This will include reporting on the uptake / coverage of training for a suite of topics. This will report into Patient Safety Strategy Board within the overall deteriorating patient metrics on a frequency that will be agreed with the Patient Safety Lead.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>10. Recommendation</b>         | <p>The audience of this paper are asked to:</p> <ol style="list-style-type: none"> <li>1. Note the review.</li> <li>2. Decide if assurance gained from this review is robust.</li> <li>3. Decide if the proposed future governance will provide robust assurance.</li> <li>4. Recommend any subsequent actions.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

ENDS

## Appendix 2

### **Deteriorating Patient Learning Forum (DPLF)**

The Deteriorating Patient Learning Forum (DPLF) is a multidisciplinary, psychologically safe forum designed to bring together all teams involved in the management of a deteriorating patient to reflect, learn, improve and address any impacts on individual and team relationships. The forum focuses on learning rather than blame, supporting both:

**Safety I:** *Learning when care does not go as expected*

**Safety II:** *Learning from episodes of excellent care and successful recovery*

The forum uses a structured reflective approach.

#### **1.0 Objectives**

The objectives of the DPLF are to foster an environment in which staff feel safe to speak openly and honestly about their experiences, decisions, and challenges when managing deteriorating patients. A central aim of the forum is to intentionally bring teams together across professional, departmental, and hierarchical boundaries to strengthen team and inter-team working and relationships, shared understanding, and communication during episodes of patient deterioration. Through collective reflection, the forum aims to build a shared understanding of how care is delivered in real-world conditions, including the pressures, constraints, and competing priorities that influence clinical work.

The forum seeks to identify system strengths, adaptive behaviours, and enablers of success, as well as to explore any gaps between what was expected to occur and what happened. Where such gaps exist, the focus is on understanding why they occurred, rather than attributing fault and repairing relationships that may have been negatively affected in the process. Learning generated through the forum is intended to be translated into practical, system-level improvements that enhance patient safety, support staff, and reinforce a just, learning and restorative culture across the organisation.

#### **2.0 Guiding Principles**

The DPLF is underpinned by the Trust values of compassion, courage, commitment and community, and guided by a set of principles that shape how discussions are conducted and how learning is generated. The forum operates on a clear commitment to no blame and no judgement, with discussions focused on systems, processes, and conditions rather than individual performance.

Central to the effective operation of the forum is psychological safety, which is the shared belief that it is safe to speak up, ask questions, admit mistakes, or challenge the status quo without fear of criticism or reprisal. The forum is designed as a space where teams can collectively with courage reflect on how they interact, communicate, and coordinate under pressure, recognising that effective management of deterioration depends on strong team relationships, compassionate interactions, and reliable communication across the care continuum. This includes respectful listening, recognition of different perspectives, equal opportunity for all participants to contribute, and an expectation of confidentiality. Curiosity is prioritised over criticism, with participants encouraged to explore how and why decisions made sense at the time, given the information and context.

Also central to the forum is the compassionate acknowledgement that healthcare is both technically and emotionally complex. When things go wrong, staff and relationships between staff can be 'hurt', creating needs which if unaddressed can cause further harm (to staff themselves and to the provision of effective care). The forum will include addressing these harms, identifying needs and bringing about repair where appropriate.

A whole-system perspective is adopted, acknowledging the inherent complexity of healthcare and the need for staff to adapt and make trade-offs in dynamic environments. Learning is intentionally balanced, with equal attention given to understanding excellence and success as well as difficulty and failure. Transparency and trust are promoted through the appropriate sharing of learning to support improvement across the organisation.

### **3.0 Governance and Sponsorship**

The DPLF outputs and themes will inform quality improvement, education, and system redesign. The forum is not a disciplinary, performance management, or incident investigation process. Upon the need to report a clinical incident, the process will comply with the Patient Safety Incident Response Framework (PSIRF).

### **4.0 Co-Chairs**

The forum is co-chaired to reinforce shared ownership of safety and culture:

- Patient Safety Specialist
- Director of Culture

The Co-Chairs are responsible for ensuring psychological safety, keeping discussions aligned to learning objectives and value, managing power dynamics, hierarchy and ensuring that any identified support needs are met. Case selection (some of which mandatory) is to be agreed by the group stakeholders and the co-chairs endorse learning outputs and actions. The meeting is attended by the Chief Medical Officer as executive sponsor.

### **5.0 Membership and Attendance**

#### **5.1 Core Participants (case dependent)**

Attendance is case-specific and includes all relevant stakeholders involved in the episode of care which may include and not limited to, medical and nursing staff, allied health professionals, rapid response / critical care teams, bed management / patient flow, other clinical or operational teams involved in the care.

The expectation is for all relevant stakeholders to be offered the time to attend and contribute to the forum.

Patients or families may be involved separately through appropriate channels, where aligned with organisational policy or formal commissioned patient safety learning responses.

### **6.0 Case Selection**

Cases are identified collaboratively using Trustwide data through dashboards, and other relevant sources (as required) and may include:

- ✓ Episodes where patient deterioration was not recognised or managed as expected and/or where there has been a significant negative impact on working relationships
- ✓ Episodes where deterioration was managed exceptionally well
- ✓ Near misses or complex recoveries
- ✓ Cases that highlight system pressures, workarounds, or adaptive capacity

The criteria will be focused on learning value rather than outcome severity.

## **7.0 Forum Structure**

The forum is itemised through an agenda and follows a consistent reflective structure.

## **8.0 Context**

Case discussion, with a briefing of the clinical situation is undertaken with the following questions at the forefront of the forum:

### **8.1 What Actually Happened?**

What unfolded, from multiple perspectives? What decisions were made and why? What pressures, constraints, or competing priorities were present?

### **8.2 Understanding the Gap (if any)**

Where did expectations and reality diverge? What system factors influenced this gap? What adaptations or workarounds were used?

### **8.3 Learning from Excellence and Challenge**

What worked well and why? What enabled success despite complexity? What made care harder than expected?

### **8.4 Key Learnings and Insights**

What does this tell us about how work is really done? What should we protect, strengthen, or redesign? What are the identified support needs for those impacted?

## **9.0 Psychological Safety Practices**

Psychological safety is actively supported through explicit practices. Ground rules are articulated at the start of each forum, first-person accounts are encouraged, and interruptions are discouraged. Senior leaders are expected to model curiosity, humility, and openness, reinforcing that the purpose of the forum is learning rather than judgement.

Language is intentionally framed around understanding what made sense at the time, given the context and information available. The forum is clearly and consistently separated from incident investigation and disciplinary processes.

## **10.0 Outputs and Follow-Up**

The outputs of the DPLF include a de-identified summary of key learning themes, agreed improvement actions with clear accountability, and identification of practices that may be shared or scaled across the organisation. A feedback loop is established to ensure participants are informed about outcomes, actions taken, and changes implemented as a result of the forum.

Learning outputs are reviewed and monitored through existing quality and safety governance structures to ensure alignment with organisational priorities and to support sustained improvement.

## **11.0 Review of Terms of Reference**

These Terms of Reference will be reviewed annually or earlier if required to ensure alignment with organisational strategy, patient safety priorities, and cultural maturity.



## BOARD OF DIRECTORS

Thursday, 5<sup>th</sup> February 2026

|                           |                                                                                                  |
|---------------------------|--------------------------------------------------------------------------------------------------|
| <b>Paper Title:</b>       | Learning from Patient Safety Incidents Q3 October-December 2025                                  |
| <b>Report of:</b>         | Chief Nursing AHP and Experience Officer                                                         |
| <b>Paper Prepared by:</b> | Associate Director of Nursing Governance and Risk<br>Patient Safety Incident Investigation Leads |

|                                           |                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Purpose of Paper:</b>                  | Decision <input type="checkbox"/><br>Assurance <input checked="" type="checkbox"/><br>Information <input type="checkbox"/><br>Regulation <input type="checkbox"/>                                                                                                                                                                                   |
| <b>Action/Decision Required:</b>          | To note <input checked="" type="checkbox"/><br>To approve <input type="checkbox"/>                                                                                                                                                                                                                                                                  |
| <b>Summary / supporting information</b>   | 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 Q3 2025/26 and next steps, noting that this is an iterative process as we continue to transition and embed PSIRF.                               |
| <b>Strategic Context</b>                  | <b>Outstanding</b> care and experience <input checked="" type="checkbox"/><br><b>Collaborate</b> for children & young people <input checked="" type="checkbox"/><br><b>Revolutionise</b> care <input type="checkbox"/><br><b>Support</b> our people <input checked="" type="checkbox"/><br><b>Pioneering</b> breakthroughs <input type="checkbox"/> |
| <b>This paper links to the following:</b> |                                                                                                                                                                                                                                                                                                                                                     |
| <b>Resource Implications:</b>             |                                                                                                                                                                                                                                                                                                                                                     |

| Does this relate to a risk? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                                                                                                           |                                                                                                                                                                  |                                                                                                  |       |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------|
| Risk Number                                                                                     | Risk Description                                                                                                          |                                                                                                                                                                  |                                                                                                  | Score |
|                                                                                                 |                                                                                                                           |                                                                                                                                                                  |                                                                                                  |       |
| <b>Level of assurance</b><br>(as defined against the risk in InPhase)                           | <input type="checkbox"/> <b>Fully Assured</b><br>Controls are suitably designed, with evidence of them being consistently | <input type="checkbox"/> <b>Partially Assured</b><br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness | <input type="checkbox"/> <b>Not Assured</b><br>Evidence indicates poor effectiveness of controls |       |

|  |  |                                      |  |  |  |  |
|--|--|--------------------------------------|--|--|--|--|
|  |  | applied and effective<br>in practice |  |  |  |  |
|--|--|--------------------------------------|--|--|--|--|

## 1. Purpose

The purpose of this report is to provide the Trust Board with a summary of activity during Q3 October-December 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 actively report incidents via InPhase and LfPSE. Following the completion of the national InPhase update, throughout January 2026, the Trust will make the necessary changes to InPhase and testing with NHS England to enable transition to LfPSE v6 taxonomy.

### 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 Q3 2025/26, the Trust commissioned **two** PSIIs, all of which were related to national priorities. The commissioned PSIIs relate to the following:

- **A Never Event (retained swab neurosurgery) National Priority**
- **A Never Event (wrong route medication administration) National Priority**

#### 2.2.1 PSII Retained swab spinal surgery InPhase ID: 27662

This incident related to a swab retained in a patient during two planned neurosurgical procedures, which was detected in surgical site 1 via X-ray prior to the patient leaving theatre. The incident occurred in October 2025 within the Surgery Division and met the national Never Event category of a retained foreign object post procedure.

The wound for surgical site 1 was reopened prior to the patient leaving theatre and safe removal of the swab completed. Family informed with verbal and written duty of candour undertaken

The patient was discharged from hospital on 19<sup>th</sup> October 2025

A PSII was commissioned and is being led by the Patient Safety Investigators in collaboration with the patient's family and key stakeholders. Following discussions with the ICB it was agreed that a full PSII was not required and that the findings from this Never Event PSII be fed into the wider subject matter expertise thematic review of swab reconciliation processes in the Theatre setting.

Therefore, it was agreed via all parties on 18 November 2025 that this PSII would seek to understand the situational factors that contributed to the incident and answer the families questions.

The PSII report has been drafted and currently with stakeholders for factual accuracy. It is anticipated that the final report will be presented to the Trust's CMO and CNO for approval on 19th January 2026, before being shared with the patient's family. The investigation remains on track for completion within the specified timeframe.

### **2.2.2 PSII wrong route medication administration InPhase ID: 29369**

The wrong route medication administration Never Event incident occurred in November 2025 within the Surgery Division, relating to the administration of medication given via an intravenous route when intended for oral administration when on HDU.

The incident was identified and reported in December 2025, 14 days after administration of the drug when it was identified by staff that the error had occurred and met the Never Event criteria for a wrong route medication administration.

Following identification of the incident, the patient was monitored closely and remained stable.

Incident discussed with pharmacy who advised that the main factor to consider is the IV solution is made up in sterile conditions, whereby the oral solution is not. Following the administration of this medication, the patient had not contracted a line infection, and no harm came to the patient.

Family informed with verbal and written duty of candour undertaken.

A PSII was commissioned and is being led by the Patient Safety Investigators in collaboration with the patient's family and key stakeholders.

Draft terms of reference for the PSII have been developed in conjunction with the Surgery Division and pharmacy leads for approval by Chief Nursing, AHP and Experience Officer and Chief Medical Officer by 8<sup>th</sup> January 2026.

## **2.2 Commissioned Learning Responses (excluding PSII's).**

During Q3 2025/26 there have been **5** learning responses (excluding PSII's) commissioned by the weekly PSIRI panel to investigate those incidents initially reported as moderate physical or psychological harm or above.

**Table 1**

| <b>Commissioned Learning Response Types<br/>Q3 2025/26</b> | <b>Number<br/>Commissioned</b> | <b>Number<br/>completed</b> |
|------------------------------------------------------------|--------------------------------|-----------------------------|
|------------------------------------------------------------|--------------------------------|-----------------------------|

|                                                                                                                                                                                                                                                                                                                                           |          |          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|
| <b>After Action Review (AAR):</b> 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. | <b>4</b> | <b>1</b> |
| <b>Learning Together Review (LTR):</b> 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.                        | <b>0</b> | <b>0</b> |
| <b>Thematic Review (TR):</b> 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.                                                                                      | <b>1</b> | <b>0</b> |

### 2.3.1 Timescale Compliance for Learning Responses Q3 25/26

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

- Medicine – 0% compliance (1 completed, 0 completed within timescale)

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

- There have been 0 learning together reviews (LTRs) commissioned by the PSIRI panel for Q3 2025/26.

#### Thematic reviews

- There has been **one** Thematic Review commissioned for Q3/Q4 2025/26.

Following two Never Event retained swab incidents in different Theatres and surgical specialties in September and October 2025 a proactive meeting with the ICB approved our approach to complete a thematic review of the two cases due to the similarities in that both cases demonstrated a lack of compliance with swab reconciliation.

This is also supported by the national PSIRF message about proportionate use of response styles for Never Events.

The use of external subject matter experts (SMEs) has been sought and TOR approved demonstrating an ambition to develop deeper understanding and drive an effective improvement plan.

The SMEs will commence their review in January 2026, with report findings expected to be presented in June 2026. Findings will also support the wider piece of improvement work across the system with regards to LocSSIPs compliance and alignment to NatSSIPs 2.

## 2.4 Training and Education

### 2.4.1 Patient Safety e-learning

The table below demonstrates the Trust compliance against Level one of the patient safety syllabus eLearning module, which is mandatory for all staff within the Trust.

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

#### 2.4.2 Level 2 Patient safety syllabus training

44 staff to date have completed Level2 of the patient safety syllabus (PSS) [not mandated for all staff, only a requirement for those in oversight, learning response and engagement lead roles] training available via ESR.

**Oversight roles** (*meeting PSIRF standards*) – 5 (including CMO, CNO)

**Learning response leads** (*meeting PSIRF standards*): 14 (6 Surgery, 1 Medicine, 2 C+MH, 5 Corporate, 0 Research)

**Engagement leads** (*meeting PSIRF standards*): 11 (4 Surgery, 1 Medicine, 1 C+MH, 5 Corporate, 0 Research)

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, this is outside of the Trusts ability to resolve currently.

#### 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. Together with the Associate Director of Nursing, both investigators have been accepted onto and are currently completing the Loughborough patient safety course (PSS Level 3 and 4), with expected completion Q3 2026.

#### 2.6 Patient Safety Partners (PSPs)

Throughout Q3 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 as outlined below:

- Engaged in a quality walk round to gather feedback to inform the patient safety team's priorities for 2026, supporting the continued embedding of the Patient Safety Strategy and PSIRF into practice.
- Attended the ICB Community of Practice to provide an update on the role, function and embedding of PSPs within Alder Hey.
- Engaged in the annual PLACE assessments to represent the voice of the patient.

- Active involvement in the Trust's Cleanliness Collaborative, sharing their own experiences and gathering feedback from patients and families to support the identification and implementation of improvements.
- Provided consultation on the Trust's hand hygiene project, the Research Division's patient safety innovations & the external charity I-Support projects. Provided feedback on the Trust's Patient Safety Incident Response Plan (PSIRP), to help inform the next iteration.

A dedicated PSP staff SharePoint page has been established and is now live, providing a central resource for information, updates and engagement.

A six-month evaluation of the PSP role will commence in January 2026. Findings from the evaluation will inform future planning and development of the role.

### **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.

To address continued challenges in meeting PSII/PSR timescales, the following action is being implemented:

- Following feedback from the divisions and the ICB that the 4 week AAR timescale was challenging, and may have contributed to missed targets, the completion deadline has now been extended to 8 weeks.
- The process for contacting staff involved in a patient safety incident that is subject to either a PSII or LTR is under review to enable faster initial communication.

The patient safety team has developed a 2026 action plan based on the findings of its internal Q3 re-audit against NHS England's PSIRF standards. Progress against PSIRF standards will be monitored through the Patient Safety Board.

### **4. Recommendations**

The Trust Board is asked to note the activity that has been undertaken during Q3 2025/26 following the Trust's transition to and embedding of PSIRF and next steps.

## BOARD OF DIRECTORS

Thursday, 5<sup>th</sup> February 2026

|                           |                                                                                                                    |
|---------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>Paper Title:</b>       | <b>Chair's Report from the Safety and Quality Assurance Committee meeting held on 21<sup>st</sup> January 2026</b> |
| <b>Report of:</b>         | <b>Fiona Beveridge, Committee Chair</b>                                                                            |
| <b>Paper Prepared by:</b> | SQAC Committee Administrator                                                                                       |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Purpose of Paper:</b>                                                  | Decision <input type="checkbox"/><br>Assurance <input checked="" type="checkbox"/><br>Information <input checked="" type="checkbox"/><br>Regulation <input type="checkbox"/>                                                                                                                                                                                                                                                               |
| <b>Action/Decision Required:</b>                                          | To note <input checked="" type="checkbox"/><br>To approve <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                         |
| <b>Summary / supporting information</b>                                   | This paper provides a summary from the Safety Quality Assurance Committee meeting held on 21 <sup>st</sup> January 2026, along with the approved minutes from the 17 <sup>th</sup> December 2025 meeting.                                                                                                                                                                                                                                  |
| <b>Strategic Context</b><br><br><b>This paper links to the following:</b> | <b>Outstanding</b> care and experience <input checked="" type="checkbox"/><br><b>Collaborate</b> for children & young people <input checked="" type="checkbox"/><br><b>Revolutionise</b> care <input checked="" type="checkbox"/><br><b>Support</b> our people <input checked="" type="checkbox"/><br><b>Pioneering</b> breakthroughs <input checked="" type="checkbox"/><br><b>Strong Foundations</b> <input checked="" type="checkbox"/> |
| <b>Resource Implications:</b>                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                            |

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

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

| Risk number | Risk description                                                                                                                                                                                                                                                                                                                                                                                      | Score                               |
|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| BAF Risks   | <ul style="list-style-type: none"> <li>Inability to deliver safe and high-quality services</li> <li>Children and young people waiting beyond the national standard to access planned care and urgent care</li> <li>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</li> </ul> | 3 x 3 =9<br>4x5=20<br><br>3x 5 = 15 |
| 1.1         |                                                                                                                                                                                                                                                                                                                                                                                                       |                                     |
| 1.2         |                                                                                                                                                                                                                                                                                                                                                                                                       |                                     |
| 1.4         |                                                                                                                                                                                                                                                                                                                                                                                                       |                                     |

|                                                                        |                                                                                                                                                             |                                                                                                                                                                  |                                                                                                  |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <b>Level of assurance</b><br>(as defined against the risk in In Phase) | <input type="checkbox"/> <b>Fully Assured</b><br>Controls are suitably designed, with evidence of them being consistently applied and effective in practice | <input type="checkbox"/> <b>Partially Assured</b><br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness | <input type="checkbox"/> <b>Not Assured</b><br>Evidence indicates poor effectiveness of controls |
|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|



## 1. Executive Summary

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 17.12.25                                        | Minutes Approved   |
| Divisional updates                                                             | Reports x4 noted   |
| Liverpool Neonatal Partnership Monthly update                                  | Report noted       |
| Update on improvements to Neurodevelopmental Pathways report                   | Report noted       |
| Patient Safety update                                                          | Report noted       |
| Sepsis Report                                                                  | Report noted       |
| Children in Care Annual Report                                                 | Report noted       |
| Drug & Therapeutics Quarterly Report                                           | Report noted       |
| Sunflower House Improvement Plan                                               | Report noted       |
| Southport Learning Review                                                      | Report noted       |
| Clinical Effectiveness and Outcomes Board Chairs Highlight Report              | Report noted       |
| Board Assurance Framework                                                      | Report noted       |
| Board Assurance Framework - Risk 1.4 Assurance Review                          | Report noted       |
| Review of Externally Sourced Service Provision – interim report                | Report noted       |
| Clinical Guideline extravasation & infiltration                                | Guideline Ratified |
| Clinical Guideline for umbilical venous catheter care                          | Guideline Ratified |
| Clinical Guidelines taking blood cultures                                      | Guideline Ratified |
| Troubleshooting Broviac & PIC central venous access                            | Guideline Ratified |
| MRU hand hygiene Standard Operating Procedure                                  | SOP Ratified       |
| Notifiable Diseases Policy – C50                                               | Policy Ratified    |
| Pertussis (Whooping Cough) Policy – C60                                        | Policy Ratified    |
| Screening and management of multi-drug resistant organisms (MDRO) Policy – C58 | Policy Ratified    |
| C76 – Record Keeping Standards Policy                                          | Policy Ratified    |
| Safe Together and Always Right (STAR) Ward Accreditation Scheme                |                    |
| Standard Operating Procedure                                                   | SOP Ratified       |

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

None

## 4. Positive highlights of note

- SQAC considered a balanced range of reports, including both regular, cyclical reports and some one-off, focussed reports covering areas of challenge or development.
- SQAC engaged in substantive discussion on a range of key topics, acknowledged progress in addressing a number of risks and recognised that a range of challenges remain.

- SQAC was assured that the Divisions are well-sighted on their risks and continue to actively address them.
- SQAC was pleased to hear detailed updates on improvements in the Neurodevelopmental Pathways and on Sunflower House, noted progress on the Southport Incident Learning Action Plan, and welcomed the Deep Dive on Corporate Risk 1.4

**5. Issues for other committees**

None

**6. Recommendations**

The Board is asked to note the contents of the report

**Safety and Quality Assurance Committee**  
**Confirmed Minutes of the meeting held on Wednesday 17<sup>th</sup> December 2025**  
**Via Microsoft Teams**

|                           |                    |                                                               |     |
|---------------------------|--------------------|---------------------------------------------------------------|-----|
| <b>Present:</b>           | Fiona Beveridge    | SQAC Chair/Non-Executive Director                             | FB  |
|                           | Nathan Askew       | Chief Nursing Officer                                         | NA  |
|                           | 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  |
|                           | Rachael Pennington | Associate Chief Nurse – Surgical Division                     | RP  |
|                           | Jackie Rooney      | Associate Director of Nursing & Governance                    | JR  |
|                           | Cathy Wardell      | Associate Chief Nurse – Medicine                              | CW  |
| <b>In Attendance:</b>     | Julie Creevy       | Executive Assistant (minutes)                                 | JC  |
|                           | Veronica Greenwood | Director of Allied Health Professionals (AHP's)               | VG  |
| <b>25-26-194</b>          | Lyndsey Neil       | Clinical Lead for Children&Young People's Gender Service (NW) | LN  |
|                           | Prof. Dan Hawcutt  | Director of Liverpool Institute & Professor of Child Health   | DH  |
| <b>25-26-197 &amp;198</b> | Danielle Cormack   | Patient Safety Investigation Lead                             | DC  |
| <b>25-26-201</b>          | Lesley Cooper      | Domestic Operations Manager                                   | LC  |
| <b>25-25-201</b>          | Lachlan Stark      | Associate Chief Operating Officer, Corporate Services         | LS  |
| <b>25-26-202</b>          | Ian Gilbertson     | Deputy Chief Digital and Information Officer                  | IG  |
| <b>25-26-207</b>          | Carla Thomas       | Consultant Paediatric Intensivist, Trust Organ Donation Lead  | CT  |
| <b>25-26-208</b>          | Rachel Isba        | Clinical Lead for Improve My Life Chances                     | RI  |
| Observing                 | Jenny Devine       | Governor                                                      | JD  |
| Observing                 | Ava Kilbride       | Governor                                                      | AK  |
|                           | Peter White        | Chief Nursing Information Officer                             | PW  |
| <b>Apologies:</b>         | Alfie Bass         | Chief Medical Officer                                         | AB  |
|                           | Kelly Black        | Deputy Head of Neonatal Nursing, LNP                          | KBL |
|                           | Julie Grice        | Trust Mortality Lead                                          | JG  |
|                           | Beatriz Larru      | Director of Infection Prevention & Control                    | BL  |
|                           | Jill Preece        | Governance Manager                                            | JP  |
|                           | Erica Saunders     | Chief Corporate Affairs Officer                               | ES  |
|                           | Susan O'Neil       | Head of Neonatal Nursing, Liverpool Neonatal Partnership      | SON |

**25/26/188 Welcome and Apologies**

The Chair welcomed everyone to the meeting and apologies were noted.  
FB welcomed Jenny Divine and Ava Kilbride, Governors who were observing the meeting.

**25/26/189 Declarations of Interest** - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

**25/26/190 Minutes of the Previous Meeting**

The Committee members were content to **APPROVE** the minutes of the meeting held on 26<sup>th</sup> November 2025.

**25/26/191 Matters Arising/Review of Action log**

The action log was reviewed and updated.

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

**25/26/192 Divisional Updates**  
**Division of Medicine**

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

report including:

**Highlights:-**

- The Bringing Cancer Care Closer to Home pilot, had launched with the Northwest Cancer Children's Operational Delivery Network and funded by Cheshire and Merseyside, delivers chemotherapy and specialist treatments directly to families in Cheshire, Merseyside, and North Wales. Starting in early 2026, Alder Hey and Royal Manchester Children's Hospital will introduce a shared mobile cancer care unit to expand specialist support locally. The committee highlighted the need to evaluate outcomes and patient throughput.
- Sepsis compliance remains strong with over 90% of inpatients and ED patients receiving antibiotics within one hour for the last four-month period.
- The Division achieved over 90% document compliance in the past 7 months, with no overdue investigations in the last 14 months.

**Challenges & Progress:**

- High-risk metabolic service - this issue remains a challenge (risk score 20), progress includes:
  - Appointment of a Band 6 specialist nurse and a PCO (for 12 months);
  - Consultant advert for a metabolic paediatrician is live;
  - Collaborative redesign of the service with dietetics. There is an anticipated risk reduction within three months.
- Incidents that had remained open for more than 30 days are being actively managed, with the number currently reduced to 18. Daily monitoring and continued collaboration with clinicians are in place to address these ongoing cases.
- Complaint response: After almost a year of maintaining 100% compliance, the Division did not meet the 25-day response target due to a single complaint being processed one day late as a result of an administrative issue. Adjustments have been implemented to prevent future occurrences.
- Business continuity plans - progress is satisfactory and plans are currently at the governance sign-off stage, with compliance envisaged for January/February 2026.
- Tactical commander compliance training remains low, however additional sessions are scheduled with improvement expected by February 2026.

NA requested that the complaint responses should be expedited as soon as they are ready. CW agreed and confirmed that changes are being made to address this.

**Division of Surgery**

RP presented the Division of Surgery update and drew attention to a few key points from the report including:-

**Highlights:-**

- The Annual Cardiac Open Day was well attended, with positive feedback received from patients and families.
- The Division had successfully launched the VIS L vestibular infant screening programme, Alder Hey is the second in the world to launch this.
- The 7<sup>th</sup> Alder Hey Paediatric Vestibular Course was a success with delegates from 10 countries.

**Challenges:**

- HDU out-of-hours consultant cover and staffing: There are currently five HDU Consultants, two of whom are on locum contracts. A decision is pending regarding whether an additional post can be advertised for a locum, which would increase the total to six consultants. To provide 24/7 coverage, a minimum of eight consultants is required. Increased pressure is anticipated during the winter period; established escalation protocols and standard operating procedures are in place.
- Increase in missed follow up patients and associated harms, review of process for referrals to peripheral clinics is being undertaken to increase oversight and controls.
- A neurosurgery Never Event is currently under review in collaboration with an external partner, focusing on evaluating theatre procedures and ensuring consistency in surgical counts.
- Sepsis compliance: There was one sepsis episode in the Division of Surgery in November 2025, this patient did not receive antibiotics within 60 minutes – 0% compliance. The incident was reviewed, and it was noted that there had been a delay in prescribing antibiotics, delay in administering antibiotics and communication delay.
- Compliance with sepsis training among medical staff is currently lower than desired. Reminders had been issued, and continuous measures are being taken to enhance compliance rates.

- Business Continuity Plans are nearing completion, and the Division is currently awaiting confirmation of exercise dates for the new year.
- Following a challenging period complaints compliance had now been restored to full compliance.

GM requested clarification on the impact of current consultant coverage in the HDU during out-of-hours periods, as well as established protocols for managing urgent issues overnight. RP provided an overview of the present workflow, noting the role of ICU consultants as a safety net, and emphasised the distinct separation between HDU and ICU at Alder Hey in comparison to other hospitals. GM also sought additional details regarding inter-hospital collaboration. RP confirmed that each trust operates independently and maintains self-sufficiency. Investment had been made in training fellows and enhancing support through ICU consultant involvement.

### **Clinical Research Division**

LR presented the Clinical Research Division update, noting that the report was prepared by the team during LR's leave. The submitted IPR was from the previous month, LR confirmed that there were no new concerns within the IPR and advised that the updated IPR would be provided in January 2026. LR highlighted a few key points in the report, including:-

#### **Highlights:-**

- Positive feedback was received from a patient's family. Although they were disappointed that their child did not qualify for the study after screening, they nonetheless expressed satisfaction with their overall experience.

#### **Challenges:-**

- Ongoing issues with the Clinical Research Facility door were noted, the door had recently been replaced and now appears to be functioning, this would be closely monitored, especially with upcoming overnight stays which are scheduled in 2026.
- Oversight concern: Certain external researchers did not comply with established procedures, indicating a need for enhanced oversight and stricter adherence to processes. This matter is under review and will be further addressed.
- Sepsis training: there has been a decrease in compliance due to lapsed individuals; all have been contacted and are expected to complete training by the next DAG.
- Business continuity: A training exercise was undertaken on 12<sup>th</sup> November 2025; action cards were evaluated; and the senior team attended.
- LR advised on the Unintended Protocol deviations and confirmed that there had been Four unintended deviations this month, all linked to clinical incidents. New process allows for better learning and linkage between protocol and clinical incidents.

FB thanked LR for the clear explanation, especially regarding protocol deviations.

### **Community and Mental Health Division**

JP presented the Community & Mental Health Divisional update and drew attention to a few key points from the report including:-

#### **Highlights:-**

- The Eating Disorder Service for young people (EDYS) achieved accreditation by the Royal College of Psychiatrists' Quality Network for Community CAMHS-eating disorder (QNCC-ED), this was awarded on 6<sup>th</sup> November 2025 and is valid until 14th May 2028.
- The rare diseases service, run jointly with Liverpool Women's hospital, is piloting a gene discovery clinic with NIHR funding. Roald Dahl funding is expected for 26/27, but matched funds would be needed, early signs of the pilot are positive
- Speech and Language Therapy team had secured funding for Liverpool Early Years Service and to restart the augmentative and alternative communication service.

#### **Challenges:**

- Sunflower House: Ongoing environmental issues, staff sickness, and a need for staff training. The unit is closed to new referrals; the unit currently has 3 children in situ.
- Staff development days are underway. A new Head of Service commenced in November 2025. A report with further detail is due to be presented at the January 2026 SQAC meeting.
- The implementation of CLEO in Developmental Paediatrics for electronic prescription transmission to community pharmacies had revealed several system issues, resulting in a temporary rise in incidents in month. These concerns are currently being managed by the Divisional Pharmacist and project team, and improvement measures are actively underway.

**Resolved:** SQAC received and **NOTED** the Divisional Assurance Reports.

**25/26/193** **Liverpool Neonatal Partnership Monthly update**  
SQAC **NOTED** the Liverpool Neonatal Partnership Monthly update.

**25/26/194** **Risk relating to Pathways Trial of puberty-suppressing hormones for gender incongruence**  
LN presented the risk relating to Pathways Trial of puberty-suppressing hormones for gender Incongruence and drew attention to a few key points from within the report; LN outlined two key risks on the divisional risk register for the service:-

- Risk regarding Safeguarding and Consent (Gillick Competence): The trial had attracted considerable attention, with controversy regarding prescribing puberty blockers to young people. This remains subject to legal scrutiny regarding the determination of Gillick competence. Alder Hey staff must assess Gillick competence, with ongoing concerns about accurately establishing the appropriate threshold. Legal advice had been sought, and relevant guidance is being developed, however the associated risks continue to be significant.
- There is currently no established endocrinology pathway for the trial. The standard procedure would involve referral to Leeds Teaching Hospital; however, Leeds had not yet been designated as a research site. Efforts are ongoing to address this matter.

FB confirmed that the Leeds issue would remain on the risk register until resolved, and emphasised the importance of establishing a comprehensive, trust-wide policy on Gillick competence to ensure consistency both within the Trust and across the broader network.

DH advised that Leeds Teaching Hospital is willing to act as the Endocrinology service; and subcontracting is possible and has precedent in other studies. DH emphasised the need for careful contracting and assurance.

DH clarified that for the trial, parental consent is legally required for under-16s, with assent from the young person; Gillick competence is relevant for clinical consent, not trial participation.

**Resolved:** FB requested DH to provide written confirmation of the legal requirements.

NA acknowledged the clarity within the report and asked if the pathway included a second opinion for families who disagree with the Gillick assessment, and whether adaptations are made for neurodiverse patients. LN advised that multiple clinicians (MDT) assess each case; both parent and child must consent/assent. The team has expertise in neurodiversity and will adapt communication as needed.

LC requested clarification regarding whether the Research Division would address the issue of subcontracting with Leeds Teaching Hospital. DH responded that this is considered standard procedure and assured that further confirmation would be provided outside of the meeting. DH & LC agreed to resolve this issue outside of this meeting. LC noted that the risk may be closed or amended once this issue had been resolved.

RP highlighted the complexity of consent for research versus treatment and offered Ethics support from Ed Horowitz and the Ethics Committee for any hypothetical case discussions.

FB supported this, suggesting MDTs use hypothetical scenarios to clarify understanding of Gillick competence.

JD sought clarity regarding the study's timeframe and long term-monitoring.

LN clarified that the trial prescribes Puberty suppressing hormones for up to two years, with follow-up up for up to five years from trial launch; longer-term follow-up may be sought if further funding is secured.

FB emphasised the significance of this discussion, as well as the need to identify and manage risks effectively to provide comprehensive board assurance.

**Resolved:** SQAC received and **NOTED** the Risk relating to Pathways Trial of puberty-suppressing hormones for gender incongruence

**25/26/195** **QNCC Accreditation - Alder Hey Community Eating Disorders Service**

- The service had gained accreditation from the Quality Network for Community CAMHS (QNCC) for eating disorders, following a thorough peer review process. Accreditation is valid until May 2028.

- Key achievements and recommended areas for further work are included in the report, along with actions taken. The accreditation strengthens Alder Hey's leadership in standardising care for children and young people with eating disorders across Cheshire and Merseyside.
- The team is proud of the recognition and continues to address recommendations for further improvement.

FB congratulated the team, highlighting the value of the accreditation and the importance of holistic service provision.

FB stated that the Trust would consider further QNCC memberships based on cost-benefit and current service ratings.

SQAC were in general agreement that the accreditation is a positive achievement and strengthens the trust's leadership in standardising care across Cheshire and Merseyside.

**Resolved:** SQAC received and **NOTED** the QNCC Alder Hey Community Eating Disorders Service Accreditation.

#### ---- Safe ----

### 25/26/196 Patient Safety Update

JR presented the Patient Safety update and drew attention to a few key points within the report:-  
The Patient Safety Programme Board met on 27<sup>th</sup> November 2025.

#### Highlights:-

- There had been sustained positive reporting of incidents alongside a decrease in medication errors.
- There are notable improvements in the timely administration of antibiotics for both inpatients and emergency department patients.
- Workstream 10 (Embedding PSIRF):-Annual self-assessment and audit against the National PSIRF had been completed and the Trust had achieved a 91% rating, an 8% improvement from the previous year. While certain areas are still identified as requiring attention, there would be an action plan in place for 2026.
- Martha's Rule had been implemented across all inpatient wards, with an average response time of 30 minutes.
- The TPN Quality Improvement project shows a reduction in TPN-related incidents and errors, with ongoing national collaboration and sharing of learning. All reported incidents were no harm or low harm.
- Major trauma data dashboard is live, and trauma training competencies had been relaunched.
- The NatSIPPS2 decision document was approved and is now a focus for quality improvement, with regular updates planned.

#### Challenges:-

- There had been an increase in unacknowledged result notifications, particularly within the Surgical departments, as well as inconsistent utilisation of the current system. The implementation of automation for normal blood result notifications is currently under consideration.
- Patient safety learning response times are not being met; timeframes are being extended to eight weeks for 2026, with a revised action plan.
- No items were escalated from patient safety this month.

NA recommended conducting a deep dive/in-depth review of unacknowledged notices within the next three to six months, noting that existing controls had reached their capacity and additional evaluation is necessary. FB concurred, highlighting the importance of determining the effectiveness of team-specific arrangements and informing teams about the forthcoming review.

KB queried whether benchmarking with other Trusts had been undertaken to identify best practices. JR confirmed this had likely been completed but would review and provide further assurance.

GM requested a completion date for the external review of never events in Surgery; JR confirmed that the review is due to commence in January 2026 and would last for six months and confirmed that this date would be added to the report. JR confirmed that the Terms of Reference for the review are approved and that the team are ready to commence in January 2026.

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

## **25/26/197 Patient Safety Incident Investigation (PSII) – Paralysis following Spinal Surgery**

DC presented the Patient Safety Incident Investigation (PSII) report – Paralysis following Spinal Surgery and provided a comprehensive overview detailing an incident summary, initial response, key findings, improvements made to date, recommendations and next steps.

### **Key findings:-**

- Internal investigation had found no evidence that paralysis could have been predicted beyond known surgical risks.
- Risk of paralysis was communicated verbally and via letter, however the family reported not being aware of this risk.
- Early signs of deterioration were noted from 8:16pm, however no medical review occurred until 11:10pm.
- Lack of an escalation process in the spinal care pathway contributed to delayed intervention.
- Investigation concluded that earlier intervention may have improved the outcome; the delay caused harm.

### **Recommendations:-**

- Strengthen trust-wide response to deteriorating patients through improved training, escalation processes, and governance.
- Develop a clear escalation process within the spinal pathway for post-operative deterioration.
- Implement e-consent for elective surgery, including links to trusted external information.
- Agree communication preferences with families of complex patients for consistent updates.
- Complete baseline neurovascular observations pre-surgery for timely detection of changes.
- Ensure clinical input in equipment purchasing for suitability and compatibility.
- Review the satellite enhanced care model (Ward 4A HDU) for consistency.
- Introduce joint medical and nursing training on early recognition and management of sepsis.

DC advised that many actions are already underway; and that all actions would be uploaded to the In-Phase database for monitoring.

FB Expressed sympathy for the family; and asked for clarification on the distinction between 4A HDU and central HDU and sought clarity how the enhanced care model would be implemented.

RP explained the need to clarify and possibly rename "high dependency" care on wards to "enhanced care" to avoid confusion and ensure clear boundaries of care.

GM praised the thoroughness of the investigation; and asked about the frequency of such complications and the adequacy of risk communication to the family. GM also queried how the initial deterioration should have been managed and whether earlier intervention would have changed the outcome.

DC had noted that the risk was mentioned in clinic and in a letter, however the family did not recall this; and emphasised the importance of using e-consent and clear, accessible information. DC stated that earlier emergency surgery could have improved the outcome, but the team initially interpreted symptoms as typical post-op recovery.

KB requested earlier circulation of such extensive reports for adequate review. KB observed the challenge of expecting nurses to recognise rare complications and questioned how escalation pathways can address all rare risks.

NA highlighted the need for generic monitoring tools and ensuring nursing staff can articulate changes to medical staff, especially as resident doctors rotate frequently. NA suggested that the deteriorating patient group should address escalation challenges.

FB highlighted concerns regarding resident doctors' timely attendance due to competing responsibilities and raised the question of whether it would be appropriate to activate the response team earlier. It was also recommended to engage patient safety partners and families in creating clear and accessible language for effective risk communication.

DC welcomed the idea of involving patient safety partners in improving risk communication.

RP highlighted the significance of the human element in clinical care, underscoring the value of well-defined escalation pathways and comprehensive baseline documentation. RP further emphasized that consent should be regarded as an ongoing process rather than merely a form.

**Resolved:** SQAC received and **NOTED** the Patient Safety Incident Investigation (PSII) – Paralysis following Spinal Surgery.

## **25/26/198 Patient Safety Incident Investigation (PSII) – Never Event Administration of medication by the Wrong Route**

DC presented the Patient Safety Incident Investigation (PSII) – Never Event Administration of medication by the wrong route and provided a comprehensive overview detailing an incident summary, initial response, key findings, improvements made to date, recommendations and next steps. DC drew attention to a few key points within the report:-

### Key Findings

- The error was facilitated by similar equipment (Mic-Key buttons and extension lines) used for both routes, lack of clear labelling, and insufficient handover communication.

### Systemic Issues Identified:

- The vesicostomy Mic-Key button is used “off-label” for bladder drainage, and there is no alternative device specifically for this purpose.
- Staff were not always confident or familiar with the equipment and procedures for off-label device use.
- Handover processes, while structured, did not always ensure critical information (like which line was on free drainage) was communicated.
- Confirmation bias in secondary medication checks was observed, with double-checking sometimes becoming a routine rather than a robust safety step.
- This was the first such incident reported in the Trust.
- Nationally, similar Never Events had occurred, highlighting a broader risk with enteral and urinary device misconnections.
- The incident did not directly cause further clinical harm, but it caused distress to the patient’s family and highlighted gaps in safety systems.

### Lessons Learned

- Importance of Clear Communication:
- Effective handover and clear labelling of medical devices are critical to patient safety, especially when multiple devices are in use for different functions.
- Need for Staff Training and Confidence:  
Many staff lacked confidence or experience with off-label device use, underlining the need for targeted education and support.
- Systemic Safeguards Over Individual Blame:  
The review emphasized learning and system improvement rather than individual blame, except in cases of reckless or malicious behaviour.
- Confirmation Bias Risks:  
Double-checking medication administration must be independent and thorough to avoid confirmation bias and prevent errors.

DM updated the committee on the Next Steps / Recommendations, education and policy, organisation actions and family and patient involvement and provided an update regarding process improvement and education and policy

JP recommended enhancements to the EPR system to facilitate inclusion of narrative descriptors for neurovascular assessments, thereby promoting improved handover and greater clarity

FB referred to the recommendation for bedside handover and raised a question about potential interruptions, which will be considered in future discussions.

**Resolved:** SQAC received and **NOTED** the Patient Safety Incident Investigation (PSII) – Never Event Wrong Route Medication

## **25/26/199 Infection Prevention Control Quarterly Report**

**Resolved:** SQAC **NOTED** the Infection Prevention Control Quarterly Report.

## 25/26/200 Fuller Recommendations Report

CW presented the Fuller Recommendations Report summarising the work on the Fuller Report Phase 2 and drew attention to a few key points within the report:-

- The original Phase One self-assessment action plan had been updated.
- A new action plan based on Phase Two recommendations had been developed; outstanding actions from Phase One are now incorporated, resulting in a single, combined plan for continuity and accountability.
- The working group continues to progress actions, with some actions outstanding.
- Assurance was provided that strong arrangements are in place to safeguard the security and dignity of deceased children and young people, and completing all actions remains a priority.

The updated consolidated action plan is scheduled for submission to SQAC, with the aim of delivering a comprehensive report to the Trust Board in early 2026. This report will integrate updates from both October and December.

FB expressed her thanks to CW and NO and noted the clarity of the report

**Resolved:** SQAC received and **NOTED** the Fuller Recommendations Report

## 25/26/201 Cleaning Standards Report

LS presented the Cleaning Standards Report and requested SQAC to NOTE the progress made against the original action plan presented in June 2025 and drew attention to a few key points within the report:-

### Progress and Highlights:

- LS reported that substantial progress has been achieved to date and advised that cleanliness data is now being generated and disseminated more broadly to both clinical and non-clinical managers, as well as to various committees. This information is also being shared with nursing staff, estates personnel, and other colleagues throughout the organisation.
- Construction of cleanliness charters and a star rating system is underway.
- Audit information is being refined and disseminated to Divisions, aiming to embed cleaning ownership across the organisation (not just domestics, but also nursing and estates).
- Support had been received for procurement of new domestic equipment, especially for cleaning floors, addressing issues identified in audits.

### Challenges:-

- Ongoing work to refine audit data and ensure it is actionable and accessible.
- Continued need to embed cleaning responsibilities across all relevant teams.

FB acknowledged the value of an objective, data-driven assessment of cleaning challenges and inquired about current approaches to communication and engagement, questioning whether additional efforts are required to ensure staff and patients or carers remain informed and involved.

LS responded that communication and engagement are progressing, citing the formation of a cleaning collaborative and strong participation from both clinical and non-clinical teams. LS noted an observable increase in responsiveness and involvement when cleanliness concerns are identified, which represents an improvement from previous practices.

LS further underscored the importance of ongoing enhancement and effective dissemination of information, particularly as cleaning standards intersect with water hygiene and the built environment.

FB stated that SQAC is assured by the report and welcomed a further progress report in June 2026.

**Resolved:** SQAC received and **NOTED** the Cleaning Standards Report and welcomed an update in June 2026.

## 25/26/202 AlderC@re Data Quality Demographic report

IG presented the AlderC@re Data Quality Demographic Report which detailed how well Alder Hey captures key demographic data, focussing on ethnicity and religion and drew attention to a few key points within the report:-

- While most demographic data is collected thoroughly, compliance rates for reporting ethnicity and religion remain below expectations, which presents challenges for initiatives aimed at reducing health disparities.

### Challenges:-

- Staff may experience challenges in requesting sensitive information, while patients and their families can be hesitant to disclose it. Additionally, current automated systems, such as check-in kiosks, often lack functionality for capturing this data.

- Legal regulations require the inclusion of a "not stated" or "prefer not to say" option.

Improvement Plan: Actions include collaborating with the EDI team; providing staff education; upgrading kiosks; creating educational materials; and developing enhanced scripts to improve data collection. The goal is to improve data quality, meet statutory requirements, and enable more effective health inequalities work.

FB expressed support for the action plan and commended the thorough approach to data collection, indicating an interest in future developments.

NA highlighted the intention to require ethnicity and religion as mandatory fields, while recognising existing legal restrictions and recommended positioning the "decline to answer" option at the end of the list to promote more comprehensive data collection.

IG concurred with this recommendation and confirmed that the proposed changes would be implemented, with ongoing oversight and a commitment to report on progress within 3 - 6 months.

FB emphasised the significance of providing clear and accessible messaging to articulate the rationale for requesting information, as this approach can foster trust and enhance compliance.

**Resolved:** SQAC received and **NOTED** the AlderC@re Data Quality Demographic report

### Southport AR Learning Review Action plan

25/26/203

NA presented the first formal action plan for the Southport Learning Review and drew attention to a few key points within the report:-

- NA advised that the Action Plan would be monitored monthly at SQAC and quarterly at Trust Board.
- Six actions had been completed, with evidence being gathered.
- Four actions remain red due to the need for agreement on dates or assignment of leads; work is ongoing to resolve these.
- The action plan is also being shared with the ICB and Lancashire Children Safeguarding Partnership as part of their rapid review.
- The Trust is awaiting confirmation on whether a full safeguarding review would be commissioned.

FB requested that the table showing action progress be replicated in the Chair's report to the Board for assurance and included quarterly.

LC noted that the digital action plan included in the pack was a divisional plan covering broader digital improvements, not just those related to the learning review, and suggested refining the evidence to focus on relevant actions.

NA agreed, suggesting JR meet with LC to refine the action plan and ensure only relevant actions are included for oversight. LC clarified the need to avoid confusion for non-executives by focusing on the main digital actions rather than listing every minor step.

Colleagues agreed to refine the plan to highlight major actions, with the understanding that minor actions support the completion of larger objectives.

**Resolved:** SQAC received and **NOTED** the AR Learning Review Action Plan

### ---- Effective ----

25/26/204

### Clinical Effectiveness and Outcomes Board Chairs Highlight report

JR presented the Clinical Effectiveness and Outcomes Board Chairs Highlight report and drew attention to a few key points within the report:-

- CEOB had met on 5th December 2025
- Continued improvement was noted in learning from clinical audits.
- The MIAA clinical audit report was presented at ARC, with recommendations to be brought to CEOB; the report received a "Moderate Assurance" rating and was signed off at ARC.
- Several policies were ratified and are on the SQAC agenda.
- A biannual clinical audit masterclass was held and was well attended by over 40 staff.
- There was no formal issues to escalate from the meeting.

**Resolved:** SQAC received and **NOTED** the Clinical Effectiveness and Outcomes Board Chairs highlight report and **NOTED** the ongoing improvements.

25/26/205

### Mortality Report Quarter 2 2025-26

**25/26/206 Board Assurance Framework**

NA presented the Board Assurance Framework and advised that the Board Assurance Framework received its usual updates and continues to be reviewed in the context of the current financial environment. NA advised that there were no specific issues for SQAC's attention this month.

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

**25/26/207 Organ Donation Annual Report**

CT presented the Organ & Donation Annual Report and drew attention to a few key points within the report:-

- 8,300 people are on the transplant waiting list, including 252 children and young people under 18 which is the highest number to date.
- During the previous year there were 64 paediatric organ donations, highlighting a significant mismatch between demand and supply.
- Alder Hey referred 24 patients for organ donation in the last financial year; only 4 were considered medically suitable by NHS Blood and Transplant. Of those 4, one was declined by the coroner, one had an acute contraindication, leaving 2 potential donors. Both families were approached; one gave consent, resulting in one actual organ donation.  
The donated heart used new technology under MHRA compassionate authorisation - the first such use in the UK for a young person. CT advised that this could change the future direction of paediatric heart transplantation.
- CT reported on the ongoing improvements in trust support for organ donation, including policy, education, and organ donation promotion.

FB highlighted the cultural change at Alder Hey, noting the importance of consistent work to increase donor identification and the impact of even a single donation. FB expressed her thanks to CT for her ongoing support.

NA echoed FB comments and thanked CT for her leadership, and acknowledged the historical challenges, and welcomed the positive change in trust support and reporting.

**Resolved:** SQAC received and **NOTED** the Organ Donation Annual Report

**25/26/208 Improve My Life Chances Report**

RI presented the Improve My Life Chances Report and drew attention to a few key points within the report:-

- Flu Fairies Programme: The team, comprising nursing professionals, administered nearly 1,000 vaccinations - more than twice the number delivered the previous year. Vaccinations were provided to children, staff, and certain parents or carers. If only children had received the vaccines, this would account for approximately 0.2% of the total child population in Cheshire and Merseyside, potentially affecting regional uptake statistics.
- Well-being Hub had helped households access over £500,000 in entitled benefits and supported debt restructuring, emphasising the broader impact beyond just benefits.
- Organisational Structure: This was the first SQAC report since aligning the Improve My Life Chances structure with Vision 2030. The first partnership meeting had strong attendance from across Cheshire and Merseyside, facilitating new connections and shared learning.
- Vaccination Programme Funding: Currently funded by NHS England for the second year. Future funding is uncertain, but early discussions with the charity are underway for small-scale support, especially for the flu fairies. The programme also generates some income per vaccine delivered.
- Upskilling Staff: There is an aspiration to offer public health upskilling to all staff, starting with vaccination conversations. RI is working with the Director of AHP's and AHP's who are already active in public health.
- Health Needs Assessment: RI advocated for a comprehensive health needs assessment for the population served by Alder Hey, to identify met and unmet needs, especially for children with complex, lifelong needs. RI noted the growing cohort of children with long-term specialist care needs due to medical advances. A focused health needs assessment is underway for Tier 4 inpatients at Sunflower House, already revealing opportunities for system improvements.

FB expressed her thanks to RI for the report and the ongoing work.

**Resolved:** SQAC received and **NOTED** the Improve My Life Chances Report

## 25/26/209 NICE Guidance Compliance Quarter 2 2025-26 report

JR presented the NICE Guidance Compliance Quarter 2 2025-26 report to provide oversight and assurance on completion and compliance with NICE Standards for Quarter 2 2025-26 and drew attention to a few key points within the report:-

- 46 NICE publications had been received; 16 were relevant to the Trust.
- 26 NICE guidance documents are open across the Trust; 23 are at baseline assessment stage, 3 at action plan stage.
- Baseline Assessment Compliance: Standard is completion within three months. Currently, 17 open baseline assessments, with 9 overdue and outside the three-month compliance rate.
- Two action plans remain open - one in the Medicine Division and one in the Community & Mental Health Division. Both had been outstanding for more than 18 months and have been escalated to the respective Divisional triumvirates for further action.
- The NICE app in InPhase had gone live since the report was submitted, expected to improve assurance and progress tracking for baseline assessments and action plans.

### Challenges:-

- The ongoing lack of compliance with completion of baseline assessments, mainly due to lack of staff availability. These have been escalated for urgent action and will be monitored at CEOB.

CW highlighted the ongoing challenges faced by the Medicine Division, particularly in the areas of epilepsy and endocrine resulting from staff illnesses and a lack of specialist support. CW further confirmed that Divisional oversight is in place and measures are being implemented to ensure compliance.

RP reported that within the Division of Surgery, one outstanding matter concerns a minor aspect of urology guidance, which will be followed up with clinicians, while another relates to neonatal guidance currently led by LNP.

SQAC acknowledged that both divisions are actively working to resolve these issues.

FB advised that should progress remain insufficient, a comprehensive review of NICE compliance may be initiated in early 2026, with additional evaluation scheduled within the January divisional reports.

**Resolved:** SQAC received and **NOTED** the NICE Guidance Compliance Quarter 2 2025-26 report

### ---- Well Led ----

#### 25/26/210 Bed and Bedrail Safety Policy

SQAC received, **NOTED** and RATIFIED the Bed and Bedrail Safety Policy

#### 25/26/211 Clinical Audit & Service Evaluation Policy

**Resolved** SQAC received, **NOTED** and RATIFIED the Clinical Audit & Service Evaluation Policy.

#### 25/26/212 C42 Dissemination of National Alerts Policy

**Resolved:** SQAC received, **NOTED** and RATIFIED C42 Dissemination of National Alerts Policy

### ---- Any Other Business ----

#### 25/26/213 Any Other Business

None received

### ---- Board Assurance ----

25/26/214 The key assurances and highlights report was presented to the Board meeting held on 6<sup>th</sup> November 2025

**Date and Time of Next Meeting:** 21<sup>st</sup> January at 9.30 – 11.30 am via Microsoft teams

## BOARD OF DIRECTORS

Thursday, 5<sup>th</sup> February 2026

|                                         |                                                                                                                                                                                                                                                                                               |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Paper Title:</b>                     | <b>Strategic People Update</b>                                                                                                                                                                                                                                                                |
| <b>Report of:</b>                       | <b>Melissa Swindell, Chief People Officer</b>                                                                                                                                                                                                                                                 |
| <b>Paper Prepared by:</b>               | Sharon Owen, Jo Potier, Katherine Birch, Angela Ditchfield, Gill Foden                                                                                                                                                                                                                        |
| <b>Purpose of Paper:</b>                | Decision <input type="checkbox"/><br>Assurance <input type="checkbox"/><br>Information <input type="checkbox"/><br>Regulation <input type="checkbox"/>                                                                                                                                        |
| <b>Action/Decision Required:</b>        | To note <input type="checkbox"/><br>To approve <input type="checkbox"/>                                                                                                                                                                                                                       |
| <b>Summary / supporting information</b> | To provide a strategic update to the Board of the key people issues during January 2025.                                                                                                                                                                                                      |
| <b>Strategic Context</b>                | <b>Outstanding</b> care and experience<br><b>Collaborate</b> for children & young people<br><b>Revolutionise</b> care <input type="checkbox"/><br><b>Support</b> our people <input type="checkbox"/><br><b>Pioneering breakthroughs</b><br><b>Strong Foundations</b> <input type="checkbox"/> |
| <b>Resource Implications:</b>           |                                                                                                                                                                                                                                                                                               |

| <b>Does this relate to a risk? Yes R No <input type="checkbox"/></b>                             |                                                                                                                                                             |                                                                                                                                                                  |                                                                                                  |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <b>If "No", is a new risk required? Yes <input type="checkbox"/> No <input type="checkbox"/></b> |                                                                                                                                                             |                                                                                                                                                                  |                                                                                                  |
| 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                                                                                               |
| <b>Level of assurance</b><br>(as defined against the risk in InPhase)                            | <input type="checkbox"/> <b>Fully Assured</b><br>Controls are suitably designed, with evidence of them being consistently applied and effective in practice | <input type="checkbox"/> <b>Partially Assured</b><br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness | <input type="checkbox"/> <b>Not Assured</b><br>Evidence indicates poor effectiveness of controls |



## **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 November and December 2025.

## **1. Thriving Culture**

The Thriving Culture programme of work continues to progress with most recent activity and focus concentrated on the new values, safety culture, thriving teams and thriving leaders.

### **New values**

Since the new values were formally agreed by the Board in December 2025, the values working group is now focussed on the implementation plan which aims to make our values visible in everyday behaviour, decision-making and leadership. The plan will ensure that our values are not just words on a wall, but actions that shape how we treat each other (staff and children & families) and partners. It also recognises that the new values are what we strive for (rather than who we are) and builds in help and support to achieve them, in addition to implementing systems to identify when there are barriers. The implementation phases focus on: awareness & understanding (including development of a new values-in-action framework and toolkit); integrating the values into people practices and patient experience (including recruitment, induction and appraisals, leadership design and development); embedding into everyday routines and practices; and measurement.

### **Safety culture**

Since the approval of the safety culture training pilot, a working group of clinical and non-clinical staff with expertise in safety culture and human factors have convened to agree and begin development of a safety culture training programme to be piloted initially in areas where staff survey safety culture indicators are low. The development phase is due to be complete in March with a view to the pilot commencing from April onwards. Additionally, as part of the deteriorating patient programme of work, two further pieces of work have been agreed with a focus on raising concerns and nursing voice, and development of a restorative, just and learning deteriorating patient learning review forum, attended and overseen by the Chief Medical Officer and facilitated by the Patient Safety Lead and Director of Culture & OD.

### **Thriving Teams**

Whilst the Thriving Teams Index is in development with the Digital team, the current staff survey data has been analysed to identify and cluster teams across the organisation according to their people promise scores. This data has been shared with the People Committee and is being actively used in the safety culture work, the Thriving Teams MDT and by the OD team to identify teams who are struggling and to identify the right support, with the right people, at the right time.

## **Thriving leaders**

A new thriving leaders programme of work is in development to support leaders to adapt to changing roles and responsibilities, understand and be supported through change themselves, and lead others through change. This programme will be offered, in addition to the Strong Foundations leadership offer already well established, to all senior leaders initially with a focus on ongoing wellbeing and coaching support, induction and orientation to changing roles, responsibilities and structures, leadership self-assessment using the new national NHS leadership and management competencies (being embedded as standard in all new leadership job descriptions and aligned with the new values), and focused collective leadership coaching and development.

## **1. Equality, Diversity, and Inclusion**

Equality, Diversity, and Inclusion (EDI) remain a core strategic priority, guiding our work to create a culture where staff feel safe, supported, and empowered to thrive, which in turn enables us to deliver exceptional care for our children and young people.

Our staff networks remain an important source of insight, helping guide the EDI work. We recognise the crucial role they play in offering our staff safe, supportive spaces, learning from lived experiences, and shaping improvement.

We are pleased to report that our Equality Delivery System (EDS22) assessment is now complete, with the Trust achieving a score of 26, rated Achieving representing an improvement on last year's position. The EDS22 is the NHS national framework for improving equality. It looks at performance across three areas:

- Commissioned or Provided Services
- Workforce Health and Wellbeing
- Leadership

Our score shows solid organisational commitment to this work, demonstrating continued progress in embedding equality across our services, workforce, and leadership.

Support needs from staff continues to increase, and so alongside closer partnership working between HR, Freedom to Speak Up Guardian, and SALS, this ensures that staff have access to timely, appropriate support, and we tailor initiatives that support both staff and managers.

In January, we also held the first Managers Reasonable Adjustments Guidance Group, delivered in partnership with EDI and HR. The session was well attended, with a high level of engagement, questions, and discussion, highlighting both the need for this space and managers commitment to support staff effectively.

We are also pleased to share that Train the Trainer Active Bystander training will begin in February, supported by 12 trained individuals who will help deliver the programme and embed learning across the organisation. This is a significant step forward in strengthening our approach to tackling inappropriate behaviour and discrimination.

In April we will launch our first ever internationally recruited staff development programme, 'Grow to Lead', and expressions of interest for our will go out in February. This programme will provide tailored development support, career progression opportunities, and resources to enhance inclusion and retention for internationally recruited colleagues.

## **4 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:

- A review of mandatory training compliance is ongoing (as previously reported). Although overall Trust compliance remains over 90% there are pockets of non-compliance linked to specific staff groups, teams, individuals and topics. The mandatory training task and finish group has met twice to consider a range of factors impacting on compliance and to explore / action solutions. Key topics of focus (as discussed extensively at Education Governance, SQAC and the last People Committee) include Safeguarding, Resuscitation and Sepsis. Sepsis was recently considered at EGC, with a refreshed framework approved, both in terms of the requirements for certain staff groups and in respect of the update to the on-line training. For those priority topics which require in person attendance, wider factors appear to be impacting on compliance and whilst a range of mitigation has been actioned, further work is required with teams / Divisions.
- The new strategic partnership with Edge Hil University was signed on the 22.1.26. This brings together the expertise, experience, and shared values of both partners to foster meaningful collaboration in the fields of health and education. Rooted in a shared commitment to improving outcomes for children and young people, this partnership will enable both organisations to work more creatively, collaboratively, and effectively across professional boundaries. Initial work is focusing on schools / early career teachers.
- As we enter Q4, the focus has turned to forward planning for 26/27, and discussions as to training needs priorities are underway (including apprenticeship opportunities). These will inform the overall plans for 26/27.

### **PDR Update**

The PDR process was reviewed and refocused in April 2025, modifying the paperwork and approach based upon feedback from a range of stakeholders. This resulted in streamlined, fresh paperwork, a clear focus on delivery and understanding of objectives, over laid by the support required to enable colleagues to fulfil their responsibilities through training and support. The training programme was relaunched accordingly and a request for senior engagement at a divisional level to articulate the overarching divisional and organisational objectives was made, facilitating the golden thread from Trust, to division, service, team and individual and team. Feedback from users has been positive with colleagues appreciating the clarity the new approach and paperwork brought and the cleanliness of the paperwork, linked to clear expectations of how to bring each section to life, through two-way discussion.

### **PDR Compliance Rates**

The Trust expectation is for all colleagues to have a PDR on an annual basis, as a minimum. To date, 76% of colleagues have an in date PDR.

The L&D team and innovation, in the form of digital innovation and RPA, with charity funding support have worked in partnership to create a PDR app, which launched 26<sup>th</sup> January 2026. The outcome of which will be once a PDR is signed off in the app; it will automatically be updated into ESR and will be visible for reporting purposes the following day. It is anticipated that this will increase compliance and initial feedback has been positive.

## **2. Employee Relations & Wellbeing**

### **Sickness Absence**

The Trust current sickness position (in-month) as of December 2025 is 7.36 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 4.66% with a target of 2.5%, and STS at 2,71% with a target of 2%). Alderhey are not an outlier, these higher rates of sickness absence are being experienced by our colleagues in other Trusts across Cheshire and Mersey.

The dedicated HR sickness support team established in September 2025 continue to provide tailored support to improve levels of absence across the Trust, and stress consultation pathways are being offered for all appropriate cases, as stress related sickness absence remains the top reason for absence. Working in collaboration with our Occupational Health Provider, SALS and managers there are interventions in place to enable staff to remain well and in work.

The team are also implementing the actions following the 90-day sickness improvement programme which has included (but not limited to):

- Enhanced and bite size training as well as bespoke training
- Support with timely and appropriate reasonable adjustments
- Working differently and in partnership with staff side colleagues
- BI power dashboard providing greater analysis of data and triangulation of data

All 38 staff members currently on long-term sick leave have action plans in place. Additionally, the team is collaborating with all managers to address hotspot areas, especially by providing extra support for managing stress.

### **Recommendations & Board Actions**

The board are asked to note the content of the report and support the actions being taken by the people services teams to support colleagues and mitigate the risks.

## BOARD OF DIRECTORS

Thursday, 5<sup>th</sup> February 2026

|                    |                                                                                               |
|--------------------|-----------------------------------------------------------------------------------------------|
| Paper Title:       | Chair's Report from The People Committee Meeting held on the 29 <sup>th</sup> of January 2026 |
| Report of:         | Chair of the People Committee                                                                 |
| Paper Prepared by: | Chair of the People Committee, Jo Revill                                                      |

|                                                             |                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Purpose of Paper:                                           | Decision <input type="checkbox"/><br>Assurance <input checked="" type="checkbox"/><br>Information <input checked="" type="checkbox"/><br>Regulation <input type="checkbox"/>                                                                                                                                                                                                        |
| Action/Decision Required:                                   | To note <input checked="" type="checkbox"/><br>To approve <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                       |
| Summary / supporting information:                           | This paper provides a summary from the recent People Committee meeting held on 19 <sup>th</sup> November 2025, along with the approved minutes from the 25 <sup>th</sup> September 2025 meeting.                                                                                                                                                                                    |
| Strategic Context<br><br>This paper links to the following: | <b>Outstanding</b> care and experience <input checked="" type="checkbox"/><br><b>Collaborate</b> for children & young people <input type="checkbox"/><br><b>Revolutionise</b> care <input type="checkbox"/><br><b>Support</b> our people <input type="checkbox"/><br><b>Pioneering</b> breakthroughs <input type="checkbox"/><br><b>Strong Foundations</b> <input type="checkbox"/> |
| Resource Implications:                                      | None                                                                                                                                                                                                                                                                                                                                                                                |

| Does this relate to a risk? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                          |                                                                                                                                    |                                     |                                                                                                                                         |                          |                                                                         |
|-------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------|
| Risk Number/s                                                                                   | Risk Description         |                                                                                                                                    |                                     |                                                                                                                                         |                          | Score                                                                   |
| BAF Risks                                                                                       |                          |                                                                                                                                    |                                     |                                                                                                                                         |                          |                                                                         |
| Level of assurance<br>(as defined against the risk in InPhase)                                  | <input type="checkbox"/> | <b>Fully Assured</b><br>Controls are suitably designed, with evidence of them being consistently applied and effective in practice | <input checked="" type="checkbox"/> | <b>Partially Assured</b><br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness | <input type="checkbox"/> | <b>Not Assured</b><br>Evidence indicates poor effectiveness of controls |



## 1. Introduction

The People Committee (PC) is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

## 2. Agenda items received, discussed / approved at meeting.

- Internal Communications Update
- Strategy People Update – Key People Issues
- Trust/Divisional Metrics Update
- Initial 2025 Staff Survey Results
- Raising Concerns FTSU Update
- Veteran Aware – Year 2 Progress Report (For information)
- Sickness Absence Programme Update
- Apprenticeship Update
- Strategic Workforce Planning Update
- Health & Safety Dashboard
- Equality, Diversity & Inclusion Update – EDS22
- Board Assurance Framework: Monitoring of Strategic Workforce Risks
- Policies for Ratification
  - Organisational Change Policy – **APPROVED**
  - Domestic Abuse - **APPROVED**
  - Job Planning Policy - **APPROVED**

## Overview

The January 2026 People Committee discussed a range of papers which demonstrated a workforce under sustained pressure, but with strong governance, active intervention, and clear strategic intent. The Trust is balancing financial constraints and headcount reduction with its commitment to staff wellbeing, inclusion, learning, and patient safety. Morale and sickness absence remain the most significant risks, while communications, culture, and EDI are key enablers in the response.

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

1. Sickness absence and stress-related illness (Return to Work focus being an area of compliance the Committee has requested further assurance on)
2. Morale and engagement during workforce changes and reductions
3. Manager capability and consistency – specifically linked to sickness absence management. Training and awareness programme already in place
4. Identification and support of teams who may be 'fragile'– as identified through staff survey data and other evidence gathered through the Thriving MDT.

## 4. Positive highlights of note

- Positive shift in organisational culture regarding health and safety, with good compliance against all areas within the reporting dashboard, with open and constructive discussions now embedded as a norm.
- Notable success in the strategic partnership with Edge Hill, highlighted by the innovative PGCE mental health specialist partnership with Edge Hill University and Alder Hey.

- Strong and credible Internal Communications Strategy was approved, aligned to Vision 2030
- Cultural risk acknowledged and actively managed with a clear line of sight from insight to intervention to governance.
- Excellent progress continues to be made on apprenticeships; recent re-accreditation of The Matrix standard demonstrates high quality support for learners and good relationships with education providers
- All divisional leaders focused on their workforce metrics, with measures and mitigations in place

#### **5. Issues for other committees**

- Ensure Safety and Quality Committee have oversight of the work of the mandatory training task and finish group with specific reference to clinical training compliance in topics such as sepsis and resuscitation.
- Work in tandem with the Finance, Performance and Transformation Committee ensuring alignment with workforce and financial planning

#### **6. Recommendations**

The Board is asked to note the Chair's Highlight report for the People Committee meeting that took place on 29<sup>th</sup> January 2026.

**People and Wellbeing Committee**  
**Confirmed Minutes of the last meeting held on 19<sup>th</sup> November 2025**  
**Teams**

**Present:**

|                  |                                                  |      |
|------------------|--------------------------------------------------|------|
| Jo Revill        | Non-Executive Director ( <b>Chair</b> )          | (JR) |
| Fiona Beveridge  | Non-Executive Director                           | (FB) |
| Rachel Greer     | Associate Chief of Operations – CAMHS            | (RG) |
| Jo Potier        | Associate Director of Organisational Development | (JP) |
| Erica Saunders   | Director of Corporate Affairs                    | (ES) |
| Melissa Swindell | Chief People Officer                             | (MS) |
| Sharon Owen      | Deputy Chief People Officer                      | (SO) |

**In attendance:**

|                   |                                           |      |
|-------------------|-------------------------------------------|------|
| Nathan Askew      | Chief Nursing Officer                     | (NA) |
| Katherine Birch   | Director of Alder Hey Academy             | (KB) |
| Audrey Chindiya   | Finance Manager                           | (AC) |
| Monica Collier    | Governor                                  | (MC) |
| Garth Dallas      | Non-Executive Director                    | (GD) |
| Angela Ditchfield | EDI Lead                                  | (AD) |
| Joe Fitzpatrick   | Internal Communications Manager           | (JF) |
| Clair Finnigan    | Operational HR Manager                    | (CF) |
| Rebecca Murphy    | Head of Marketing & Communications        | (RM) |
| Ellen Matthews    | Head of Service Development & Performance | (EM) |
| Nikita Pritchard  | Senior Manager Medicine Division          | (NP) |
| Jill Preece       | Governance Manager                        | (JP) |
| Christine Pope    | Interim General Manager Surgery           | (CP) |
| Joseph Smitha     | Governor                                  | (JS) |
| Neil Thomas       | Interim Health & Safety Manager           | (NT) |
| Kerry Turner      | FTSU Guardian                             | (KT) |
| Tracey Jordan     | Executive Assistant (Minutes)             | (TJ) |

**Apologies:**

|                      |                                                  |       |
|----------------------|--------------------------------------------------|-------|
| Alfie Bass           | Chief Medical Officer                            | (AB)  |
| Adam Bateman         | Deputy Chief Executive & Chief Operating Officer | (AB)  |
| Pauline Brown        | Deputy Director of Nursing                       | (PB)  |
| Sian Calderwood      | Associate Chief Operating Officer, Medicine      | (SC)  |
| Chloe Lee            | Associate COO – Surgery                          | (CL)  |
| Sarah Leo            | Associate Chief Operating Officer – Research     | (SL)  |
| Jeanette Chamberlain | Staff Advice & Liaison Manager                   | (JC)  |
| John Chester         | Director of Research & Innovation                | (JC)  |
| Urmi Das             | Director, Division of Medicine                   | (UD)  |
| John Grinnell        | Managing Director                                | (JG)  |
| Jacqui Pointon       | Associate Chief Nurse                            | (JP)  |
| Maisie StJohn        | Service Manager                                  | (MSt) |
| Adrian Hughes        | Deputy Medical Director                          | (AH)  |
| Lisa Cooper          | Director of Community & Mental Health Services   | (LC)  |
| Jacqui Lyons-Killey  | Associate Chief Nurse – Research                 | (JLK) |
| Julie Worthington    | Staffside                                        | (JW)  |
| Jennie Williams      | Head of Quality Hub, Brilliant Basics            | (JW)  |
| Darren Shaw          | Head of Organisational Development               | (DS)  |

25/26/160

**Declarations of Interest**

No declarations were declared.

25/26/161 **Minutes of the previous meeting held on 25<sup>th</sup> September 2025.**  
The minutes of the last meeting were approved as an accurate record.

25/26/162 **Matters Arising and Action Log**  
Action log was updated accordingly.

- **Mandatory Training Insight Report**

The Committee received the Mandatory Training Insight Report.

The mandatory training insight report was prompted by a request from the Safety and Quality Assurance Committee (SQAC) to conduct a deeper review of persistent issues in mandatory training compliance, particularly for safeguarding Level 3, sepsis, and resuscitation.

- The report highlighted a growing pattern of challenges not only in mandatory training but also in clinical skills and wider education activities, with attendance difficulties becoming more common across divisions.
- There is concern that these are mandatory and critical trainings, yet compliance is not improving despite significant efforts
- SQAC referred the issue to the People Committee for broader discussion on possible incentives ("carrots") and enforcement measures ("sticks").
- Suggestions included linking mandatory training checks to the preparation for Personal Development Reviews (PDRs), ensuring managers do not complete PDRs without confirming training compliance.
- There was debate about balancing enforcement with the risk of reducing PDR completion rates.
- The need for operational support to help managers manage compliance at the departmental level was emphasized, with a call for divisions to propose practical solutions.
- Detailed compliance data is available, including proactive flagging of staff about to go out of date, and personal email reminders are sent to non-compliant staff. However, persistent non-compliance remains, especially among medical staff.
- The shift from the previous ESR system to the current management system (E-Roster) has reduced individual staff awareness of their compliance status, as it is no longer the first thing they see when logging in.

**Action:** Mandatory Training proposal to form a small working group to develop 2–3 firm action proposals for divisions to consider, aiming to address the multifaceted nature of the problem and "shift the dial" on compliance. FB requested assurance that persistent individual non-compliance is being tracked and addressed, especially where it is long-standing and across multiple training areas.

The committee agreed to include this in the working group's remit and report back with proposals and assurance on individual compliance monitoring.

The committee acknowledged the complexity of the issue, the need for both operational and cultural change, and agreed to reconvene with concrete proposals for action after further divisional input and working group review.

**Resolved:** The Committee noted the contents of the Mandatory Training Insight report.

25/26/163

**Internal Communications Update:**

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

The committee reviewed progress on the internal communications review, following up on previous concerns relating to evaluation and effectiveness. The review was already planned, aiming to modernise and improve internal comms across the organisation.

- A trust-wide staff survey was launched on 19<sup>th</sup> September 2025 to gather feedback on preferred communication channels, formats, and overall effectiveness. The survey remains ongoing with a closing date of 28<sup>th</sup> November 2025, with results to be used as a baseline for future comparison.
- Audience profiling is being conducted to better understand staff demographics and preferences, which had not been previously mapped.
- Early survey results indicate the most valued channels are the intranet, posters, and emails. However, only 2% of intranet access is via mobile, suggesting an opportunity to promote mobile access, especially for hard-to-reach staff without regular PC access.
- Email overload is a concern, with too many all-staff emails diluting impact.
- Most staff report being based on-site, which influences the effectiveness of on-site communication methods.
- There is gender and personality differences in channel and language preferences, with women tending to prefer collaborative and softer communication styles, and valuing opportunities for feedback.
- The Communications Team is still analysing the data and plans to dig deeper into how preferences vary by shift pattern, gender, and other characteristics. There is recognition that a "one size fits all" approach is no longer effective, and a more segmented, multi-channel strategy is needed.
- The team aims to launch a new internal comms strategy in January 2026, incorporating survey findings and further evaluation. The strategy will be brought back to the People Committee for review.
- NA suggested triangulating survey data (e.g by shift pattern and gender) to better target hard-to-reach groups, such as night shift staff.
- The importance of not discarding essential channels (like clinical briefings) was noted, even if they are not universally accessed, and the need for clear audience segmentation and channel purpose was emphasized.

**Action:** JF will draft an internal communications strategy report and bring the January 2026 meeting for further discussion.

The committee welcomed the comprehensive analysis and looks forward to a more targeted, data-driven approach to internal comms, with a draft strategy and further survey results to be discussed at the January meeting.

**Resolved:** The Committee noted the contents of the Internal Communications Report.

## 25/26/164 Strategic People Update – Key People Issues

The Committee received a verbal update on the Strategic People Plan update. MS highlighted the following:

- The Strategic People Update covered current workforce challenges, including a drop in staff survey response rates compared to 2024 (currently at 48%, compared to 62% previously), with traditional engagement methods proving less effective and reflecting lower morale across the NHS. Survey fatigue and the need to make the survey more relevant to staff were raised as possible factors. The team is considering additional outreach, such as more visible reminders and in-person sessions, but acknowledged the national deadline
- Key people metrics such as PDR completion, sickness absence, turnover, and headcount reduction were reviewed, with ongoing operational challenges and a focus on supporting managers to meet targets.
- Divisional updates highlighted specific workforce pressures, including high sickness rates, fragile services, and the need for targeted interventions like job sharing.
- The MARs Scheme (Mutually Agreed Resignation Scheme) is under review, with 96 applications being assessed to balance staffing levels and service needs.
- Sickness absence and turnover are being closely monitored, with some improvements in certain areas with ongoing challenges in others, especially as the trust works to reduce headcount in line with financial imperatives.
- The impact of headcount reduction on morale and patient-facing teams was discussed, with efforts underway to reconcile vacancies and workforce planning across corporate and clinical areas.
- Low morale is a recurring theme, affecting survey participation, sickness rates, and overall engagement. The committee is aware of the need for ongoing support, communication, and targeted interventions to address these issues.
- The British Medical Association (BMA) have announced they intend to hold Resident Doctor industrial action which will take place between:
  - **7:00am on Friday 14 and 7.00am Wednesday 19 November 2025**

### Next Steps:

- Continued push for staff survey completion in the remaining two weeks.
- Ongoing review of MARS applications and workforce planning to meet headcount and financial targets.
- Monitoring and support for divisions facing operational and workforce challenges, with a focus on maintaining service quality and staff wellbeing.

**Resolved:** The Committee noted the contents of the Key People Issues.

## 25/26/165 Trust wide Metrics

The Committee received the Trust Wide Metrics report. (October 2025) data.

- **PDR:** The trust maintains a 90% target for PDR completion. There are ongoing support and training for managers to achieve this, but operational challenges

persist, especially at the team level. The process is now more streamlined, but responsibility remains with managers and leaders.

- **Sickness absence** remains a significant challenge. The trust's target is 4.5% overall (2% short-term, 2.5% long-term), but actual rates are higher, with recent figures around 6.26%. The main reasons are stress, anxiety and depression (36.1%), gastrointestinal issues (7.7%), and musculoskeletal problems (6.8%). These trends are consistent with previous years and regional data.
- **Turnover** rates are being closely monitored, with some divisions expecting increases due to workforce reduction programmes (e.g MARS Scheme). Divisions are tracking turnover and reconciling vacancies to manage headcount reduction and maintain service delivery.
- **Headcount:** The trust plan is to reduce headcount as part of financial efficiency measures. There is a process to reconcile vacancies and workforce numbers, with executive oversight panels reviewing requests to fill posts. The MARs scheme is being used to support voluntary leavers, with 96 applications under review. The trust is balancing the need to support staff departures with maintaining safe staffing levels across service provisions.
- **Bank & Agency:** Divisions are working to reduce reliance on bank and agency staff. Medicine reported a reduction in bank usage due to temporary bed closures, and Surgery has maintained zero agency usage since June. However, some areas are still experiencing high temporary staffing costs, particularly in theatres.
- **Return to work** compliance after sickness is improving in some divisions but remains below target in others. Short-term sickness spikes are noted in specific teams, impacting bank spend and operational resilience. Maternity leave rates are higher than in 2024 in some areas, adding to workforce pressures.

The trust is facing ongoing challenges with sickness absence, turnover, and headcount reduction, all of which are impacting morale and operational resilience. There is a strong focus on supporting managers, improving processes, and targeting interventions to address these issues, with regular monitoring and executive oversight.

**Resolved:** The Committee received and noted the Trust Wide Metric report.

- **Divisional Metrics**

Corporate

The Committee received the corporate metrics report (October 2025) data.

- **Sickness Absence:** Improvements in sickness absence have been noted, with Senior HR Leaders continuing to closely manage cases by supporting colleagues.
- **PDR:** No significant shift in PDR completion rates, it remains a key area of concern, with ongoing emphasis on the importance of quality conversations.
- **Headcount:** Narrative included for the first time about the impact of efforts to reduce headcount, with workforce numbers reflecting targeted areas. There is an

ongoing process to reconcile vacancies across disparate corporate teams and to feed this intelligence into the executive oversight process.

- **Turnover** is being monitored, with expectations of a possible increase due to recent MARS applications.
- **Mandatory Training:** Corporate areas continue to perform well in mandatory training compliance, with staff able to bring themselves up to date more easily than in clinical areas.
- Morale is noted as being impacted by headcount reduction efforts.

Corporate metrics show improvement in sickness absence, ongoing challenges with PDR completion, active management of headcount reduction and vacancies, stable turnover with a possible increase expected, strong mandatory training compliance, and concerns about morale due to workforce changes.

➤ **Resolved:** The Committee noted the contents of the Corporate Metric Report.

### Surgery Division

The Committee received the Surgery Division metrics report (October 2025) data.

- **Mandatory Training:** Surgery division maintains mandatory training compliance above target, currently at 92% to date.
- **Agency usage** has been at zero since June 2025, which is a positive achievement for the division. There has been an increase in overtime spend in September 2025, and short-term sickness absence has also increased, though it remains within internal targets.
- **Sickness absence** is a significant challenge, currently reporting at 6.8%. Theatres were identified as a hotspot area for sickness, with HR working closely with the division to support staff and manage returns to work. There is a noted increase in maternity leave, with numbers significantly higher than last year (19 more cases). This is putting additional pressure on staffing and may increase temporary staffing costs.
- The division is focusing on priority areas to improve performance. There is increased scrutiny on agency and overtime spend, with senior leadership team (SLT) reviews and centralisation of ordering and stationery to better control costs. The division is actively promoting the staff survey and has carefully reviewed MARS applications to support headcount reduction.
- Theatres face multifactorial challenges, including high sickness rates, morale issues, and significant temporary staffing costs (around £156k per month on temporary staffing in the division as a whole).
- Overtime and bank rates for theatre staff are the highest in the region, and there is a need to balance support with clear messaging about pay and expectations.
- An external partner has been requested to review some issues in theatres, particularly following a series of never events related to incorrect count processes.
- FTSU walkabouts are being conducted in theatres to engage with staff and address concerns.

## Next Steps

- The division is reviewing potential for job sharing and role adaptation to address vacancies and workforce risks, though much of this has been reactive rather than proactive.
- There is a focus on reducing temporary spend, improving overtime approval processes, and supporting staff through operational changes.

Surgery division is performing well in mandatory training and agency usage but faces ongoing challenges with sickness absence, particularly in theatres, and increased maternity leave. Financial controls and workforce planning are being strengthened, and there is a strong focus on staff engagement and cultural improvement.

**Resolved:** The Committee noted the contents of the Surgery Metrics Report.

## Clinical Research Division

The Committee received The Clinical Research Division metrics report (October 2025) data.

There was no representation at the meeting. The committee noted the contents of the report.

**Resolved:** The Committee noted the contents of the Clinical Research Metrics Report.

## Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (October 2025) data.

- **Turnover:** The division has seen a slight downward trend in staff turnover, which is viewed positively.
- **Return to Work:** There is a focused effort on improving return to work compliance after sickness absence. While not yet at the desired level, compliance is on a slight upward trend and continues to be monitored.
- **Sickness Absence:** The division is experiencing spikes in sickness absence, with a positive reduction in long-term sickness rates but an increase in short-term sickness in certain teams.
- Sunflower House, Outpatients Booking and Scheduling, and Crisis Care were highlighted as having sickness rates around 10%: High sickness rates in Sunflower House are impacting bank spend, which has also increased in the last month.
- **Staff Survey** response rates are currently reporting at 60% to date. The division is actively encouraging participation, aiming to reach last year's 70% response rate, though it is recognised that this year is more challenging.
- **Bank Spend:** Increased bank-spend is directly linked to high sickness rates in specific teams, particularly Sunflower House and is being managed accordingly.

The division is working through MARS to understand which can be supported and to identify opportunities

The division is making progress in reducing turnover and long-term sickness, but short-term sickness and related bank spend remain challenges in specific teams. There is ongoing work to support workforce changes through Mars and to boost staff survey engagement.

**Resolved:** The Committee noted the contents of the Community and Mental Health

### Medicine

The Committee received the Medicine Division metrics report (October 2025) data.

- **Bank usage** has reduced further, and the division is closely monitoring this trend to maintain reductions.
- **Mandatory Training:** Compliance remains above 92%, though there are hotspot areas needing focus, especially around face-to-face training and medical staffing.
- **Sickness Absence** is a major challenge. Long-term sickness has improved, but short-term sickness has increased, offsetting gains and resulting in a net impact on workforce availability. Some short-term sickness is expected to convert to long-term in the coming weeks. Sickness is affecting fragile services, particularly where there are single-handed clinicians or niche skill sets, leading to operational challenges and increased risk register entries.
- **PDR** Efforts are focused on improving appraisals for Band 7 and above, with a steady increase in this area. However, overall appraisal rates have declined and remain a struggle. Hotspots have been identified, with some managers having a high number of appraisees, and work is underway to spread the load and support these managers.
- **Organisational Change** Positive progress reported on the Snowdrop Bereavement Team change going live on 1<sup>st</sup> December 2025 and the radiology change (new start date 2<sup>nd</sup> March 2026) Both changes are on track. The division is not yet at the requested headcount reduction, and current vacancies and MARS applications are not always in teams targeted for reduction. Deep dives are being conducted to identify sustainable workforce solutions, with specialist nursing teams under review.
- Radiology change will be reviewed after 12 months, Snowdrop change will be reviewed at 3, 6, and 12 months. The Snowdrop change was particularly challenging, with lessons learned about consultation and team anxiety.
- Job sharing and role adaptation are being used reactively to manage workforce risks, but there is a need for more proactive planning. This is a focus for upcoming discussions.
- **Staff Survey** promotion is ongoing, and all colleagues are encouraged to take part. The survey is discussed regularly in briefings and communications.

Medicine division is managing reductions in bank usage and maintaining high mandatory training compliance, but faces significant challenges with sickness absence, fragile services, and appraisal rates. Organisational changes are

progressing, with ongoing reviews and workforce planning efforts to meet headcount targets.

**Resolved:** The Committee noted the contents of the Medicine Metric Report.

## 25/26/166      **Sickness programme – Update on Progress**

The committee received the Sickness Programme update and noted the contents. The committee's attention was drawn to the following:

The trust's sickness absence target is set at 4.5% (2% short-term and 2.5% long-term). However, since June, the actual rates have exceeded this target and have been on an upward trend since May. Currently, the rate stands at 6.26%. Notably, 36.1% of these absences are attributed to stress, anxiety, or depression, followed by gastro issues at 7.7%, and musculoskeletal problems at 6.8%. This pattern aligns with data from previous years and regional statistics.

Sickness rates are high across Cheshire and Merseyside, with a regional workstream aiming for a 1% reduction and a move toward a collective sickness absence policy. Socioeconomic factors, such as the cost of commuting and childcare, are contributing to short-term sickness, especially among lower-paid staff groups.

A dedicated HR support team was established in September 2024 to focus on sickness absence, continuing the 90-day improvement programme. Actions include data cleansing, collecting feedback from those returning from long-term sickness, and developing training for managers, especially around reasonable adjustments. The project revealed that over 80% of return-to-work interviews are completed within 48 hours, with very few delayed beyond a week.

A key barrier identified managers lack in confidence in implementing reasonable adjustments. Training and a new "Manager Connection Hub" are being introduced to support managers in handling reasonable adjustments, sharing experiences, and building confidence. There is a focus on ensuring adjustments are regularly reviewed and not seen as indefinite, and on supporting both colleagues and managers through the process.

A deep dive into medical staffing revealed that less than full-time working (especially at 0.6 or 0.8 FTE) is a greater pressure on staffing than reasonable adjustments. This is being mapped and reviewed for better workforce planning.

### **Next Steps**

- The programme has uncovered isolated but real issues with manager confidence and consistency in handling sickness and adjustments.
- The HR team is intensively supporting managers over the winter months, and ongoing data analysis is being used to target interventions and track progress.

- The trust is committed to compassion in its approach and is monitoring the impact of interventions, with further regional policy changes expected.

**Resolved:** The Committee noted the contents of the Sickness Programme Update.

## 25/26/1667 **Raising Concerns FTSU Update**

The Committee received the Raising Concerns FTSU Update and noted the contents. KT drew the committee's attention to the following:

There has been an increased number of staff raising concerns through FTSU, particularly related to stress and reasonable adjustments. These concerns closely mirror those being raised through staff-side channels.

- Morale has noticeably declined recently, with increased visits to FTSU and a perceived change in the organisation's atmosphere.
- There is a need for both managers and colleagues to be better educated about what constitutes a reasonable adjustment. Some staff do not fully understand the criteria or process, as highlighted by recent conversations.
- Ongoing work is being done with Angela Ditchfield, EDI Lead to review lessons learned from FTSU cases and network feedback.
- A recent case review led to a decision to review the FTSU policy, triage process, and manager guidance to better support staff in raising concerns and ensure managers are equipped to respond appropriately.
- KT/CEO have been conducting regular walkabouts, increasing visibility and accessibility of the FTSU service. This includes engaging with staff in various settings, such as the atrium and domestic staff meetings, as part of Speak Up Week activities.
- Visibility is seen as crucial for the service, with positive feedback from staff who are able to approach FTSU representatives directly.
- Mandatory FTSU Training compliance is good and continues to improve.
- The "Listen Up" module from the National Guardians Office is mandated for managers, but there are technical issues with accessing it, which are being addressed.
- The FTSU app, which allows anonymous reporting, is now in use and showing a trend of increased usage.
- Interviews for the deputy FTSU post are scheduled for December, with hopes to fill the role before Christmas.
- Efforts are ongoing to recruit more FTSU champions, with a focus on inclusivity and representation from HR and other areas.
- The current champion group does not yet fully reflect the organisation's diversity, but this is a priority for the coming year.
- FTSU is working closely with staff networks, particularly on issues affecting those with protected characteristics, to understand and address barriers to speaking up.
- There is a strong emphasis on inclusivity and ensuring that staff who may not access networks or FTSU directly are also reached.

- The FTSU service is experiencing increased engagement, particularly around stress and reasonable adjustments.

There is a focus on policy review, manager and staff education, increased visibility, and expanding the champion network to ensure all staff feel able to raise concerns safely and effectively.

**Resolved:** The Committee noted the contents of the FTSU Report.

## 25/26/168 **Thriving Teams & Culture Report**

The Committee received the Thriving Teams & Culture Report and noted the contents. The committee's attention was drawn to the following:

The thriving teams and culture programme is progressing well, focusing on connected leadership and organisational values. The report is primarily for information and assurance of ongoing work.

- Significant work has been done to develop new organisational values, led by JF and supported by the charity (at no cost to the trust).
- Over 600 staff have been engaged in the consultation process, including extensive input from staff networks.
- The new values designs are included in the appendix of the report and have been shared with the executive team. They will be presented to the Trust Board in December 2025 for final sign-off.
- Once approved, the new values will be rolled out, starting with new lanyards that meet safety standards and reflect the updated values.

### **Next Steps**

- The formal launch of the new values and associated materials is planned following Trust Board approval in December 2025.
- The committee will revisit the topic in January for a fuller discussion and to review the broader work and strategy.
- The programme includes the development of a new "Thriving Teams Index," which will serve as a key measure for team and culture health going forward.
- Questions and feedback on the report are encouraged, with the option to forward them to Joe or the team for inclusion in future updates.

**Resolved:** The Committee received and noted the contents of the report.

## 25/26/169 **Flu Vaccine Update**

The Committee received the Flu Vaccine Update. The committee's attention was drawn to the following:

- As of the latest update, 42% of the total workforce (1,905 staff) have received their flu vaccine.
- 44% of frontline staff are now vaccinated, surpassing last year's figure of 41% for frontline staff. The trust is now only 6% away from meeting the ICB's minimum target of 50% for frontline staff, with the team aiming to exceed this benchmark.
- The flu vaccination team's approach this year has been described as agile, with significant effort and dedication contributing to the improved uptake.
- The main barriers to further uptake are vaccine hesitancy and the fact that some staff are ineligible due to health conditions (though this is a small group).
- This year, frontline health and social care workers are not entitled to the COVID vaccine through the trust, so those eligible are choosing to get both flu and COVID vaccines together at external sites, which may affect internal flu vaccine data.
- The trust has made significant outreach efforts to make the vaccine accessible, but daily job demands, and hesitancy remain obstacles.
- The committee is regularly updated with compliance figures, and the data is closely monitored to track progress toward targets.

**Resolved:** The Committee noted the contents of the Flu Vaccine Update.

## 25/26/171 **IWL for Resident Doctors**

The Committee received the IWL for Resident Doctors Report. The committee's attention was drawn to the following:

The IWL initiative for resident doctors covers both internal action plans and recent directives from the Department of Health and NHS England, including requirements for trusts and lead employers.

The update summarises three main areas:

- GMC survey results for Alder Hey (received in summer).
- Compliance with the national IWL dashboard (currently at 83%).
- NHS England GMC Quality Review (action plan included in the report).
- Resident doctors typically rotate through multiple trusts for periods of 3–12 months, so the trust aims to ensure they feel supported and integrated during their time at Alder Hey.
- The trust achieved significant improvement, with no red ratings in composite figures.
- Some specialty areas still face challenges, which are being addressed by the oversight team.
- Alder Hey is at 83% compliance.
- The trust provides designated access to the multi-storey car park for resident doctors on call, but this is technically marked as non-compliant due to the lack of individually reserved spaces.
- The review, triggered by previous concerns in critical care, found substantial improvements and cited Alder Hey as an exemplar in that area.

- The action plan is comprehensive and will be updated as actions are completed.
- Support for residents covering out-of-hours shifts, including escalation processes and clarity on available on-site support, especially for managing seriously unwell patients.
- Strong engagement from resident doctors and divisional teams, with ongoing work and a comprehensive action plan in place.
- There are challenges related to rota management, particularly due to the high number of less-than-full-time staff, which is common in paediatrics and among female doctors.
- The lead employer allocates whole-time equivalent resources, but the distribution of staff does not always match service needs, requiring further data analysis and mapping.
- The trust has made substantial improvements in the working lives of resident doctors, with ongoing monitoring and targeted actions to address remaining issues.

**Action:** Conduct deep dive into reasonable adjustments and less than full-time working patterns for resident doctors, map findings against establishment, and share results with divisions

**Resolved:** The committee received and noted the contents of the report.

25/26/172

### **Closing the Gap Workforce Efficiencies**

The Committee received the Closing the Gap Workforce Efficiencies update and noted the contents. SO drew the committee attention to the following:

The trust is working on medium-term workforce planning for 2026–2029, with success measures including reducing sickness absence and reducing agency staffing to zero by 2029/30.

- Workforce numbers have remained largely static, with a 148 WTE (whole-time equivalent) gap against budget for March 2026 and a 94 WTE gap against staffing posts for the same period.
- A combined workforce establishment and vacancy panel was introduced in August 2025, merging previous processes to strengthen oversight.
- The trust provides regular workforce returns to the ICB for external assurance and continues to monitor workforce gaps and additional spend internally.
- Each division has presented its own plan for closing the gap, including measures such as ending fixed-term contracts and conducting work reviews.
- Corporate areas are also undergoing similar planning and review processes.
- The vacancy panel reviews all roles considered by divisions, but it has proven difficult to reject enough posts to meet reduction targets due to safety and service risks.
- Attempts to set monthly approval limits (e.g. only 15 posts per month) have proved difficult, with actual approvals often much higher.
- The process is being adjusted to set divisional budget targets, requiring divisions to manage their own workforce reductions within those limits.

- There has been a marked drop-off in vacancy requests, possibly due to local decisions and ongoing conversations about workforce reductions.
- Some mechanisms for workforce reduction (e.g. self-checking in ED) are still in development, making immediate reductions challenging.
- The ICB is considering a full recruitment freeze across the system, but individual trusts may not support this due to risk-based decision needs.
- The trust continues to monitor progress, update plans, and adjust control mechanisms to meet targets, with regular reporting and external review by bodies such as PwC.

The trust is actively pursuing workforce efficiencies through a combination of central controls, divisional planning, and ongoing review, but faces significant challenges in balancing service delivery, safety, and reduction targets.

**Resolved:** The Committee received and noted the contents of the report.

## 25/26/173      **Visa & Immigration Changes**

The Committee received the Visa and Immigration changes update. The committee's attention was drawn to the following:

- On April 9, 2025, UK immigration policy introduced a minimum salary threshold of £25,000 for sponsorship, affecting entry-level Band 3 roles.
- Only those at the top point of Band 3 are eligible for sponsorship, the pay award did not raise all entry points above the threshold.
- Individuals in the trust were impacted: twelve Band 3 healthcare assistants and one Band 2 administrative assistant.
- Five staff on graduate visas may also be affected in the coming year.
- The trust explored multiple options to retain affected staff while complying with Home Office rules.
- Support provided includes trade union involvement, staff networks, SALS and referrals to Citizens Advice.
- Affected staff with higher qualifications are being added to the recruitment system to help them find alternative roles.
- Following an RCN request, the trust reviewed starting salaries and confirmed that all twelve healthcare assistants had prior experience qualifying them for the top Band 3 pay point, resolving their sponsorship eligibility.
- The Band 2 administrative assistant remains ineligible for sponsorship due to salary requirements, but the division is aware, and support is ongoing.

The HR team was formally thanked for their extensive work in finding solutions that comply with legal requirements to help support our staff at Alder Hey.

The trust is monitoring for further visa changes and continues to support affected staff.

**Resolved:** The committee received and noted the contents of the report.

## 25/26/174      **Overpayments**

The Committee received the Overpayments update. The committee's attention was drawn to the following:

- The trust's KPI for correct pay is set at 99.5%, this decreased to 99.2% in October.
- Overpayments have increased: volume is up 7.6% and value up 63% compared to the previous financial year.
- From April to October 2025, there were 109 overpayments, with 12 cases exceeding £5,000; the largest was £24,854, caused by a late notification of a work plan change.
- The trust's position has shown a decline in benchmarking against 13 other trusts: now 9th for number of overpayments and 10th for value, down from 5th and 9th previously.
- Most overpayments are due to late notifications of changes in hours or terminations from within the trust.
- Individuals responsible for errors receive letters explaining the impact and pay dates.
- Manager Essentials guides and monthly communications remind managers of payroll deadlines and correct processes.
- Payroll process maps are being developed for managers.
- Overpayment data is reviewed at HR governance and risk meetings, and detailed information is shared with divisions for targeted intervention.
- Recruitment and employment services are now monitoring change forms approaching payroll deadlines and escalating as needed to avoid missed deadlines.
- Only one overpayment between August and October related to a consultant, indicating the issue is not concentrated among doctors in training.

The trust is disappointed with the current overpayment position and is focusing on identifying hotspots, providing targeted education, and improving processes to reduce errors.

**Resolved:** The committee received and noted the contents of the report.

## 25/26/175      **Health & Safety Dashboard**

The Committee received the Health & Safety Dashboard. The committee's attention was drawn to the following:

The dashboard provides a snapshot of health and safety performance, showing high compliance across all mandatory training areas.

- Specific targets are set by the Health and Safety Executive or NHS England, not by the trust itself.

- Training for risk assessments and manual handling ensures managers are competent to discharge their duties safely.
- Demand for risk assessment training has dropped, as most managers are already trained and no refresher is required unless needed.
- No RIDDOR-reportable incidents occurred in Q1. In Q2, a couple have occurred recently and will be reported in Q3.
- All historical health and safety risks have been mitigated and removed from the register.
- Overall incidents are decreasing each quarter: from 333 in Q4 last year, to 312 in Q1, and 258 currently.
- The reduction is mainly due to fewer incidents in the Tier 4 unit and overall improved reporting and management.
- Daily rounds by the health and safety team ensure safe working practices for estates, facilities, and contractors.
- Training helps staff identify risks they may not have previously considered.
- The Estates team has developed a full suite of systems and is now 80–85% compliant in assurance. The remaining 15–20% is due to the time required to review procedures and train staff.
- Retraining and upskilling within the health and safety team is ongoing to replace recent losses and improve validation of systems.
- Plans are in place to start validating systems (environmental audits, ladder safety, equipment audits) from January onward.
- The health and safety team is confident that the trust is moving in the right direction, with strong engagement from estates, facilities, and clinical staff.

The trust's health and safety compliance is high, incidents are decreasing, and ongoing training and system validation are supporting a positive safety culture.

**Resolved:** The committee received and noted the contents of the report.

25/26/176

#### **Equality, Diversity & Inclusion Plans – Monitoring Progress WRES/WDES/Ethnicity Pay Gap Report**

The Committee received the Equality, Diversity and Inclusion Plans Update. The committee's attention was drawn to the following:

- There has been an increase in staff reporting racist behaviour, both formally and informally, as well as incidents involving patients and families experiencing racial abuse.
- The trust is committed to implementing the Northwest Assembly Anti-Racism Framework and is working to become an anti-racist organisation, ensuring staff, children, young people and their families know such behaviour is not tolerated.
- Recommendations include considering a standalone anti-racism policy or strategy, enhancing training (including anti-bias and anti-racism), and developing an anti-racism toolkit.

- Pathways for reporting are being clarified, with new policies (SAFE and Behaviour at Work) is to be rolled out in early 2026.
- The trust will apply for the bronze award in the Northwest Assembly Anti-Racism Framework.
- Collaboration is ongoing with the staff REACH Network, The Youth Forum (for communications and strategy input), and external partners such as Mersey region organisations.
- There is a plan to use anonymised case studies to demonstrate actions taken against racist behaviour, ensuring sensitive communication and learning from incidents.
- The Youth Forum is involved in shaping messaging to make it impactful and relevant.
- The trust is engaging with partner organisations (e.g. contractors, school staff) to ensure a consistent anti-racism approach across all who work with or visit the trust.
- Governance is being strengthened by requesting regular reporting on incidents and actions taken, with the EDI Steering Group monitoring progress.
- Formal HR cases involving racism are being anonymised and shared through the Staff Partnership Forum and cascaded across the organisation to show that action is taken and to encourage reporting.
- Support is provided to those affected by racist incidents, including working with clinical teams to ensure families feel safe when returning to the trust.

The trust is prioritizing visible action, sensitive communication, and a collaborative approach to embed anti-racism and EDI principles throughout the organization.

**Resolved:** The Committee noted the contents of the Health & Safety Dashboard.

## 25/26/177 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

### - **BAF Risks: 2.1 2.2 & 2.3**

The Committee received the Board Assurance Framework and noted the contents. ES drew the committee's attention to the following:

ES drew attention to an upcoming Extraordinary Risk Forum to review the risks relating to any decisions made regarding workforce changes. The forum will focus on identifying additional risks to the system, particularly those arising from team reductions. This includes considering the cumulative impact of mitigations and ensuring that agreed mitigations are implemented and effective.

FB emphasised the importance of tracking whether these mitigations for workforce risks are being put in place and whether they remain effective over time. They noted the need to review the cumulative effect of multiple mitigations and the robustness of decision-making processes.

There is an intention to analyse risk assessments (QIA) conducted at the time of decisions and to monitor if risks have increased, with a plan to adjust monitoring based on findings from the first review.

**Resolved:** The committee received and noted the contents of the BAF report.

25/26/178 **Policies for ratification:**

- **Medical Revalidation & Appraisal Policy**

The Committee received the Medical Revalidation and Appraisal policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

**Resolved:** The Committee APPROVED the Medical Revalidation & Appraisal Policy.

- **Apprenticeship Policy**

The Committee received the Apprenticeship Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

**Resolved:** The Committee APPROVED (*subject to changes*) the Apprenticeship Policy

25/26/179 **Staff Partnership Forum Committee (SPF) Minutes**

The Committee received the approved minutes of the SPF meeting held on (July 2025)

25/26/180 **Equality, Diversity & Inclusion Steering Group (EDISG) Minutes**

The Committee received the approved minutes of the EDISG meeting held on (May 2025)

25/26/181 **Health & Safety Committee Minutes**

The Committee received the approved minutes of the Health & Safety meeting held on (May 2025)

25/26/182 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the EGC meeting held on (June 2025)

24/26/183 **Any Other Business**

Schwartz Round – Living Our Values

JP announced to the committee that Alder Hey will run the Schwartz Round on:

- Friday 26<sup>th</sup> September 2025 at 12:30pm held in Lecture Theatre 3 – Institute.

Schwartz rounds are a structured forum where all colleagues, clinical and non-clinical, can come together to discuss the emotional and social aspects of working in healthcare. The rounds support our culture through the sharing of stories that focus on our common humanity, promoting our connection with each other and our work and reducing isolation.

The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work.

All welcome to attend.

25/26/184

## Review of Meeting – Chair's Report to Board

- **Visa and Immigration Changes:** Significant discussion on the impact of recent government immigration law changes affecting staff visas, with urgent actions planned to support affected colleagues and explore alternative visa arrangements.
- **Education Governance Committee Terms of Reference:** Annual refresh approved, with modernised language and focus on wider representation.
- **Internal Communications Review:** Plans for a comprehensive review of internal communications, including evaluation methods, audience targeting, and feedback mechanisms.
- **Staff Awards and Recognition:** Over 500 nominations received; commitment to sharing positive stories throughout the year and aligning recognition with patient safety initiatives.
- **Sickness Absence:** Rising sickness rates flagged as a major concern, with a dedicated HR team established to address and support managers.
- **Digital Training Offer:** Development of a tiered digital skills and AI training program for staff, with three levels of training planned.
- **Mandatory Training Compliance:** Changes in NHS England reporting requirements noted; issues with ESR notifications and compliance tracking discussed.
- **Reasonable Adjustments:** Ongoing challenges in managing reasonable adjustments for staff, with plans for manager forums and improved tracking.
- **Workforce Efficiencies:** Presentation on workforce reduction targets, recruitment pauses, and cost-saving measures, with ongoing monitoring of impact on safety and service delivery.
- **Staff Survey Action Plan:** Focus on discrimination, PDR/appraisals, and continuous improvement, with new reasonable adjustment hubs and leadership programs for international staff.
- **Equality, Diversity & Inclusion:** Updates on WRES, WDES, and first ethnicity pay gap report; emphasis on anti-racism, discrimination policies, and visible support for staff.
- **Medical Revalidation & Appraisal Policy:** Policy updates ratified, including new requirements for job plans, letters of good standing, and improved appraisal management.
- **Apprenticeship Policy:** Approval sought for changes to functional skills requirements, aiming to reduce barriers for apprenticeships.

**Date and Time of Next meeting.**

Thursday 29<sup>th</sup> January 2026 at 2pm – 4:30pm onsite: Room LT1

## BOARD OF DIRECTORS

Thursday, 5<sup>th</sup> February 2026

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

## FREEDOM TO SPEAK UP – QUARTERLY PROGRESS REPORT

### 1. Purpose

The purpose of this paper is to provide the committee with a summary of the activities of the FTSU service for Quarter 3 and to outline the actions planned for the coming period.

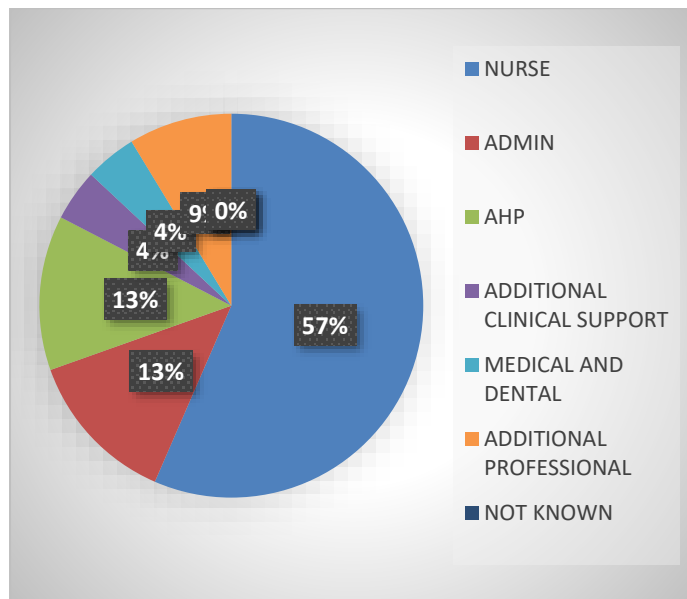
### 2. Recommendation

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

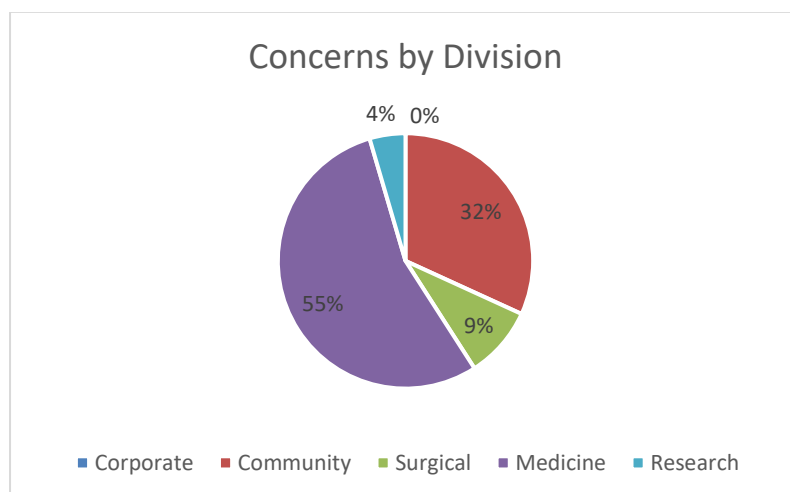
### 3. FTSU Q3 Activity

#### Q3 Data

#### Staff Group raising concerns



#### Concerns raised by Division



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

| Theme                                         | Open | Closed | Total |
|-----------------------------------------------|------|--------|-------|
| <b>Patent Safety and Quality</b>              | 0    | 0      | 0     |
| <b>Worker Safety and Wellbeing</b>            | 0    | 0      | 0     |
| <b>Inappropriate Attitudes and Behaviours</b> | 7    | 3      | 10    |
| Policies, Processes, Procedures, Systems      | 11   | 2      | 13    |
| Infrastructure/Environment                    | 0    | 0      | 0     |
| Cultural                                      | 0    | 0      | 0     |
| Leadership                                    | 0    | 0      | 0     |
| Senior Management Issue                       | 0    | 0      | 0     |
| Middle Management Issue                       | 0    | 0      | 0     |
| <b>Total</b>                                  | 0    | 0      | 23    |
|                                               |      |        |       |

### Contacts by Professional Groups

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

[Recording Cases and Reporting Data \(nationalguardian.org.uk\)](https://nationalguardian.org.uk)

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

### Open Cases Q3

Of the 18 cases open in Q3, 7 relate to inappropriate attitudes and behaviours, 11 relate to policies/processes; of those that are closed, 3 relate to inappropriate attitudes and behaviours and 2 relate to policies/processes.

Of the 18 cases open, the following provides clarity to the status of these cases.

- 4 - A formal HR process is underway, following outcome, the cases will potentially close.
- 2 - Pending closure once closure meeting has taken place
- 2 - Pending outcome of mediation
- 1 - Waiting for assurance from the avoidable employee harm programme of work, particularly relating to staff going through a formal HR process.
- 6 - Pending meeting with staff to determine if the process concern raised has now been correctly adjusted and implemented.
- 3 - Waiting for meetings with managers with a view to resolve their concerns

To view results from the questionnaire post closure please click on the link below:

<https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=OVmEMfpVb8x8dRhYPVxLZDFdyaHlx6lu&id=G888R1c5sE6Cur6KaqH2Sri2S89zA4NJtHQSSVjh0UBUQktJNk5OWUNCN01YUVNOWjlSTkVQSFBDMC4u>

### 4. Detriment

The Public Interest Disclosure Act 1998 (PIDA) states that it is unlawful to treat a worker who has spoken up detrimentally or dismiss them. As part of the Alder Hey FTSU programme we actively promote that staff are safe to raise concerns, through the FTSU route, but just as importantly we also promote that all routes of escalation are safe and, that any member of staff who believes they have suffered a detriment will be supported, their concerns are fully explored and any necessary steps taken.

The numbers of cases being reported by staff, believing they have suffered a detriment, remains significantly low, this is monitored frequently during the course of the case and reference made to the Detriment Guidance for Guardians, [Detriment-guidance.pdf](#). Post closure of the concern raised, monitoring is maintained over a 12 month period, at 3 monthly intervals.

## **5. Lessons Learnt**

Speaking up is an opportunity to learn and improve; sharing lessons from the process will aid the organisation in making suggestions for improvement. Evidence has demonstrated that a significant reason for staff not raising concerns is because they believe nothing will change, therefore, the 'so what' cannot be underestimated in its importance when we are thinking of barriers to raising concerns.

The cases brought to the FTSUG in Q3, sit within the themes of inappropriate behaviours and attitudes and policies/processes, these remain the 2 highest reported themes within the Trust and are reflected in the national picture. There is significant work being undertaken within the organisation in relation to civility and how this impacts on both patient and staff safety, the intelligence gathered through the FTSU process feeds into this work, so that all data is triangulated, thus identifying 'hot spots' where a targeted approach to change can be taken. One of the routes for triangulation is the Thriving Teams meeting, where staff survey results are also shared, these results often correlate with the intelligence sought from other platforms.

Recently we have seen the launch of our new Trust values: Commitment, Community, Compassion and Courage. The FTSUG was a member of the working group responsible for the development and communication of these values. The new values will be hugely beneficial in promoting the expected behaviours of our staff and will also aid staff when the values framework is produced, in challenging poor behaviour in a non-confrontational way.

The sickness policy remains the policy most likely to be adopted inappropriately, particularly around reasonable adjustments, and staff frequently raise concerns relating to this policy. The FTSUG is part of the Sickness/Absence group, the focus being to look at how sickness can be reduced within the Trust and staff can be supported to remain safely in work. The intelligence gathered through FTSU regarding sickness is shared at this meeting so that a greater understanding of some of the challenges that staff, including managers, face, when trying to positively reduce sickness.

The collaborative approach to concerns continues between the FTSUG and the Trust EDI lead. These concerns have focused on reasonable adjustments and issues around racial abuse and in response to this intelligence we are piloting reflective sessions with staff, in a safe space, for staff to share experiences, listen to one another and reflect on behaviours, the aim of which, is to identify lessons learnt so that we can help develop a more inclusive culture.

## **6. Deputy FTSUG role**

The NGO'S guidance for FTSU champions, is that they should not hold cases; only the FTSUG having received the NGO training and registered on the NGO public directory, can hold these cases. Alder Hey has a full-time FTSUG and a network of champions, however this structure could not deliver sustainable capacity to meet the requirements of the People Strategy in relation to speaking up, therefore a deputy FTSUG post was developed so that sustainability and consistency could be offered. Following an internal recruitment process among the group of champions, we have now successfully recruited into the position which will aid in the proactive element of the role as well as investing in supporting the development of the FTSU champions' network.

## **7. FTSUG Visibility Programme**

The FTSU visibility programme, developed in early 2024, to promote the FTSU service and the principles of the service, continues to be well received across the organisation, with heads of department requesting the visits. The walkabouts maintain the support of the members of the Executive and Non-executive team, there are monthly walkabouts scheduled with the CEO, whose attendance is proving beneficial for staff and providing them with an opportunity to raise concerns directly with the CEO.

Recent visits to theatre have been facilitated by the monthly update sessions that are held for the theatre department, to aid their training and development, the visit provided access to approximately 100 staff members, who spoke openly and honestly and shared their concerns. Further visits to theatre are to be scheduled, along with areas not yet visited and off-site visits to community services.

## **8. Collaborative working**

The success of the FTSU service partly depends on working collaboratively across the organization; this enables sharing of information and a demonstration that the service is committed to breaking down barriers to speaking up, this can be evidenced by the work with the EDI lead, the REACH, ACE, LGBTQI+ and Armed Forces community staff networks.

Further collaboration can be seen with staff side colleagues, HR colleagues, Nurse Retention Lead, Patient safety investigation leads, OD and SALS. This approach ensures greater understanding of the challenges that staff face, a wider view of what's really going on and the opportunity to prevent duplication of improvements, whilst sharing learning.

## **9. Mandatory training**

The Speak Up training module as of the 31<sup>st</sup> December 2025 was 89.66% compliant, this is a decline in compliance and is currently being reviewed to determine this decrease. Currently it is not possible to launch the Listen Up, Follow Up training as the ESR system requires adaptation to accommodate this training, however this is also being reviewed, as both these modules will aid in the development of leads and senior leads when staff raise concerns directly with them.

## **10. Speak Up Policy**

The current speak up policy, is aligned to the NGO speak up policy, and is now due for review. The review of the policy is underway as a result of recommendations following an internal case review, which highlighted a number of issues regarding speaking up, that required further clarity. The review is being undertaken by a number of key staff including representation from staff side, HR, SALS and EDI.

## **11. FTSU App**

There is a requirement for further development regarding the FTSU App, however it needs to be established with the app developer, as to whether this development is possible, should this not be possible then consideration needs to be given as to whether the app development continues. If we are unable to progress with the app, we will move to the InPhase system which is being used in other organisations and does allow staff to report anonymously, which was the primary driver for the app development.

**Kerry Turner**  
**Freedom to Speak Up Guardian**  
**January 2026**

## BOARD OF DIRECTORS

Thursday 5<sup>th</sup> February 2025

|                           |                                                                                                                                 |
|---------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <b>Paper Title:</b>       | <b>Chair's Report from the Finance, Transformation &amp; Performance Committee meeting held on 21<sup>st</sup> October 2026</b> |
| <b>Report of:</b>         | <b>John Kelly Committee Chair</b>                                                                                               |
| <b>Paper Prepared by:</b> | Julie Tsao, Executive Assistant                                                                                                 |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Purpose of Paper:</b>                                                  | Decision <input type="checkbox"/><br>Assurance <input checked="" type="checkbox"/><br>Information <input checked="" type="checkbox"/><br>Regulation <input type="checkbox"/>                                                                                                                                                                                                        |
| <b>Action/Decision Required:</b>                                          | To note <input checked="" type="checkbox"/><br>To approve <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                       |
| <b>Summary / supporting information:</b>                                  | Finance, Transformation & Performance Committee minutes from the meeting that took place on 28 <sup>th</sup> October 2024.                                                                                                                                                                                                                                                          |
| <b>Strategic Context</b><br><br><b>This paper links to the following:</b> | <b>Outstanding</b> care and experience <input checked="" type="checkbox"/><br><b>Collaborate</b> for children & young people <input type="checkbox"/><br><b>Revolutionise</b> care <input type="checkbox"/><br><b>Support</b> our people <input type="checkbox"/><br><b>Pioneering</b> breakthroughs <input type="checkbox"/><br><b>Strong Foundations</b> <input type="checkbox"/> |
| <b>Resource Implications:</b>                                             | None                                                                                                                                                                                                                                                                                                                                                                                |

| Does this relate to a risk? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                        |                                                                                                                                    |                                     |                                                                                                                                         |                          |                                                                         |
|-------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------|
| Risk Number/s                                                                                   | Risk Description                       |                                                                                                                                    |                                     |                                                                                                                                         |                          | Score                                                                   |
| BAF Risks                                                                                       | 1.2, 1.3, 1.4, 3.1, 3.2, 3.4, 3.6, 4.2 |                                                                                                                                    |                                     |                                                                                                                                         |                          |                                                                         |
| <b>Level of assurance</b><br><small>(as defined against the risk in InPhase)</small>            | <input type="checkbox"/>               | <b>Fully Assured</b><br>Controls are suitably designed, with evidence of them being consistently applied and effective in practice | <input checked="" type="checkbox"/> | <b>Partially Assured</b><br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness | <input type="checkbox"/> | <b>Not Assured</b><br>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
- M9 Financial update including forecast for year end.
- M9 Debt Write Off
- M9 Integrated Performance Report
- Quarterly Divisional Updates
- Medium Term Plan
- Board Assurance Framework
- Outpatient Pharmacy Business Case

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

- Extraordinary Board to be arranged to approve the Medium Term Plan

## **4. Positive highlights of note**

- Divisions moving forward with financial challenges
- Approval given to Outpatient Pharmacy Cabinet 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 11<sup>th</sup> December 2025.

## MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

**Confirmed** Minutes of the meeting held on **Thursday 11<sup>th</sup> December 2025 at 1pm**  
Via Teams

|                       |                    |                                                 |       |
|-----------------------|--------------------|-------------------------------------------------|-------|
| <b>Present:</b>       | Mr J. Kelly        | Non-Executive Director (Chair)                  | (JK)  |
|                       | Dame. J. Williams  | Non-Executive Director                          | (JW)  |
|                       | Mr. J. Grinnell    | Chief Executive Officer                         | (JG)  |
|                       | Mr. A. Bateman     | Deputy Chief Executive/ Chief Operating Officer | (AB)  |
|                       | Mrs. R. Lea        | Chief Financial Officer                         | (RL)  |
|                       | Mrs. K. Warriner   | Chief Digital and Information Officer           | (KW)  |
| <b>In Attendance:</b> |                    |                                                 |       |
|                       | Mr G Dallas        | Non-Executive Director                          | (GW)  |
|                       | Ms. A. Chindiya    | Associate Finance Director                      | (AC)  |
|                       | Mr. G. Wadeson     | Associate Director of Finance                   | (GW)  |
|                       | Ms. E. Kirkpatrick | Deputy Director of Finance                      | (EK)  |
|                       | Mrs. D. Jones      | Chief Strategy and Partnerships Officer         | (DJ)  |
|                       | Mrs E. Matthews    | Head of Service Development and Development     | (EM)  |
|                       | Mr A McColl        | Deputy Director of Finance                      | (AMc) |
|                       | Ms. E. Saunders    | Chief Corporate Affairs Officer                 | (ES)  |
|                       | Mrs. M. Swindell   | Chief People Officer                            | (MS)  |
|                       | Mrs. J Tsao        | Executive Assistant (Minutes)                   | (ER)  |
| <b>Apologies:</b>     |                    |                                                 |       |
|                       | Mr. M. Jennings    | Non-Executive Director                          | (MJ)  |
|                       | Mr. N. Askew       | Chief Nursing Officer                           | (NA)  |
|                       | Ms. N. Palin       | Director of Transformation                      | (NP)  |

|                  |                                                                                                                                                                                                                                                                                                                                                                                                  |
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| <b>25/26/137</b> | <b>Welcome and Apologies</b><br>The Chair welcomed Gareth Dallas, Non-Executive Director to FTPC.                                                                                                                                                                                                                                                                                                |
| <b>25/26/138</b> | <b>Minutes of the Last Meeting</b><br>The minutes of the last meeting held on 24 <sup>th</sup> November 2025 were approved.                                                                                                                                                                                                                                                                      |
| <b>25/26/139</b> | <b>Matter Arising and Action Log</b><br>FTPC went through the 2 actions on the log:<br><br><b>Strengthening TOM and supporting delivery in 2025/26</b><br>RL referred to the implementation discussion agreed at Trust Board. Due this FTPC agreed this action could now be closed.<br><br><b>Pharmacy Outsourcing</b><br>An update on the pharmacy project will return to FTPC in January 2026. |
| <b>25/26/140</b> | <b>Declarations of Interest</b><br>There were none to declare.                                                                                                                                                                                                                                                                                                                                   |
| <b>25/26/141</b> | <b>M8 Finance Overview Report</b><br>EK presented the M8 finance report highlighting the key areas across I&E and capita. In month the Trust have reported a £0.3m surplus in line with plan.<br><br>The Chair asked if there was a risk with capital underspend. EK responded noting that whilst a number of projects are delayed underspend is not expected.                                   |

|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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|                  | <p>National approval had been received for the SDEC business case with regional approval expected and funding to be received in Q4.</p> <p>RL responded to a query in relation to capital adjustments and PFI accounting advising any changes would be reported to the Audit Committee's next meeting in February 2026.</p> <p>The Chair queried the robustness of in-month accruals and coding, referencing previous Meditech issues. GW noted the process for estimating codes and the impact of challenges within the coding team due to staff vacancies. AM clarified the previous month's Meditech downtime had resolved and was not a factor in this month process.</p> <p>A query was raised in relation to the income risk due to coding backlog. GW explained that process includes freeze data with commissioners and confirmed activity will be coded by this date to mitigate the risk.</p> <p>EK and GW discussed the impact of national contract guidance on next year's figures, highlighting the need to improve coding by flex and the risk of using a low starting point for next year.</p> <p><b>Resolved:</b><br/>FTPC noted the M8 Finance report</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>25/26/142</b> | <p><b>Medium Term Plan</b></p> <p>A presentation was received on the two year plan.</p> <p>JG gave a strategic overview of the medium term plan, broadly covering 3 strategic initiative drives: Streamlining processes boosting productivity, supporting transformational Initiatives, Shifting focus to strategic transformation and changing clinical pathways, Consolidating and Reconfiguring clinical and support services.</p> <p>JG outlined a phased approach over the 3 years:</p> <ul style="list-style-type: none"> <li>- Year one focuses on resetting and resizing AH with productivity improvements;</li> <li>- Year two emphasizes system development and lead provider models;</li> <li>- Year three aims for a mature, collaborative system with broader workforce and service integration.</li> </ul> <p>The Chair and JW questioned alignment with Vision 2030 and the need to reflect this in the narrative. DJ and AB supported linking new services and system authority to Vision 2030.</p> <p>EM provided an overview on operational delivery targets for 2026/27 and the Trust response and plan on how they will be achieved, highlighting areas of challenge. There is a target within the planning guidance to have zero children waiting over 104 weeks, from a mental health perspective, we currently have zero, but there is a known issue with data submissions across the country.</p> <p>AC presented the financial plan for 26/27 noting the key assumptions that the plan has been built on. The CIP requirement is currently set to achieve a financial breakeven position and includes number of key assumptions including inflation, IFRS16 calculation, existing cost pressures, and pre approved business case investments. The plan is not based on contract offers from commissioners as</p> |

they have not yet been received. It is expected this will be reflected in the final submission.

AB highlighted the misalignment between the performance standards and the financial framework.

FTPC discussed a key risk that commissioners may not pay for additional activity resulting from productivity improvements, as they may be considered already funded through transformation monies. RL emphasized the need to clarify the system's approach to productivity gains with commissioners.

GW described the process of developing the draft activity plan, which includes a 7% RTT improvement target and factors in productivity gains. Divisions provided input on achievable activity within current workforce constraints, resulting in a plan that could reach 77% RTT, exceeding commissioner expectations.

AMc presented a summary of the work undertaken on recurrent CIP to reduce the carry forward assumption and overall target for 26/27 to £21m noting that further approval is required to action the savings identified recurrently. The need for further modelling of phasing, investment costs, and the impact of workforce reductions was highlighted. JG noted a clearer plan on workforce reductions was required with options to accelerate.

FTPC discussed the indicative target on non NHS income included in the plan for growth and how plans can be developed at pace to deliver noting some areas are already underway and plans in place. This will be developed further for the final plan in February.

EK presented the Capital slides noting that the allocations for the next four years are higher than previously. In addition as a Trust in segment 1, the guidance now allows carry forward of surplus from 24/25 to reinvest into capital. AFT status would give us the ability to also reinvest over multiple years. The current plan assumes this in 26/27 based on delivery of £7.2 million surplus this year.

It was noted that Alder Hey has been awarded £2m elective incentive funding for our performance this year which will also be spent in 26/27.

KW noted a significant expenditure required in 26/27 due to replacement of the IT network for the main hospital site with business case to follow through CMG.

EK presented cash forecast and assumptions included in the plan on cash. It was agreed a review of the current cash policy and working days requirement would be presented back to FTPC ahead of the new financial year.

**Action: EK to bring review of cash policy and working days requirement to February FTPC meeting.**

JG requested a follow on review on capital spend across next 4 years based on cash modelling and suggested reviewing the total capital allocation.

**Action: EK to present scenarios on capital based on cash assumptions.**

MS provided an update on the Workforce plan, noting it will be presented in further detail at the People Committee next week. A number of principles set out in the workforce plan to be submitted by Monday. HR and finance are working closely to build in the detailed figures.

|                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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|                  | <p>There are a range of actions in development to progress the workforce reductions including for example a session to review all fixed term contracts. The conclusion of the MARS scheme is now factored into the plan.</p> <p>NP went through key message on transformation noting programmes outlined earlier around outpatients, centres of excellence which includes cardiology, in the next few weeks further detail is to be provided in terms of those intended benefits.</p> <p>ES provided an overview on Board Assurance statements noting a separate meeting would be required closer to the submission date.</p> <p>EM went through the timeline in the final slide highlighting FTPC will approve the final submission at the January meeting.</p> <p>GD thanked FTPC for the breadth of detail the teams presented today, noting the meeting had provided detail he would take forward to People Committee next week.</p> <p><b>Resolved:</b><br/>FTPC noted the current position in relation the Medium Term Plan.</p> |
| <b>25/26/143</b> | <p><b>Any Other Business</b><br/>No further business was discussed</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>25/26/145</b> | <p><b>Review of the Meeting</b><br/>FTPC noted the continued focus on the medium-term plan for the next meeting.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                  | <p><b>Date and Time of Next Meeting:</b> Wednesday 21<sup>st</sup> January at 1pm, via Teams.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

# 25/26 FTPC Key Risks – Month 9 Position

|                                     | Initial Risk                                                                                                                                                                                                                                                                                                                                                                                       | Initial RAG   | Latest Position                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | RAG M9        |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| <b>Trust Financial performance</b>  | <p>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.</p> <p>Plan assumes delivery of £22.7m recurrent savings. Highest level set in any one year. Delivery contingent on both BAU and transformation savings</p> | <b>High</b>   | <p>Month 9 position reported £0.3m deficit in month and £0.1m surplus YTD which is ahead of plan (£0.2m). £0.7m industrial action funding was confirmed in M9 which covers the cost incurred in M8&amp;M9. ICB forecast (SW) at M9 reported likely forecast of £5m surplus position for the year and a best-case forecast of £7.2m surplus, in line with M8. Ongoing discussions with PWC/NHSE re the ongoing FPRM and risk rating for AH.</p> <p>PBR/ERF in month performance is estimated above plan by £0.4m in-month, with some challenge in the month due to high level of uncoded activity. Action being taken on mitigating future risk. YTD PBR overperformance (£0.8m) within divisional positions.</p> <p>CIP is behind plan in M9 and YTD. Total savings of £19.6m have been transacted (green) , forecasting to deliver £20.2m following the risk based methodology adopted by region. . AH reported a £2m gap to the full year CIP target in M9 – with remaining gap to be mitigated through run rate savings and further rev to cap subject to ICB approval. There is a £11m gap (fully developed/amber/red/black) on recurrent plan as at M9 however actions are underway to take recurrent opportunity CIP ideas through FIP for approval to post, with intention to reduce the carry forward CIP to £5m</p>                                                                                                                                                                                                                     | <b>High</b>   |
| <b>System financial performance</b> | <p>Challenging 25/26 plan for C&amp;M</p> <p>System plan is deficit and risk of further restrictions and controls that will retract resources/time.</p>                                                                                                                                                                                                                                            | <b>High</b>   | <p>Key data shared on M9 indicates achievement of the M9 and YTD plan, however the system has not received deficit support funding for Q4 which places significant cash risk in the system for those provider with DSF in the plan.</p> <p>PWC remains in the system with FPRM meetings taking place in January, Year end forecast remains significantly away from the £178m deficit plan.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>High</b>   |
| <b>Campus and Capital Programme</b> | <p>Limited CDEL allocation in 25/26</p> <p>Complex campus programme across multi sites, with several key buildings opening in year (Neo/Alderpark).</p>                                                                                                                                                                                                                                            | <b>High</b>   | <p>Capital – Currently the core capital forecast to be underspent (£1.1m). With range from £1.7m under spend to £0.8m overspend in best and worst case scenario. Underspend primarily driven by successful VAT claim in relation to Sunflower House (£1.3m). Funding assumes £3.1m of other funding not yet confirmed. If funding not available then it is believed the year end position will still be manageable through pulling forward phasing of charitable funding. Successful PDC funding now granted for solar for Catkin, Sunflower and the Institute (£104k), Building Management System for Alder Centre (£24k), Generator (£330k), Cyber funding (£390k), Audiology (£320k), all of which anticipated to be spent in 25/26.</p> <p>The Capital plan for 26/27 is currently over subscribed against the planned CDEL limit,. therefore Capital prioritisation panel is scheduled for 27th January. Bids being submitted for several national funding pots (£0.3m secured from 25/26 Estates Safety fund to date).</p> <p>Campus – Ongoing review of delayed schemes: NICU, Elective Surgical Hub and CT Scanners. Equipment procurement to commence for long lead items, and where suppliers can store at nil cost. Opportunities for beneficial access (NICU) to be progressed with contractor. Cost pressures highlighted on 4-year plan as priority for '26/'27 including further Estates Safety Fund bidding. Demolition, infrastructure, car park and site completion works currently being managed within approved budgets.</p> | <b>High</b>   |
| <b>Transforming Alder Hey</b>       | <p>Transforming Alder Hey (ways of working, futures, AI &amp; Digital)</p>                                                                                                                                                                                                                                                                                                                         | <b>High</b>   | <p>Transformational work continues in line with the now-approved <b>2026/27 Transformation Plan</b>, alongside the ongoing development of a new <b>Target Operating Model (TOM)</b> that will define the future shape of Alder Hey.</p> <p>Collaborative actions are being prioritised to create greater simplicity, focus and accountability across delivery. The <b>Closing the Gap</b> programme has been established to accelerate high-impact value initiatives across key workstreams—including workforce, procurement, diagnostics and productivity. A detailed delivery plan, aligned to the emerging TOM, will support continued progress, provide clarity of delivery, and ensure integration within the Trust's transformation oversight framework. The TOM and Transformation Programme will be brought together into a single, coherent <b>Medium-Term Plan</b>, currently in development</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>High</b>   |
| <b>Operational performance</b>      | <p>National focus on productivity and benchmarking to drive down costs. Efficiency programme contingent on driving up productivity in order to reduce costs.</p>                                                                                                                                                                                                                                   | <b>Medium</b> | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Medium</b> |

## BOARD OF DIRECTORS

Thursday, 5<sup>th</sup> February 2026

|                           |                                                         |
|---------------------------|---------------------------------------------------------|
| <b>Paper Title:</b>       | <b>Board Assurance Framework Report (December 2025)</b> |
| <b>Report of:</b>         | Erica Saunders, Chief Corporate Affairs Officer         |
| <b>Paper Prepared by:</b> | Executive Team and Governance Manager                   |

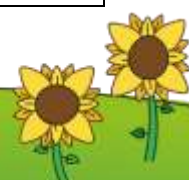
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|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Purpose of Paper:</b>                  | Decision <input type="checkbox"/><br>Assurance <input checked="" type="checkbox"/><br>Information <input type="checkbox"/><br>Regulation <input type="checkbox"/>                                                                                                                                                                                                         |
| <b>Action/Decision Required:</b>          | To note <input checked="" type="checkbox"/><br>To approve <input type="checkbox"/>                                                                                                                                                                                                                                                                                        |
| <b>Summary / supporting information</b>   | Monthly BAF Reports                                                                                                                                                                                                                                                                                                                                                       |
| <b>Strategic Context</b>                  |                                                                                                                                                                                                                                                                                                                                                                           |
| <b>This paper links to the following:</b> | <b>Outstanding</b> care and experience <input checked="" type="checkbox"/><br><b>Collaborate</b> for children & young people <input checked="" type="checkbox"/><br><b>Revolutionise</b> care <input checked="" type="checkbox"/><br><b>Support</b> our people <input checked="" type="checkbox"/><br><b>Pioneering</b> breakthroughs <input checked="" type="checkbox"/> |
| <b>Resource Implications:</b>             | 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 ☐

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

| Risk number               | Risk description                                                                                           | Score                     |
|---------------------------|------------------------------------------------------------------------------------------------------------|---------------------------|
| As detailed in the report | This report provides an update against all Board Assurance Framework Risks for the month of December 2025. | As detailed in the report |

|                                                                       |                                                                                                                                                             |                                                                                                                                                                  |                                                                                                  |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <b>Level of assurance</b><br>(as defined against the risk in InPhase) | <input type="checkbox"/> <b>Fully Assured</b><br>Controls are suitably designed, with evidence of them being consistently applied and effective in practice | <input type="checkbox"/> <b>Partially Assured</b><br>Controls are still maturing – evidence shows that further action is required to improve their effectiveness | <input type="checkbox"/> <b>Not Assured</b><br>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 13 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 not having 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      | Increased waiting times for Specialist Mental Health community services.                                                                                                                                       | Finance, Transformation and Performance Committee |
|          |                                                                                                                                                                                                                | Safety & Quality Assurance Committee              |
| 2.1      | Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people                                                                    | People Committee                                  |
| 2.2      | Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families                                                          | People Committee                                  |
| 2.3      | Failure to successfully embed workforce equality, diversity and inclusion across the organisation                                                                                                              | People Committee                                  |
| 3.1      | Failure to fully realise the Trust's Vision for the 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 13<sup>th</sup> January 2026

| Ref,<br>Owner                                                         | Risk Title                                                                                                                                                                                                     | Monitoring<br>Cttee | Risk Rating:<br>I x L |        |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------|--------|
|                                                                       |                                                                                                                                                                                                                |                     | Current               | Target |
| <b>STRATEGIC OBJECTIVE: Outstanding care and experience</b>           |                                                                                                                                                                                                                |                     |                       |        |
| 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                | 4x4                   | 2x3    |
| 1.4 LC                                                                | Increased waiting times for Specialist Mental Health community services.                                                                                                                                       | FTPC / SQAC         | 3x5                   | 3x3    |
| <b>STRATIC OBJECTIVE: Support our people</b>                          |                                                                                                                                                                                                                |                     |                       |        |
| 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    |
| <b>STRATEGIC OBJECTIVE: Collaborate for children and young people</b> |                                                                                                                                                                                                                |                     |                       |        |
| 3.1 RL                                                                | Failure to fully realise the Trust's Vision for the Alder Hey Campus                                                                                                                                           | FTPC                | 3x2                   | 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    |
| <b>STRATEGIC OBJECTIVE: Pioneering breakthroughs</b>                  |                                                                                                                                                                                                                |                     |                       |        |
| 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    |
| <b>STRATEGIC OBJECTIVE: Revolutionise care</b>                        |                                                                                                                                                                                                                |                     |                       |        |
| 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 December 2025 updates:

- ***Inability to deliver safe and high-quality services (NA).***

Risk has been reviewed. Controls are in place to mitigate any gaps in assurance with regular review and oversight of this risk at SQAC and Trust board. The challenging financial environment continues to be a cause for concern in relation to this risk.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***

BAF risk closed in December 2025 – now being monitored divisionally.

- ***Children and young people not having timely and safe access to elective, urgent and follow up care (AB).***

December performance against 2025/26 targets

- Acute (78%) - ED performance remained above target at 84%

- RTT (63% by March 2026) - 63% in month

- Pts >52 weeks (1% by March 2026) - Currently 2% with the majority under dentistry

- DMO1 (95%) - Performance dropped from compliant to 93%. This is primarily due to reduced capacity in Gastro

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***

Settlement

The Trust is awaiting confirmation from the Project Co Directors on the next steps following approval of the settlement.

Water Safety

Water Safety Group meetings continue in parallel with operational forums to monitor and manage out-of-range water temperatures. A report from the SPV Board has been received and is currently under review. We are pursuing with the dosing system and step in maybe required.

Tap Filters

A formal notification relating to tap filters has been issued to Project Co. No response has been received to date.

Chillers

Ongoing performance issues with the chillers remain. A project plan outlining the proposed approach to full reinstatement has been received although no timelines have been included.

Combined Heat and Power (CHP)

The CHP unit has been offline for approximately one year. The Trust continues to await an update from Project Co on the status of the unit and the proposed next steps.

Summary

A formal notification addressing all of the above matters has been issued to Project Co. No responses have been received at the time of this update.

- **Increased waiting times for Specialist Mental Health community services. (LC).**  
Risk cause and consequence updated.
- **Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).**  
This risk continues to be closely monitored - the risk score remains unchanged. The WTE position is closely monitored and is also addressed through the medium-term planning round, and reported to both FTP Committee and People Committee. Target Operating Model will also address the Trust workforce plan. Impact and plans to mitigate associated risk are reviewed regularly and has been raised in a recent extraordinary Risk management meeting and an extraordinary People Committee. MIAA are currently auditing the workforce efficiencies programme, which will be reported to Risk Committee in January. Staff availability due to sickness continues to receive bespoke interventions.
- **Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families (MS).**  
Risk reviewed and all actions reviewed and updated. New action added relating to identifying, understanding and supporting "fragile" teams. No change to risk rating.
- **Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).**  
Work is ongoing, all actions have been reviewed and remain on track.
- **Failure to fully realise the Trust's Vision for the Alder Hey Campus (RL).**  
Risk reviewed. No change to score.
- **Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (KW).**  
Work has progressed on the development of a Target Operating Model (TOM), which will define how the organisation is structured and operates to deliver Vision 2030 sustainably. In parallel, the next phase of the Transformation Programme is being actively scoped, with the TOM a core enabler of future delivery. A key risk being managed is the organisation's capacity to deliver significant strategic change at the same time as transitioning to new operating arrangements.

Alongside this, the Medium-Term Plan is being developed to set out a single, aligned three-year transformation programme, bringing strategic, operational, workforce and financial priorities together.

There remains a risk that the Vision 2030 Transformation Programme will not deliver the required in-year financial savings to meet CIP targets. While strategic progress continues, the pace of in-year benefit realisation has been slower than planned, creating a residual financial gap.

Mitigations include accelerating targeted actions to maximise in-year savings, strengthening governance and prioritisation, and enhancing benefit tracking with a focus on recurrent savings. Monthly Transformation Programme Board reviews enable dynamic reprioritisation to protect delivery capacity while supporting medium-term sustainability.

- **Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).**

Risk score remains at 20. Discussions continue with commissioners regarding the year end forecast and outstanding risk areas.

The draft medium term Plan submitted in December shows achievement of the financial targets across the next 2 years assuming delivery of a 5% CIP target. Further detail is awaited from commissioners on contract offers for 26/27. A final submission will be made in February to account for any changes and the final 3rd year.

- **System working to deliver 2030 Strategy (DJ).**

Risk, control and actions reviewed and updated for January 2026.

- **Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).**

Risk score remains 9. Actions updated to reflect progress with financial gap and comms plan oversight.

- **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 remains at 16. Infrastructure work progressing well and on track to be completed by Feb 26. Future capital requests being prepared for prioritisation group on 20/01. Good progress being made via Digital, Data and AI Collab. Target Operating Model work in progress and on track to meet deadlines. New CTO in post who is reviewing technology and Cyber portfolio.

## 5. Corporate risks (15+) linked to BAF Risks (as at 6<sup>th</sup> January 2026)

There are currently 27 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

| Risk                                                                   | Risk Title                                                                                                                                                                      | Score (CxL) | Division | Linked | Date opened | Increased to Corporate |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------|--------|-------------|------------------------|
| <b>STRATEGIC OBJECTIVE: Outstanding care and experience</b>            |                                                                                                                                                                                 |             |          |        |             |                        |
| <b>1.1 Inability to deliver safe and high-quality services (3x3=9)</b> |                                                                                                                                                                                 |             |          |        |             |                        |
| 485                                                                    | Potential for no laboratory haematology/transfusion service due to Increased workload pressures, inadequate staffing levels (training/sickness/vacancies) (legacy risk ID 2450) | 5x4         | Medicine | 2.1    | Jul 2021    | Mar 2024               |
| 027                                                                    | Fragility of Inherited Metabolic Disease Service (IMD)                                                                                                                          | 5x4         | Medicine | 1.2    | Jun 2023    | Dec 2024               |

| Risk | Risk Title                                                                                                                                         | Score (CxL) | Division           | Linked    | Date opened | Increased to Corporate |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------------|-----------|-------------|------------------------|
| 179  | Lack of compliance with major trauma standards                                                                                                     | 4x5         | Surgery            |           | Apr 2024    | May 2025               |
| 038  | No neurophysiology consultant in post                                                                                                              | 5x4         | Medicine           | 2.1       | Jul 2023    | Oct 2025               |
| 513  | Insufficient Capital funding (legacy risk 2677)                                                                                                    | 4x4         | Surgery            | 3.4       | Aug 2022    | Feb 2024               |
| 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               |
| 238  | Clinical Coding                                                                                                                                    | 4x4         | Corporate Services | 3.4       | May 2025    | Nov 2025               |
| 287  | Radiology consultant on-call is at risk of failure                                                                                                 | 4x4         | Medicine           | 2.1       | May 2025    | Sept 2025              |
| 293  | Staffing in Biochemistry                                                                                                                           | 4x4         | Medicine           | 2.1       | Dec 2024    | May 2025               |
| 297  | Transcription delay and increase of turnaround times                                                                                               | 4x4         | Corporate Services | 2.1       | Dec 2024    | Apr 2025               |
| 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               |
| 409  | Inability to provide safe staffing levels (legacy risk 2100)                                                                                       | 4x4         | Corporate Services | 2.1       | Jan 2020    | *Apr 2023              |
| 444  | Then there is a risk the organisation will be unable to provide an effective and timely service for tertiary Neurology patients (legacy risk 2719) | 4x4         | Medicine           | 2.1       | Apr 2023    | June 2024              |
| 458  | Disruption in patient's supply of medication and / or treatment (legacy risk 2487)                                                                 | 4x4         | Community          | 2.1       | Oct 2025    | Oct 2025               |
| 464  | Reduced Haematology consultant workforce (legacy risk 2684)                                                                                        | 4x4         | Medicine           | 2.1 & 2.2 | Aug 2022    | Jan 2024               |
| 492  | NICU go live delay                                                                                                                                 | 4x4         | Corporate Services | 3.1       | Nov 2025    | Nov 2025               |
| 496  | NICU delay due to isolation of live services and service connections                                                                               | 4x4         | Corporate Services | 1.3       | Nov 2025    | Nov 2025               |
| 288  | CAMHS Planned Safeguarding Supervision                                                                                                             | 3x5         | Community          | 2.1       | Nov 2024    | Nov 2024               |
| 318  | Failure to deliver the Appropriate Places of Care programme                                                                                        | 5x3         | C&M CYP Programme  |           | Feb 2025    | Sept 2025              |
| 362  | Lack of psychology support in the Emergency Department                                                                                             | 3x5         | Medicine           |           | May 2025    | May 2025               |
| 520  | Pharmacy Capacity <b>(NEW)</b>                                                                                                                     | 4x4         | Medicine           | 2.1       | Dec 2025    | Dec 2025               |

| Risk                                                                                                                                                             | Risk Title                                                                                                                                                                      | Score (CxL) | Division           | Linked    | Date opened | Increased to Corporate |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------------|-----------|-------------|------------------------|
| <b>1.2 Children and young people not having timely and safe access to elective, urgent and follow up care (5x3=15)</b>                                           |                                                                                                                                                                                 |             |                    |           |             |                        |
| 462                                                                                                                                                              | Children and young people will not receive their ASD assessment within the agreed timescale (legacy risk 2463)                                                                  | 4x4         | Community          | 1.4       | Jul 2021    | *Apr 2023              |
| <b>1.3 Building and infrastructure defects that could affect quality and provision of services (4x4=16)</b>                                                      |                                                                                                                                                                                 |             |                    |           |             |                        |
| 496                                                                                                                                                              | NICU delay due to isolation of live services and service connections                                                                                                            | 4x4         | Corporate Services | 1.1       | Nov 2025    | Nov 2025               |
| <b>1.4 Increased waiting times for Specialist Mental Health community services. (3x5=15)</b>                                                                     |                                                                                                                                                                                 |             |                    |           |             |                        |
| 462                                                                                                                                                              | Children and young people will not receive their ASD assessment within the agreed timescale (legacy risk 2463)                                                                  | 4x4         | Community          | 1.2       | Jul 2021    | *Apr 2023              |
| <b>STRATEGIC OBJECTIVE: Support our people</b>                                                                                                                   |                                                                                                                                                                                 |             |                    |           |             |                        |
| <b>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)</b> |                                                                                                                                                                                 |             |                    |           |             |                        |
| 485                                                                                                                                                              | Potential for no laboratory haematology/transfusion service due to Increased workload pressures, inadequate staffing levels (training/sickness/vacancies) (legacy risk ID 2450) | 5x4         | Medicine           | 1.1       | Jul 2021    | Mar 2024               |
| 038                                                                                                                                                              | No neurophysiology consultant in post                                                                                                                                           | 5x4         | Medicine           | 1.2       | Jul 2023    | Oct 2025               |
| 297                                                                                                                                                              | Transcription delay and increase of turnaround times                                                                                                                            | 4x4         | Corporate Services | 1.1       | Dec 2024    | Apr 2025               |
| 458                                                                                                                                                              | Disruption in patient's supply of medication and / or treatment                                                                                                                 | 4x4         | Community          | 1.1       | Oct 2025    | Oct 2025               |
| 464                                                                                                                                                              | Reduced Haematology consultant workforce (legacy risk 2684)                                                                                                                     | 4x4         | Medicine           | 1.1 & 2.2 | Aug 2022    | Jan 2024               |
| 444                                                                                                                                                              | Then there is a risk the organisation will be unable to provide an effective and timely service for tertiary Neurology patients (legacy risk 2719)                              | 4x5         | Medicine           | 1.1       | Apr 2023    | June 2024              |
| 287                                                                                                                                                              | Radiology consultant on-call is at risk of failure                                                                                                                              | 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              |
| 288                                                                                                                                                              | CAMHS Planned Safeguarding Supervision                                                                                                                                          | 3x5         | Community          | 1.1       | Nov 2024    | Nov 2024               |
| 027                                                                                                                                                              | Fragility of Inherited Metabolic Disease Service (IMD)                                                                                                                          | 5x4         | Medicine           | 1.2       | Jun 2023    | Dec 2024               |
| 293                                                                                                                                                              | Staffing in Biochemistry                                                                                                                                                        | 4x4         | Medicine           | 1.2       | Dec 2024    | May 2025               |
| 520                                                                                                                                                              | Pharmacy Capacity ( <b>NEW</b> )                                                                                                                                                | 4x4         | Medicine           | 1.2       | Dec 2025    | Dec 2025               |

| Risk                                                                                                                                                                                                                               | Risk Title                                                                                                          | Score (CxL) | Division           | Linked    | Date opened | Increased to Corporate |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------|--------------------|-----------|-------------|------------------------|
| <b>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)</b>                                                          |                                                                                                                     |             |                    |           |             |                        |
| 464                                                                                                                                                                                                                                | Reduced Haematology consultant workforce (legacy risk 2684)                                                         | 4x4         | Medicine           | 1.1 & 2.1 | Aug 2022    | Jan 2024               |
| <b>2.3 Failure to successfully embed workforce Equality, Diversity &amp; Inclusion across the organisation (4x3=12)</b>                                                                                                            |                                                                                                                     |             |                    |           |             |                        |
|                                                                                                                                                                                                                                    | None                                                                                                                |             |                    |           |             |                        |
| <b>STRATEGIC OBJECTIVE: Collaborate for children and young people</b>                                                                                                                                                              |                                                                                                                     |             |                    |           |             |                        |
| <b>3.1 Failure to fully realise the Trust's vision for the Alder Hey Campus (3x2=6)</b>                                                                                                                                            |                                                                                                                     |             |                    |           |             |                        |
| 496                                                                                                                                                                                                                                | NICU go live delay                                                                                                  | 4x4         | Corporate Services | 1.1       | Nov 2025    | Nov 2025               |
| <b>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)</b>                                                                             |                                                                                                                     |             |                    |           |             |                        |
|                                                                                                                                                                                                                                    | None                                                                                                                |             |                    |           |             |                        |
| <b>3.4 Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments. (4x5=20)</b>                                                                                |                                                                                                                     |             |                    |           |             |                        |
| 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               |
| 238                                                                                                                                                                                                                                | Clinical Coding                                                                                                     | 4x4         | Corporate Services | 1.1       | May 2025    | Nov 2025               |
| <b>3.5 System working to deliver 2030 Strategy (4x4=16)</b>                                                                                                                                                                        |                                                                                                                     |             |                    |           |             |                        |
|                                                                                                                                                                                                                                    | None                                                                                                                |             |                    |           |             |                        |
| <b>STRATEGIC OBJECTIVE: Pioneering Breakthroughs</b>                                                                                                                                                                               |                                                                                                                     |             |                    |           |             |                        |
| <b>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)</b>                           |                                                                                                                     |             |                    |           |             |                        |
| None                                                                                                                                                                                                                               |                                                                                                                     |             |                    |           |             |                        |
| <b>STRATEGIC OBJECTIVE: Revolutionise Care</b>                                                                                                                                                                                     |                                                                                                                     |             |                    |           |             |                        |
| <b>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)</b> |                                                                                                                     |             |                    |           |             |                        |

| Risk | Risk Title                                                            | Score (CxL) | Division           | Linked | Date opened | Increased to Corporate |
|------|-----------------------------------------------------------------------|-------------|--------------------|--------|-------------|------------------------|
| 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               |
| 501  | Home Reporting Hardware (Radiology)                                   | 3x5         | Medicine           |        | Dec 2025    | Dec 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                            |        |
| Safe                                                                                                                                                                                                                                                       |              | Nathan Askew | Actual                                 | Target |
|                                                                                                                                                                                                                                                            |              |              | 9                                      | 4      |
|                                                                                                                                                                                                                                                            |              |              | Assurance Committee                    |        |
|                                                                                                                                                                                                                                                            |              |              | Safety and 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<br>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 via Audit & Risk Committee minutes.<br>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.<br>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<br>2. Robust reduction programme in the number of medication incidents and near misses<br>3. Emerging CQC oversight framework which may reduce our CQC ratings<br>4. The 2030 vision sees a shift towards and experience led organisation without additional resources for delivery of the plan<br>5. Increased oversight relating to the financial pressures resulting in inability to deliver 2030 Strategy |                                                                                                                                                                                                           |

| Action                                                                                                                            | Description                                                                                                                                       | January 2026 |                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------|
|                                                                                                                                   |                                                                                                                                                   | Due Date     | Action Update                                                          |
| <input checked="" type="checkbox"/> 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)       |
| <input checked="" type="checkbox"/> 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)       |
| <input checked="" type="checkbox"/> 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   | Trust continues to engage with CQC through regular engagement meetings |
| <input checked="" type="checkbox"/> 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   | PEG continues to report into SQAC                                      |
| <input checked="" type="checkbox"/> 5. Delivery of 2030 Strategy                                                                  | 5. Revise EQIA process, establish a Clinical Cabinet. Oversight through SQAC, FTFC 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        | Risk Rating                     |        |                                                                                                                                                      |
| Effective                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              | Adam Bateman | Actual                          | Target | Assurance Committee                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |              | 15                              | 4      | <ul style="list-style-type: none"> <li>Finance Transformation &amp; Performance Committee</li> <li>Safety and Quality Assurance Committee</li> </ul> |
| Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |              |                                 |        |                                                                                                                                                      |
| <p>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.</p> |              |              |                                 |        |                                                                                                                                                      |

| Control description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Control assurance (How is this control monitored?)                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Controls for improving access to follow-up care: - Real time report on the follow-up waiting list, waiting times and risk categories</p> <p>- Patient Initiated Follow Up (PIFU) pathway and system initiated - Patient portal for ISLA Care supports waiting list validation and PIFU</p>                                                                                                                                                                                                                                                                                                                                         | <p>Weekly Executive Summary</p> <p>- Follow up metrics included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board</p> <p>- Safe Waiting List Management Group Chaired by Patient Safety Lead</p>                                                                                                              |
| <p>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</p>                                                                                                                        | <p>- Weekly Performance Report to Executive Directors</p> <p>- The NHSE weekly waiting time submission is reviewed and signed off by the Head of Performance</p> <p>- RTT performance is included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board</p>                                                       |
| <p>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 - li) Acute, Diagnostics and Urgent Care</p> | <p>Daily reports to NHS England</p> <p>-Daily situational reports and patient flow meetings</p> <p>-</p> <p>Staffing reports reviewed at staffing huddle meetings</p> <p>- Daily Performance summary</p> <p>-@ monthly ED performance report to Operational delivery group</p> <p>-@ Performance reports to FTP Board Sub-@Committee</p> |

## 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                                                                                                                                                                                                                                                                                                                                                                                           | January 2026 |                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                       | Due Date▲    | Action Update                                                                                                                                                                                                                                                                       |
| <input checked="" type="checkbox"/> Recruit a Locum Consultant in ENT            | The executive board have approved a paper which allows the department to recruit a Locum Consultant                                                                                                                                                                                                                                                                                                   | 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 |
| <input checked="" type="checkbox"/> 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.                                                                                                                                                                                                          |
| <input checked="" type="checkbox"/> 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<br>- Dentistry<br>- Plastic Surgery<br>- Community Ophthalmology and Ophthalmology<br><br>The following services go live from 13th October<br>- Urology<br>- Paediatric Surgery<br>- Gynaecology                               |
| <input checked="" type="checkbox"/> Request mutual aid for dentistry patients    | Mutual aid request submitted which asks for 35 patients to be transferred to the community dentists. The trust is also exploring whether MFT can accept 25 patients.                                                                                                                                                                                                                                  | 31/12/2025   |                                                                                                                                                                                                                                                                                     |
| <input checked="" type="checkbox"/> 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   |                                                                                                                                                                                                                                                                                     |

|                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                              |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> 3. Deploy Ambient Artificial Intelligence to improve productivity             | <p>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</p> | 30/03/2026 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <input checked="" type="checkbox"/> 4. Move to a self-check in model for some patients, using a digital solution  | <p>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</p> | 30/03/2026 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <input checked="" type="checkbox"/> 5. Establish performance reports on the number of patients seen per clinician | <p>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</p> | 30/03/2026 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <input checked="" type="checkbox"/> 1. Expanded Paediatric Assessment Unit                                        | <p>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</p> | 31/03/2026 | <p>Action completion date aligned with new ground floor SDEC build completion.</p> <p>Actions reviewed and action containing the below split into 5 separate actions on request.</p> <ol style="list-style-type: none"> <li>1. Expanded Paediatric Assessment Unit</li> <li>2. Open Same Day Emergency Care Centre</li> <li>3. Deploy Ambient Artificial Intelligence to improve productivity</li> <li>4. Move to a self-check in model for some patients, using a digital solution</li> <li>5. Establish performance reports on the number of patients seen per clinician</li> </ol> <p>Ownership of action will be transferred to ED Leadership and the action split into specific actions</p> |

| 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      | Risk Rating                     |        |                                                                                                                                                      |
| Safe                                                                                                                                                                                                                                                                                      |              | Rachel Lea | Actual                          | Target | Assurance Committee                                                                                                                                  |
|                                                                                                                                                                                                                                                                                           |              |            | 16                              | 4      | <ul style="list-style-type: none"> <li>Finance Transformation &amp; Performance Committee</li> <li>Safety and Quality Assurance Committee</li> </ul> |
| Description                                                                                                                                                                                                                                                                               |              |            |                                 |        |                                                                                                                                                      |
| - Building defects that remain unresolved could impact on patient services, reputation and financial sustainability and the ability to carry out changes and variations which could lead to delays and challenges.<br>- Risk relating to the contractual position on the Project Company. |              |            |                                 |        |                                                                                                                                                      |

| 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<br>- 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.<br>- 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.<br>- 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<br>- Escalation meetings when required with FTPC                                                                                                                       |
| Sharing of information with NHSE and DoH                                                                                                                                                                                                                 | Regular dialogue with NHSE and DoH                                                                                                                                                                                                                   |
| Sub oversight group established delegated by Board                                                                                                                                                                                                       | Group to feed into FTPC monthly to include NED membership                                                                                                                                                                                            |
| 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                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                      |
| - Lack of progress with remedial works<br>- Lack of confidence in timescales for completion of remedial works<br>- Lack of ownership / accountability by SPV on issues<br>- Lack of transparency<br>- Risk of issues escalated impacting on NHS services |                                                                                                                                                                                                                                                      |

| Action                                                       | Description                                                         | January 2026 |                                                                                                                                                                  |
|--------------------------------------------------------------|---------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                              |                                                                     | Due Date     | Action Update                                                                                                                                                    |
| <input checked="" type="checkbox"/> Appropriate Legal Advice | Continue to seek appropriate legal, commercial and technical advice | 31/03/2026   | Legal advice remains ongoing with Bevan Brittan.                                                                                                                 |
| <input checked="" type="checkbox"/> Corroded pipework report | Report from Project Co on corroded pipe work and plans to resolve.  | 31/03/2026   | still awaiting detailed plans from Project Co. Discussions are ongoing, although progress continues to be challenging due to difficulties engaging with the SPV. |
| <input checked="" type="checkbox"/> Defect Survey            | Output from defect survey                                           | 31/03/2026   | The defect survey now 31 March 2026 to allow for SPV coordination                                                                                                |

| Increased waiting times for Specialist Mental Health community services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |             |                                                                                                                                                                                                                                    |        |                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------|
| Risk Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |             | Strategic Objectives                                                                                                                                                                                                               |        |                                                |
| 1.4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              |             | Outstanding care and experience                                                                                                                                                                                                    |        |                                                |
| CQC Domains                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Linked Risks | Owner       | Risk Rating                                                                                                                                                                                                                        |        |                                                |
| <ul style="list-style-type: none"><li>▪ Caring</li><li>▪ Effective</li><li>▪ Responsive</li><li>▪ Safe</li><li>▪ Well-Led</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              | Lisa Cooper | Actual                                                                                                                                                                                                                             | Target | Assurance Committee                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |             | 15                                                                                                                                                                                                                                 | 4      | Finance Transformation & Performance Committee |
| Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |             |                                                                                                                                                                                                                                    |        |                                                |
| Since 2020 there has been a significant increase in demand for Specialist Mental Health Services at Alder Hey, which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours, there has also been an increase in the clinical urgency of referrals received. This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks. In addition Partnership Agencies offering emotional health and wellbeing support have periodically closed access to their services further impacting waiting times. |              |             |                                                                                                                                                                                                                                    |        |                                                |
| Control description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              |             | Control assurance (How is this control monitored?)                                                                                                                                                                                 |        |                                                |
| Business case for investment submitted to Liverpool and Sefton Place and approved. This is 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. Meetings and regular meeting with commissioners to update on service delivery and any challenges.                                                                                                                                                                                                                                                                                                                                                                                                           |              |             | Monthly assurance processes include:<br>□ Monthly contract statements<br>□ 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<br>- Feedback loop agenda item as part of Mental Health Business Meeting<br>- 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<br>- leadership meetings<br>- weekly waiting times & access to care<br>- regular meetings with divisional director<br>- 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.                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |             | Weekly allocation meetings                                                                                                                                                                                                         |        |                                                |
| Weekly performance monitoring in place for operational teams which includes: □ Weekly Tuesday/Wednesday meeting with PCOs □ Divisional Waiting Times Meeting each Thursday □ Trust Access to Care Delivery Group fortnightly This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.                                                                                                                                                                                                                                                                                                                     |              |             | Minutes available for each meeting saved on Teams                                                                                                                                                                                  |        |                                                |
| Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |             | Recent check in audit (attached)                                                                                                                                                                                                   |        |                                                |
| Gaps in Controls / Assurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |             |                                                                                                                                                                                                                                    |        |                                                |
| 1) Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to reduction in capacity. This is due to difficulties recruiting as a result of national workforce shortages; increased sickness, and delays with recruitment processes due to vacancy control. There is also an increase in maternity leave, with backfill being fixed term and less hours than substantive post which can be difficult to fill.                                                                                                                                                                         |              |             |                                                                                                                                                                                                                                    |        |                                                |

| Action                                                                                                                          | Description                                                                                                                                                                                                                                                                                                                | January 2026 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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|                                                                                                                                 |                                                                                                                                                                                                                                                                                                                            | Due Date     | Action Update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input checked="" type="checkbox"/> 104 week waits                                                                              | task and finish group implemented to review 104+ week waits and CYP expected to "tip in"                                                                                                                                                                                                                                   | 30/01/2026   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <input checked="" type="checkbox"/> 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   | <p>Trajectories for improvement are in place, and agreed with commissioners:</p> <p><b>Liverpool CAMHS:</b><br/>           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<br/>           0 CYP waiting over 52 weeks by 30.09.2025 - not achieved, but 0 expected by 31.10.2025<br/>           92% CYP receiving choice within 6 weeks of referral by 31.10.2025 - off track, but RTT improved in Sept. Expected to achieve.<br/>           0 CYP waiting over 40 weeks by 31.01.2026 - on track<br/>           75% CYP receiving partnership withing 18 weeks of referral by 31.1.2026 - on track<br/>           10% WNB rate by 31.12.2025 - off track, WNB rate for Aug higher than expected. Work ongoing</p> <p><b>Sefton CAMHS:</b><br/>           92% CYP receiving choice within 6 weeks of referral by 31.1.2026 - on track<br/>           92% CYP receiving partnership within 18 weeks of referral by 30.4.2026 - on track</p> |
| <input checked="" type="checkbox"/> 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.                                                                                                                | 31/03/2026   | work ongoing to streamline services, introduction of risk and triage calls to Liverpool CAMHS in Aug 2025<br>regular meetings to be scheduled with clinical leads to progress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <input checked="" type="checkbox"/> MHSDS data reporting                                                                        | lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214                                                                                                                                                                                                                  | 31/03/2026   | 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <input checked="" type="checkbox"/> ROMS collection and reporting                                                               | improve recording and reporting of routine outcome measures                                                                                                                                                                                                                                                                | 31/03/2026   | work ongoing -meeting scheduled with ROMS lead, CXIO, GM and Director for Oct 2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

| 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            | Risk Rating          |        |                     |
| <ul style="list-style-type: none"> <li>Safe</li> <li>Well-Led</li> </ul>                                                                     |              | Melissa Swindell | Actual               | Target | Assurance Committee |
|                                                                                                                                              |              |                  | 16                   | 4      | People Committee    |

| Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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| <p>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.</p> <p>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.</p> <p>3. Not developing inclusive recruitment and development practices to improve workforce diversity and progression</p> <p>4. Not developing a Trust wide approach to succession planning and talent management</p> <p>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</p> <p>6. Impact of national financial pressures on workforce numbers to deliver patient care</p> <p>7. Not having a sustainable workforce will impact upon culture</p> |

| 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 FTFC                                                                                                              |
| 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 portal enables all staff to see their chosen IT device.                                             | monthly reporting to the Board via the Integrated Performance Report<br>- 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                                                                                        |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |
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| 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<br>2. Sickness absence levels higher than target<br>3. Lack of workforce planning across the organisation<br>4. Lack of robust talent and succession planning<br>5. Lack of a robust Trust wide Recruitment Strategy<br>6. Lack of inclusive practices to increase diversity and progression opportunities across the organisation<br>7. The national and regional requirements to reduce NHS financial deficit, which is directly impacting on WTE |                                                                        |

| Action | Description | January 2026 |               |
|--------|-------------|--------------|---------------|
|        |             | Due Date     | Action Update |

| Action                                                                                                           | Description                                                                                                                                                                                                                                                                                                                                                                                                                        | January 2026 |                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                    | Due Date     | Action Update                                                                                                                                                                    |
| <input checked="" type="checkbox"/> 2. Sickness absence levels higher than Trust Target                          | 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%                                              |
| <input checked="" type="checkbox"/> 3. Future Workforce                                                          | 3. 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 |
| <input checked="" type="checkbox"/> 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 establishes (virtual)                                                                                                                           |
| <input checked="" type="checkbox"/> 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                                                                                                                                           |
| <input checked="" type="checkbox"/> 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            | Risk Rating          |        |                     |
| <ul style="list-style-type: none"> <li>Caring</li> <li>Safe</li> <li>Well-Led</li> </ul>                                                              |              | Melissa Swindell | Actual               | Target | Assurance Committee |
|                                                                                                                                                       |              |                  | 12                   | 4      | People Committee    |

| Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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| <ul style="list-style-type: none"> <li>- 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.             <ul style="list-style-type: none"> <li>- Failure to create a happy, healthy, fair place to work for staff that is trauma informed and based on restorative, just and learning principles                 <ul style="list-style-type: none"> <li>- Failure to communicate effectively with staff and have the right intelligence to be responsive to their unmet needs                     <ul style="list-style-type: none"> <li>- Failure to design, develop and support compassionate and effective leadership at all levels</li> </ul> </li> </ul> </li> </ul> </li></ul> |

| Control description                                                                                                                                                                                                 | Control assurance (How is this control monitored?)                                                                                                                      |
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| 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<br>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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |
| <ul style="list-style-type: none"> <li>- lack of embedded safety culture across the organisation</li> <li>- lack of understanding about a just and restorative culture approach               <ul style="list-style-type: none"> <li>- lack of consistent compassionate leadership</li> </ul> </li> <li>- Inconsistent application of Trust values and behavioural framework</li> <li>- insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas               <ul style="list-style-type: none"> <li>- insufficient OD resource available to fully address all culture tensions and challenges when they arise</li> <li>- lack of aligned communications approach that is responsive to organisational needs</li> </ul> </li> <li>- lack of control of system decisions and pressures regarding the financial environment</li> </ul> |                                                                                                  |

| Action                                                                                         | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | January 2026 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due Date     | Action Update                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <input checked="" type="checkbox"/> 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. | 30/03/2026   | Safety culture training programme agreed at execs with Patient Safety lead. Working group established to develop the programme and pilot and evaluate in selected clinical areas.                                                                                                                                                                                                                                                                                             |
| <input checked="" type="checkbox"/> 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   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <input checked="" type="checkbox"/> Identifying, understanding, and supporting "fragile" teams | Ensure mechanisms are in place to identify "fragile" teams, i.e. teams with adverse culture, provide effective interventions and provide robust assurance regarding impacts, actions and outcomes. Agree reporting mechanism and process where there are issues of concern. Develop effective tools to empower leaders to assess and understand their team culture and source appropriate support where needed.                                                                                                  | 31/03/2026   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <input checked="" type="checkbox"/> 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   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <input checked="" type="checkbox"/> 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   | Phase 2 Connected Leadership proposal agreed at execs to be fully operationalised in January/Feb 2026. Phase 2 to include team connect and new leader connect programmes<br><br>Phase 1 now launched with Managers and Leaders briefings (Connecting Leaders) now underway and being evaluated. Phase 2 plans to be detailed for execs on 11th December with a view to full launch of the team connect and exec connect (new leader first 100 days) elements in January 2026. |

30/06/2026

 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.

Work to commence on developing a pilot "static" Thriving Teams Index dashboard Jan-March 2026 with a view to full development of "live" system when the new data system is in place in Q3 2026. Data scoped and data sources agreed.

Meeting with Head of Analytics to discuss timescales for development of the Thriving Teams Index. All data agreed with a view to full scoping by Analytics/Digital and development of a prototype dashboard. Capacity challenges in Analytics and planned move to new data system in 2026 mean that development work cannot commence until Q3 2026. Agreed that Director of Culture will escalate to Head of Digital to ascertain if this work can be re-prioritised in view of its strategic importance.

Thriving Staff Index launched on 1st July 2025. Implementation plan developed to ensure both organisational and more targeted approaches and uses of the tool.

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 with Data lead to agree all data for Thriving Teams Index planned for 9th October to enable prototype dashboard to be developed for testing

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.

31/07/2026

Values finalised and agreed at Board in December 2025. New lanyards produced and being distributed by way of formal launch. Implementation plan to be agreed with Values Working Group in January and new values framework to be developed.

Engagement and consultation events now complete with over 750 staff (and 45 teams) contributing. Feedback analysed and incorporated into a new values statement and new values designs. Approval being sought from Board in December for the above so that the new values can be formally launched in January 2026 and the implementation work can begin.

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.

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.

Values working group established focussing on communications and engagement and developing a new values in action/behavioural framework. Work progressing well with a view to launch on the 19th September to coincide with the next Staff Awards event.

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.

- ☒ Values and behavioural framework review, update and implementation

New values and behavioural framework to be developed and embedded across the organisation.

- ☒ 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

28/09/2026

Safety culture training programme agreed by execs with Patient Safety Lead. Group meeting in November to develop the programme and pilot with evaluation.

Second AEH workshop planned with HR, Staffside and FTSUG to progress 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            | Risk Rating          |        |                     |
| <ul style="list-style-type: none"> <li>Effective</li> <li>Well-Led</li> </ul>                   |              | Melissa Swindell | Actual               | Target | Assurance Committee |
|                                                                                                 |              |                  | 12                   | 4      | People Committee    |

| Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| <ul style="list-style-type: none"> <li>- Failure to attract, recruit, and retain a workforce which reflects the demographics of the local population.</li> <li>- Failure to foster an inclusive work place where staff feel respected, valued, and are able to contribution fully as an individual.</li> <li>- Failure to provide equitable access to career development, progression, and leadership opportunities.</li> <li>- Failure to meet statutory obligations under the public sector equality duty and wider equality obligations.</li> </ul> |

| 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<br>- 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<br>- 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.                                                                                                                                           |
| Sufficient EDI resourced to support the EDI agenda                                                                                                                                |                                                                                                                                                                                                                                                                                                |
| Work with Communications colleagues to ensure that messaging is inclusive, supported by a dedicated communications plan, fostering a culture of belonging across the organisation | Work with communications to ensure that we are providing the organisation with the right messages. Support with all EDI related events. Head of EDI supports staff awards judging, communications colleagues are members of the EDI steering group. Development of a clear communication plan. |

## Gaps in Controls / Assurance

1. Recruitment practices are not accessible and inclusive and do not target diverse communities
2. Lack of inclusive leadership behaviour and accountability for embedding cultural change.
3. Informal processes that limit equitable access to career development and advancement of opportunities.
4. Limited organisational awareness, training, and governance around legal duties.

| Action                                                                                                                                  | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                      | January 2026 |                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Due Date     | Action Update                                                                                                                                                                                                                                                                                                                                                                        |
| <input checked="" type="checkbox"/> Informal processes that limit equitable access to career development and advancement of opportunity | Launch: - Mutual Mentoring programme. - 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                                                                                                       |
| <input checked="" type="checkbox"/> Lack of inclusive leadership behaviour and accountability for embedding cultural change             | Inclusive training for managers to be launched as part of the Thriving leaders Programme. Mutual Mentoring Programme to be launched with staff networks. Staff Survey Action Group to be developed, focusing on targeted EDI results, High Impact Actions plan to be implemented. Trust EDI Objectives to be 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. |
| <input checked="" type="checkbox"/> 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   |                                                                                                                                                                                                                                                                                                                                                                                      |
| <input checked="" type="checkbox"/> Recruitment practices are not accessible and inclusive and do not target diverse communities        | Establish Accessible and Inclusive Recruitment Practices working group. Launch Recruitment and Selection training incorporating EDI throughout. Revise Recruitment and Selection Toolkit 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   | Recruitment practices have been reviewed and resources developed to support candidates and also recruiting managers. Inclusive recruitment training has been launched.<br><br>Accessible and Inclusive Recruitment Practices working group established. Recruitment and Selection training incorporating EDI throughout now launched.                                                |
| <input checked="" type="checkbox"/> 1. Multi-factoral issues spanning training and education                                            | Launch EDI training programme. Training needs to be assessed to identify learning needs. Inclusive recruitment and selection training to be developed and launched which includes EDI. Neurodiversity training to be 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                                                                                                                   |
| <input checked="" type="checkbox"/> 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 Alder Hey Campus      |              |            |                                         |        |                                                |
|---------------------------------------------------------------------------|--------------|------------|-----------------------------------------|--------|------------------------------------------------|
| Risk Number                                                               |              |            | Strategic Objectives                    |        |                                                |
| 3.1                                                                       |              |            | Collaborate for children & young people |        |                                                |
| CQC Domains                                                               | Linked Risks | Owner      | Risk Rating                             |        |                                                |
| <ul style="list-style-type: none"> <li>Effective</li> <li>Safe</li> </ul> |              | Rachel Lea | Actual                                  | Target | Assurance Committee                            |
|                                                                           |              |            | 6                                       | 4      | Finance Transformation & Performance Committee |

| Description                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The Alder Hey long term vision for the Alder Hey Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale and in partnership with the local community and other key stakeholders as a legacy for future generations. |

| Control description                                                               | Control assurance (How is this control monitored?)                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Business Cases developed for clarity on work required to complete Park and campus | <ul style="list-style-type: none"> <li>- Information provided to capital prioritisation on areas that require capital spend</li> <li>- Tracking of budget and spend in line with business cases through the development team and finance.</li> </ul>                                                                                                                                     |
| Delivery of Design and Access Statement (included in planning application)        | - Compliance reporting from Park Project Team                                                                                                                                                                                                                                                                                                                                            |
| Development monthly meetings with Divisions                                       | <ul style="list-style-type: none"> <li>- Monthly meetings held with Development Team and Divisions tracking progress of various schemes and escalation of issues</li> <li>- Outputs reported to FTPC via Project Update</li> </ul>                                                                                                                                                       |
| Executive Design group to seek input into plans                                   | <ul style="list-style-type: none"> <li>- Quartely meeting to take place with key executives to share master plans, schemes and seek input</li> <li>- Feedback into Trust Board</li> <li>- NED sponsor</li> </ul>                                                                                                                                                                         |
| 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.                            | <ul style="list-style-type: none"> <li>- Full planning permission gained in December 2019 for the park development in line with the vision</li> <li>- Tracking of works completed to ensure in line with planning approval</li> <li>- Regular updates and meeting with Liverpool City Council and the planning department to discharge pre-commencement conditions</li> <li>-</li> </ul> |

|                                                                                                                      |                                                                                                                                                                                                                                                                                                |
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| 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<br>- 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<br>- Campus highlighted as a top 5 risk at FTPC and reported through this mechanism with clear risk and escalation where required.<br>- Stakeholder events / reported to Trust Board and CoG<br>- 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                                                                                                                                                                                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>PARK:</p> <ol style="list-style-type: none"> <li>1. Adoption of the SWALE by United Utilities</li> <li>2. Weather conditions causing potential delays</li> </ol> <p>CAMPUS:</p> <ol style="list-style-type: none"> <li>1. Stakeholder Engagement</li> <li>2. Successful realisation of the moves plan.</li> </ol> |  |

|                                                                                         |                                                                                                 | January 2026 |                                                                                                                                                                                                                                                               |
|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Action                                                                                  | Description                                                                                     | Due Date     | Action Update                                                                                                                                                                                                                                                 |
| <input checked="" type="checkbox"/> 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.                                                                                                                     |
| <input checked="" type="checkbox"/> 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.                                                                                                                                                                                             |
| <input checked="" type="checkbox"/> 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         | Risk Rating                             |                                                |
| Well-Led                                                                                                                           |              | Kate Warriner | Actual                                  | Assurance Committee                            |
|                                                                                                                                    |              |               | 16                                      | Finance Transformation & Performance Committee |

| Description                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Risk of failure to:</p> <ul style="list-style-type: none"> <li>- 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.</li> </ul> |

| 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                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>1. Shift of focus to meet demands</li> <li>2. Failure to develop capacity for delivery</li> <li>3. Failure to build capacity and skills within our workforce to deliver the 2030 Strategy</li> <li>4. Failure to deprioritise to enable requisite focus on areas of need and transformational change</li> <li>5. Risk of 'mission creep' associated to the Strategy</li> </ul> |

| Action                                                                                                                                | Description                                                                                                                                                                                                                                                                                                                                                            | January 2026 |                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                        | Due Date     | Action Update                                                                                                                                                |
| <input checked="" type="checkbox"/> 1. Developing skills and capacity to deliver the Strategy 2030                                    | The approval of the People Plan 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. | 31/03/2026   | Development of our Strategic Blueprints has allowed us to identify the future skills and capabilities required to support successful delivery of Vision 2030 |
| <input checked="" type="checkbox"/> 2. Failure to deprioritise to enable requisite focus on areas of need and transformational change | Focus on transformational change                                                                                                                                                                                                                                                                                                                                       | 31/03/2026   | Draft of new Strategic Programme 2026-2030 has been developed and is going through further iterations                                                        |
| <input checked="" type="checkbox"/> 3. Risk of mission creep associated to the Strategy                                               | Sharp focus at Strategy Board on core mission                                                                                                                                                                                                                                                                                                                          | 31/03/2026   | Continue to manage as a duty of the Portfolio Board                                                                                                          |

| 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                             |        |                                                |
| <ul style="list-style-type: none"><li>▪ Effective</li><li>▪ Responsive</li><li>▪ Safe</li><li>▪ Well-Led</li></ul>                                                                                                                                       |              | Rachel Lea | Actual                                  | Target | Assurance Committee                            |
|                                                                                                                                                                                                                                                          |              |            | 20                                      | 4      | Finance Transformation & Performance Committee |
| Description                                                                                                                                                                                                                                              |              |            |                                         |        |                                                |
| Failure to deliver financial targets in particular the level of efficiency and cost reduction required.<br>Inability to invest in the capital programme due to constrained capital and cash allocation.<br>Detrimental impact due to system performance. |              |            |                                         |        |                                                |

| Control description                                                                                                                                                                                               | Control assurance (How is this control monitored?)                                                                                                                                                                                                                                                                                      |
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| Active engagement within ICB, NHSE both regional and national.                                                                                                                                                    | <ul style="list-style-type: none"> <li>- Attendance at system forums.</li> <li>- Cascade of system and national information on a regular basis.</li> <li>- Advocate for CYP</li> <li>- Hosting of Beyond programme</li> </ul>                                                                                                           |
| 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.<br>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').<br>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.<br>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.<br>Divisional Directors report on performance at Trust Board. |

|                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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| Financial systems, budgetary control and financial reporting processes.                                          | <ul style="list-style-type: none"> <li>-@Daily activity tracker to support divisional Performance management of activity delivery</li> <li>-@ Full electronic access to budgets &amp;@ specialty Performance results enhanced further with Finance App</li> <li>-@ Finance reports shared with each division/@department monthly and now readily available on Finance App</li> <li>-@ Financial in-month and forecast position reported through SDG, Exec team, FT&amp;P, and trust Board including run rate analysis in detail</li> <li>-@ Financial recovery plans reported through SDG and FT&amp;P</li> <li>-@ Internal and External Audit reporting through Audit Committee.</li> <li>-@ interactive financial dashboard rollout to all budget holders with all information readily available in one place.</li> </ul> |
| Focused programme on closing the financial gap in year and realising the recurrent benefits.                     | <p>8 key areas including in year transformation programme, with executive lead to drive financial benefits at pace to close the CIP gap in year</p> <p>Reporting into FIP and strategic command fortnightly with decision documents on financial savings.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Organisation-wide financial annual plan monitored throughout year by Board and sub-committee to ensure delivery. | <ul style="list-style-type: none"> <li>- Specific Reports submitted monthly and annually as part of business plan process.(i.e annual plan reviewed by FTPC)</li> <li>- Monitored through IPR and the monthly financial report that is shared with FTPC and Trust Board.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Transformation Programme & benefits realisation                                                                  | <p>Weekly meetings are in pace for the transformation collaborative which includes benefits realisation and cost reduction and savings.</p> <p>Reported to FTPC as a top 5 key risk.</p> <p>Enhance reporting through FIP and strategic command for 2 of the areas to accelerate in year financial savings.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Monthly monitoring of FTPC Top 5 risks                                                                           | Risks monitored through FTPC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

#### 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

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                       | January 2026 |                                                                                                                                                            |
|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Action                                                                         | Description                                                                                                                                                                                                                                                                                                                                                           | Due Date     | Action Update                                                                                                                                              |
| <input checked="" type="checkbox"/> Inflationary pressures                     | Requirement to closely monitor impact of inflation increases. Close working with HPL to obtain data on supplier increases and inflation avoidance through negotiations.                                                                                                                                                                                               | 31/03/2025   | Monitor closely impact of inflation increases working with HPL to obtain data on supplier increases and inflation avoidance through negotiations.          |
| <input checked="" type="checkbox"/> 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                                                                                                          |
| <input checked="" type="checkbox"/> 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 |
| <input checked="" type="checkbox"/> Devolved specialist commissioning          | Regular reporting to strategic execs and assurance to FTP and Trust Board<br>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<br>Regular exec to exec meetings with specialized commissioning continues        |
| <input checked="" type="checkbox"/> High risk recurrent Efficiency programme   | Transformation programme to be established 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.                         |
| <input checked="" type="checkbox"/> 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          | Risk Rating                             |                                                                                                              |
| Well-Led                                |              | Danielle Jones | Actual                                  | Assurance Committee                                                                                          |
|                                         |              |                | 16                                      | <ul style="list-style-type: none"> <li>Growth and Opportunities Committee</li> <li>Strategy Board</li> </ul> |

| Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| <p>Risk of inability to control execution of 2030 Vision due to system complexities, constantly evolving statutory and political and system environment.</p> <p>Impact of membership of a system that is in national financial recovery.</p> <p>Risk of failure to keep CYP prioritised in the wider NHS context and competing priorities, and therefore risk to delivery of Vision 2030.</p> <p>Risk of constantly changing relationships and key personnel due to destabilisation of the commissioning environment.</p> |

| Control description                                                                                                      | Control assurance (How is this control monitored?)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West | <p>MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually).</p> <p>Update: New CEO &amp; leadership arrangements at RMCH - exec to exec scheduled for July 25</p> <p>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.</p> <p>Oct 25 Update: No further update this month.</p> <p>Dec 25 Update: Alder Hey continue to work in partnership with RMCH on a variety of clinical services. The NWPPB has not yet re-grouped - though MDs routinely connect and the new RMCH CEO is now connected with Alder Hey CEO and the new RMCH CEO. Management structures supporting the ODNs at RMCH are under change; Alder Hey lead maintaining close liaison.</p> <p>Jan 26 Update: Control is unchanged.</p> |
| Beyond - C&M CYP Transformation Programme hosted at Alder Hey                                                            | <p>Beyond Programme recurrently funded by ICS - update funding confirmed for 25/26 March 25</p> <p>Beyond Board fully established and reporting into ICS, North West region and Alder Hey Trust Board.</p> <p>Dec 25 Update: No change to arrangements</p> <p>Jan 26 Update: Control is unchanged.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| C&M ICS CYP Committee                                                                                                    | <p>C&amp;M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy.</p> <p>Dec 25 Update: No change to arrangements</p> <p>Jan 26 Update: Alder Hey are working with the C&amp;M ICB to determine the best governance structure for CYP in 2026.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

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| <p>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.</p> | <p>Incorporated into Executive Away Day planning discussions and development of 2025+ transformation plan</p> <p>Update Jun 25: Further embedding of the partnership priorities/leadership within the Tx Clinical Collaboratives</p> <p>Sept 25 update: capacity and capability building will be captured in the forthcoming blueprints and TOM work.</p> <p>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.</p> <p>Dec 25 Update: A final version the clinical blueprints is developed. The target operating model work is ongoing.</p> <p>Jan 26 Update: Control is unchanged and the TOM work is ongoing.</p> |
| <p>Continual reflection of the impact of delegation of specialist services into ICBs. Routine reflection of the risks / opportunities for CYP.</p>                                                                                                                                                                                                                                                                                    | <p>Children's Hospital Alliance proposals (under development). On current CHA agenda in March 25</p> <p>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.</p> <p>Oct 25 Update: No further clarity on structure or time frames available.</p> <p>Dec 25 Update: Specialised services are due to be fully transferred to the ICB by March 27 (not delegated). Awaiting further clarity on structure and phases.</p> <p>Jan 26 Update: Control is unchanged.</p>                                                                                                                                                                                 |
| <p>Engagement and working relationships with ICS and partners</p>                                                                                                                                                                                                                                                                                                                                                                     | <p>For example peer to peer arrangement such as C&amp;M DoF meetings.</p> <p>Feb 25 - System-wide CYP Neighbourhood engagement event with LCR and all key partners</p> <p>Oct 25 Update: Relationships with ICS and other system partners are active and Alder Hey continue to engage appropriately.</p> <p>Dec 25 Update: Relationships with ICS and other system partners are active and Alder Hey continue to engage appropriately.</p> <p>Jan 26 Update: Changes in the C&amp;M ICS structure and leadership team are underway - Alder Hey continue to engage with existing and emerging key stakeholders.</p>                                                                                                                                   |
| <p>Growth and Opportunities Committee oversight of growth element of Vision 2030.</p>                                                                                                                                                                                                                                                                                                                                                 | <p>Oct 25 Update: New control</p> <p>Dec 25 Update: The first committee meeting took place in Oct, with the subsequent meeting due in Dec. The Committee is developing the work plan and metrics. TOR approved Dec 25.</p> <p>Jan 26 Update: The second GO Committee took place in Dec 25 and received updates on research, innovation, private patients, global health and strategic partnerships. The workplan is developing.</p>                                                                                                                                                                                                                                                                                                                  |

|                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| <p>Horizon scanning - tracking of system / legislative developments, continued engagement and action planning</p> | <p>Regular Presentations to Trust Board &amp; CoG, Strategy Board</p> <p>Oct 25 Update: continue to track developments and report back into the relevant forums.</p> <p>Dec 25 Update: continue to track developments and report back into relevant forums.</p> <p>Jan 26 Update: Control is unchanged.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <p>Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements</p>                 | <p>Reporting through Strategy Board</p> <p>Update Jun 25 : Strategic Pships governance within new 'GO' Committee developments</p> <p>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.</p> <p>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.</p> <p>Dec 25 Update: Inaugural Strategic partnership assurance piece reported to GO Committee in Dec 25. The breadth of partnership working has increased and this will be reflected into the new Committee with refreshed / appropriate level of governance arrangements in place.</p> <p>Jan 26 Update: An assurance paper was taken through GO Committee in Dec 25, and a decision was reached to create a sub committee focusing on strategic partnerships. This will provide oversight and assurance that Alder Hey have the right partnerships, with appropriate governance in place, with all partners receiving the intended benefits.</p> |
| <p>Joint development of new models of care to enable 10 year plan 3 shifts / Vision 2030 on a wider footprint</p> | <p>Get me well: Lung Health respiratory co-created with partners across Liverpool.</p> <p>Sept 25 update: Recent Lung Health event took place, organised by Tripartite: Alder Hey, Merseycare and LUHG.</p> <p>Neighbourhood Model - system wide development with Place Partners</p> <p>Oct 25 Update: Joint models of care continue to evolve, for example 0-19 services and tripartite lung health.</p> <p>Dec 25 Update: Joint models of care continue to evolve, and positive progress is being made against e.g. tripartite lung health programme and neighborhood models.</p> <p>Jan 26 Update: Control is unchanged.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p>Maintain existing relationships and continually build new ones with system regulators</p>                      | <p>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</p> <p>Dec 25 Update: relationships are consistently maintained.</p> <p>Jan 26 Update: Control is unchanged.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| Membership of CMPC Provider Collaboratives - to ensure CYP voice high on agenda | <p>Membership of CMPC provider collaboratives.</p> <p>Dec 25 Update: Membership and engagement in place.</p> <p>Jan 26 Update: Control is unchanged.</p> <p>Engagement on Vision 2030 with PLACES</p> <p>Partnership Plans developing with CYP focus.</p> <p>Update Jun 25: High disruption of Places due to ICB new model - however Alder Hey continued commitment in all 3</p> <p>Oct 25 Update: Alder Hey continue to represent at Place. Alder Hey leading Place CYP Neighbourhood models, C&amp;M-wide, through 'Beyond' programme and as local provider in all 3 North Mersey Places.</p> <p>Dec 25 Update: Alder Hey continue to represent at Place; significant local work re: Neighbourhood/CYP model ongoing.</p> <p>Jan 26 Update: Control is unchanged.</p> |
| PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

#### 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                                                                                                                                                                                                                                                                                | January 2026 |                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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|                                                                                                                                  |                                                                                                                                                                                                                                                                                            | Due Date     | Action Update                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <input checked="" type="checkbox"/> 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   | Alder Hey continue to monitor system developments through various system forums, and are working within the C&M ICS to shape the future models of care for CYP.                                                                                                                                                                                                                                                                               |
| <input checked="" type="checkbox"/> 2. Impact of delegation of Specialist Commissioned services into ICBs                        | 2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals                                                                                                                                                                                                               | 31/03/2026   | The delegation agenda has been delayed, and is likely to result to services being transferred to the ICS by March 27. Structures and timelines are yet to be confirmed, but Alder Hey continue to engage with commissioners to get clarity.                                                                                                                                                                                                   |
| <input checked="" type="checkbox"/> 3. CYP System and Partners                                                                   | 3. NHS England's Medium Term Planning guidance has clarified the NHS Operating Model including a re-set of the foundations in which to transform care and deliver on the 3 shifts of the 10 Year Health Plan. This will need to done in collaboration / partnership across the CYP system. | 31/03/2026   | We continue to convene partners from across the Cheshire & Merseyside ICB footprint on what an integrated 'children's system' could offer; going further faster with partners on improving outcomes for CYP. Alder Hey has been nominated to apply for Advanced Foundation Trust status which would offer more strategic and operational autonomy, with the expectation of playing a more substantial leadership role locally and nationally. |
| <input checked="" type="checkbox"/> 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   | National drivers and system finance remains challenging. We continue to be agile in our response to this, and are actively horizon scanning.                                                                                                                                                                                                                                                                                                  |

| 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              |        |                                    |
| <div><div>▪ Caring</div><div>▪ Effective</div><div>▪ Safe</div><div>▪ Well-Led</div></div>                                                                                                                                                                                                                                                                                                     |              | John Chester | Actual                   | Target | Assurance Committee                |
|                                                                                                                                                                                                                                                                                                                                                                                                |              |              | 9                        | 4      | Growth and Opportunities Committee |
| Description                                                                                                                                                                                                                                                                                                                                                                                    |              |              |                          |        |                                    |
| Risk of not attaining a balanced portfolio of activities and cross-sector collaborations - including commercial partnerships - which would delay new discoveries.<br>Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities.<br>Risk of exposure to ethical challenges and national and international reputational risks. |              |              |                          |        |                                    |

| Control description                                                                                                                                                                                                                                                                                                                                                                                                                                          | Control assurance (How is this control monitored?)                                                        |
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| 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                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |
| <p>1. Integration of R&amp;I activities into Futures not yet fully determined.</p> <p>2. Levels of activity targeted at maintaining and enhancing reputation not yet sustainable.</p> <p>3. Financial model and levels of income not yet consistent with growth and sustainability.</p> <p>4. Capacity and capability of clinical staff and services to participate in R&amp;I activities.</p> <p>5. Comms Strategy for Futures not yet fully described.</p> |                                                                                                           |

| Action                                                                                                                   | Description                                                                                                                                                                                                                                                                                                                                                                                          | January 2026 |                                                                                                                                                                                                                                                                                                     |
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|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      | Due Date     | Action Update                                                                                                                                                                                                                                                                                       |
| <input checked="" type="checkbox"/> 5. Comms Strategy for Futures                                                        | Development of Futures comms approach                                                                                                                                                                                                                                                                                                                                                                | 30/09/2025   | Plan established - moving to implementation phase                                                                                                                                                                                                                                                   |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Draft comms plan completed by end of Sept - under review by Futures Management Board                                                                                                                                                                                                                |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Draft comms plan underway - draft to be finalised in Sept                                                                                                                                                                                                                                           |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Comms officer now in post and comms plan is underway                                                                                                                                                                                                                                                |
| <input checked="" type="checkbox"/> 1. Establishment of Futures Management Board to ensure integrated Futures leadership | Integration of activities across Research, Innovation, Education and Digital into Futures through the establishment of Futures Management Board with representation from Research, Innovation, Education and Digital. Includes monitoring performance against external targets from major funders to mitigate reputational risk.                                                                     | 31/12/2025   | New Futures Comms and Marketing officer starting in post on 14th July                                                                                                                                                                                                                               |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | new performance reporting structure with data focus tested at Nov FMB - feedback will be actioned for Dec FMB                                                                                                                                                                                       |
| <input checked="" type="checkbox"/> 2/3. 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   | External income progressing well against targets. Financial gap remains for MRI and RPA (see departmental risks). Decisions taken at FIP on 20th Nov to set up priority setting group and releasing operational resource for CRD for MRI and review MARS and other benefit release options for RPA. |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Options agreed for closing the gap in MRI and RPA business cases to break even at year end - actions underway and improved position expected in M6. Transactions re external POIZ funding contribution to existing innovation team agreed in M6                                                     |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Challenges with acheiving income targets for MRI and RPA business cases driving current issues with financial position - being managed through FIP - report due on 28th August                                                                                                                      |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Actions continue to close financial the gap in MRI and RPA business cases. POIZ transactions up to date to end of Sept.                                                                                                                                                                             |
| <input checked="" type="checkbox"/> 4. Capacity and capability                                                           | Create an R&I enabled workforce through the Futures Develop Pillar                                                                                                                                                                                                                                                                                                                                   | 31/03/2026   | Innovation ambassador plan and clinical fellow post adverts in planning for Jan release                                                                                                                                                                                                             |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Idea framework business case approved in Oct SDG with launch planned for March 26                                                                                                                                                                                                                   |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Idea framework business case due to be considered at SDG n Sept. Training prog including thriving ops managers continues to develop.                                                                                                                                                                |
|                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                      |              | Currently looking at research champions model and incentivisation approaches to address challenges with clinical capacity                                                                                                                                                                           |

| Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families |              |               |                      |        |                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------|----------------------|--------|------------------------------------------------|
| Risk Number                                                                                                                                                                                                    |              |               | Strategic Objectives |        |                                                |
| 4.2                                                                                                                                                                                                            |              |               | Revolutionise Care   |        |                                                |
| CQC Domains                                                                                                                                                                                                    | Linked Risks | Owner         | Risk Rating          |        |                                                |
| <ul style="list-style-type: none"> <li>Effective</li> <li>Safe</li> </ul>                                                                                                                                      |              | Kate Warriner | Actual               | Target | Assurance Committee                            |
|                                                                                                                                                                                                                |              |               | 16                   | 4      | Finance Transformation & Performance Committee |

| Description                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families. |

| Control description                                                                                                                                            | Control assurance (How is this control monitored?)                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Clinical and Divisional Engagement in Digital Strategy                                                                                                         | Divisional CCIOs and Digital Nurses in place.                                                             |
| Digital Centre of Excellence in place & fully resourced - Chaired by Trust CCIO                                                                                | Digital Centre of Excellence tracking delivery                                                            |
| Digital Data and AI Collaborative Established as part of transformation programme                                                                              | Multidisciplinary leadership roles identified. Delivery programme in place.                               |
| Digital Strategy refresh underway to reflect changing environment. Digital Data and Insights key components of Vision 2030 and associated governance and plans | Digital Centre of Excellence. Relationship with Futures. Digital and Data Collaborative established.      |
| Disaster Recovery approach agreed and progressed                                                                                                               | Disaster recovery plans in place                                                                          |
| Executive level CIO in place                                                                                                                                   | Commenced in post April 2019, Deputy CDIO in place across iDigital Service                                |
| External oversight of programme                                                                                                                                | Strong links to system, regional and national digital governance via internal and external relationships. |
| Formal change control processes in place                                                                                                                       | Weekly Change Board in place                                                                              |
| High levels of externally validated digital services                                                                                                           | HIMSS 7 Accreditation                                                                                     |
| Monthly digital performance meeting in place                                                                                                                   | iDigital performance meeting in place. Performance reported as part of Corporate Collaborative.           |
| Regular update to Trust Board on digital developments, Monthly update to FTP                                                                                   | Board agendas, reports and minutes                                                                        |

| Gaps in Controls / Assurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none"> <li>1. Cyber security investment for additional controls approved - dashboards and specialist resource in place. Continual review underway to assess additional requirements.</li> <li>2. Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs</li> <li>3. Issues securing experienced resources in some services</li> <li>4. Aging hardware/device estate and financial restrictions preventing all equipment being replaced, most notably in clinical areas</li> <li>5. Capital investment anticipated lower than required</li> <li>6. Optimizing user experience of digital systems review</li> </ol> |

| Action                                                                                                                              | Description                                                                                                                                                                                                                                                    | January 2026 |                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                     |                                                                                                                                                                                                                                                                | Due Date     | Action Update                                                                                                                                                                                                                                                                                                                                                            |
| <input checked="" type="checkbox"/> 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. Links to experience resource gap in control. | 31/12/2025   | Current baseline assessment has been completed and now working through the future state and proposed structures. On track to deliver by required deadline.                                                                                                                                                                                                               |
| <input checked="" type="checkbox"/> Cyber Assurance Framework & Strategic review of Cyber Security with Recommendations and Outputs | This has replaced the action around Cyber Essentials +. Links to the Cyber continual review gap in control                                                                                                                                                     | 27/03/2026   |                                                                                                                                                                                                                                                                                                                                                                          |
| <input checked="" type="checkbox"/> Review of Benefits from Digital, Data and AI Collab and produce report.                         | Produce a report on realised benefits. Links to Transformation at Pace gap in control                                                                                                                                                                          | 27/03/2026   | Good progress has been made across the Digital, Data and AI collaborative, with a number of benefits already identified and realised. There are further initiatives planned to deliver prior to March and a comprehensive report will be produced at the end of the financial year outlining all qualitative and quantitative benefits achieved through this workstream. |
| <input checked="" type="checkbox"/> Replace all aging hardware and infrastructure                                                   | Completion of business cases and deployment of refreshed technology in 4 key areas: End user Devices, EPR Data Centre, Core Data Centre and Hospital Network. This links to the Aging infrastructure gap in control.                                           | 31/03/2026   |                                                                                                                                                                                                                                                                                                                                                                          |
| <input checked="" type="checkbox"/> Digital systems review                                                                          | Digital systems review                                                                                                                                                                                                                                         | 30/10/2026   | Work to consolidate all clinical users onto Meditech is underway focussing on EMIS and aiming for March completion. AlderCare 2.2 Business case has been presented at Execs and work will commence before the end of 2025 with a 12 month deployment plan.                                                                                                               |