BOARD OF DIRECTORS PUBLIC MEETING
Thursday 8th January 2026, commencing at 13:35
Lecture Theatre 1, Institute in the Park, Alder Hey
AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**25/26/288**	**13:35 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**25/26/289**	**13:36 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**25/26/290**	**13:37 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **4th December 2025.**	**D**	Read enclosure
4.	**25/26/291**	**13:39 (1 min)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**25/26/292**	**13:40 (10 mins)**	**Chair's/Chief Executive's Update.**	Chair/ J. Grinnell	To receive an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update							
6.	**25/26/293**	**13:50 (30 mins)**	**Future Shape of Alder Hey – Update; including:** • **AFT Application.** • **Medium Term Plan update.** • **C&M Financial**	K. Warriner/ A. Bateman J. Grinnell A. Bateman R. Lea	To receive an update on progress. To discuss the wider implications. To receive an update on the current position. To receive an update on the current position.	**A** **N** **A** **A**	Presentations
Performance Against Annual Plan							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
7.	**25/26/294**	**14:20 (35 mins)**	**Evidence of Our Performance:** • **Flash Report, M9** • **Integrated Performance Report for M8, 2025/26:** - **Experience and Safety.** - **Revolutionising Care.** - **Pioneering.** - **People.** - **Collaborating for CYP.** - **Resources.** - **Divisions.**	A. Bateman A. Bateman N. Askew A. Bateman J. Chester M. Swindell D. Jones R. Lea Divisional Directors	To receive the Trust's Integrated Performance Report for scrutiny and discussion, highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position. To receive an update on the current position.	**A**	Read report
Unrivalled Experience							
8.	***25/26/295**	**14:55 (5 mins)**	**Mortality Report, Q2.**	A. Bass	To receive the mortality report for Q2.	**A**	Read report
9.	***25/26/296**	**15:00 (5 mins)**	**Organ Donation Annual Report.**	A. Bass	To receive the organ donation annual report.	**A**	Read report
10.	***25/26/297**	**15:05 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 17.12.25.** - **Approved minutes from the meeting held on the 26.11.25.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 26.11.25.	**A**	Read enclosures
Collaborating in Communities							
11.	**25/26/298**	**15:10 (5 mins)**	**LNP Board:** - **Chair's Highlight Report from the**	A. Bass	To escalate any key risks and receive updates.	**A**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			meeting held on the 1.12.25.				
12.	**25/26/299**	**15:15 (10 mins)**	**Collaborate for Children and Young People: Partnerships Update:** • **Neighbourhood working for CYP.**	D. Jones	To receive an update on the current position.	**A**	Presentation
Pioneering Breakthroughs							
13.	**25/26/300**	**15:25 (5 mins)**	**Growth and Opportunities Committee:** - **Chair's verbal update from the meeting held on the 16.12.25.** - **Approved minutes from the meeting held on the 7.10.25.**	M. Jennings	To escalate any key risks, receive updates and note the approved minutes from the 7.10.25.	**A**	Read enclosure
Supporting our People							
14.	**25/26/301**	**15:30 (5 mins)**	**Strategic People Update; including:** • **EDI update.**	M. Swindell	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
16.	**25/26/302**	**15:35 (5 mins)**	**NHSE Board Capability Assessment Feedback.**	E. Saunders	To receive an update.	**A**	Verbal
17.	***25/26/303**	**15:40 (5 mins)**	**Emergency Preparedness, Resilience and Response, Annual Report, 2024/2025.**	N. Askew	To receive and note the EPRR Annual Report for 2024/25.	**N**	Read report
18.	***25/26/304**	**15:45 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 18.9.25.	**A**	Read enclosure

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			meeting held on the 10.12.25. - **Approved minutes from the meeting held on the 18.9.25.**				
19.	***25/26/305**	**15:50 (5 mins)**	**Finance, Transformation and Performance Committee:** - **Chair's verbal update from the meeting held on the 11.12.25.** - **Approved minutes from the meeting held on the 24.11.25.** - **2025/26 top key risks (M8).**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 24.11.25.	**A**	Read enclosure
20.	***25/26/306**	**15:55 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read reports
21.	**25/26/307**	**16:00 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
22.	**25/26/308**	**16:04 (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, 5th February 2026, LT1, Institute in the Park.							

NB * agenda items/reports will be taken as read with questions (only) to be put forward.

REGISTER OF TRUST SEAL
The Trust seal was used in December 2025: 431: Planning Application Ref: No: 24F/2756 – Land Alder Lodge, Alder Road, L.12 2AZ – Liverpool City Council/Alder Hey NHS FT

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M8, 2025/26	R. Lea
Improving the Working Lives of Resident Doctors	M. Swindell

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 4th December 2025 at** Lecture Theatre 1, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mr. N. Askew	Chief Nursing, AHP and Experience Officer	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer/Deputy CEO	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. R. Lea	Chief Finance Officer	(RL)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
In Attendance	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Dr. J. Chester	Chief Scientific Officer	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Ms. C. Lee	ACOO, Division of Surgery	(CL)
	Mrs. K. McKeown	Board Administrator (minutes)	(KMC)
	Ms. A. Prendergast	Assoc. Director of Strategy and Partnerships	(AP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
Item 25/26/270	Dr. J. Potier	Assoc. Director of Organisational Development	(JP)
Item 25/26/270	Mr. J. Fitzpatrick	Internal Communications Manager	(JF)
Apologies	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Dr. B. Owolabi	Non-Executive Director	(BO)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Director of Development	(DP)

National Provider Network for Children's Gender Services for England - Update

Dr. Camilla Kingdon, Chair of the National Provider Network (NPN) for Children's Gender Services in England, provided an update on the work of the NPN for Children's Gender Services for England. A number of slides were shared with the Board that provided information on the following areas:

- The journey of the NPN and National Multi-Disciplinary Team (NMDT).
- The NPN governance structure for the Gender Service for children and young people (CYPGS).
- The purpose of the NMDT.

Dr. Kingdon addressed questions from the Board regarding the involvement of CYP and their families in MDT processes, the recruitment and engagement of paediatric endocrinologists, and the need for cultural change within the specialty. It was clarified that only a small minority of children in gender services are expected to access medical interventions, reflecting a holistic, child-centered approach. The importance of building an evidence base through

research was emphasised, particularly for puberty blocker hormones, with ongoing work to identify future research priorities.

Finally, Dr. Kingdon discussed the need for robust data and rapid reporting mechanisms to monitor consistency across Centres and clinicians and acknowledged the complexity and sensitivity of the work. Dr. Kingdon concluded by highlighting the importance of safeguarding, investment in training, and the ongoing commitment to holistic care for CYP.

The Chair offered thanks to Dr Kingdon for her leadership as Chair of the NPN for Children's Gender Services in England, and for attending December's Trust Board to provide an update on work of the NPN.

25/26/253 Welcome and Apologies

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

25/26/254 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.

25/26/2255 Minutes of the previous meeting held on 6th November 2025.
Resolved:
The minutes from the meeting held on the 6.11.25 were agreed as an accurate record of the meeting.

25/26/256 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

25/26/257 Chair's and CEO's Update

The Chair reported on a recent Grand Round that provided an overview of Alder Hey's role in delivering medical care to children evacuated from Gaza. This effort involved a multi-disciplinary response across the city and included participation from local government. The Chair recommended that Board members take time to listen to the recording of the session.

Reference was made to the Advanced Foundation Trust (AFT) application, noting that the process has accelerated with significant data requests and upcoming committee observations. The Chair asked for full attendance during February's Trust Board as the AFT team will be observing the Board on the 5.2.25.

The Board was informed that the Trust has remained in segment 1 within the national NHS Oversight Framework for Q2 and has risen from position 17 to 10 in the league table, reflecting strong performance against the organisation's plan.

It was reported that Resident Doctors are due to take industrial action on the 17.12.25 to the 22.12.25. A lot of work has been undertaken to improve the lives of Resident Doctors which has received positive feedback. It was agreed to submit a report to the Board to highlight the changes that have been made.

25/26/257.1 Action: MS

Attention was drawn to the ongoing changes to the leadership at C&M ICB.

The Board was informed of the recent agreement with the University of Liverpool, highlighting the positive engagement and collaboration with the faculty delegation. The partnership is expected to support progress in life science projects and strengthening ties between the Trust and the University.

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

25/26/258 Advanced Foundation Trust Application

The Board was provided with a summary of the Government's Advanced Foundation Trust Programme, the proposed eligibility criteria, and the assessment process. Alder Hey is one of only eight NHS providers to have been invited to apply for the programme following it being announced by the Secretary of State early in December.

It was reported that the AFT process has accelerated significantly, with a comprehensive data request received from the assessment team and tight deadlines for submission of the required documentation. Attention was drawn to the anticipated benefits of AFT status, such as strategic and operational autonomy, a capability-based regulatory approach and financial flexibilities.

The assessment team will observe key assurance committee meetings and the Board as part of their evaluation, with a provisional timeline suggesting completion could occur by April, pending further clarification. The Board emphasised the importance of involving the ICB, commissioners, clinicians, and other relevant stakeholders to ensure broad engagement and support for the application. Additionally, it was noted that the assessment team is keen to understand how effectively the Trust can articulate its vision within its plan, as well as the anticipated benefits of attaining AFT status.

A discussion took place about how AFT status would improve the lives of CYP and the Board was of the consensus that the Trust should focus on Vision 2030 as part of the assessment process in terms of how it has positioned the organisation and how the organisation is enacting it, i.e. service transformation, partnership working, etc.

A suggestion was made about having a session with the Youth Forum on the AFT application, and a request was made to further discuss the implications of changes to particular relationships resulting from attaining AFT status.

25/26/258.1 Action: Board

Resolved:

The Board:

- Noted the report and next steps.
- Endorsed the direction of travel.

25/26/259 Future Shape of Alder Hey; including Medium Term Plan

The Board received a presentation on the Trust's emerging Medium-Term Plan. A number of slides were shared that provided information on the following areas:

- The Trust's ambitions for CYP.
- Key assumptions guiding the plan.
- Operational performance metric snapshot.
- Productivity (*emerging plan to improve on productivity*).
- Financial Plan.
- Latest income and expenditure position for 2026/27.
- Capital 4-year draft Plan.
- Financial strategy.
- Targeted Operating Model (TOM).
- Workforce Plan.
- 2026-29 programme shape.
- 3-year Level 1 Strategic Change Programme Delivery Plan for 2026-29.
- Board assurance *(15 statements which the Board must provide a maturity assessment for).*
- Risks.
- Next steps;
  - 4.12.25: Submit overview to Trust Board.
  - 5.12.25: First draft activity plan to be submitted to the Integrated Care Board (ICB).
  - 11.12.25: Extraordinary Finance, Transformation and Performance Committee (FTPC) to approve the 2-year submission and 4-year Capital Plan.
  - 12.12.25: Submission to the ICB.
  - 16.12.25: Submission to North West NHS England (NHSE).
  - 17.12.25: Submission to NHSE.
  - 26.1.26: FTPC to meet to approve final submission.
  - 12.2.26: Final 3-year plans, 4 year capital plan, submission to NHSE with narrative.
- Actions for Board;
  - Confirm approach to delegated approval to the FTPC for plan sign off, prior to external submission.
  - Agree how the Board completes and reviews the Board Assurance Maturity Assessment.
  - Provide feedback on the emerging Medium-Term Plan.

The Chair acknowledged the substantial volume of information presented, particularly given the tight deadlines, and emphasised the importance of aligning the maturity assessment with the AFT assessment process.

A number of questions/concerns were raised and responded to in respect to ambition versus the realism of a £31m savings target/achieving a 2% improvement in productivity, balancing transformation and operational safety, and governance and avoiding overreach. Board members emphasised the need for realistic financial targets, requesting further analysis and validation of the £31m savings

figure. Emphasis was also placed on the significance of transformation yielding tangible outcomes.

25/26/259.1 Action: RL

The TOM presentation slide relating to wave 3 was referenced, and it was suggested that, as a clinically led organisation, this should be prioritised above wave 2, with some elements even placed before wave 1. It was emphasised that establishing an effective clinical design is crucial and should precede the implementation of operational functions.

Following discussion, the Board agreed to delegate detailed review and assurance of the Medium-Term Plan to FTPC, including the maturity assessment and assurance statements via extraordinary review sessions.

Resolved:
The Board:

- Delegated approval to FTPC for sign-off of the Medium-Term Plan prior to external submission.
- Agreed for FTPC members to complete and review the Board Assurance Maturity Assessment and assurance statements via extraordinary review sessions.
- Provided feedback on the emerging Medium-Term Plan.

25/26/260 Digital, Data and Artificial Intelligence Update, Q2

The Board received an update on progress on Digital, Data and Artificial Intelligence (AI), which incorporated an overview of the overall service, key areas of transformation and operational performance. A number of slides were shared that provided information on the following areas:

- Achievements over 2025 (summer/autumn);
  - Artificial Intelligence (AI) Strategy launch.
  - Integrated observations system (OBs)/national paediatric early warning system (PEWS).
  - E-prescribing.
  - Etiometry AI in Paediatric Intensive Care Unit (PICU).
  - Ambient Voice Technology (AVT) scale up enabling admin redesign and increased productivity (*ongoing*).
- What's coming in 2026;
  - Family portal.
  - Integration (*Peadiatric Chain/neighbourhoods*).
  - AI Patient and Care Optimiser (PACO) Assist.
  - Future AI thinking – Hitachi want to partner with Alder Hey and the wider system around the Outpatient model.

A question was raised about the training implications for the Trust's workforce. It was reported that the specific training requirements will be determined by the nature of the technology involved; once this is established, an assessment of training needs will be undertaken.

Resolved:
The Board noted the Digital, Data and Artificial Intelligence Update for Q2.

25/26/261 System Wide Update; including C&M financial position update

It was reported that the Trust is actively involved in the mobilisation of neighbourhood working for children and young people (CYP) across Liverpool, Sefton and Knowsley Places. Each has a mobilisation approach and has identified cohorts of CYP for support, most notable in Liverpool. The following points were highlighted:

- *Test, learn and grow;*
  - This government-led public sector reform is being delivered by local communities. Alder Hey and Liverpool City Council are collaborating on a lung health partnership programme focused on pre-birth to age 5, targeting early intervention and prevention to lower future chronic disease risk. The aim is to co-design and test interventions at neighbourhood level, with the intention of reducing avoidable escalation to emergency care. Progress is underway.
- *Tripartite;*
  - The tripartite members are working to collaboratively develop a coordinated pathway for proactive lung health. Notable progress includes the drafting of a Memorandum of Understanding (MoU), which will be submitted to the Trust Board in January following approval by senior directors. At a recent meeting, it was collectively agreed to advance Board engagement, with a recommendation that all parties undertake broader engagement in the New Year.
- *Cheshire and Merseyside (C&M);*
  - The ICB is currently reviewing both its structure and its sub-committees. As a result, Alder Hey is collaborating with the system to ensure that CYP continue to have representation within any new framework or structure. Additionally, it was noted that the Cheshire and Merseyside (C&M) Integrated Care System (ICS) began its voluntary redundancy programme on the 3.12.25, 2025, which is expected to lead to some changes.
- *North West;*
  - The CEO of the Royal Manchester Children's Hospital (RMCH) is to visit Alder Hey in the new year.
  - *Specialised Commissioners* – There is a possibility that responsibility for specialised services may be transferred to ICSs instead of being delegated, resulting in a change in accountability for these services.
  - NHSE has launched its voluntary redundancy programme nationally and is currently in the two-week voluntary period.

Resolved:
The Board noted the system wide update.

25/26/262 Neurodiversity Transformation Programme Update

The Board received an update on the enhancements implemented within the Neurodevelopmental Service since February 2025. The following points were highlighted:

- The new Alder Hey Neurodevelopmental Service (ND Service) went live on 1.9.25 with CYP and families now receiving support from two specialised teams: the Assessment Team, responsible for diagnostic evaluations, and the Treatment Team, which oversees ADHD medication management as well as post-diagnostic support for ASD.

- The Transformation Board, which was established as part of the Transformation Programme, remains active and will monitor the benefits of the new Neurodevelopment service on a monthly basis.
- As at the 31.10.25 there was a total of 11,254 CYP open to the ND assessment pathway with an average wait to diagnosis of 92 weeks. The Trust provides ND services across Sefton and Knowsley. Improvements have been made around assessments, and the service also employs ND peer support workers who explain the process to families. The Trust continues to fund this role.
- An overview was provided of the improvements that have been implemented, including the rapid assessment initiative that is especially for highly vulnerable CYP on the edge of care or involved with the justice system. This model adapts appointments, customises engagement strategies, and monitors each young person's progress to ensure assessments proceed effectively despite complex circumstances.
- The Board was advised of the challenge of demand outstripping capacity. It was pointed out that it will take almost two years to see all children currently in the service, and the organisation is providing more than it is funded for. A comprehensive assessment of capacity and demand will be undertaken in 2026 as the spike is still increasing post-Covid. It was confirmed that discussions are ongoing with ICB colleagues regarding funding.

It was noted that two years is a considerable duration to wait for an appointment, yet the Trust's waiting time remains the shortest nationally. Alder Hey has a clear understanding of its demand, unlike others that operate across multiple services and may not have the same clarity. A discussion ensued about possible opportunities and strategies that might help reduce waiting times. It was pointed out that any decisions made within the service will significantly affect the broader system. To build a strong case, it will be helpful to determine what is required to address this issue. This would also benefit CYP and help advance strategic goals too.

Resolved:
The Board noted the Neurodiversity Transformation Programme update.

25/26/263 Evidence of Our Performance

Flash Report, M8

The Board received the Flash Report for M8 and an overview of the NHS performance requirements for segments 1, 2, 3 and 4.

Integrated Performance Report (IPR)

Outstanding Care and Experience – Safe and Caring

- A high number of restrictive interventions were recorded in October and the highest in the rolling twelve months.
- Martha's Rule is progressing.
- The Trust has challenged a decision related to an incident classified as a Never Event. It has been noted that a comparable incident reported by another trust was documented as a near miss. Additionally, the Trust has contacted CQC to ask them to reach out to NHSE about having consistency in the management of such cases.

Financial Sustainability - Well Led

- M7 reported a £300k surplus in line with plan, and a YTD of £420k in line with plan. This was seen as a strong result for the second half of the year.

Community and Mental Health Division

- *Sunflower House:* There has been an increase in incidents relating to two complex patients that have resulted in staff being injured. Weekly meetings are taking place to agree a recovery plan for Sunflower House. A meeting has also taken place with Wirral Partnership who have had similar challenges. The Trust is collaborating with a partner in Manchester to develop training across the patch for Tier 4 Units.

There are a number of cultural challenges in Sunflower House that need resolving. Further sessions are to be scheduled to address these issues, and it was confirmed that a new manager is in place at Sunflower House.

Division of Medicine

- *Neurology Service:* The service has recruited a further two consultants who will commence in post in 2026.
- *Microbiology:* The scientist recruited by the Trust last year has successfully passed one of the most challenging exams and has since been invited to join the team during ward rounds. This marks the first time in a paediatric setting that a non-medical professional is taking part in ward rounds and sharing on-call duties with a medical colleague.
- *Laboratories:* The Laboratory Service is in a significantly improved position and is prepared for the winter with staff who are fully trained.

Division of Surgery

- There has been a slight increase in the number of CYP waiting over 52 weeks this month, primarily within ENT and Dentistry. An action plan is in place for ENT, and mutual aid arrangements have been established with the community Dental team in C&M, and RMCH. These measures will facilitate support for 50 patients.
- The Trust has secured funding of over £200k through the ICB for additional capacity to support challenged areas.

The Chair emphasised the value of incorporating percentages in the report to improve the clarity of the information presented.

Resolved:
The Board:

- Noted the Flash Report for M8.
- Noted the content of the IPR for Month 7.

25/26/264 Compliments, Complaints and PALS Report, Q2

The Board received an update and on the performance against complaints and PALS targets in Q2, 2025/26 and a thematic analysis of the top reasons for complaints and PALS.

Attention was drawn to the continued downward trend in formal complaints received for the fourth consecutive month. The Board was also informed of the lovely compliment from a family that recognised all staff members involved in the care of their loved one.

A question was raised about how lessons learned are being shared. It was reported that a year-end review will be conducted and discussed at SQAC in January 2026.

Resolved:
The Board noted the Compliments, Complaints and PALS report for Q2, 2025/26.

25/26/265 Mid-Year Nursing Workforce Report, 2025/26.

The Board received the Mid-year Nursing Workforce report for 2025/26 and was provided with assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing.

An overview was provided on the outcome of the 2025 establishment reviews of wards and departments. Reference was made to sections 3.2 and 3.3 in the report which provides details on nursing establishment determined by occupancy rates, patient dependency, and professional judgment, and explains the rationale underpinning current staffing levels. The report underscores the importance of monitoring and adjusting staffing levels in order to align with service requirements and financial planning.

Following discussion, the Board noted and endorsed the establishment reviews conducted in 2025 and approved the recruitment plan.

Resolved:
The Board noted and endorsed the establishment reviews conducted in 2025 and approved the recruitment plan.

25/26/266 Veteran Aware - Year 2 Review Report

The Board received the Veteran Aware Year 2 Review Report for information purposes. The following points were highted:

- The Trust has been on a two-year journey to improve its Veteran Aware status, with significant progress reported.
- The report highlights the partnership work that has taken place locally and with organisations to strengthen the support offered to veteran families.
- The report is submitted to the regional team to provide assurance that Alder Hey is meeting the respective standards for its veterans.
- It was confirmed that work is ongoing to further enhance support for veterans.

Resolved:
The Board noted the Veteran Aware Year 2 Review Report and the progress that has been made.

25/26/267 Infection, Prevention and Control Report, Q2

The Board was provided with oversight of Infection Prevention Control (IPC) activity and reporting for the Q2 period (1.7.25 – 30.9.25).

A productive health and safety meeting was held with 4C to discuss infection, prevention and control. During the meeting, it was agreed to develop an action

plan in collaboration that will incorporate data and testing protocols. Oncology is one of the areas that is experiencing cases of C. difficile therefore changes in practice have been implemented and a focussed piece of work has been undertaken on environmental factors, including evaluating cleaning methods and products to determine best practices, as well as developing an education package. The forthcoming action plan will address these areas, and an update will be provided in the new year. Additionally, an information pack has been produced for families.

Resolved:
The Board received and noted the content of the Infection, Prevention and Control Report for Q2, 2025/26.

25/26/268 Safety and Quality Assurance Committee

Resolved:
The Board noted the Chair's Highlight Report from the meeting held on the 26.11.25 and the approved minutes from the meeting held on the 22.10.25.

25/26/269 Strategic People Update

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

- Sickness absence rose from 6.7% to 6.9% in November; with the Division of Surgery reporting figures of 6%+, and Corporate Services at 5.3%. A team has been established to address long-term sickness with plans in place for all cases over 12 months. Managers are receiving training focused on empowering managers to make decisions and manage locally.
- It was reported that stress and mental health issues are the main contributors to sickness absence. Colleagues and managers are being well supported, and the new occupational health provider has recommended that the Trust try to resolve sickness absence issues internally, using the occupational health route only when local solutions aren't possible.
- There has also been a spike in short term sickness absence therefore meetings are taking place with the managers of teams flagged as a hotspot area.
- A piece of work is being undertaken across C&M to enable providers to adopt a standard policy which is was pointed out is very similar to the Trust's existing policy.

A query was raised about how the Trust is addressing the link between sickness absence and vaccination. It was confirmed that Alder Hey isn't an outlier but is monitoring the connection. It was reported that efforts are ongoing to address sickness absence.

It was pointed out that not receiving reasonable adjustment is linked to sickness absence and it was queried as to how this is being managed. The Board was advised that reasonable adjustments are being encouraged, with training for managers to make timely decisions to avoid unnecessary sickness absence.

Resolved:
The Board noted the People Plan strategic update.

25/26/270 Trust Values

The Board received an update on the progress in the development of the design and implementation of the new Trust values. The engagement and consultation events are now complete for the values and designs and a summary of the main themes and outcomes of this process was shared along with the new values statement and new values designs.

The feedback received following engagement was collated to help the Trust understand what the organisation feels about the four new values. It was reported that broadly they have been well received and where there was challenge, which was less about the values themselves, intervention work has taken place with respective teams. Input was also received from the Trust's governors which was taken into consideration and resulted in reduced narrative and the values being incorporated on one page.

The Board was provided with a number of slides that provided a visual of the Trust's values main icon design, the secondary icon design, and the lanyard design.

Attention was drawn to the importance of ensuring that the values are anchored around the behaviours that the Trust expects thus enabling staff to connect and embrace them truly. In terms of the organisation's brand values, this will distinguish what the organisation does versus behaviours.

Thanks were offered to Jo Potier and Joe Fitzpatrick for the work that has been undertaken on the Trust's new values that are evidence bound and take into account the feedback from engagement sessions.

Following a recent question raised by governors regarding the cost of the lanyards, it was confirmed that the overall cost is just under £10k and is being funded by the Charity.

Resolved:
The Board approved the new designs, including the new lanyard design and values statement to enable the values to be formally launched.

25/26/271 People Committee

The approved minutes from the meeting held on the 25.9.25 were submitted to the Board for information and assurance purposes.

During November's meeting the Committee focussed on areas of mandatory training that have low compliance such as safeguarding Level 3, sepsis and resuscitation training. A mandatory training working group is to be established with a focus on developing targeted proposals, increasing session capacity, and enhancing mechanisms for personal responsibility and accountability. It was reported that the uptake of the Staff Survey has declined this year compared to previous years. To combat this the Trust is implementing targeted communications, offering incentives and engaging divisions more actively. The Committee also discussed the increase in reported racist incidents affecting staff and families. To address this the Trust is going to develop an Anti-Racism Strategy and tool kit.

The Chair highlighted the importance of addressing people issues to ensure the organisation's success in the coming year. It was suggested that a small working

group be established to focus on one or two specific concerns and report findings to the People Committee.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 25.9.25.

25/26/272 Finance, Transformation and Performance Committee

The approved minutes from the meeting held on the 22.10.25 were submitted to the Board for information and assurance purposes.

It was reported that it has been agreed to incorporate a risk relating to the monitoring of the Trust's ranking, as one of the Committee's top key risks.

Resolved:
The Board noted the update, the approved minutes from the meeting held on the 22.10.25, and the Committee's top key risks in M7.

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:

- FTPC has approved the inclusion of an explicit risk related to the new Neonatal Unit on the BAF. Further discussions will be held to determine the appropriate framing of this risk.
- The Trust's segmentation risk is to be weaved into the BAF at a strategic level, and further discussions are to be held regarding the scoring of People risks.
- It was confirmed that the SQAC is sighted on assessment of the impact that the financial situation is having on quality and safety of services.
- The Board received an overview of forthcoming work that is to be undertaken on the BAF, including discussions on previous risk ranking decisions, identifying linkages within the organisation's risk management practices, and evaluating the potential repurposing of the Risk Management Forum (RMF) for reporting to the Audit and Risk Committee (ARC).

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

25/26/274 Risk Appetite and Tolerance

The Board was advised that work has been paused whilst the Trust assesses how risk appetite/tolerance is evolving in the context of the external landscape. It was reported that the Community and Mental Health Division has rolled out a pilot on risk appetite to manage its risks; however, given the evolving and dynamic environment, the organisation may need to review and potentially adjust its overall approach.

Resolved:
The Board noted the update on risk appetite and tolerance.

25/26/275 Any Other Business

There was none to discuss.

25/26/276 Review of the Meeting

The Chair acknowledged the challenges that the organisation has faced over the past year and expressed gratitude to all staff across the Trust for their dedication and efforts. The Chair also extended best wishes to everyone for an enjoyable festive period.

Non-Executive Fiona Beveridge (FB) was invited to share her insights on the meeting. FB felt that the Board addressed key issues currently influencing the Trust, including ongoing financial challenges and complex strategic planning. It was pointed out that the Executive team and the subsequent two management layers face considerable demands, especially in relation to the AFT process and the provision of extensive data. The importance of maintaining robust governance amid rapid developments was emphasised. FB also felt that acknowledging pressures is critical, as is recognising the value of resilience and understanding personal and organisational limitations.

Date and Time of Next Meeting: Thursday 8.1.26, 9:00am, LT1, Institute in the Park.

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

Date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for January 2026							
1.5.25	25/26/45.1	People Plan Strategic Update	Landmark Supreme Court Judgment - Provide an update on the implications of this case for the Trust once further guidance has been published.	M. Swindell	Jul-25	**Jan-26**	
4.12.25	25/26/258.1	Advanced Foundation Trust Application	Discuss the implications of changes to particular relationships resulting from attaining AFT status.	Board	Jan-26	**On track Jan-26**	
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	**On track Jan-26**	
Actions for February 2026							
1.5.25	25/26/46.1	FTSU	Include data that maps themes in terms of concerns by staff group, in the next quarterly report.	K. Turner	Sep-25	**Feb-26**	**2.10.25** - This data will be included in January's FTSU report. **ACTION TO REMAIN OPEN**
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	**Feb-26**	**2.1.26 –** It was agreed to submit this report during February's Board. **ACTION TO REMAIN OPEN**
Actions for April 2026							
7.11.24	24/25/214.2	Integrated Performance Report	Invite the family of a patient who were supported by the Wellbeing Hub, to a future Board meeting to share their story.	D. Jones/ K. McKeown	Feb-24	**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 Apr-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
4.12.25	25/26/257.1	Chair's and CEO's update	Submit a briefing paper during January's Trust Board to highlight the positive changes that have been made to improve the lives of Resident Doctors.	M. Swindell	Jan-26	**Closed**	2.1.26 – This item has been included on January's agenda. **ACTION TO BE CLOSED**
Status							
Overdue							
On Track							
Closed							

BOARD OF DIRECTORS

Thursday, 8th January 2026

Paper Title:	**Medium Term Plan update**
Report of:	**Adam Bateman, Chief Operating Officer and Deputy Chief Exec**
Paper Prepared by:	Ellen Mathews, Head of Service Development & Performance

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	To provide an update to the Trust Board on the development on the Medium Term Annual Plan.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Implications:	

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

Risk number	Risk description	Score

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

1. Executive Summary

On the 12th December 2025, the Trust submitted the first iteration of the medium term plan, covering 2026/27 and 2027/28. The next key milestone is the final submission date, which is 12th February 2026. This paper provides 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.

2. Introduction

On the 24th October 2025, the Medium Term Planning Guidance was released, with the expectation that organisations are to create a three year activity, finance and workforce plan, alongside a five year narrative plan. Within the plan, organisations are required to address the three shifts within the NHS 10-year plan, Hospital → Community, Sickness → Prevention, and Analogue → Digital. It also asks organisations to improve productivity to balance system budgets and improve quality and safety of services, particularly community and mental health services.

On the 12th December, the following documents were submitted:

- 2-year activity plan
- 2-year workforce plan
- 2-year financial plan
- 4-year capital plan
- Integrated Medium Term Plan Template (including Board Assurance statements)

The next key milestone is Thursday 12th February. The Trust is required to submit the following:

- 3-year activity plan
- 3-year workforce plan
- 3-year financial plan
- 4-year capital plan
- Integrated Medium Term Plan Template (including Board Assurance statements)
- 5-year narrative plan.

This paper provides an overview of the first submission, and the current state of plan development in preparation for the February deadline.

3. Current Position

A Planning Delivery Group has been set up to oversee plan development, consisting of a multidisciplinary team of finance, performance, analytics, workforce, digital and divisional representatives. It is through this group that key messages are shared. Given the scale of the plan, the Executive team set five planning assumptions that the plan must achieve:

With these assumptions at the forefront, the year one and two plans were drafted. The internal financial and activity modelling incorporated stripping out non-recurrent income and expenditure, including 24/25 carry forward of unachieved efficiency schemes, including a 2% national efficiency target, and any internal service development plans that would impact upon activity. It was also paramount that the Trust submitted a compliant plan with the new national access standards.

3.1 Financial plan position

The internal financial approach is summarised below:

3.2 Workforce plan position

Alongside this, the workforce plans are in development and the priorities are shared below. It must be noted that the workforce plans will also incorporate any redesign of services following the implementation of the Trust's new Targeted Operating Model.

3.3 Performance plan position

Below is an overview of the key performance metrics contained within the planning guidance for the next three years, as well as an overall assessment on deliverability.

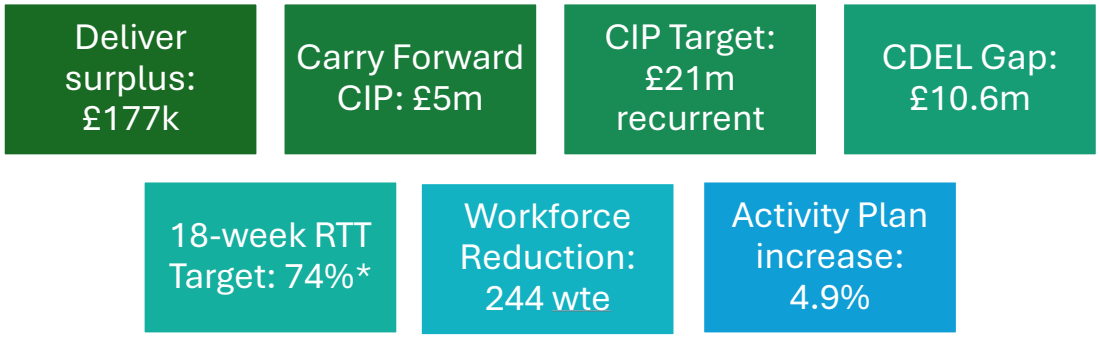
Priority	Measure	Current	2026/27 Target	2027/28 Target	2028/29 Target	Assessment to deliver
Improve ED Waiting times	Improve A&E waiting times to treat patients within 4 hours	87%	95% (By Sept'26)	95% (avg. across 27/28)	95% (avg. across 28/98)	
Reduce the time people wait for elective care	% of patients waiting no longer than 18 weeks for treatment (in hospital)	62%	70%	81% (TBC)	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	95%	97% (TBC)	98% (TBC)	99%	
	Improve performance against the headline 62 day cancer standard		80%	82.5%	85%	
	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)	0	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 (TBC)	£0k	
	10% year on year reduction of bank spend compared to 2025/26 M6 FOT	£4.9m	£4.5m	£4.0m	£3.6m	

3.4 Plan Summary

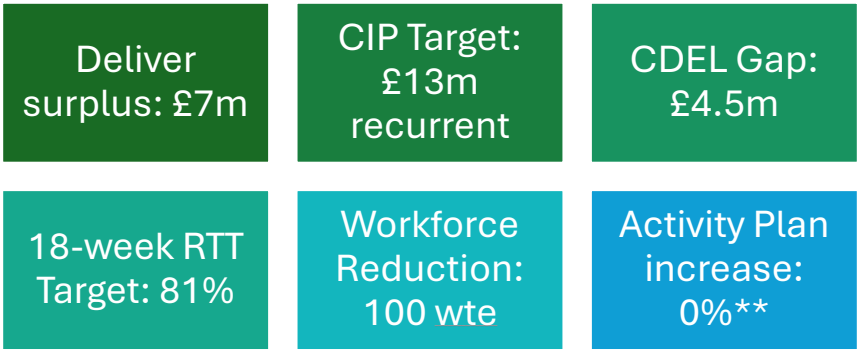
Overall, a significant amount of work has been completed and triangulated to create the Trust's medium-term plan for years one and two, and this work will be

replicated for year three and beyond. For ease, a high-level summary of year one and two submissions is presented below to highlight the key metrics:

Year One:



Year Two:



* Stretch target set internally, local target from ICB is 70%
**Further modelling is required on the year two activity plan; therefore, a flat plan was submitted and will be rectified in the final submission.

Alongside the numerical submissions, the Board Assurance statements were also completed and shared as part of the 12th December submission. These can be seen at Appendix One.

4. Next Steps

The focus for January is revising the 2-year plans following feedback from the Cheshire & Merseyside ICB and NHS England, as well as creating the third-year numerical plans and drafting the five-year narrative plan. In addition to this, the divisional teams have been tasked with creating divisional packs which are to be presented to the Exec team in mid-January to review progress prior to submission in February.

Key milestones are included below:

Event	Date
First draft of 5-year narrative plan due for Exec review 3- year plans & 4-year capital plans from divisions,	16th January
Divisional Presentations to Exec team	20th January
Finance, Transformation & Performance Committee	21st January
Trust Board	5th February
Activity & Performance pack to C&M ICB	6th February
Final Submissions (3-year plans, 4-year capital plan, 5-year narrative plan) to Regional NHS England team **(supersedes the deadline below)**	11th February, 5pm
Final Submissions (3-year plans, 4-year capital plan, 5-year narrative plan)	12th February, noon

5. Conclusion

Overall, a significant amount of work has been carried out to produce the first submission plans. Work is now ongoing to refine and expand into year three, as well as develop the overall five-year plan. The Board is asked to take note of progress to date so far, and the upcoming key milestones.

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

Appendix One:

Ref	Area For Assurance	Statement	Response	Commentary
1	Foundational activities	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]	
2	Governance and leadership	The board can confirm strong clinical leadership is involved in the development of plans.	1. Embedded [Full Assurance]	
3	Governance and leadership	The board can confirm processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans.	2. Maturing	Vision 2030 is a needs based approach to developing the medium term plan, with an underpinning strategy that is based around, with partners, improving the life chances of Children and Young People.
4	Governance and leadership	Robust quality and equality impact assessments (QEIA) are underway or are planned to be undertaken and reviewed by the board to inform development of the organisation's plan.	1. Embedded [Full Assurance]	
5	Governance and leadership	The board is playing an active role in setting direction, reviewing drafts, and constructively challenging assumptions during the plan's development.	1. Embedded [Full Assurance]	
6	Governance and leadership	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]	
7	Governance and leadership	The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	1. Embedded [Full Assurance]	

8	Plan development	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.	3. Developing	At this stage of development and considering the ambition outlined in the plan, the Board is satisfied with progress. However, it is recognised that comprehensive implementation programmes are ongoing and will further reinforce this position. Additionally, the full intentions of the commissioners are not yet clear, which could influence both the phasing and feasibility of delivery over the next three years.
9	Plan development	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.	1. Embedded [Full Assurance]	
10	Productivity	The board can guarantee that the organisation is fully considering and reflecting productivity opportunities in plans. This should include those identified in national data packs as well as any local opportunities to improve productivity.	2. Maturing	The plan is underpinned by a productivity opportunity assessment with ongoing work on the implementation of the opportunities identified.
11	Risk	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]	
12	NHS standard contract and commissioning	The board can confirm work is underway to ensure contract values used in planning submissions are aligned across (commissioner and provider) activity and financial plans.	3. Developing	An initial contract offer has been received from the commissioners; however, additional work is necessary, particularly concerning the implications of deconstructing the block and levels of activity to be commissioned to deliver RTT improvement.
13	NHS standard contract and commissioning	The board can confirm that there is an effective process in place to manage the sign-off of contracts.	1. Embedded [Full Assurance]	

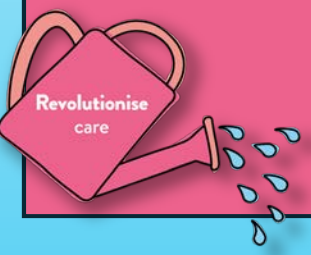
14	NHS standard contract and commissioning	The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	1. Embedded [Full Assurance]	
15	Workforce	The board can confirm the impact of the 10 Year Health Plan on the workforce is being considered in the development of 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.

Flash Report December 2025

Alder Hey Children's NHS Foundation Trust

Performance is subject to change

1	1	90.8%	4	18
Severe/Fatal Incidents/Never Events	Patent Safety Incident Investigations	FFT - % Recommending Trust	Healthcare associated Infections	Patients deteriorating from an inpatient bed



84.1%	258	62.5%	1.61	93%
ED: %Treated within 4 Hours	Number of RTT Patients waiting >52weeks	% Patients waiting within 18 weeks (RTT)	Elective activiy per clinical WTE	Diagnostic Performance

+4.5	11%	76.7%	7.10%
Estimated Workforce Plan	Staff Turnover	%PDRs Completed	% Sickness

HIGHLIGHTS

- Sustained performance for time to be seen and treated in ED - 9th consecutive month 80%+.
- High proportion of diagnostic tests completed in six weeks.
- Improved performance for % patients waiting under 18 weeks for treatment.
- Good patient experience scores.
- Sustained reduced volume of patients deteriorating from an inpatient bed.

CHALLENGES

- 1 Never Event; PSII is being undertaken.
- Sickness rates.
- Estimated Workforce slightly above plan.

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: December 2025

Contents

VISION 2030

Our Journey To 2030

BRILLIANT BASICS

IPR – Executive Summary

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience

	Value	Target	Trend
Patients deteriorating from an inpatient bed admitted to PICU	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.

*RTT Targets based trajectory

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring

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

Highlights:

• Reduction in restrictive intervention required; this figure will fluctuate depending upon clinical need • No severe incidents reported • Sustained compliance above 90% in ED for administration of antibiotics for sepsis • No C-diff cases reported. Working collaboratively with UKHSA to review cleaning our methods • 97% of PALS responded to within 5 working days

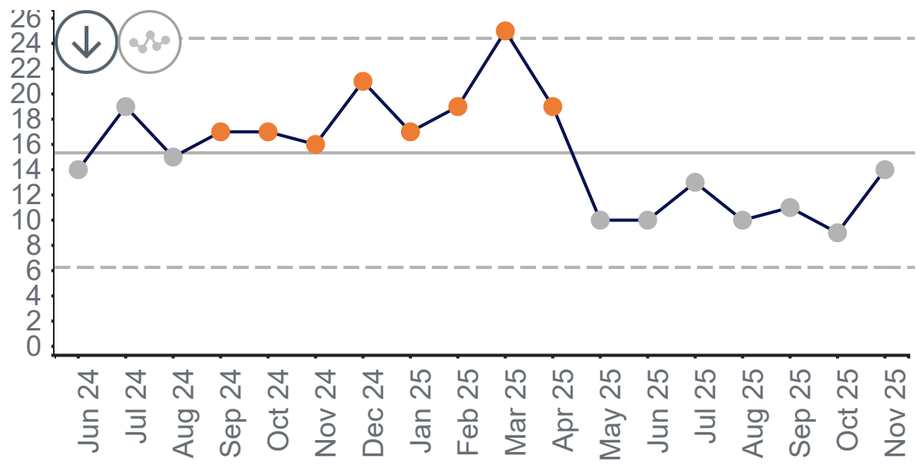
Areas of Concern:

• Increase in MSSA cases in month to 3 • 7 patients admitted to PICU from HDU following deterioration.

Forward Look (with actions)

• Reducing infection rates: review terminal cleaning and decontamination strategy and then update the policy and roll out training. We have engaged the UKHSA to review our cleaning methods and identify improvements • Reducing preventable deterioration: Deteriorating Patient workstream progressing all actions as outlined below

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



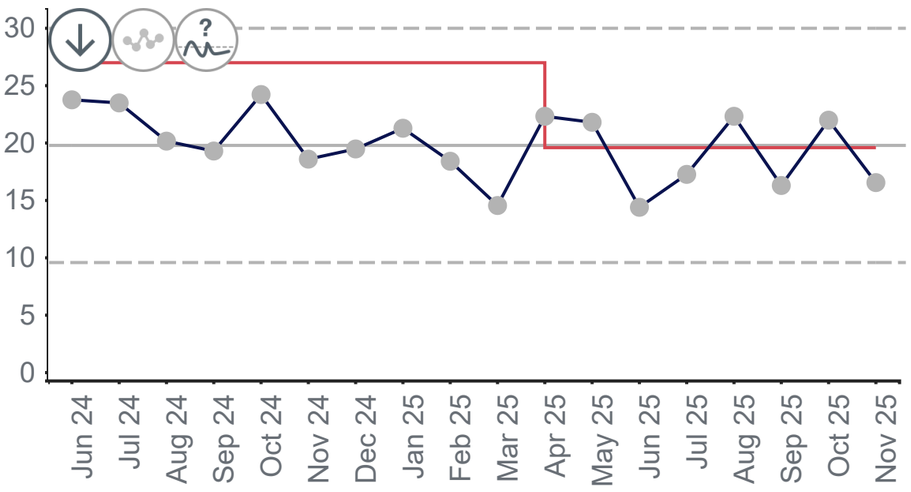
Technical Analysis:

Common cause variation observed with 14 patients deteriorating from an inpatient bed to PICU with an average of 15 a month during the last 18 months. 7th consecutive month below the average.

Actions:

Sustained reduction in incidences; Deteriorating Patient workstream reports through to Patient Safety Board. Overarching actions in train are • Consistent and systematically applied processes for the prevention, escalation, identification and response to deterioration • Trust wide education and training to develop and maintain the knowledge, skills and competence required • A comprehensive clinical governance process in place that supports learning, continuous improvement and assurance at all levels of the organisation.

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



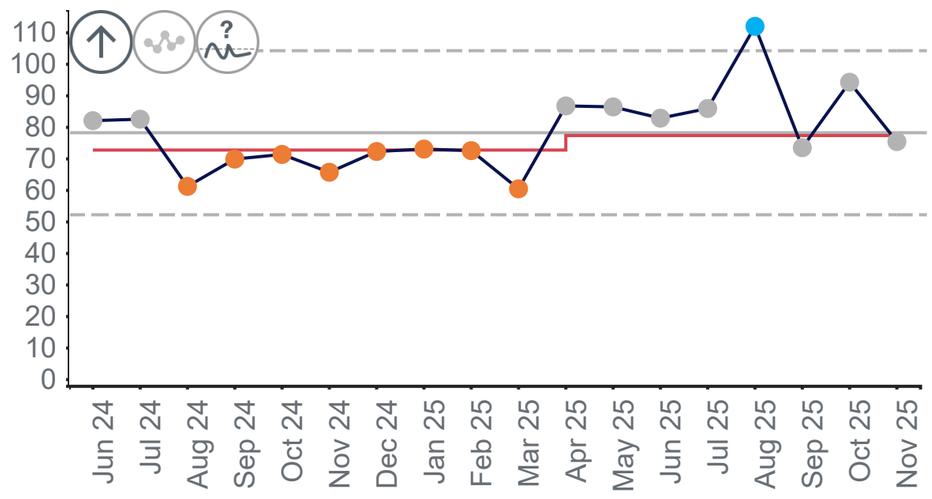
Technical Analysis:

Common cause variation with performance of 17 incidents of harm per 1,000 bed days, with a monthly average of 20 incidents during the period. Incidents are assessed on Physical and Psychological Harms. The target is set on a 5% reduction of 24/25, with a monthly target of 19.6.

Actions:

Refer incidents reviewed at PSIRI to the Patient Safety Meeting to ensure wide dissemination and share learning. The category that results in the most low and above harms between Apr – Dec 2025 is skin damage; this is a new category on InPhase, hence increase in reporting. This relates to friction, moisture damage and reactions and not pressure ulcers, which are separate category (1-4). Most occurrences are in critically unwell patients in PICU. Tissue viability ward rounds in place to identify high risk patients and referral process available.

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



Technical Analysis:

Common cause variation observed with 75 incidents of no harm per 1000 bed days, with a monthly average of 78. Incidents are assessed on both Physical and Psychological Harms. The target is set against a 5% improvement on 24/25 with monthly target 77.4.

Actions:

Continue to share learning and identify potential for improvement

Integrated Performance Report | December 2025

NHS
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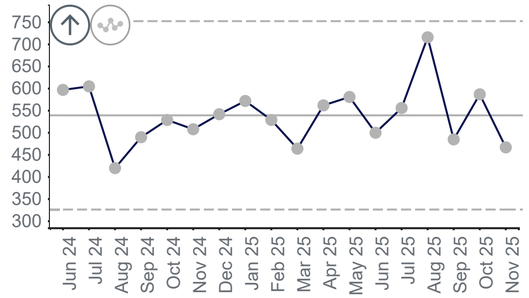
NHS Foundation Trust

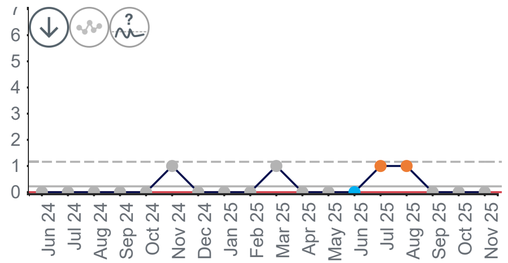
Outstanding Care and Experience- Safe & Caring - Watch Metrics

Patient Safety Incidents (All)



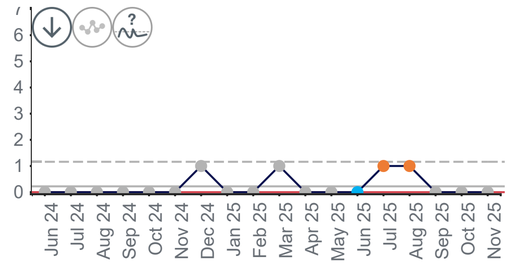
Severe or Fatal Incidents – Physical only

Target: Internal

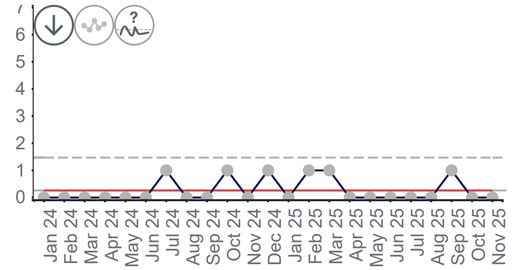


Severe or Fatal Incidents – Physical & Psychological

Target: Internal

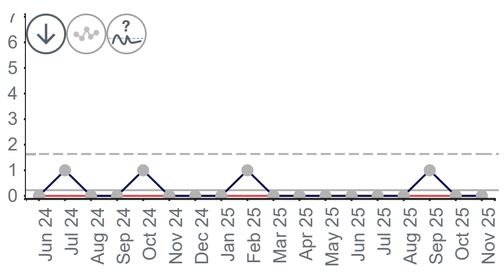


Number of PSIIs (Patient safety incident investigation) undertaken



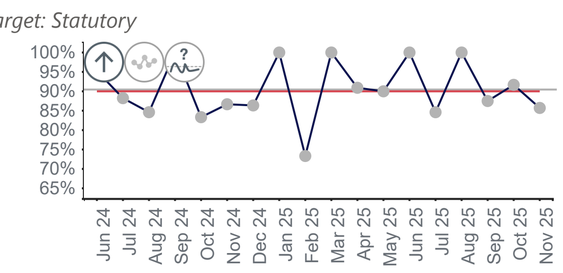
Number of Never Events

Target: Internal



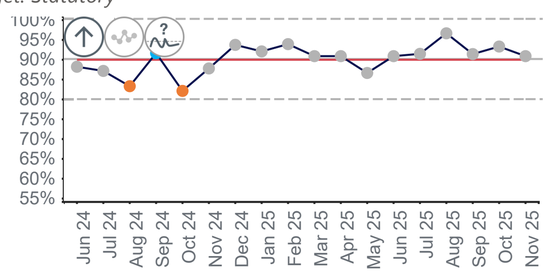
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients

Target: Statutory

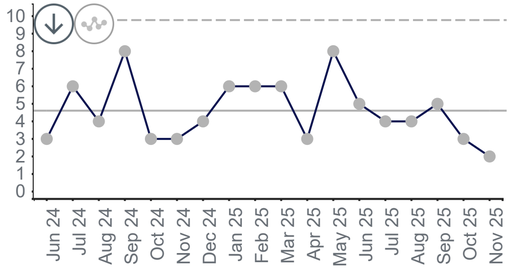


Sepsis % Patients receiving antibiotic within 60 mins for ED

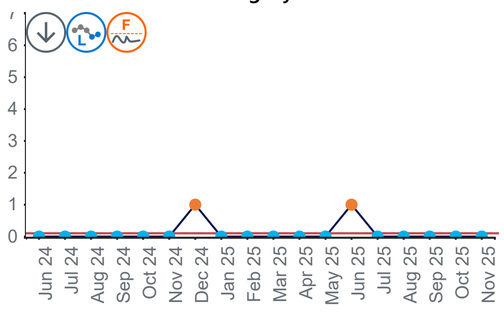
Target: Statutory



Medication Errors resulting in Harm (Physical and Psychological)

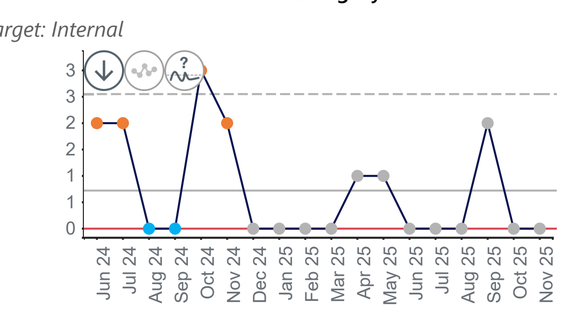


Pressure Ulcers Category 3 and 4

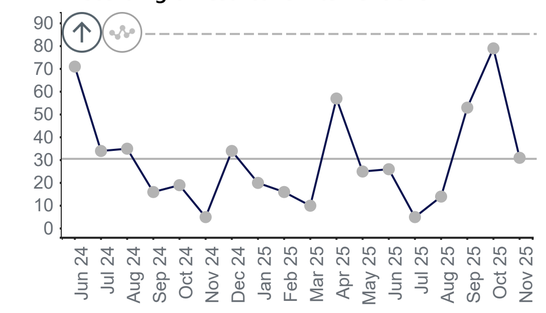


Pressure Ulcers Category 2

Target: Internal

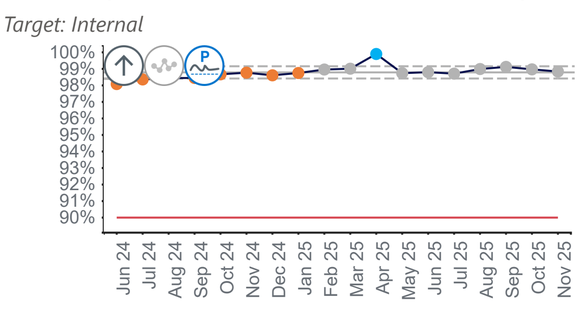


Recording of restrictive interventions



Employees trained in new Level 1 of Patient Safety

Target: Internal



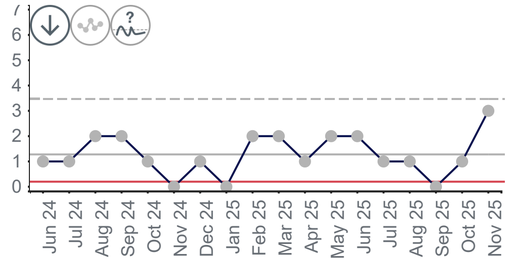
Integrated Performance Report | December 2025

Alder Hey Children's NHS Foundation Trust

Outstanding Care and Experience - Safe & Caring - Watch Metrics

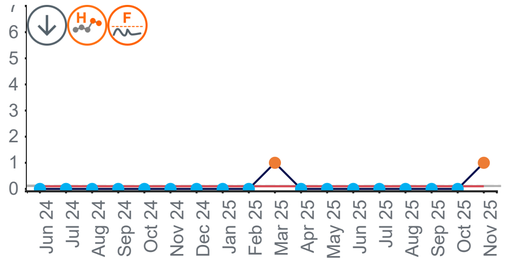
Hospital Acquired Organisms - MSSA

Target: Internal



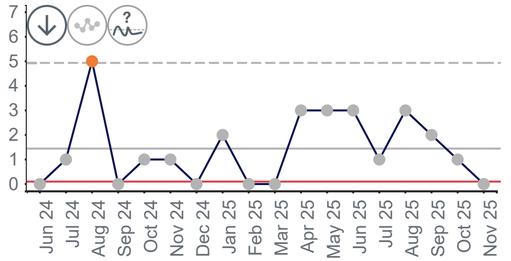
Hospital Acquired Organisms - MRSA (BSI)

Target: Internal



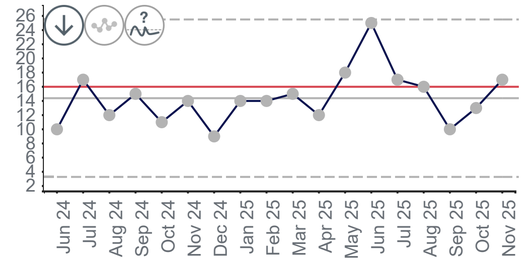
Hospital Acquired Organisms - (C.Difficile)

Target: Internal



Number of formal complaints received

Target: Internal



% PALS Resolved within 5 Days

Target: Internal

Number of PALs contacts

Target: Internal

% Complaints Responded to within 25 working days

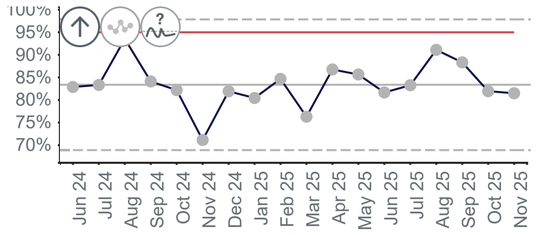
Target: Internal

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

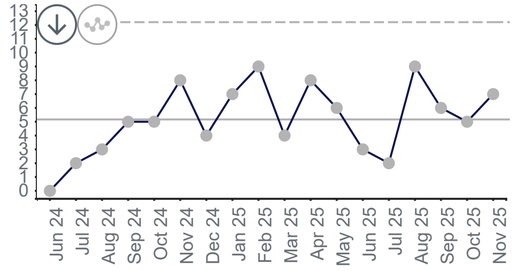
Target: Statutory

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

Target: Internal

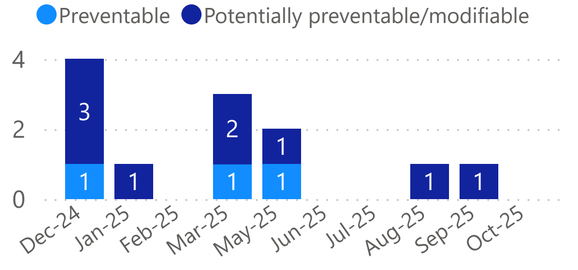


Number of patients deteriorating from HDU admitted to PICU

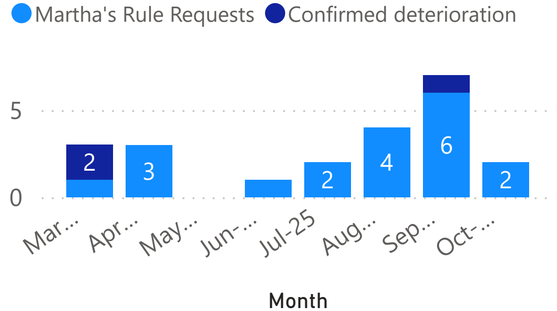


Predictable and preventable deteriorating patients

Not inclusive of all categories



Martha's Rule



Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

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

Highlights:

• Consistent delivery of timely urgent and emergency care: November saw 83.8% of patients treated within 4 hours • Over 95% of diagnostics performed within 6 weeks • YTD performance (income) for elective and outpatient activity remains above plan • Was not brought rate has reduced for a third consecutive month

Areas of Concern:

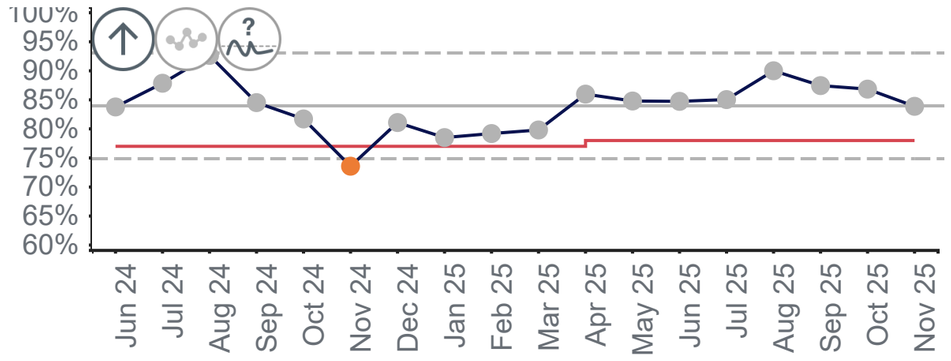
• The number of patients waiting over 52 weeks remains above the 1% target • The volume of overdue (2 years) follow-up has increased for a fourth consecutive month • The number of IHAs completed within 20 days has remained at 50% for a second month.

Forward Look (with actions)

• Improving elective waiting times: quarter 4 outpatient accelerator plan submitted; roll out of Ambient Voice Technology to increase capacity (Q4); and we have requested system aid for capacity in paediatric dentistry (Q4) • Reducing overdue follow-ups: roll-out of fail-safe meetings and patient validation sessions in high-risk specialities (by Feb 2026).

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

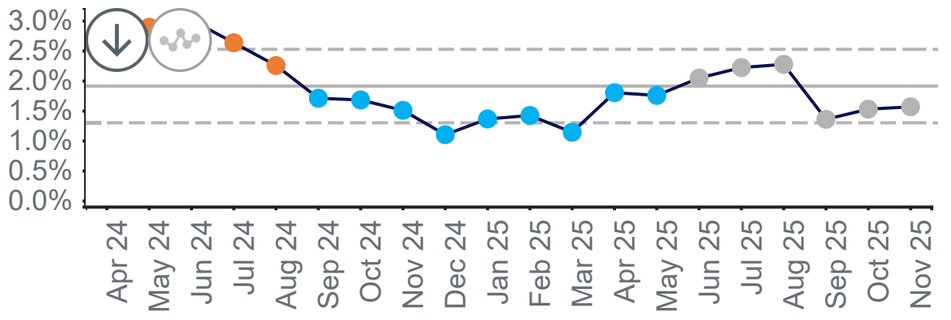
Achieved the national target in November-25 with the 12th consecutive month above target. Common cause variation observed with performance of 83.8% in November, slight decrease from Oct-25 (86.7%) however November experienced on average +17 attendances each day compared to October. Nov-25 represents a +10.3% increase compared to Nov-24, when performance was 73.5%.

Actions:

• Enhanced ED escalation plan is in place, with additional specialty in-reach support • Advertising and social media messaging utilised to support 'choosing well' • Additional capacity secured in the primary care stream, in response to high volume of low acuity presentation.

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

Target : Statutory



Technical Analysis:

1.57% 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 slight increase from October position of 1.53%. With the total volume now at 266 breaches. 78% of current waits >52 weeks within Dentistry service.

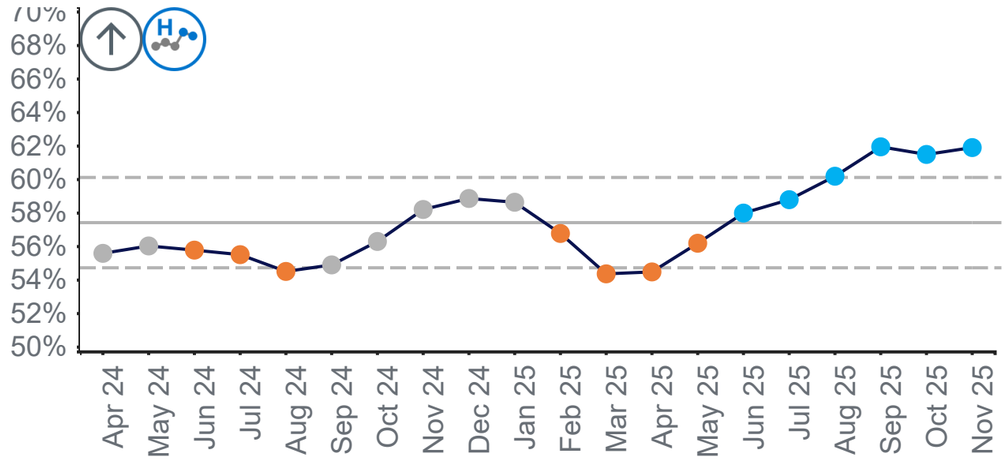
Actions:

The vast majority of remaining 52 week waits are in Dentistry. To meet the 1% standard, our high-impact actions for the specialty in Q4: • Mutual aid requests submitted in and out-of region • Three 'Super Saturday' high volume outpatient clinics planned • Allocation of additional theatre lists prioritised.

Alder Hey Children's NHS Foundation Trust

Revolutionise Care- Effective & Responsive

RTT waiting list within 18 weeks



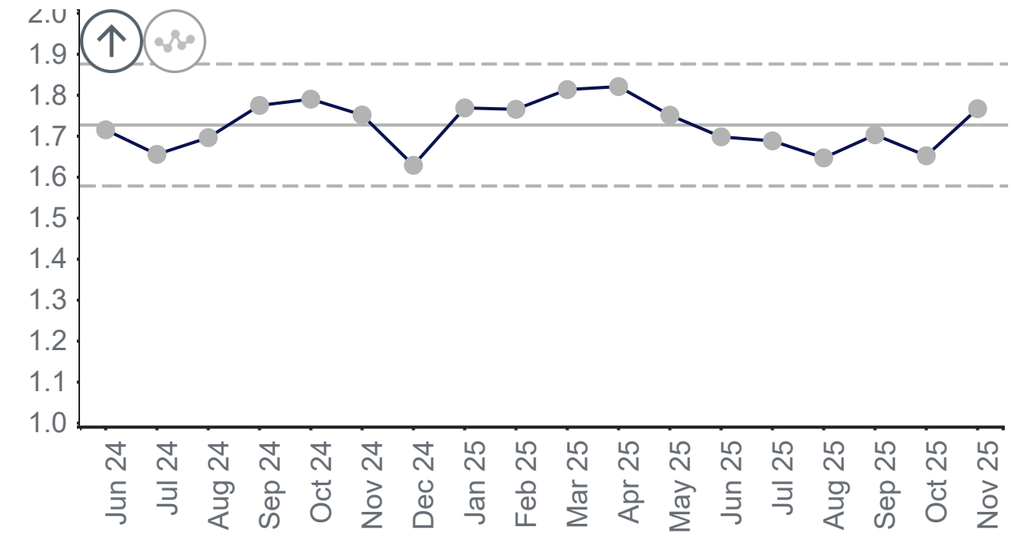
Technical Analysis:

Special cause variation with performance of 61.9% against a year end target of 63.1% by March 2026. This is an increase from October 2025 position of 61.5%. Oral Surgery and Dentistry lowest performing of services with >100 waiters.

Actions:

Outpatient clinic capacity is being increased (Jan-April 2026), in a phased way, to reflect the productivity benefit of Ambient Voice Technology. Optimised booking system is being expanded, to ensure actual utilisation is higher by compensating for Was Not Brought rates.

Elective admissions (IP & DC) per clinical WTE



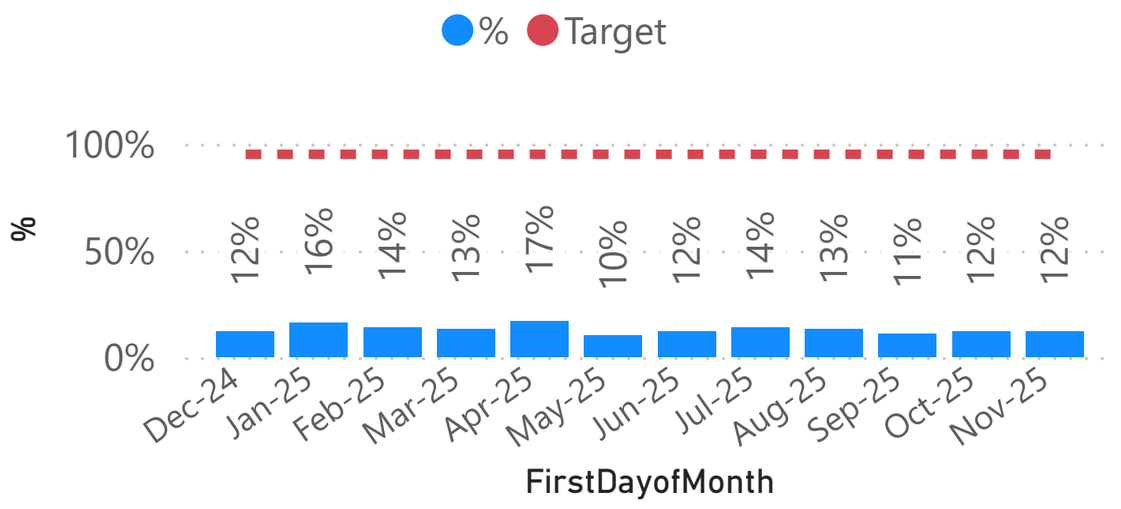
Technical Analysis:

Common cause variation has been observed with performance of 1.77 admissions per Clinical WTE (1611). Increase from November-24 rate at 1.75. Nov-25 experiencing +2.2 admissions per working day compared to Nov-24.

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 November 2025 is 12% against a target of 95% which is same performance of October 2025.

Actions:

The new single neuro-developmental pathway went live Sept- 25. • Evaluation is underway • Review of the referral triage pathway undertaken. Number of triage sessions increased in M9 • Risk documentation to be completed for all CYP open to service - phase 1 commenced. Demand and Capacity work commenced and due January 2026.

Integrated Performance Report | December 2025

NHS
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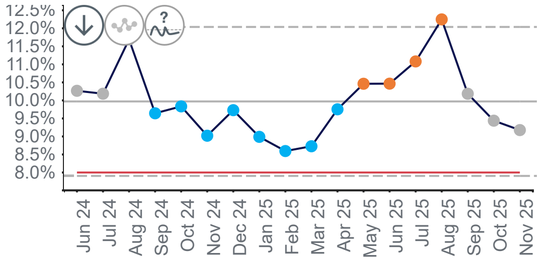
Revolutionise Care - Effective & Responsive - Watch Metrics

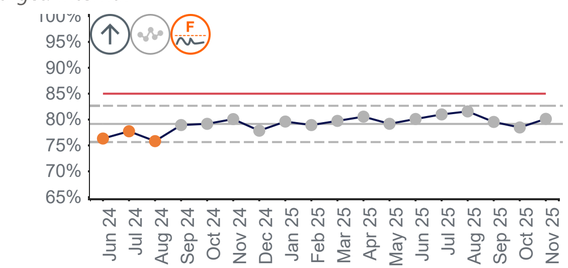
% Was Not Brought Rate (All OP: New and FU)

Target: Internal

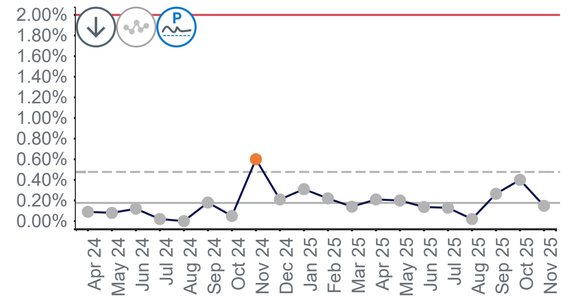


Theatre Utilisation (Capped Touch Time)

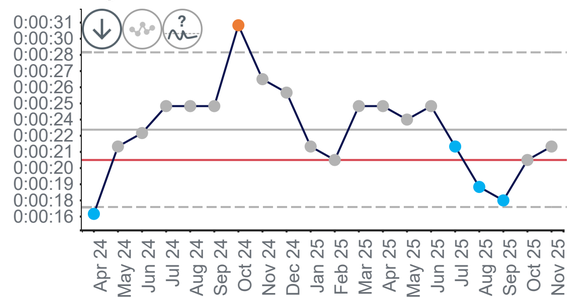
Target: Internal



% of ED attends over 12 hours

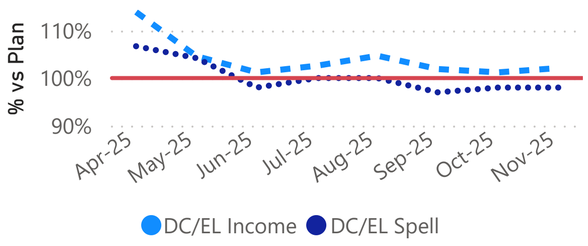


Average Ambulance Vehicle to Handover Time



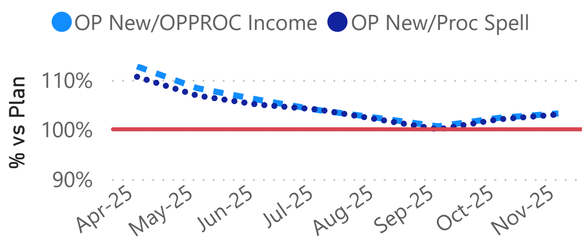
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance



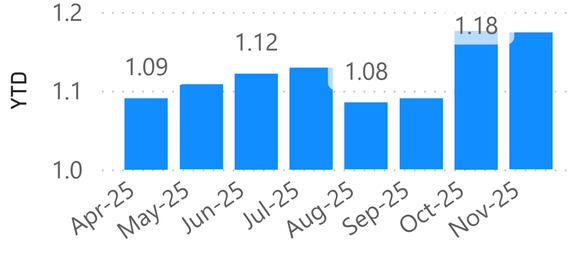
Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

SLAM Performance

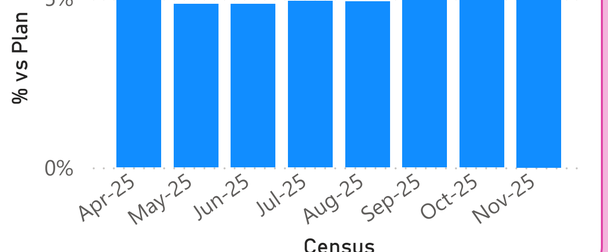


Activity per £1k Operating Expenditure

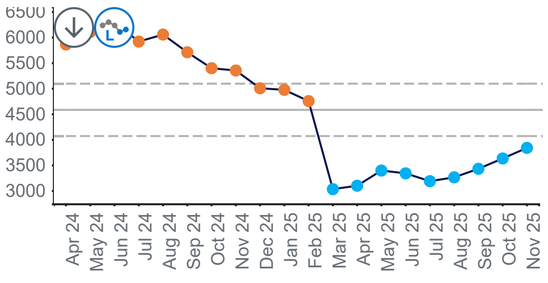
YTD Position



% follow up waiting list on PIFU

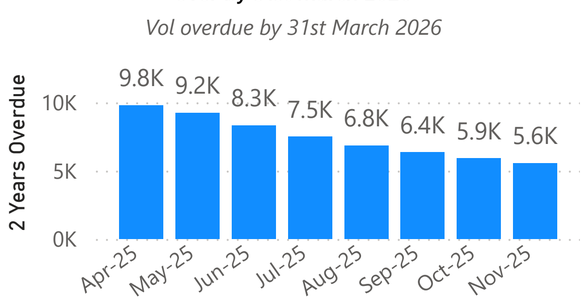


Volume of active outpatient follow up waits - 2 Years & Overdue

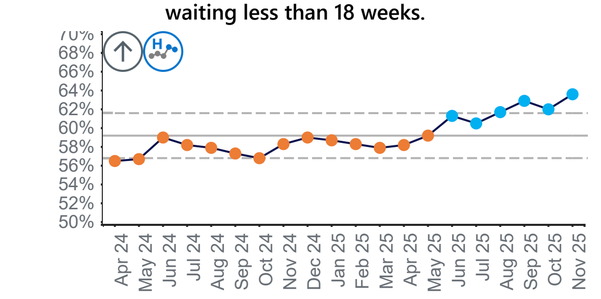


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

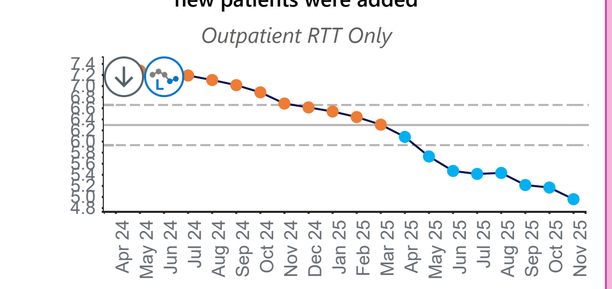


Time to first attendance, waiting for first event and of those waiting less than 18 weeks.



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

Outpatient RTT Only



Integrated Performance Report | December 2025

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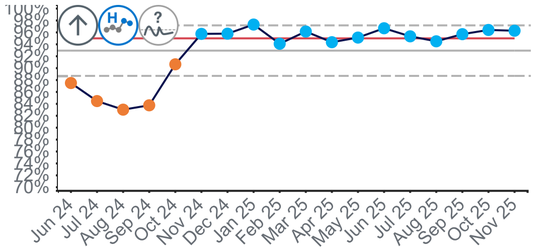
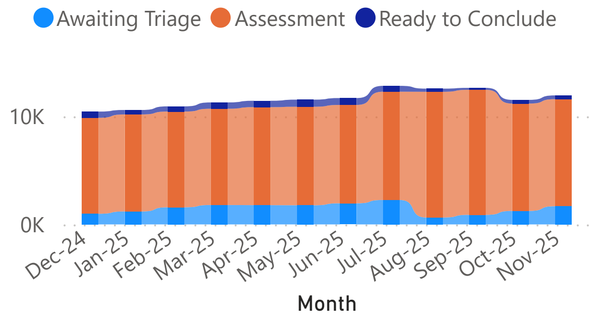
Revolutionise Care - Effective & Responsive - Watch Metrics

Diagnostics: % Completed Within 6 Weeks of referral

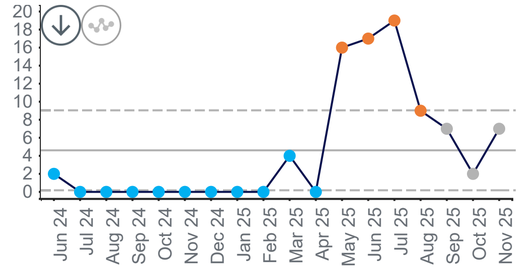
Target: Statutory



Neurodevelopmental Diagnosis Status

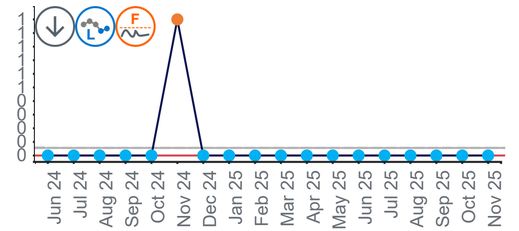


CAMHS: Number of children & young people waiting >52weeks



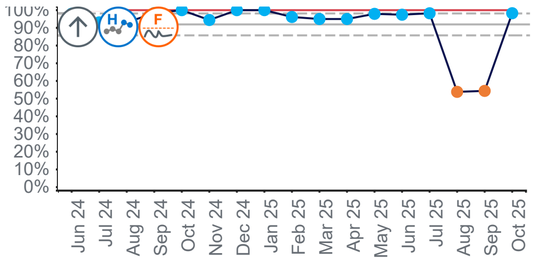
Number of Paediatric Community Patients waiting >52 weeks

Target: Internal



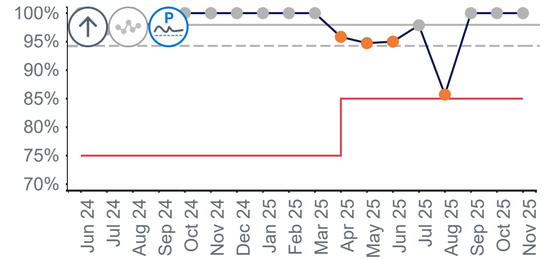
IHA: % complete within 20 days of referral to Alder Hey

Target: Internal



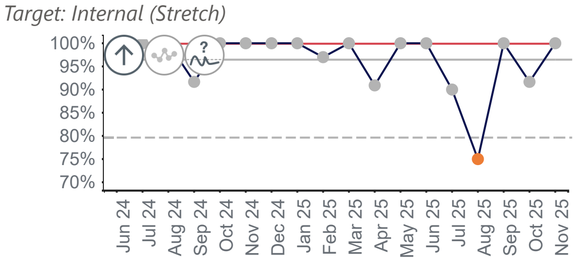
Cancer: Faster Diagnosis within 28 days

Target: Statutory



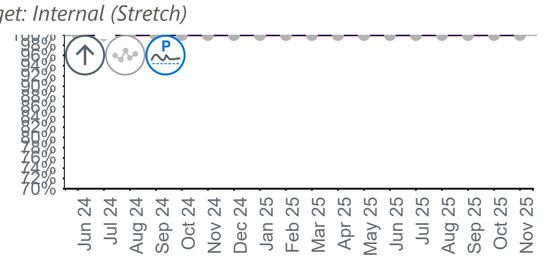
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Target: Internal (Stretch)

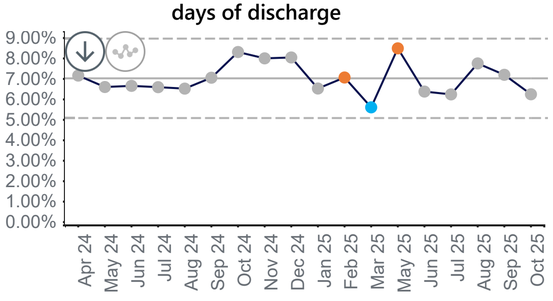


31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

Target: Internal (Stretch)



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



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

• Mandatory training completion remains over 90%. Further work is being undertaken reviewing modules with lower compliance levels
• Overtime decreased in November to the lowest level this year

Areas of Concern:

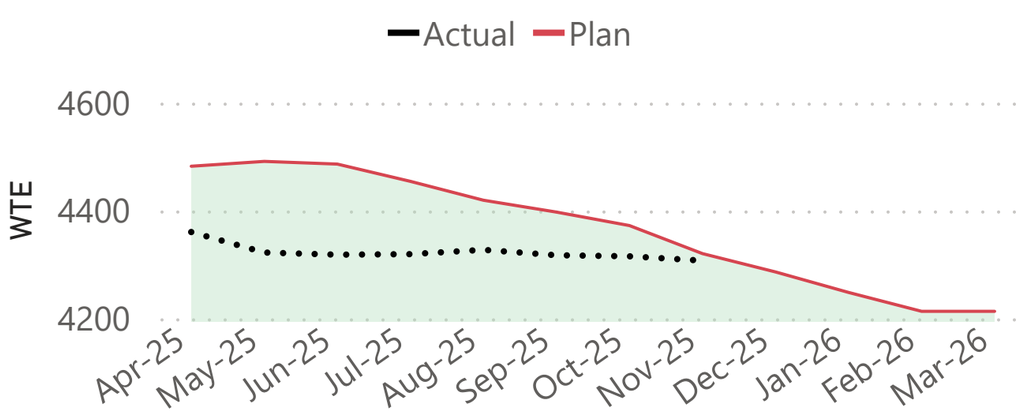
• Total workforce has remained largely static, with reductions anticipated in Q4 of 25/26, including the MARS programme with 33 approved applications • While long term sickness absence has reduced, short term sickness has increased again in month. The refreshed sickness absence support team report to Execs regularly.

Forward Look (with actions)

• PDR Completion: L&D colleagues continue to support managers to achieve PDR completion; a gap between completion levels and the 90% target remain. • The sickness absence team remain fully focused on a range of actions to reduce both short term and long-term absence

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

Total workforce for the end of November 2025 was 13 WTE below original plan. Actual WTE was 4,307 against a plan of 4,320

Actions:

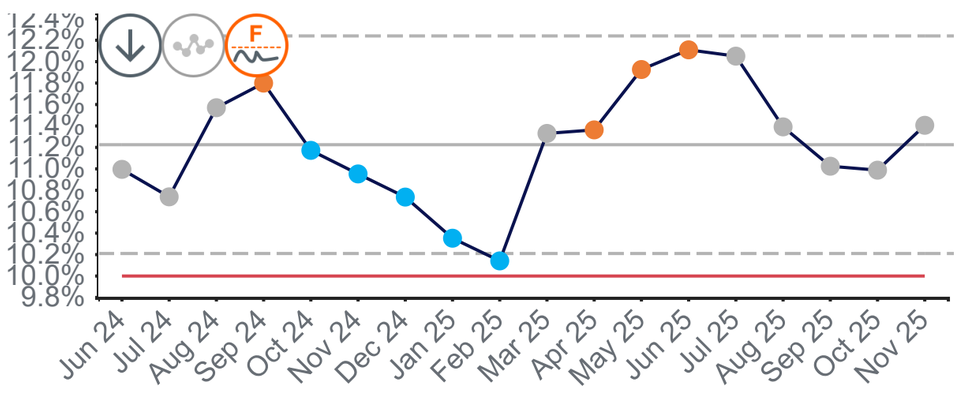
M8 Total workforce (Inc. Trainees): 4307.13 (M7: 4315.34)

Substantive Colleagues (Inc. Trainees): 4225.80 (M7: 4217.18), Bank usage: 78.37 (M7: 95.25) and Agency usage: 2.96 (M7: 2.91)

In addition, overtime decreased in November to the lowest level this year (£59,726.38).

Staff Turnover

Target: Internal



Technical Analysis:

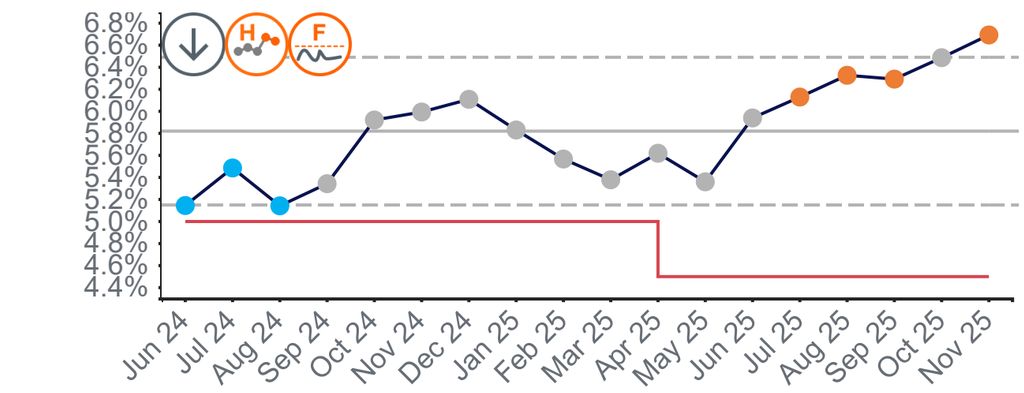
Common cause variation observed with performance of 11.4% in November 2025 against an internal target of 10%. Slight increase from October 25 at 11%. Consistently failing metric.

Actions:

Turnover has increased slightly in month due to the end of fixed term contracts, transfer of the digital team, and the leaving dates for colleagues who left as part of the MARS scheme. A further MARS scheme is currently open.

Sickness Absence (Total)

Target: Internal



Technical Analysis:

Special cause varation of concerning nature observed. Total sickness absence in November 2025 is 6.69% which is above the 5% target, a 0.2% increase from October 2025 at 6.49%. November 2025 performance comprises STS at 2.30% and LTS at 4.39%. Highest sickness rate in the last 2 years with target being 4.5% in 2025/2026.

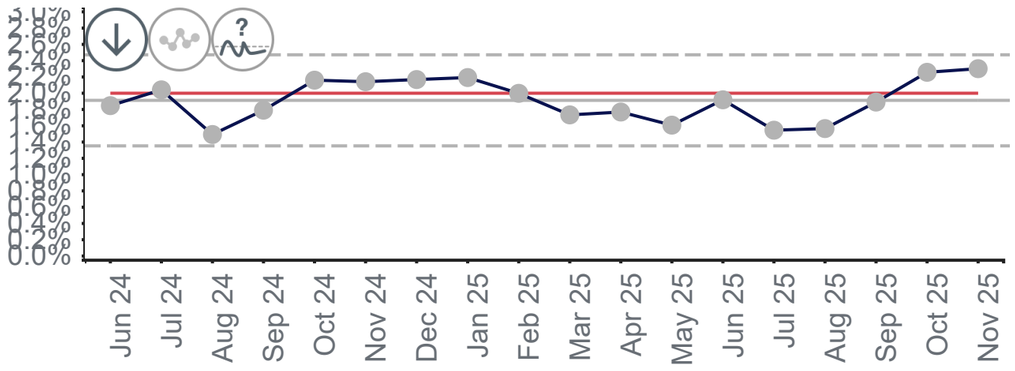
Actions:

Sickness absence levels are challenging. As a part of the Closing the Gap programme and target to reduce sickness absence, the move to realign HR support to a central model has been extended to 31/03/2026. Additional resources on stress and stress risk assessments are being developed in collaboration with SALS.

Supporting Our People - Watch Metrics

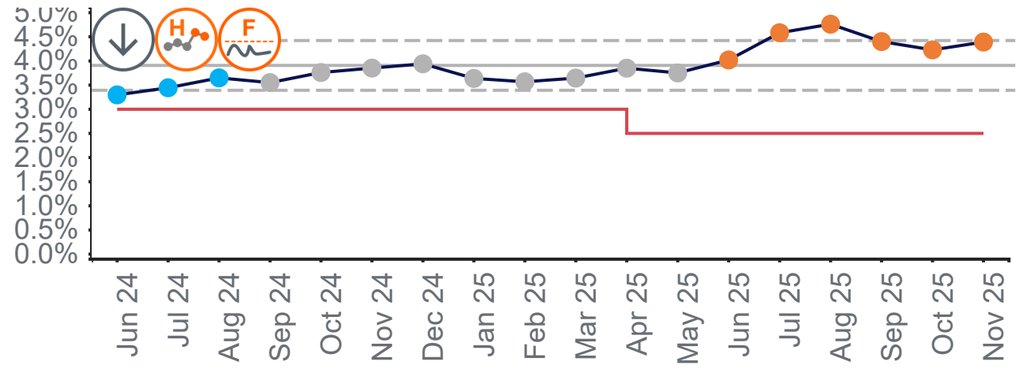
Short Term Sickness

Target: Internal



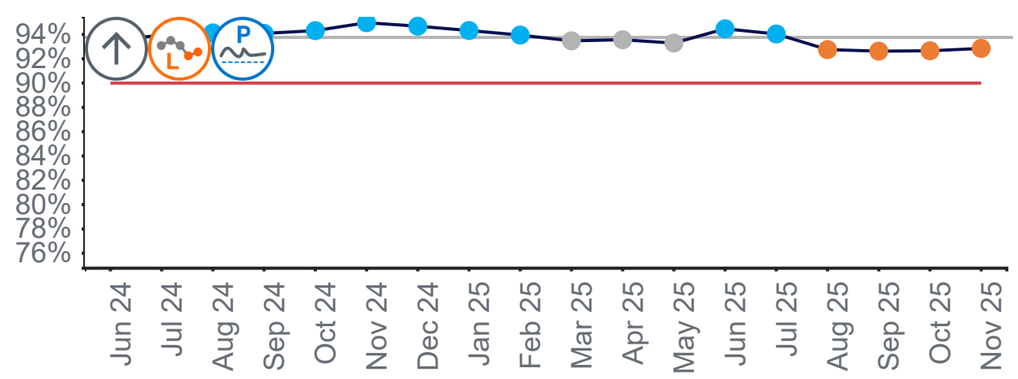
Long Term Sickness

Target: Internal

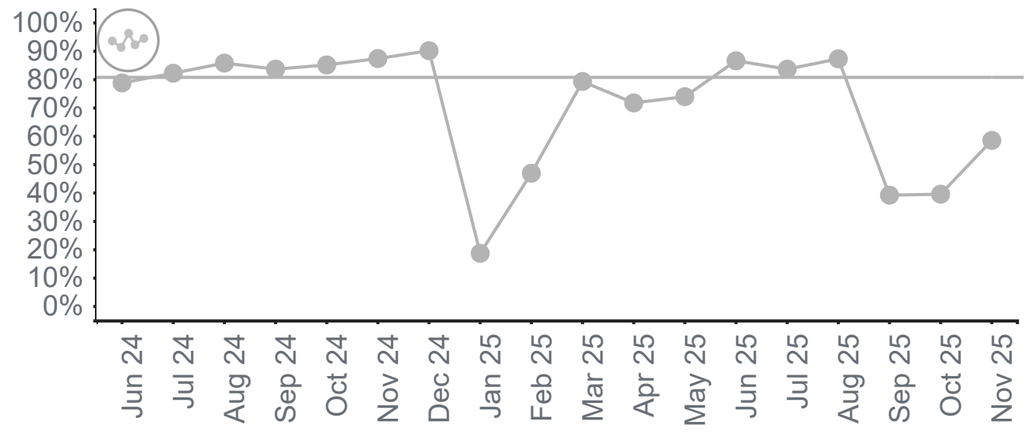


Mandatory Training

Target: Internal

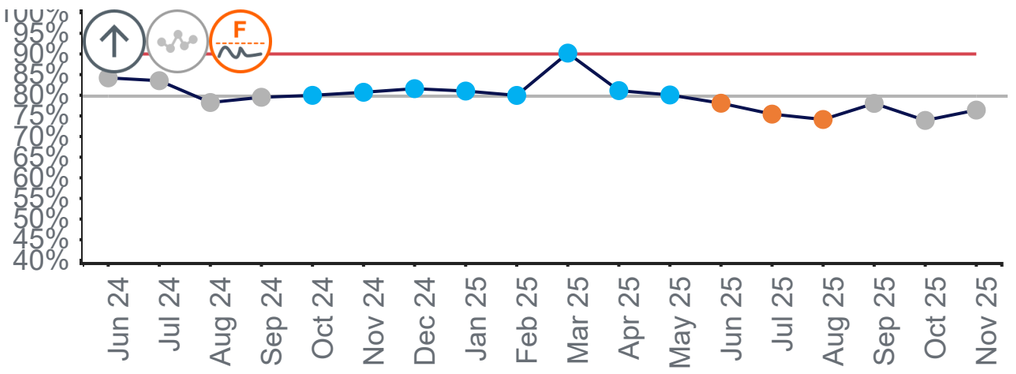


Medical Appraisal

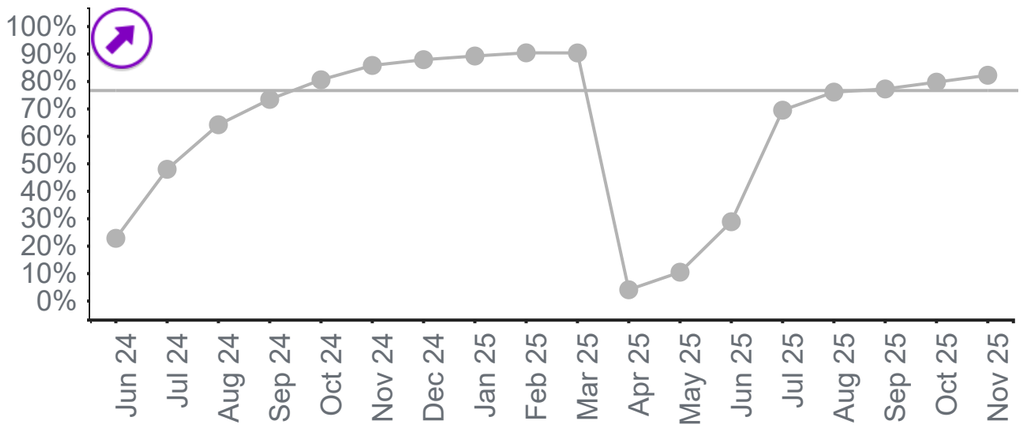


% PDRs Completed (Rolling 12 Months)

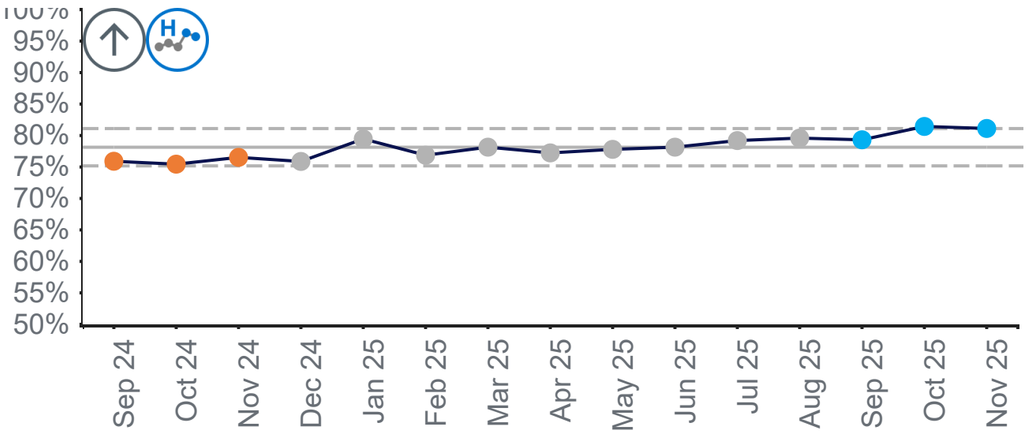
Target: Internal



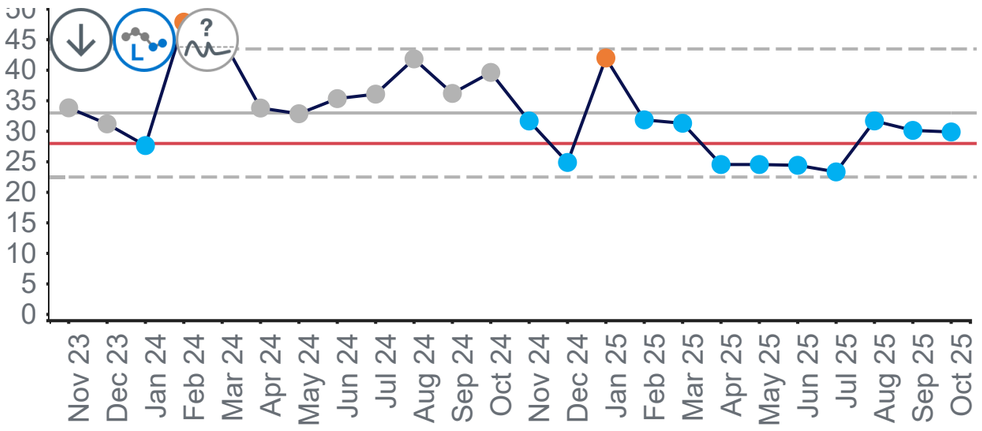
PDR B7+ Completed (Rolling 12 Months)



Workforce Stability



Average Time to Hire



Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

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

Highlights:

• Prof Dan Hawcutt commenced in post as Director of the Liverpool Institute of Child Health & Wellbeing • Alder Hey hosted a visit from the University of Liverpool Pro-Vice Chancellors from across faculties to identify collaborative opportunities across research, innovation and education • The National Institute of Health and Care Research and DHSC carried out a site visit to Liverpool for the C&M Commercial Research Delivery Centre and Primary Care Commercial Research Delivery Centre with Alder Hey in attendance as the paediatric hub lead – new opportunities for commercial research are now routinely being reviewed within Alder Hey • The NIHR Clinical Research Facility annual report feedback was positive with an overall green rating and identified areas for further development • The 3rd meeting of the Independent Research Advisory Panel took place with a clear recommendation to allocate internal investment in a focused way • The Paediatric Open Innovation Zone reporting to the LCR Combined Authority is on track and 6 companies have been identified for challenge fund support (cohort 1) • The transformation bid to the regional NHSE fund to roll out Lyrebird across C&M was successful • 2 proposals have been submitted to the LCR Combined Authority for consideration for the UKRI Local Innovation Partnership Fund (one collaborative and one AH only) • The Hartree Centre (STFC) visited Alder Hey to feedback on a collaborative project using mathematical modelling to automate surgical rotas with positive results • The Innovation competition in primary and secondary schools was formally launched with positive initial feedback • The Junior Research Faculty was launched (led by Dr Rachel Harwood) to support early career researchers • Evaluating the impact of a parent champion model on bronchiolitis hospitalisation rates: a difference in differences study | Archives of Disease in Childhood was published in the BMJ.

Areas of Concern:

• Financial challenges remain relating to the 3rd MRI and the Automation business cases although there have been improvements in month – remains under review at FIP Strategic Command • Clinical capacity remains a concern in some specialties – opportunities for incentivisation and protected funding are being explored across innovation and research.

Forward Look (with actions)

• Continued focus on closing the financial gap to ensure break even across the combined Futures budget • Development of platform study protocol for rapid evaluation of innovation technology – in discussion with MHRA prior to obtaining full research approvals • Combined research and innovation training to be delivered to thriving operational managers in Feb/Mar 2026 following positive feedback on innovation training from cohort 1 • Innovation celebration event planned for March 2026 including a formal launch of the Paediatric Open Innovation Zone (POIZ) by the Liverpool Metro Mayor and a keynote from the Children's Commissioner for England • An AI clinical coding model is being developed internally following unsuccessful efforts to source an external partner • Plans are underway to secure robust clinical leadership across research innovation following the change in role for the current Research Director and the upcoming retirement of the Chief Scientific Officer.

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

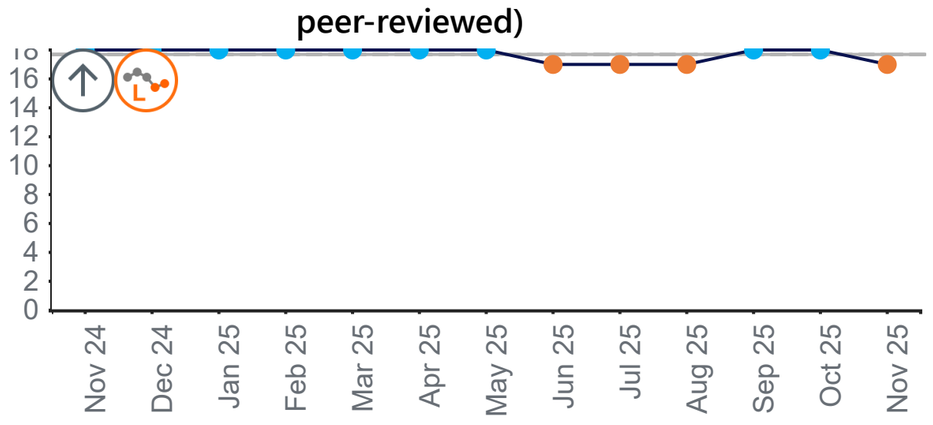
Technical Analysis:

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:

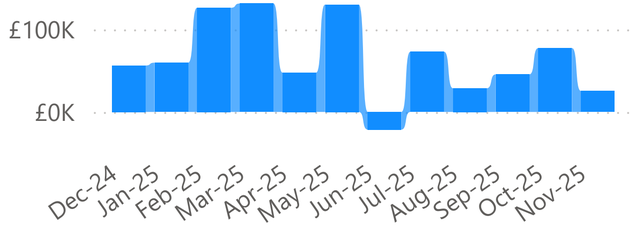
Remains stable – strategic funding calls have supported potential researchers to submit external grant applications. New internal funding call being developed for Jan launch.

Integrated Performance Report | December 2025

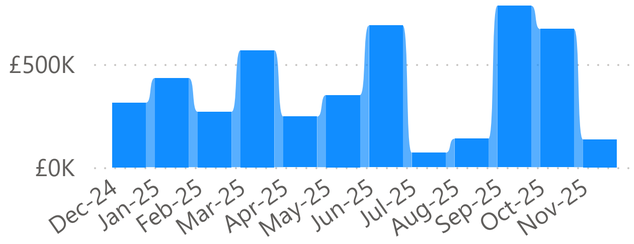
Alder Hey Children's NHS Foundation Trust

Pioneering Breakthroughs

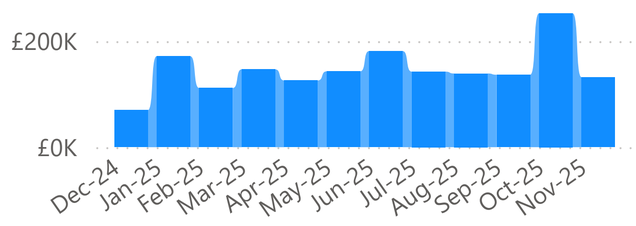
External innovation income received by month (commercial and non-commercial)



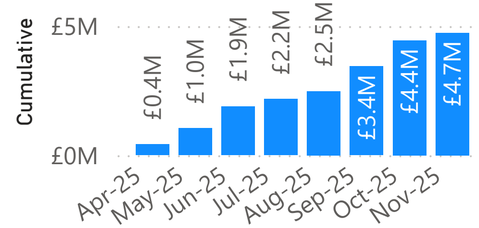
External research income received by month (commercial and non-commercial but excluding NIHR)



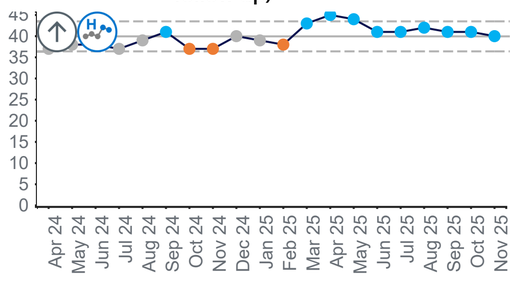
NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)



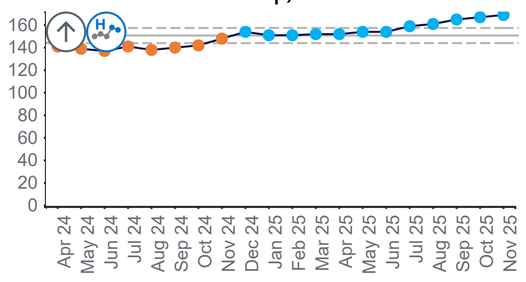
External income received by month across Research and Innovation (YTD Cumulative)



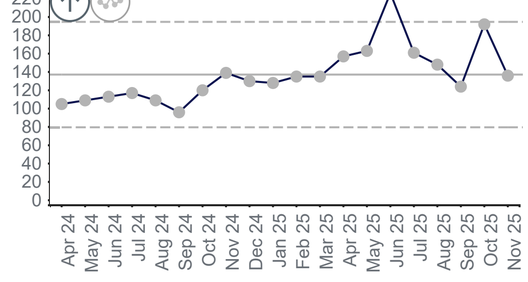
Number of open commercial studies (recruiting and in follow up)



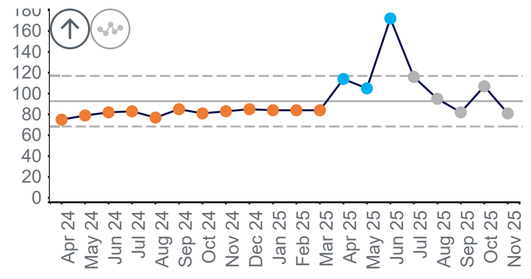
Number of open non-commercial studies (recruiting and in follow up)



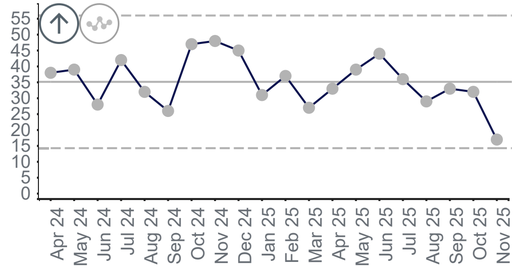
Number of participants recruited to all studies



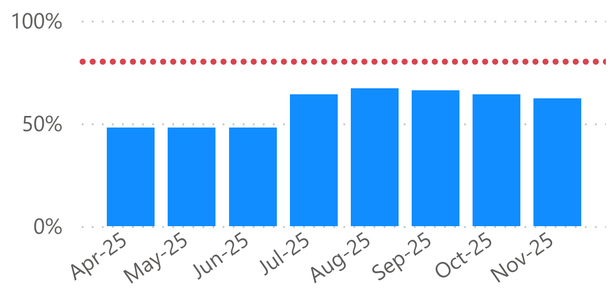
Number of participants recruited to all NIHR portfolio studies



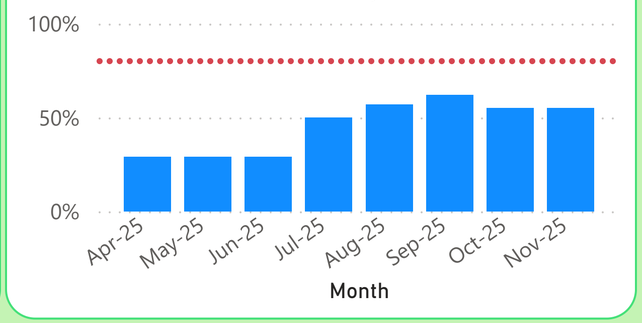
Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



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



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



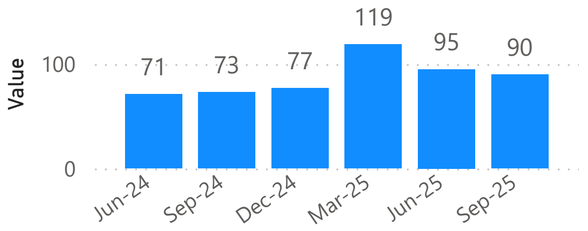
Integrated Performance Report | December 2025

Alder Hey Children's NHS Foundation Trust

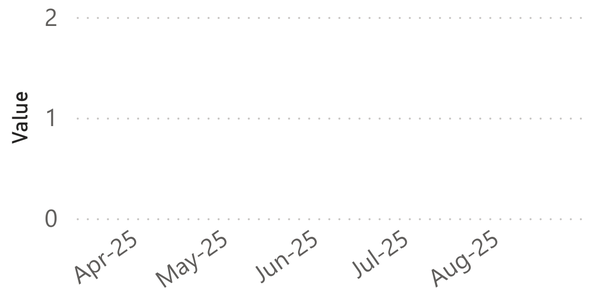
Pioneering Breakthroughs

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

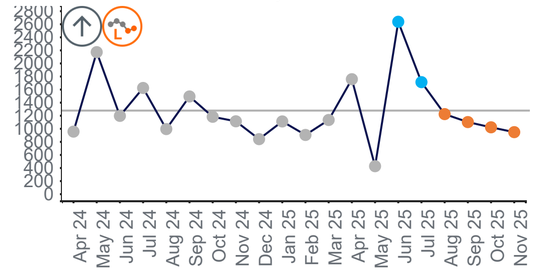
Quarterly



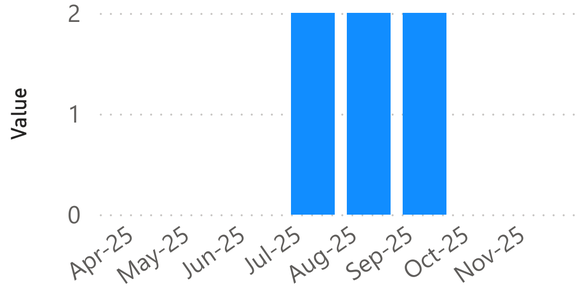
Number of businesses supported by POIZ



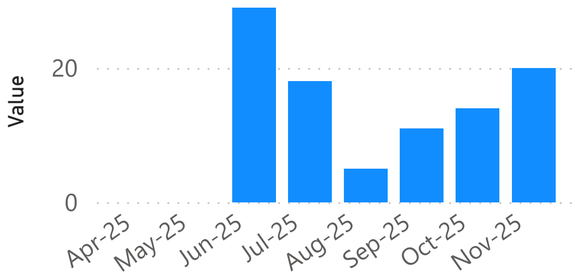
Manual hours released from automation/AI solutions - Monthly



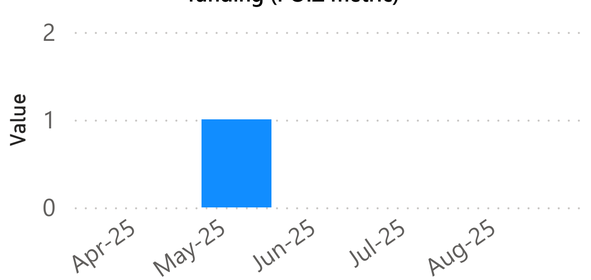
Number of staff trained in innovation methods



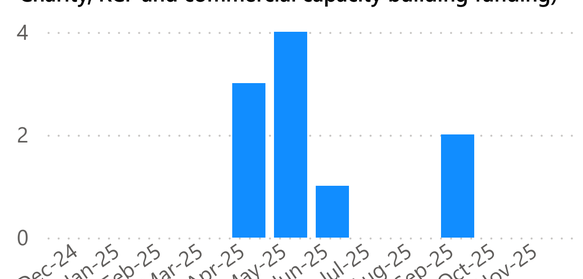
Number of staff trained in research methods



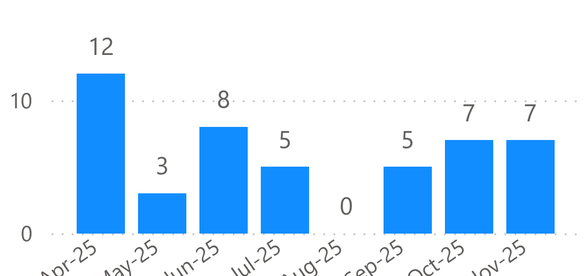
Number of AH-hosted jobs created through new external funding (POIZ metric)



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



Number of primary and secondary schools engaged with Futures activities



Financial Sustainability: Well Led

SRO: Rachel Lea, Director of Finance and Development

Highlights:

£0.3m surplus reported in month, £0.4m surplus YTD in line with plan, including mitigating IA impact (£0.3m). Externally forecasting £7.160m surplus. Extrapolated forecast £5m surplus (£2.7m improvement from M7). £19.3m CIP has been transacted in year (£7.5m recurrently) - £1.6m 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.

Areas of Concern:

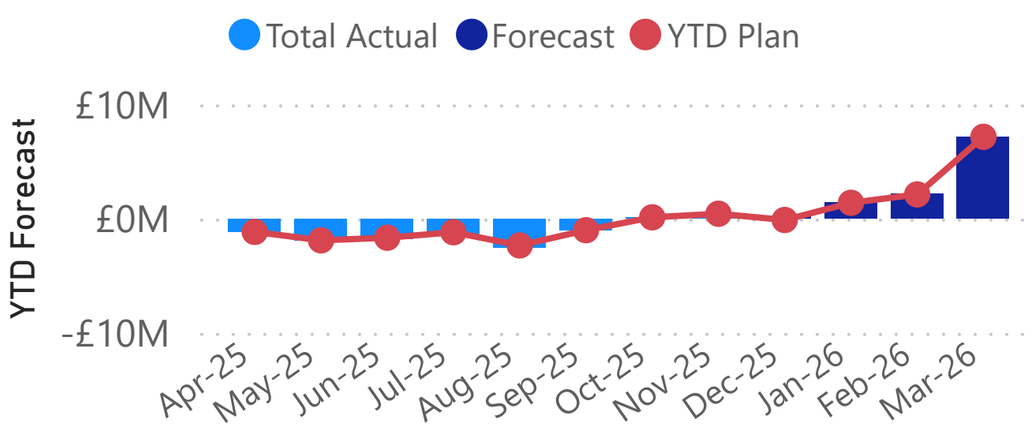
Delivery of recurrent CIP programme continues to present a risk, which, alongside other mitigations, links to deliver of overall plan for the year (including system stretch). Capital funding also presents a risk, with SDEC funding (£2.2m) awaiting confirmation from NHSE panel. Cash is being closely monitored 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 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:

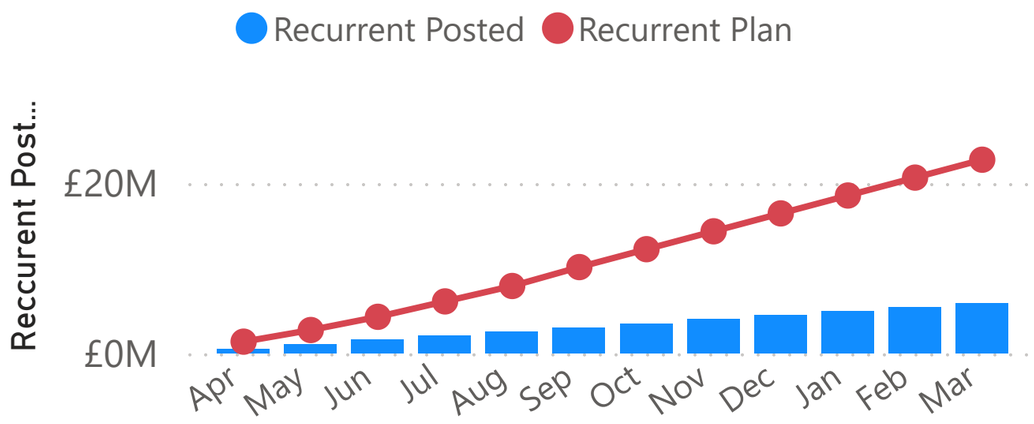
Current plan is £7.160m surplus which we aim to achieve. Risks to delivery of this is linked to achievement of CIP still in progress, identification of system wide schemes to deliver stretch target and management of in year pressures.

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



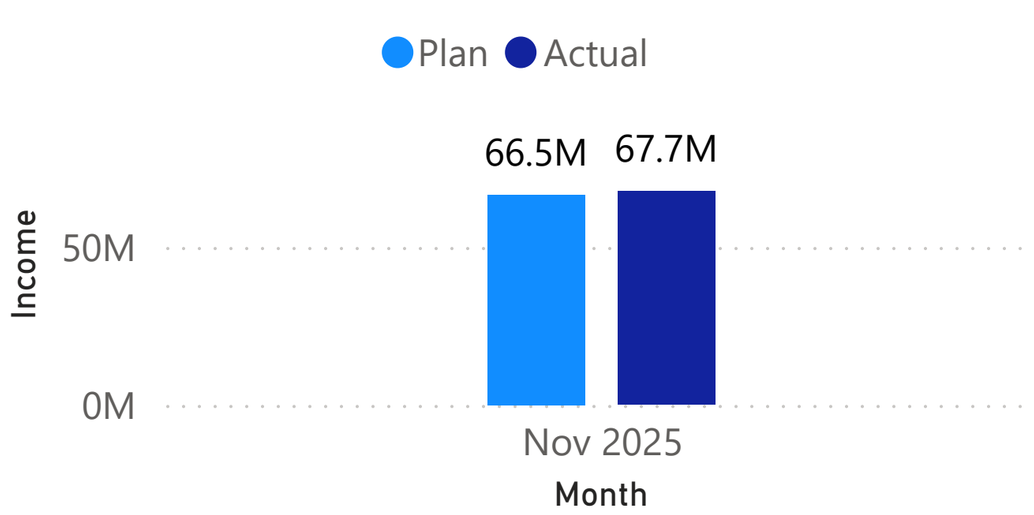
Technical Analysis:

November performance estimated at 102%.

Actions:

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

YTD ERF Income



Technical Analysis:

Recurrent CIP identified is £7.5m which leaves a recurrent gap of £15.2m to be carried forward to 26/27.

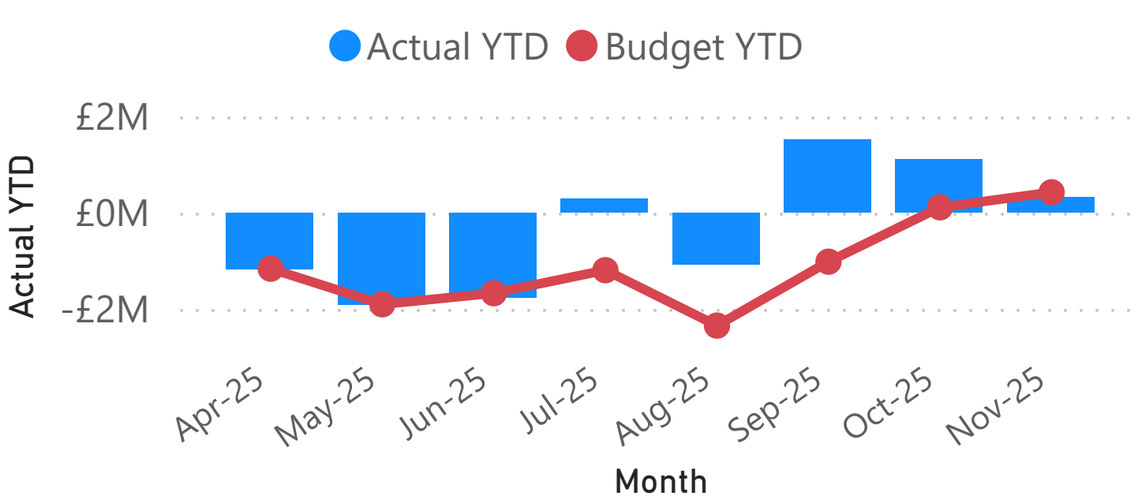
Actions:

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.

Financial Sustainability: Well Led - Watch Metrics

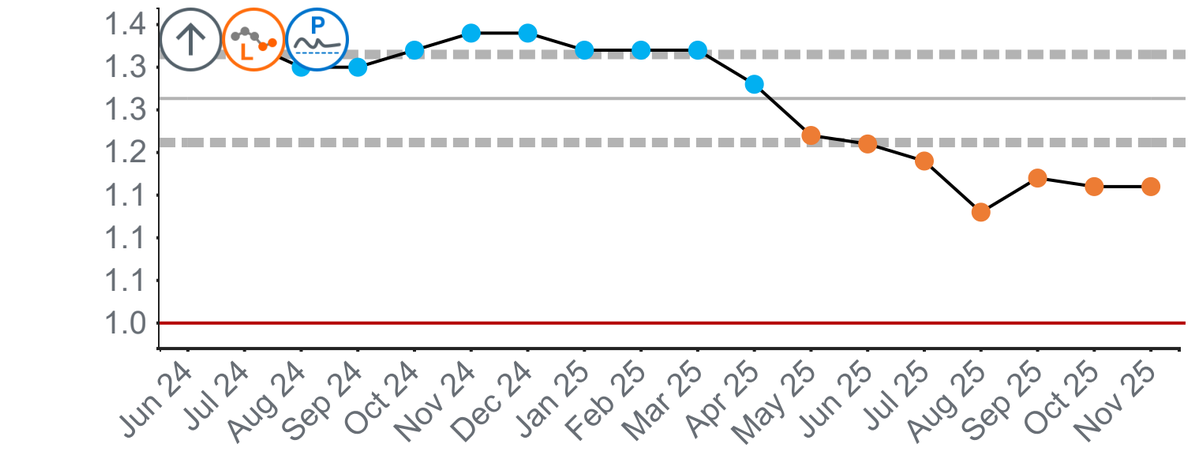
I&E distance from target (cumulative YTD)

Target: Internal

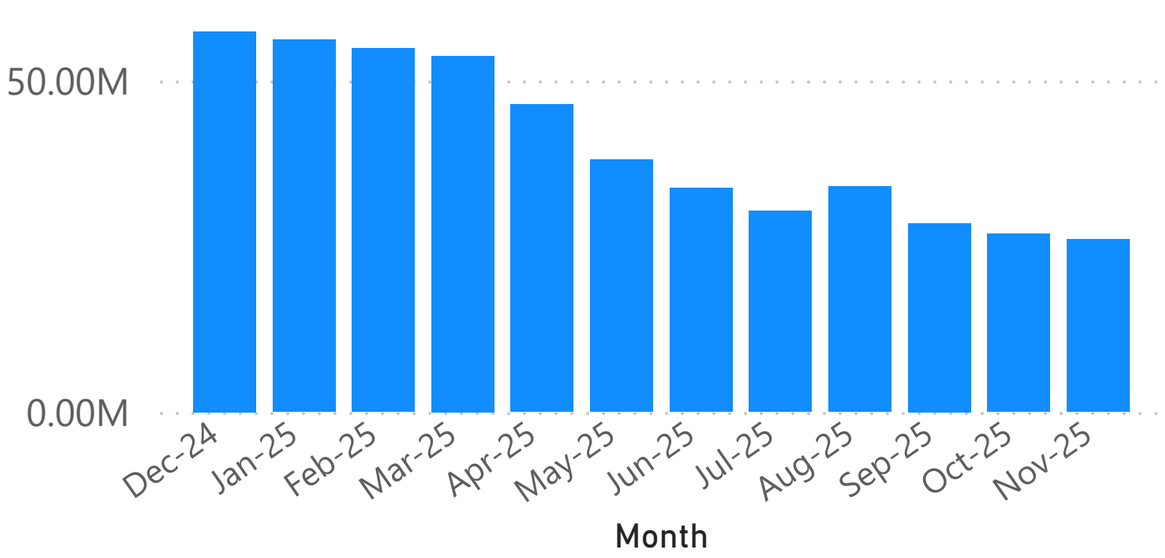


Liquidity

Target: Internal

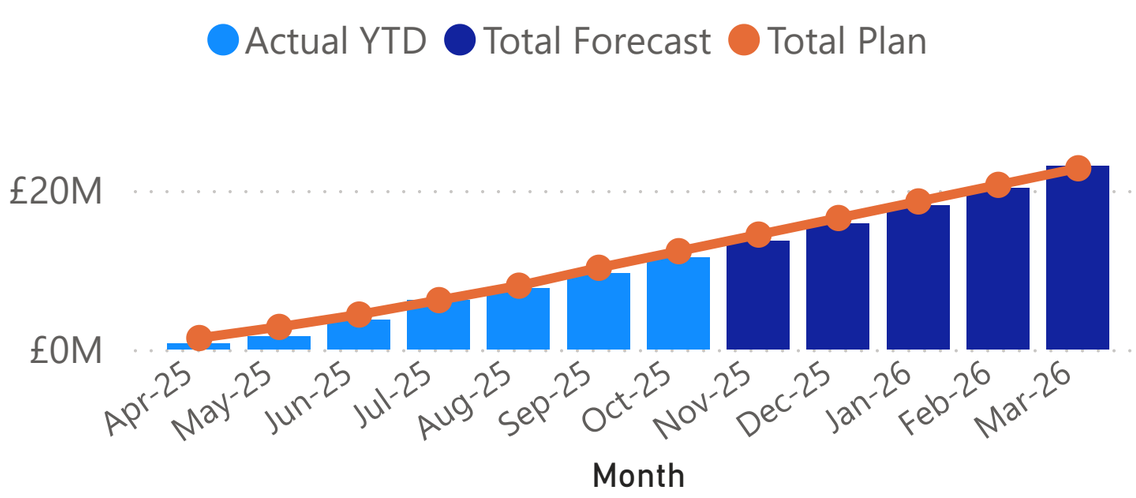


Cash In Bank



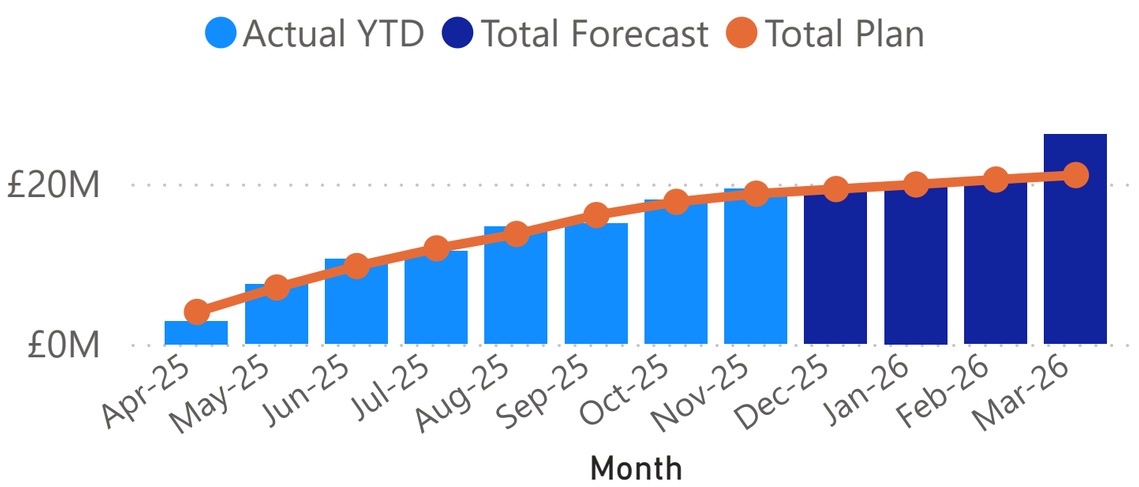
In Year CIP – forecast against plan

Target: Internal



Capital – YTD spend and forecast against plan

Target: Internal



Well Led - Risk Management

SRO: Erica Saunders, Chief Corporate Affairs Officer

Highlights:

• Continued positive engagement with divisions/risk owners • Extraordinary RMF meeting held November to review risks • Update to Risk Management Policy completed

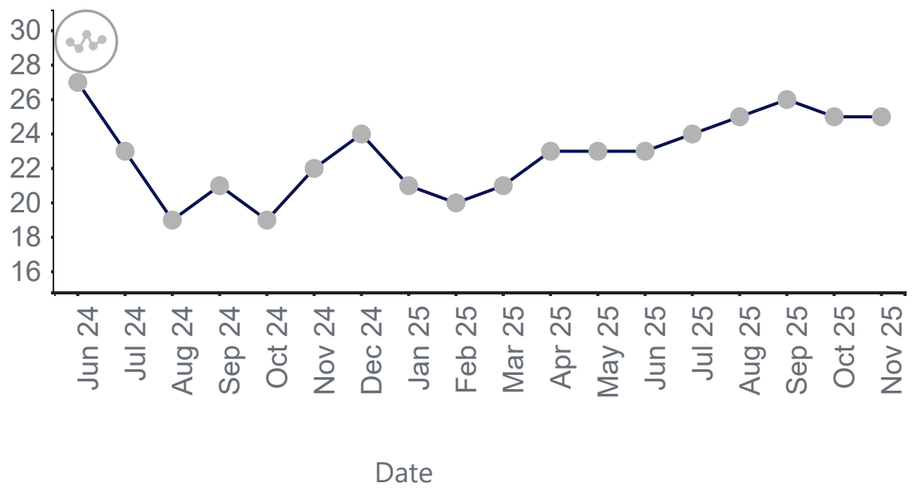
Areas of Concern:

• Roll out of Risk Appetite currently on hold pending further review and approval of risk tolerances by Trust Board

Forward Look (with actions)

• Risk appetite review by Trust Board to inform Risk Appetite principles document • Review functionality of InPhase to enable triangulation of risks with patient safety/complaints/incidents etc • Deep dive into robustness of risk mitigations and whether mitigations are currently within/outside of Trust control to be part of risk oversight meetings with risk owners

Number of High Risks (scored 15 and above)



Technical Analysis:

Number of high risks is 25 as of the end of November

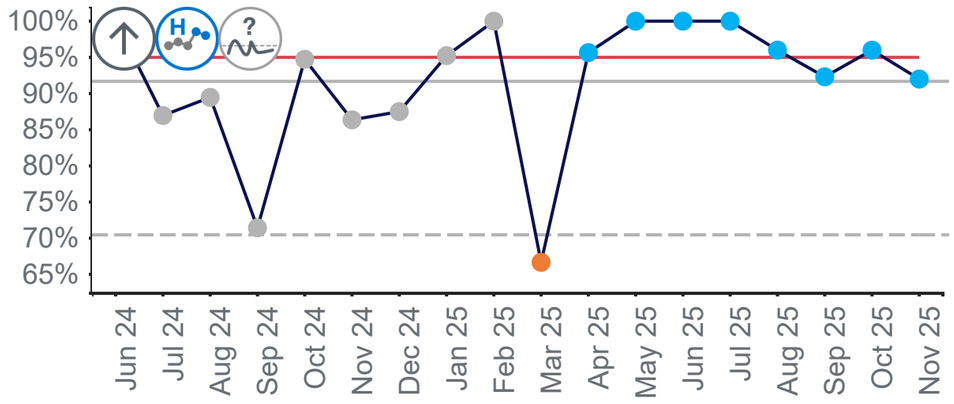
Actions:

25 high risks on register as of 30th November 2025

Reporting categories as outlined below:
• Quality – Safety = 12 risks • Workforce - Sustainability = 5 risks • Compliance and Regulatory = 3 risks • Financial – Investment = 2 risks • Commercial- 2 risks • Financial-Compliance-1 risk

% of High Risks within review date

Target: Internal



Technical Analysis:

92% of high risks within review date (2 risk overdue)

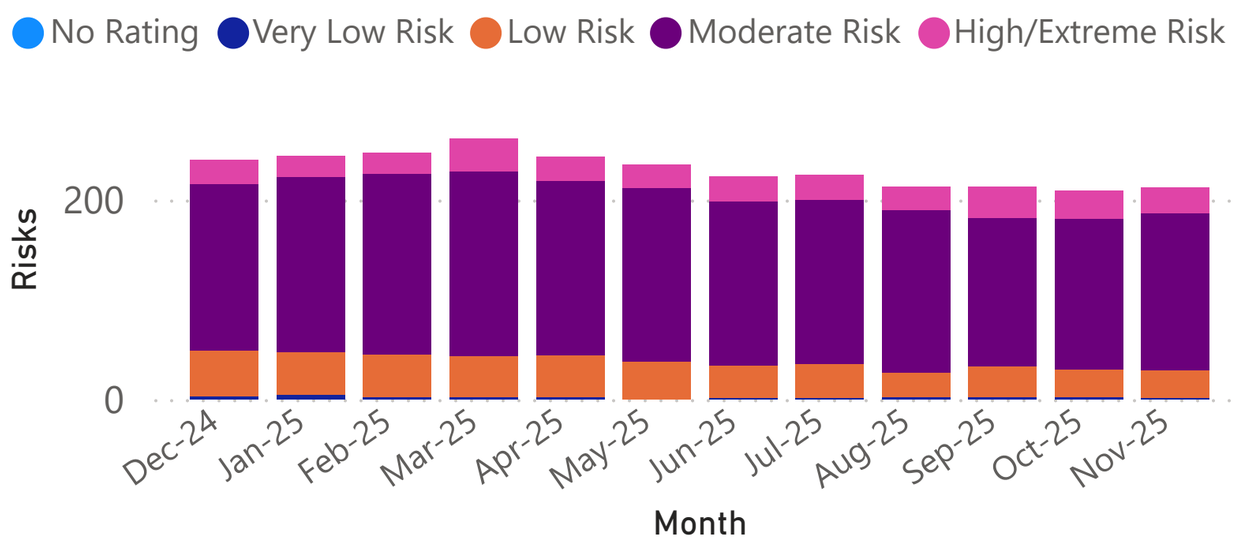
Actions:

92% of high risks within review date (2 risks overdue)

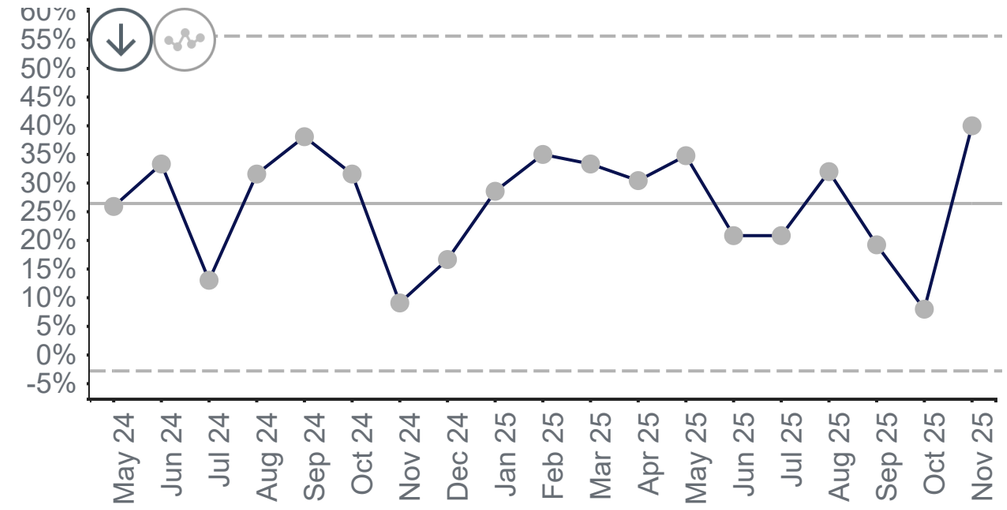
Risk watch metric: 40% of high risks with actions past expected date of completion (10 / 25)

Well Led - Risk Management

Trust Risk Profile



% of high risks with actions past expected date of completion



Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

- Continued improvement in 18 week RTT for Community Paediatrics (69%) and continued reduction in waiting list size
- Community Dietetics service continued to meet 18 week RTT target (100%)
- Improvement in number of CYP waiting under 6 weeks for first CAMHS appointment (83%)
- Improvement in Community SALT RTT (92%)
- Improvement in RTT for Clinical Health Psychology (86%)
- Continued reduction in WNB rate (12%)
- Continued increase in number of PALS responded to within 5 days (90%)
- Mandatory training compliance remains above target (96%)
- Slight improvement in sickness absence (6.7%)
- Reduction in patient safety incidents rated low and no harm

Areas of Concern

- Venus Centre closed due to unprecedented demand – impacting on referrals and capacity for Sefton CAMHS. Escalated to ICB.
- Reduction in number of complaints responded to within 25 working days (80%)
- Staffing levels within Sunflower House due to increased levels of sickness absence rates in month M8 (11.6%)
- Increase in staff turnover (10.3%)
- Deterioration in timeliness to triage for ND assessments (82%)
- Increase in number of children and young people waiting over 52 weeks for treatment to start in Community Mental Health Services (Liverpool) – improvement plan in place (7)
- Ongoing concerns regarding the number of clinical letters outstanding - deterioration in number of clinical letters completed within 10 days (34%) due to delays in transcription process
- Ongoing challenges with ADHD medication shortage which is impacting on waiting times for the treatment pathway

Forward Look (with actions)

- ND single assessment pathway went live September 2025:
- Work ongoing to streamline and validate data
- Review of the referral triage pathway has been undertaken with expectations reinforced and introduction of admin to ensure clinical staff are supported to reach targets. Number of triage sessions increased from M9 with improvement in KPI expected M9.
- Risk documentation to be completed for all CYP open to service - phased approach agreed – phase 1 commenced
- Demand and Capacity work commenced to identify resource needed to meet maximum 52 week wait to conclude – due January 2026.

- Liverpool CAMHS performance improvement plan in place using A3 brilliant basics methodology
- Waiting times managed against improvement trajectory. Increase in 52+ weeks due to vacancies and sickness. Trajectory to be reviewed.
- WNB rate remains high, introduction of reminder calls using WNB predictor, action plan under review.

- Mental Health data reporting – work ongoing
- MHSDS Phase 2 (Crisis Care) commenced, with Meditech developments completed in October 2025, testing ongoing during November & December 2025 – go live currently planned for Jan 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

- No child or young person waiting longer than 2 years for follow up. Work ongoing to address children waiting 1+ year.
- Work ongoing to provide psychological support to children impacted by the Southport critical incident. PIFU discharge pathway agreed to enable follow up until CYP turn 18.

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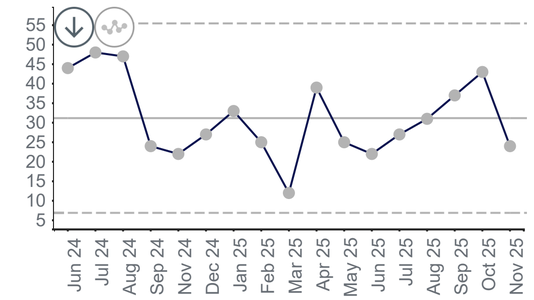
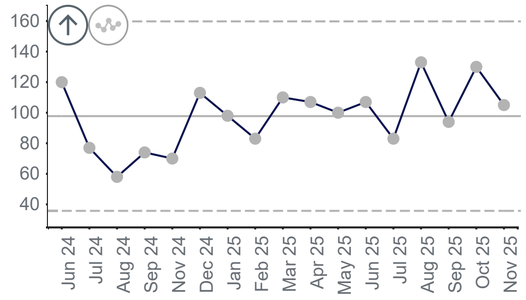
Divisional Performance Summary - Community & Mental Health

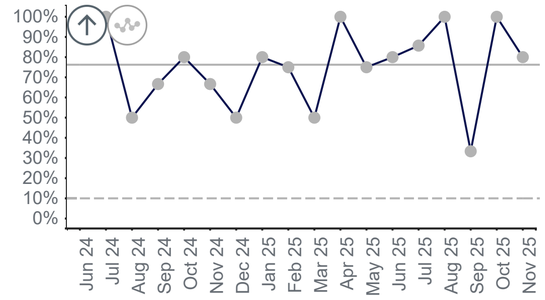
Patient Safety Incidents rated Low Harm & Above



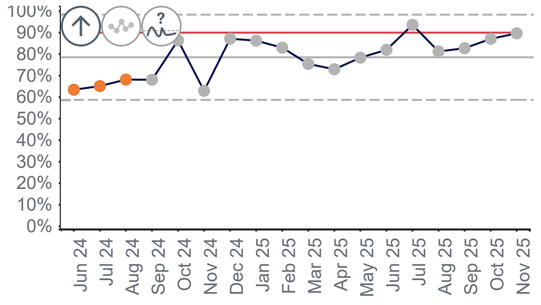
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

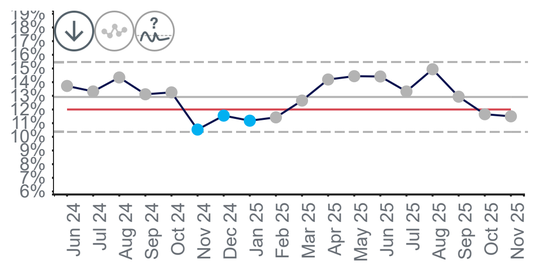


% PALS Resolved within 5 Days

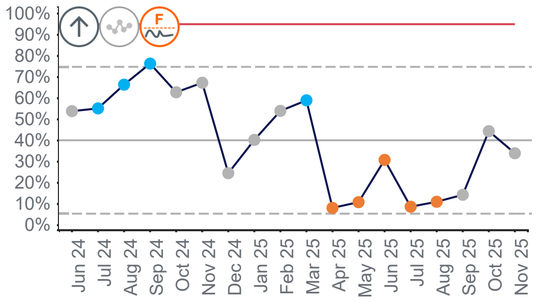


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

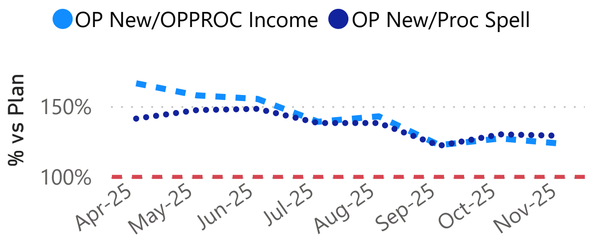


% of Clinical Letters completed within 10 Days

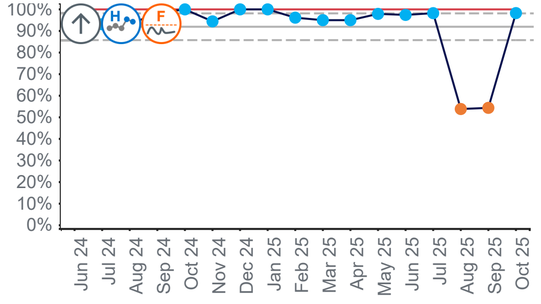


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

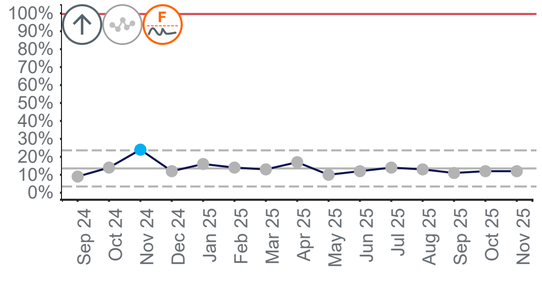
SLAM Performance



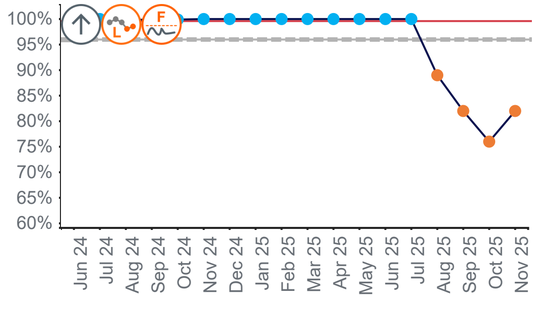
IHA: % complete within 20 days of referral to Alder Hey



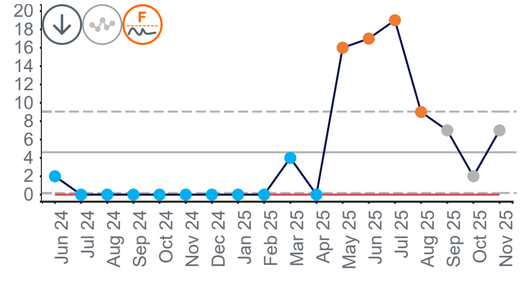
ND Assessment: % waiting <65 weeks for concluded diagnosis



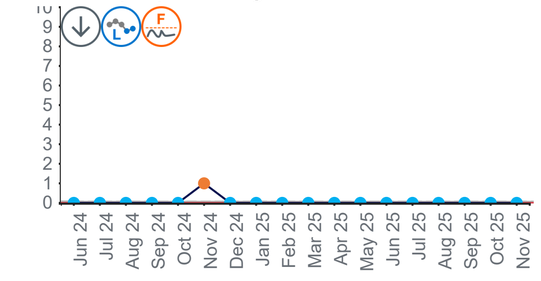
ND Assessment: % triage within 12 weeks



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

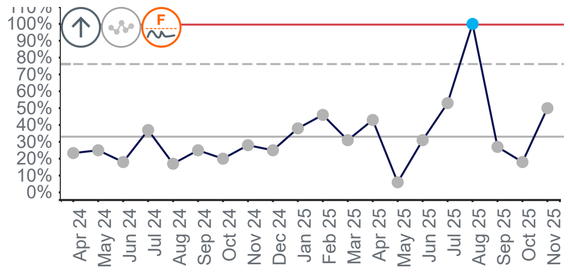


Community Paediatrics: Number of children and young people waiting >52 weeks



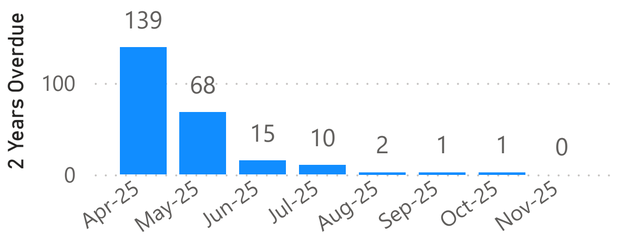
Divisional Performance Summary - Community & Mental Health

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

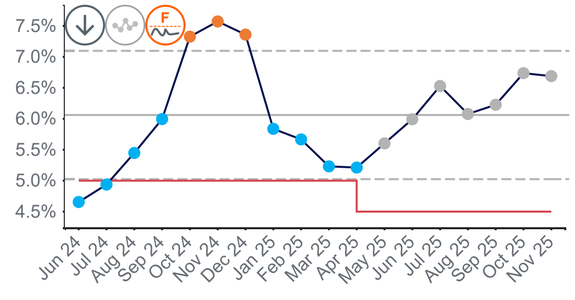


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

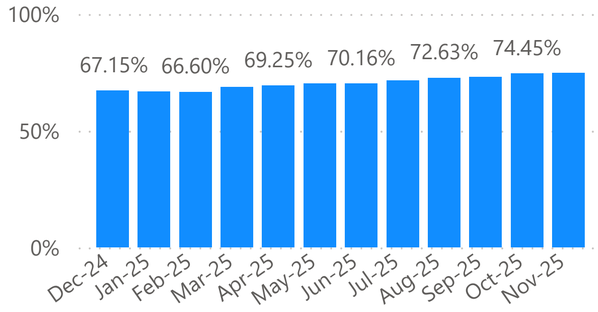
Vol overdue by 31st March 2026



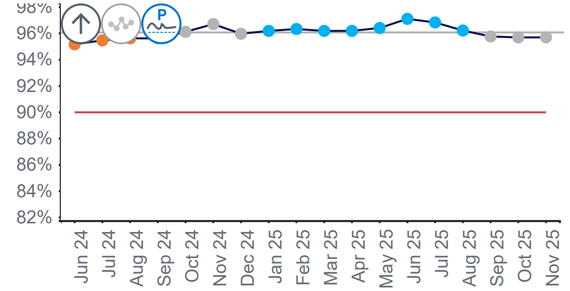
Sickness Absence (Total)



Workforce Stability

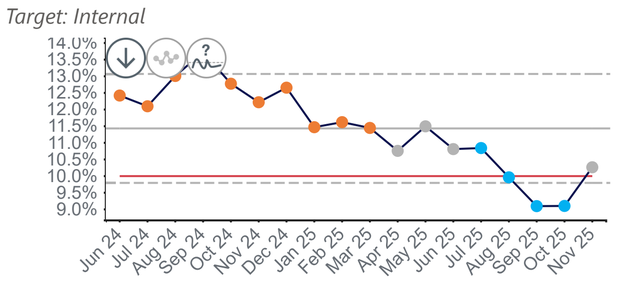


Mandatory Training

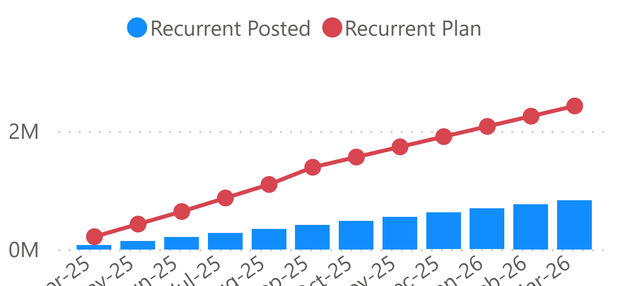


Staff Turnover

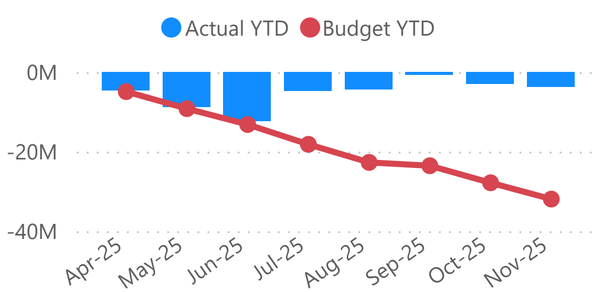
Target: Internal



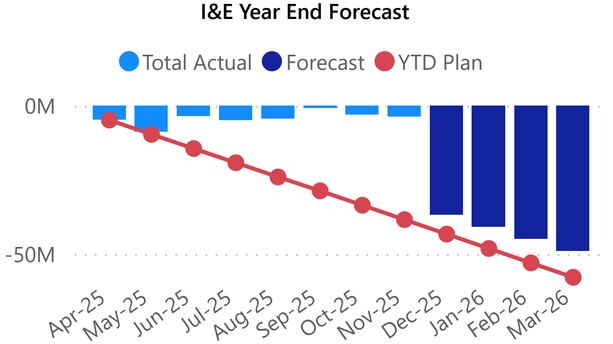
Recurrent Efficiency Plans Delivered (Forecast)



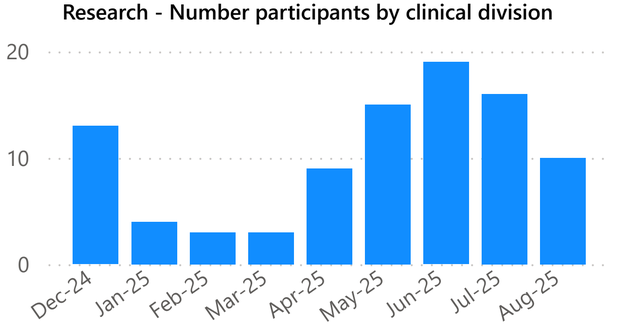
I&E distance from target (cumulative YTD)



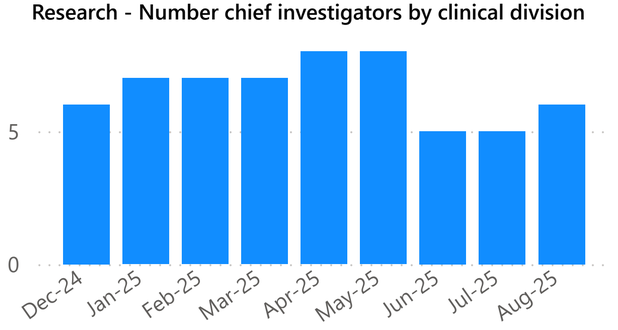
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• ED: % of Patients Treated within 4 Hours
- Whilst there has been a decline of 3.1% compared to October, we have still achieved 83.8% for November. For comparison, attendances this November were 9.7% higher than November 2024 and performance was 2.7% higher this year. YTD performance is 85.3%.
• RTT
- Patients waiting over 52 weeks has maintained at 0. This is a significant improvement maintained from January 2025 when we had 62.
• DM01
- DM01 has improved from 96% to 97%. This marks 12 months consistent improvement of the standard.
• Reduction in Overdue Follow Ups
- Reduced by a further 109 from October 2025, bringing the current position to 338 overdue. This is a maintained significant improvement with a reduction for the 7th month in a row and an overall reduction of 769 since April 2025.
• Activity
-Electives and Daycases is at 100% of plan for the second month in a row. November income is at 106% of plan demonstrating improvements in coding.
-Outpatient New and OPPROCs were at 98% of plan, a 3% improvement compared to October 2025. Work is ongoing to improve further.
• PALS
- PALS responded to within 5 days has increased to 100% after a challenging month in October at 92%.

Areas of Concern

• Was Not Brought Rates
- Whilst WNB has maintained a 2% improvement compared to August 2025, 8% is still higher than we would like.
• Inpatient Discharges
-Inpatient discharges per working day has decreased in November. This may be a result of more complex and sicker patients with the surge in flu and RSV attendances however we need to ensure process for review and discharge are efficient to minimise impact on occupancy.
• Sickness Absence
- Sickness absence maintains high within the Division at 6.2%. There has been a shift in the split of long term (reduction) and short term (increase) absence. Whilst positive for long term, short term absence produces acute challenges on the day impacting staff morale or increased premium spend of last minute cover.

Forward Look (with actions)

• UEC – Forward Look Jan/Feb
-Reviewing dates for expected predicted peak in attends post- Christmas to proactively look at increasing streaming capacity, surge ward capacity, tactical support to manage flow and public communications around alternatives to ED.
• Lyrebird Roll Out
- Rolling out Lyrebird clinic template increase to Cohort 1 users with a view to increasing new patient capacity having a positive impact on income, RTT and waiting times for first appointment.
• Activity Management
-Weekly forecasting meetings understanding expected activity levels and early mitigations for deviation from plan. Also working in conjunction with clinical teams to maximise coding opportunities within key specialities to increase average tariff per case.
• Opt In
- Rolling out the Opt In process for new referrals awaiting appointments with high waiting lists or high WNB rate to maximise capacity within clinics and reduce waiting lists of those that no longer require an appointment.
• Increase in OPD New Activity
- Additional outpatient clinics implemented in General Paediatric from January 2026 onwards with a new model of working for the PAU clinicians pending the build opening.
- Expected maintained increase in OPD new activity for ED owing to seasonal trends which will bring them back to plan for the year; working closely with Primary Care Stream provide to deliver this.
• Sickness Management
- Continued engagement with the sickness management team with a deep dive focus on medical staff through a biweekly MDT to discuss complex cases with DMD, ACOO and HR.

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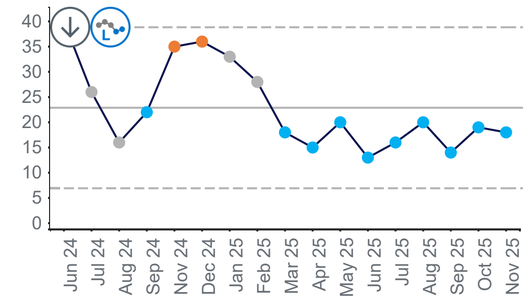
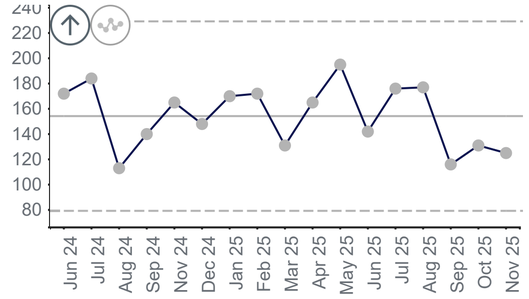
Divisional Performance Summary - Medicine

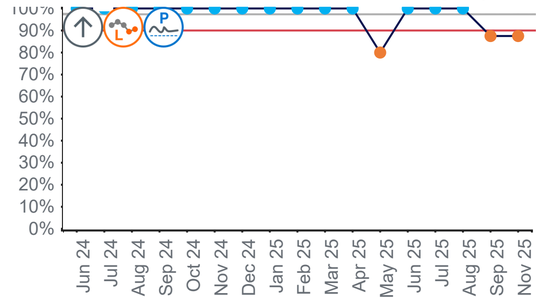
Patient Safety Incidents rated Low Harm & Above



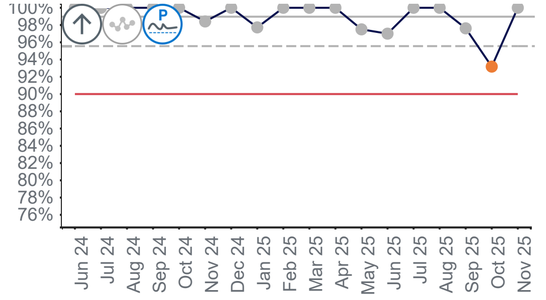
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

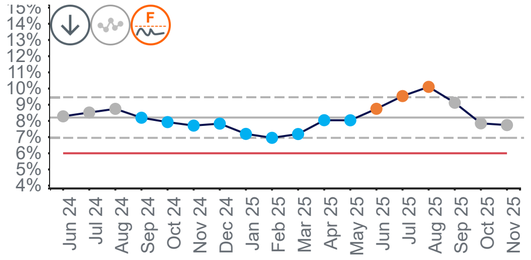


% PALS Resolved within 5 Days

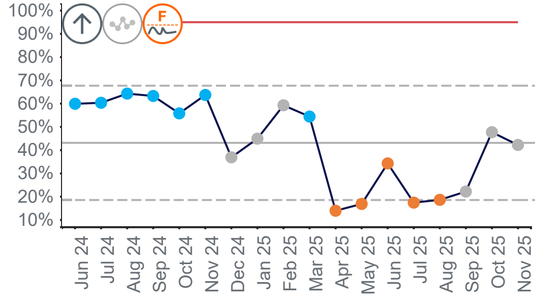


% Was Not Brought Rate (All OP: New and FU)

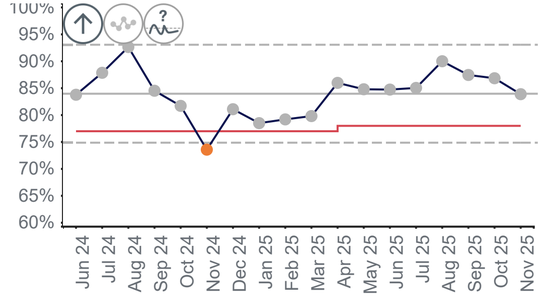
Target: Internal



% of Clinical Letters completed within 10 Days

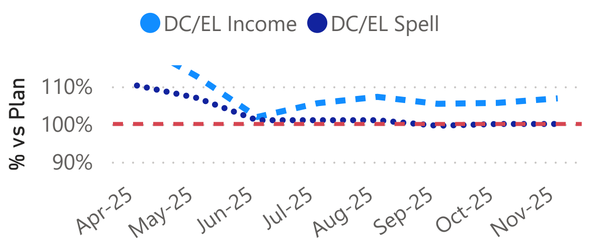


ED: % treated within 4 Hours



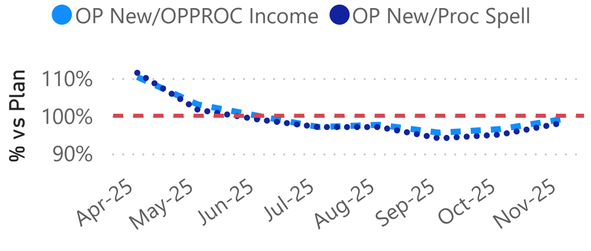
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

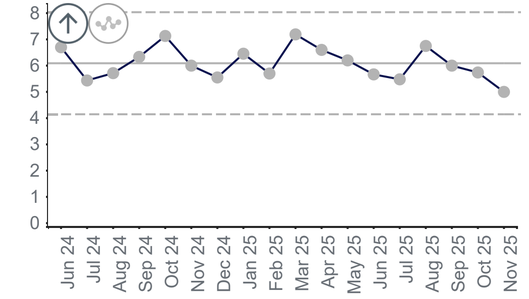


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

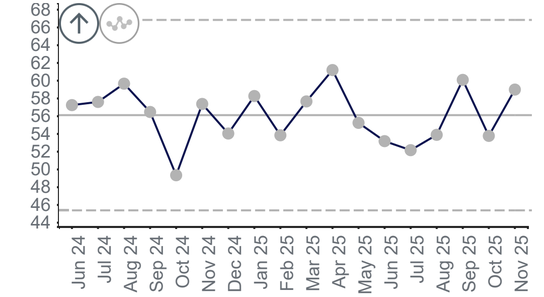
SLAM Performance



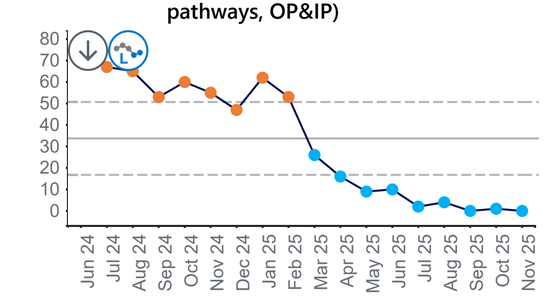
Inpatient Discharges per working day



Day Cases per working day



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



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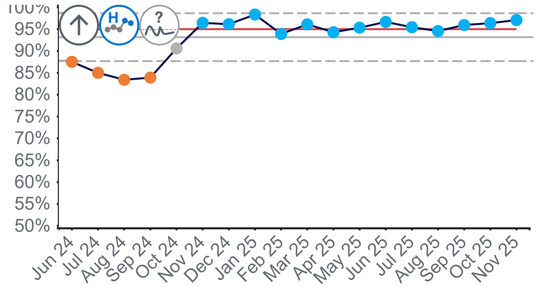
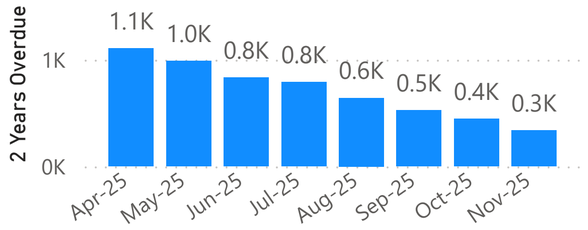
Divisional Performance Summary - Medicine

Diagnostics: % Completed Within 6 Weeks of referral

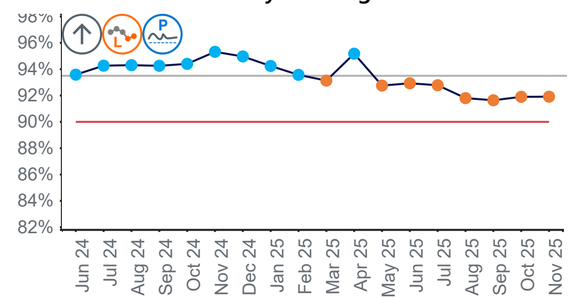


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

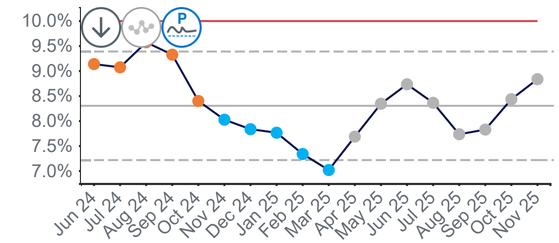


Mandatory Training

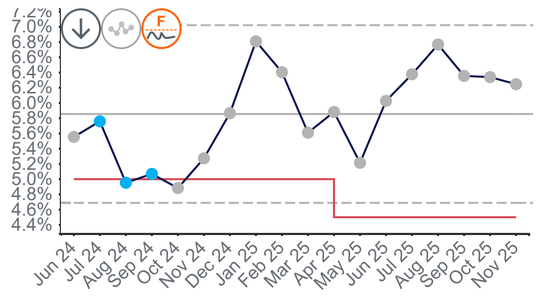


Staff Turnover

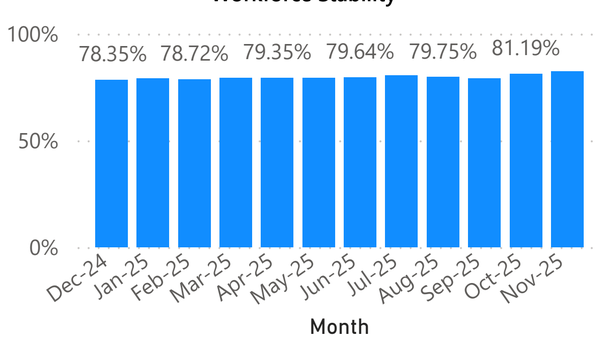
Target: Internal



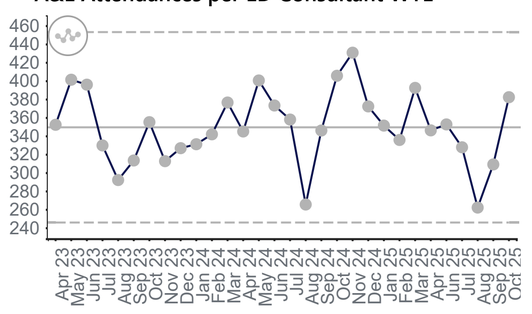
Sickness Absence (Total)



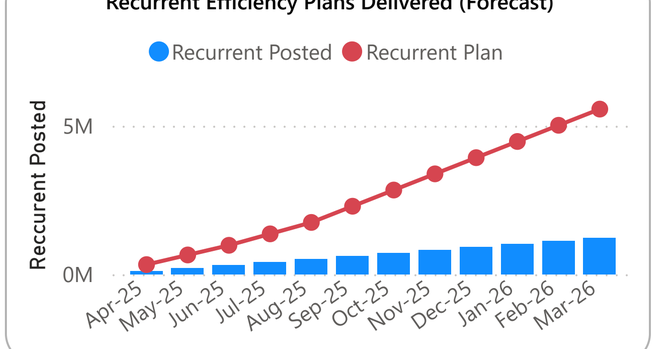
Workforce Stability



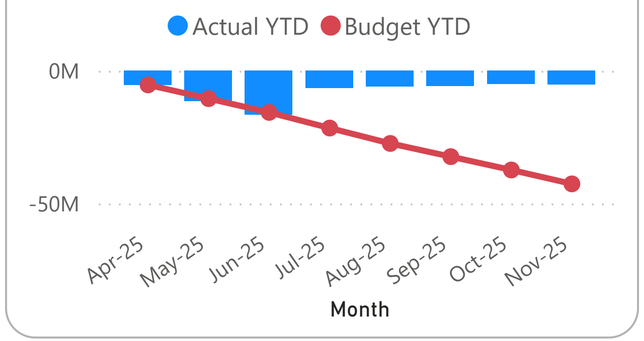
A&E Attendances per ED Consultant WTE



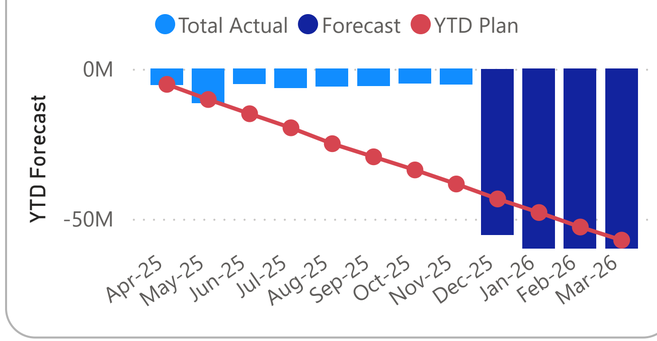
Recurrent Efficiency Plans Delivered (Forecast)



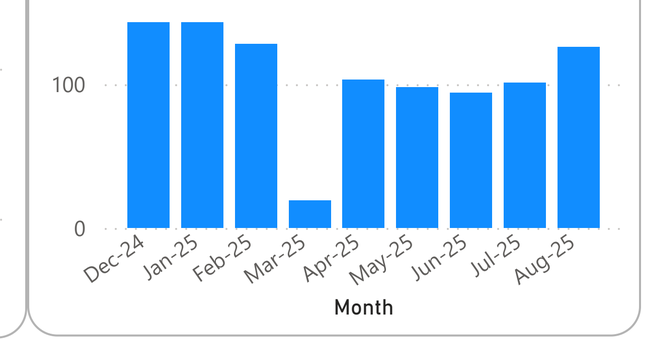
I&E distance from target (cumulative YTD)



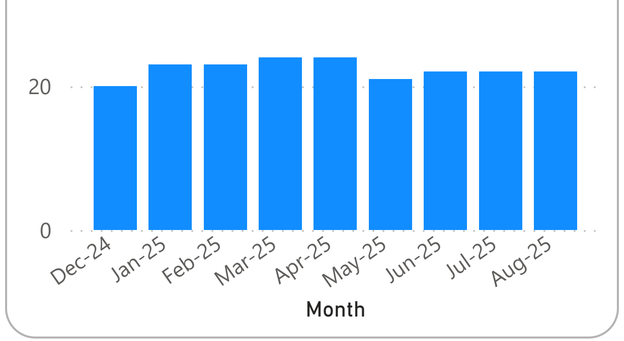
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

•100% compliance with responses to PALS and formal complaints- over 12 months PALS compliance with trust target

• ERF income for all PBR PODS was on or above plan in month giving an income overperformance of £176k. YTD slight underperformance of £45k however £213k pressure remains around excess bed days, impacting the position.

• Increase in day cases per working day for 3rd consecutive month. Improvement based on specific action plan to convert more appropriate pathways to day case

• Mandatory training remains above trust target and has done consistently for previous 18 months

Areas of Concern

• Although a reduction in month at 9%, WNB rate remains less than trust target

• 47 % clinical letters signed within 10 days although lower than target is a significant improvement on previous quarters within the year

• Number of CYP waiting over 52 weeks remains static in month, predominantly due to Dentistry where we have ongoing capacity constraints.

• Sickness continues to increase for the 5th consecutive month at 7.3%

• Although overdue follow ups continued to decrease in month, volume over 2 years is still significant. Key action plans in place with 3 specialities with higher volume and impact should start to be seen from January onwards. Opt in rollout also continues across areas.

Forward Look (with actions)

• Close monitoring of % clinical letters signed which based on clinical discussion is improving due to the immediate availability of letters to sign on the day via Lyrebird implementation. Focused roll out of Lyrebird will enable consistent improvement.

• Continued work within Dentistry to support additional capacity via KPI. Mutual aid explored in December with 2 providers however neither of which are able to support our cohort of patients. Work to continue internally and externally.

• Close monitoring of sickness levels and ensuring safe staffing in clinical areas, however this is resulting in increased temporary spend. Hotspot areas in theatres and anaesthetics and both are being supported by HR team. Ongoing work to ensure wellbeing strengthened in terms of ensuring adequate breaks, engagement with flu vaccination programme alongside leadership visibility for support and escalation. Anaesthetic department currently has significant high levels of long-term sickness which is being managed appropriately but that is creating departmental pressure. Department working flexibly/additional to cover theatre schedule.

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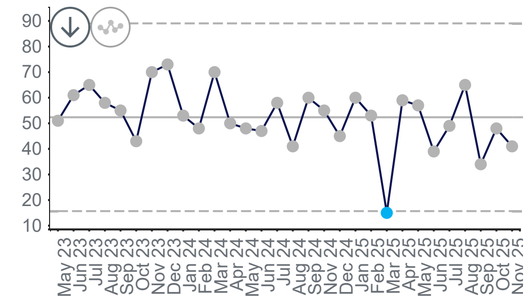
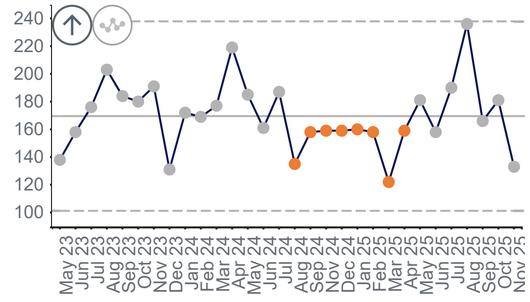
Divisional Performance Summary - Surgery

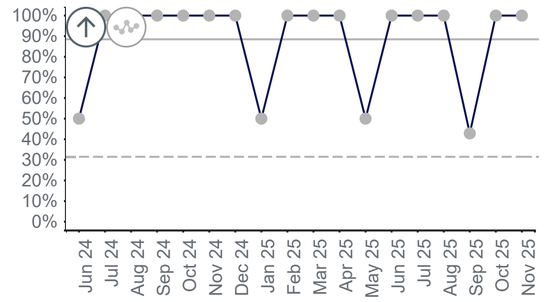
Patient Safety Incidents rated Low Harm & Above



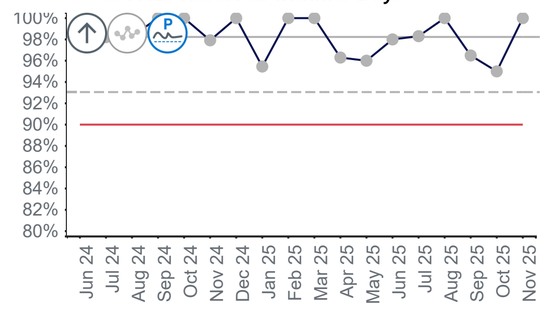
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

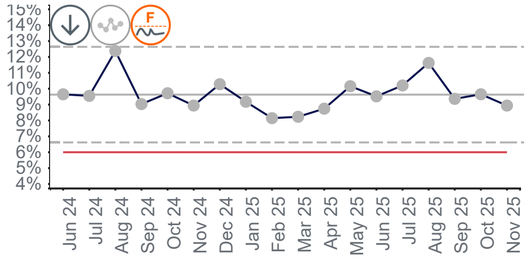


% PALS Resolved within 5 Days

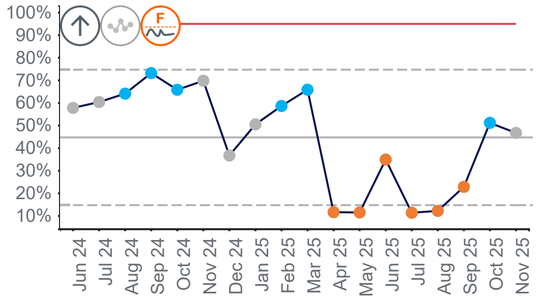


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

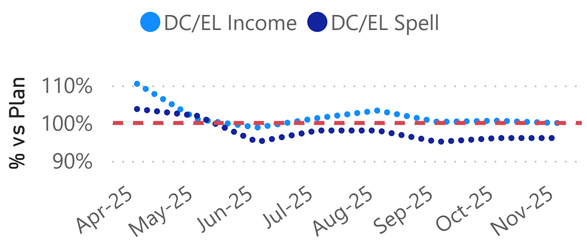


% of Clinical Letters completed within 10 Days



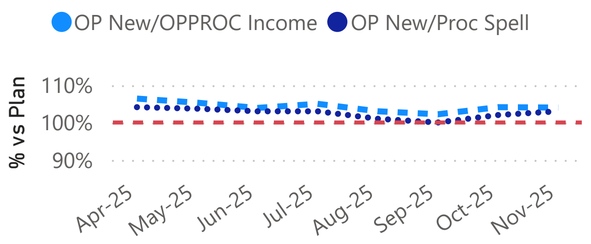
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

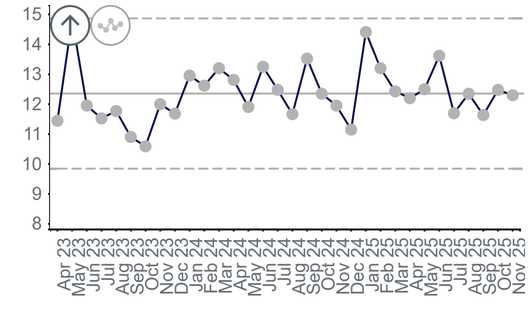


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

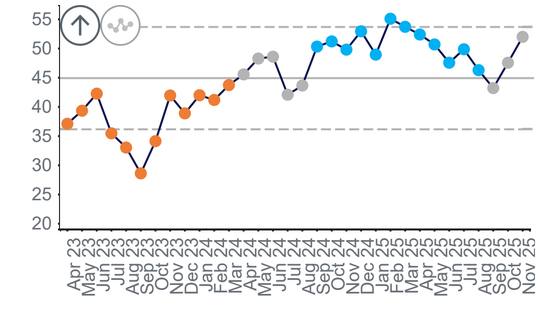
SLAM Performance



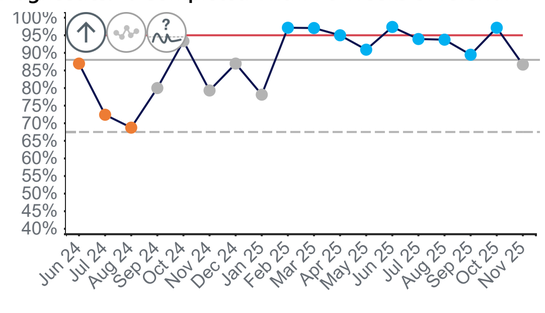
Inpatient Discharges per working day



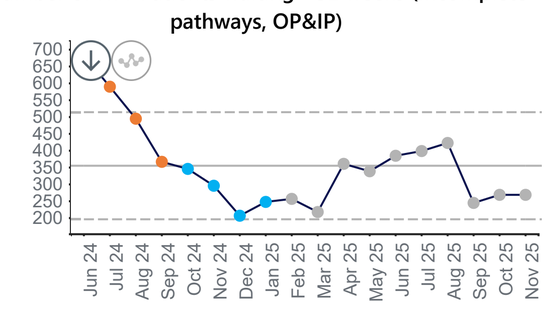
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



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



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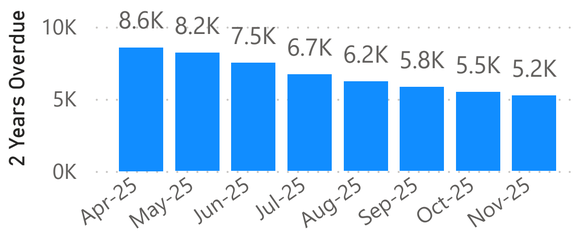
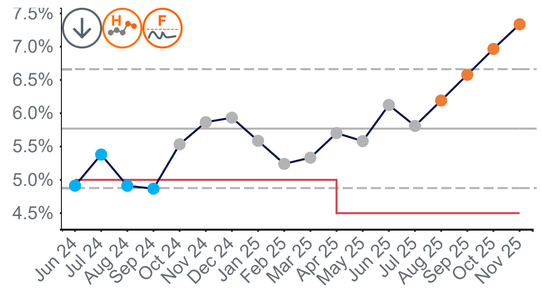
Divisional Performance Summary - Surgery

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

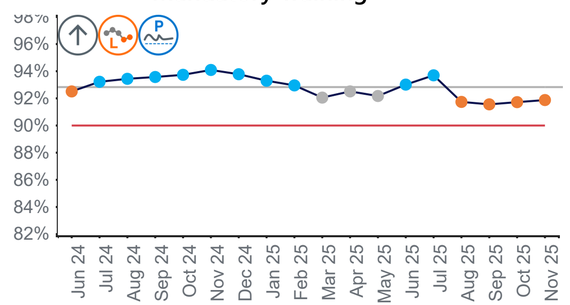
Vol overdue by 31st March 2026



Sickness Absence (Total)

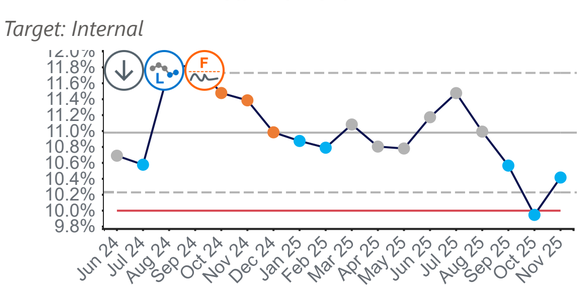


Mandatory Training

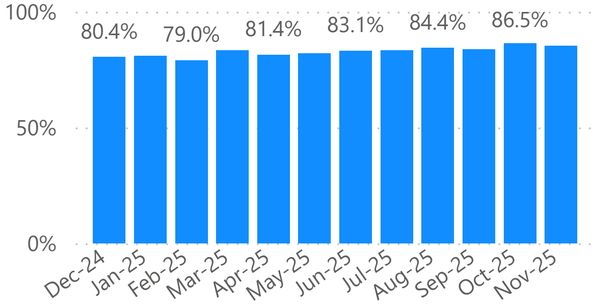


Staff Turnover

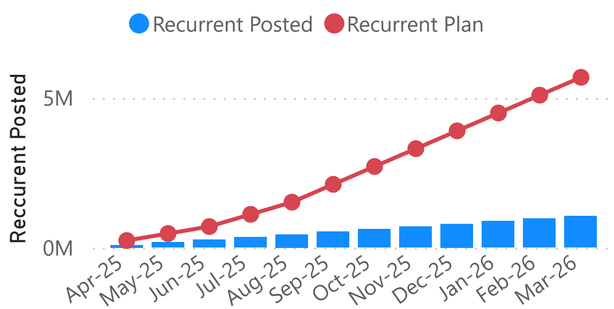
Target: Internal



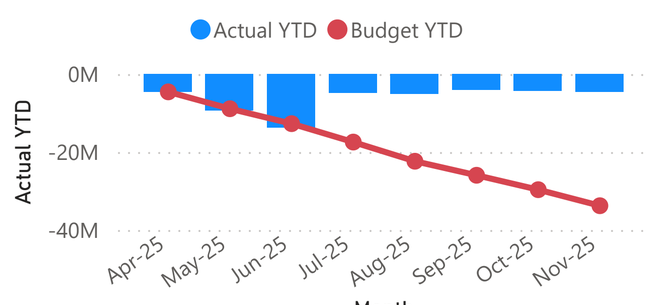
Workforce Stability



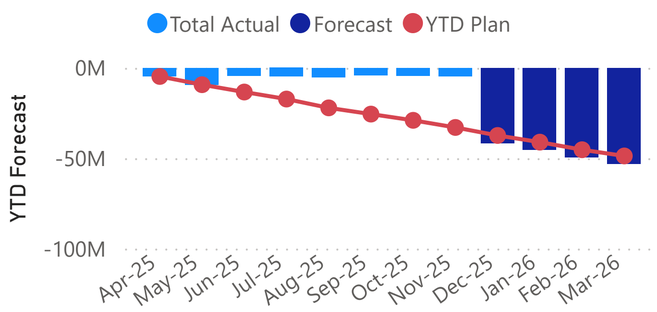
Recurrent Efficiency Plans Delivered (Forecast)



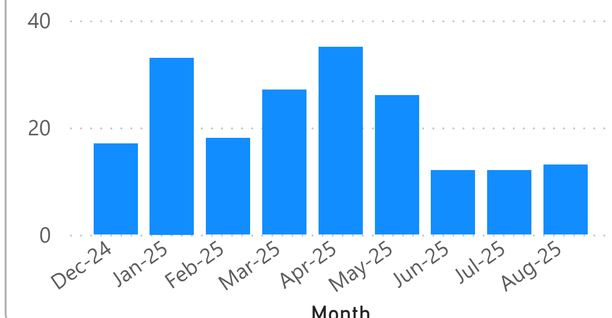
I&E distance from target (cumulative YTD)



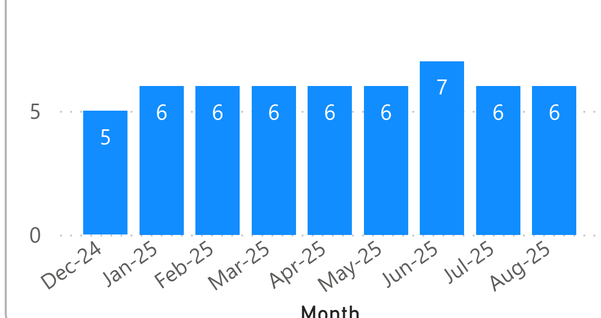
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

- No concerns re workforce or safety metrics for research
- Improvements in month in financial position with forecast year end surplus (which can partially offset MRI stretch target)
- See Pioneering Breakthroughs section for highlights.

Areas of Concern

- MRI stretch target remains a concern – operational resource has been seconded (from 1st Dec) and priority setting group established with first meeting planned for 9th Dec.

Forward Look (with actions)

- See Pioneering Breakthroughs section for forward look.

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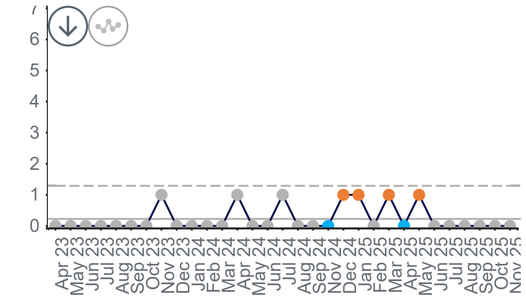
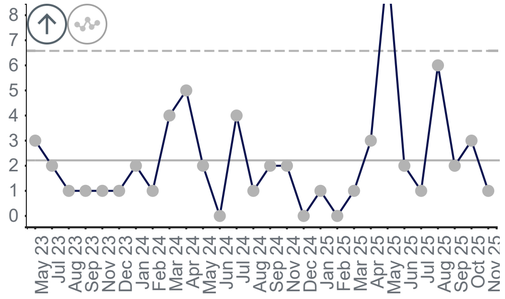
Divisional Performance Summary - Clinical Research

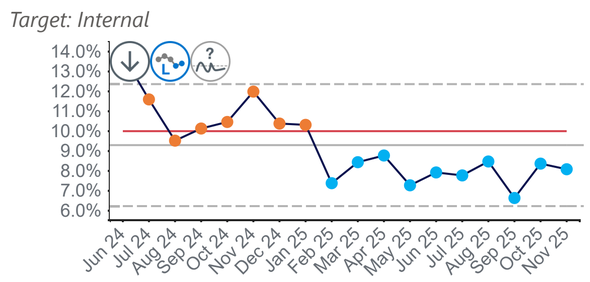
Patient Safety Incidents rated Low Harm & Above



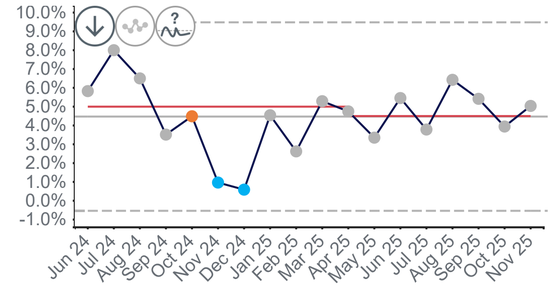
Patient Safety Incidents rated No Harm



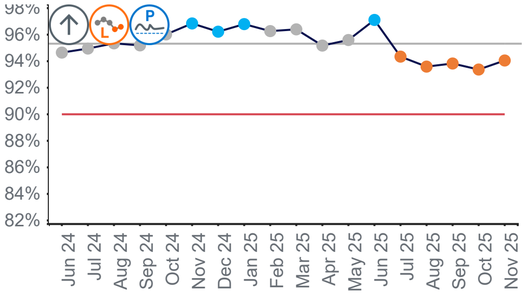
Staff Turnover



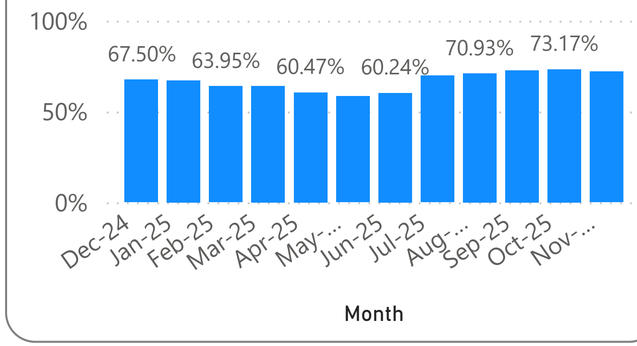
Sickness Absence (Total)



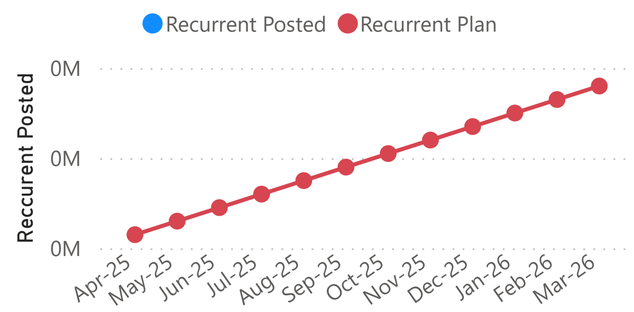
Mandatory Training



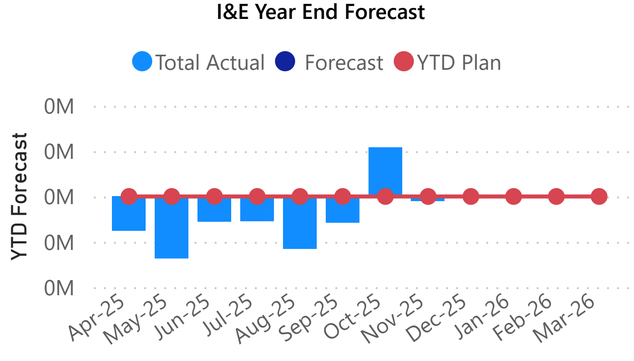
Workforce Stability



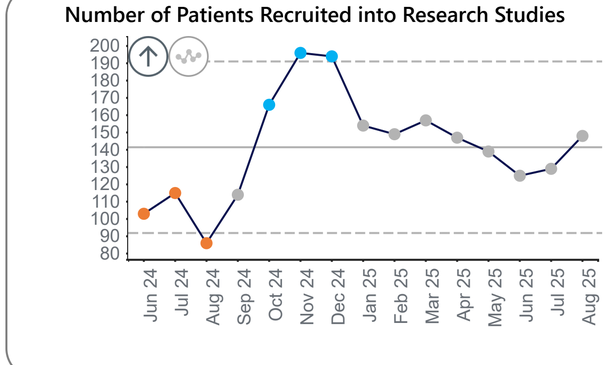
Recurrent Efficiency Plans Delivered (Forecast)



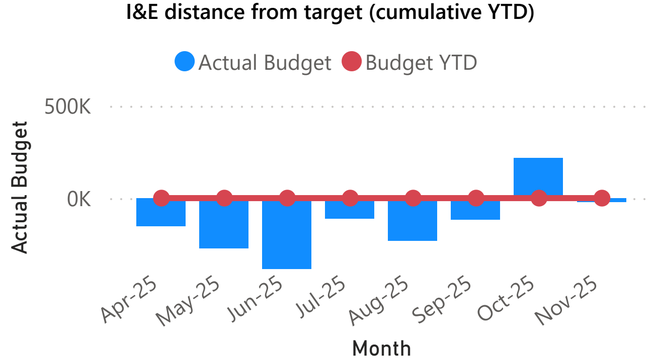
I&E Year End Forecast



Number of Patients Recruited into Research Studies



I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Chief Corporate Affairs Officer

Highlights

The Corporate Services Collaborative met on 15th December; highlights from the November data include:

- Mandatory training remains above Trust target at 93%.
- B7+ PDR is at 90% meeting Trust target
- 89% of risks in date.
- In terms of CIP, the Corporate Collaborative identified plans and/or delivered a total of £5.7m, £3.9m recurrently.

Areas of Concern

- Short term sickness absence increased slightly to 2.3% and is now slightly above Trust target of 2%.
- Overall PDR compliance 80%.
- Overall sickness outside of Trust target at 6.96% and remains above the 4.5% trust target.
- Long term sickness is currently sitting at 4.61% against a target of 2.5%

There is still a £1.35m gap in recurrent CIP to be identified.

Forward Look (with actions)

- Continued focus on financial position, system finance and internal controls/opportunities including WTE.

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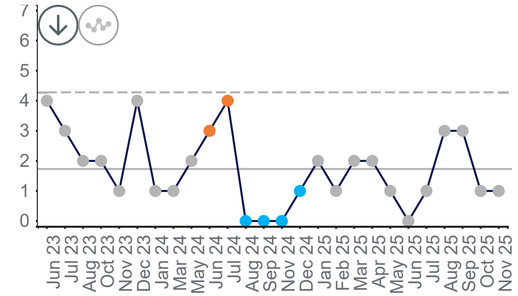
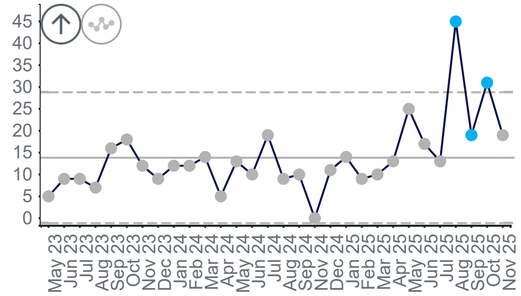
Divisional Performance Summary - Corporate

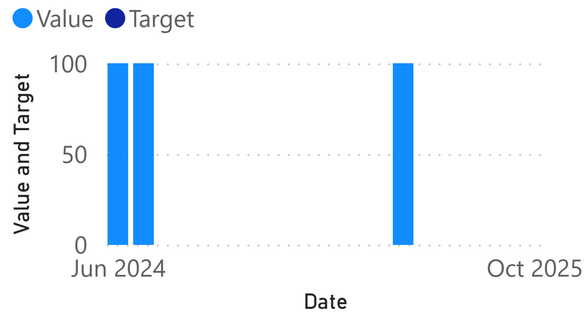
Patient Safety Incidents rated Low Harm & Above



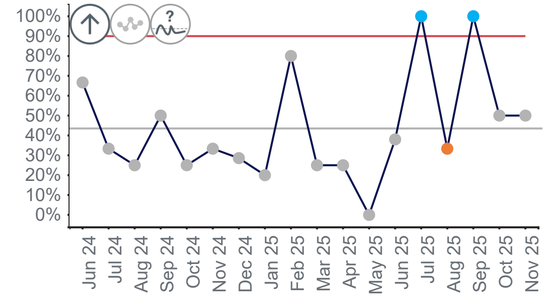
Patient Safety Incidents rated No Harm



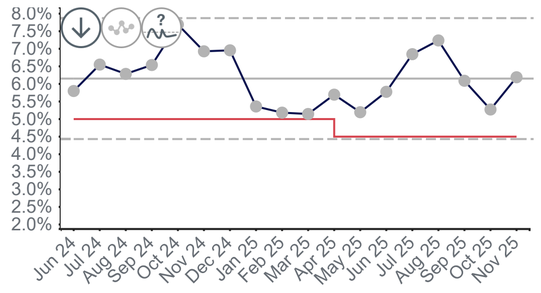
% Complaints Responded to within 25 working days



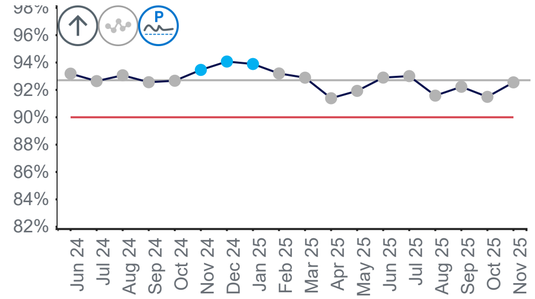
% PALS Resolved within 5 Days



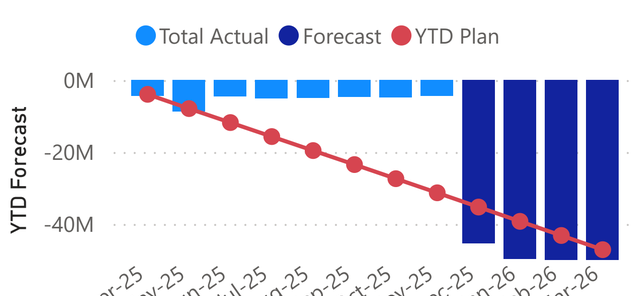
Sickness Absence (Total)



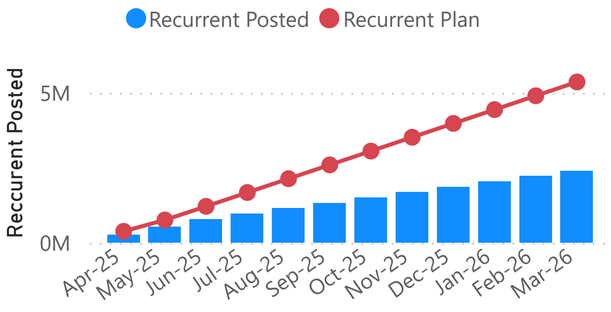
Mandatory Training



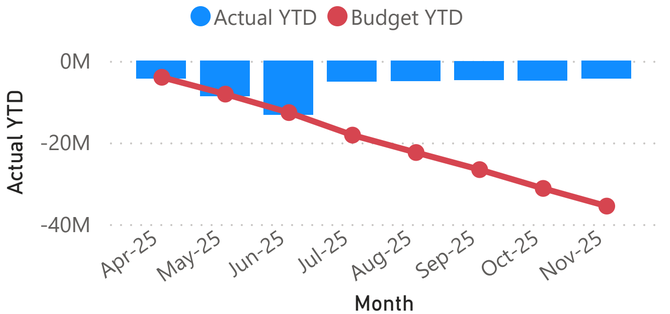
I&E Year End Forecast



Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

BOARD OF DIRECTORS

Thursday, 8th January 2026

Paper Title:	**Trust Mortality Report Quarter 2 2025-26**
Report of:	**Hospital Mortality Review Group (HMRG)**
Paper Prepared by:	Alfie Bass/Julie Grice

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

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

Risk number	Risk description	Score

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

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report- Quarter 2 2025-26

The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG) including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims. Section two is the Quarter 2 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

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

Figure 1 below illustrates the number of deaths at Alder Hey from 2020 to 2025. While there is some fluctuation month to month, certain patterns emerge. For example, March and November consistently show relatively higher death counts across multiple years, especially in 2024 and 2025. In contrast, months like April and June tend to have lower death counts in several years. The trend line for 2025 shows an initial drop from January to February, a sharp rise in March, and then a stable period from April through August, followed by a gradual increase in the last few months. Overall, while the number of deaths varies by month and year, 2025 shows a relatively steady trend with spikes in March and toward the end of the year.

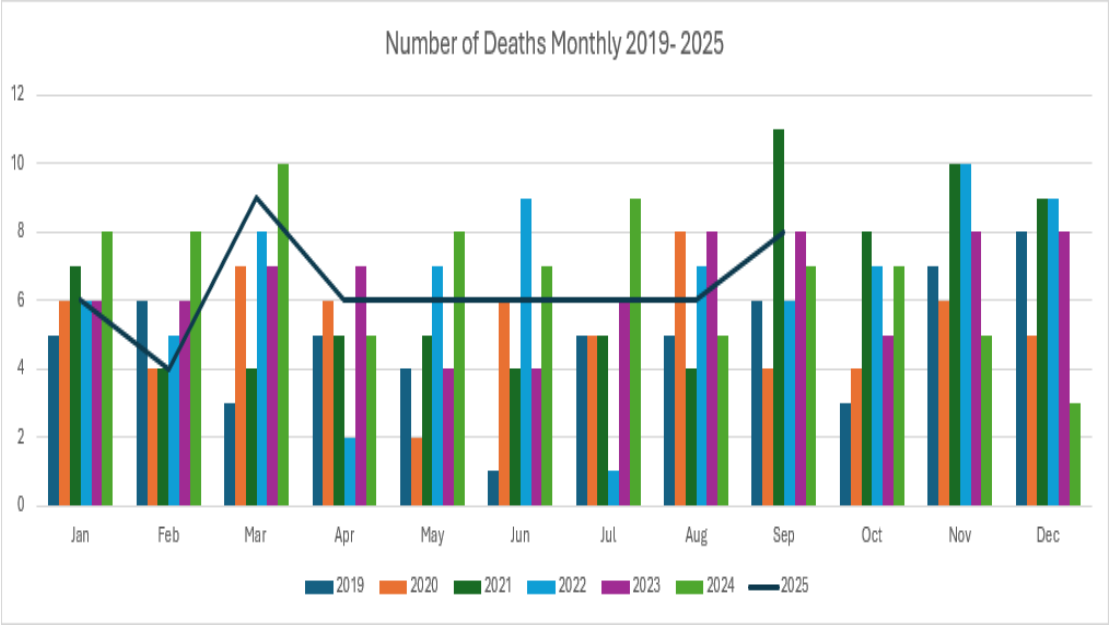


Figure 1

Figure 2 shows total deaths from 2020 to 2024. Deaths increased from 63 to a peak of 82, with relatively stable figures between 76 and 77 from 2021 to 2023. The apparent drop to 37 deaths in 2025 reflects only partial-year data, so the

final total is likely to align more closely with previous years. While the overall number of deaths has remained relatively consistent in recent years, a slight upward trend can be attributed to changes in reporting practices. Previously, deaths occurring in the Emergency Department were excluded, as they weren't classified as inpatient deaths. However, recent updates to the Child Death Review Process now include these cases in the National Child Mortality Database. Additionally, an increase in complex cases referred to Alder Hey, often involving inevitable outcomes linked to organ donation or supporting family acceptance has also contributed to the rise in reported deaths.

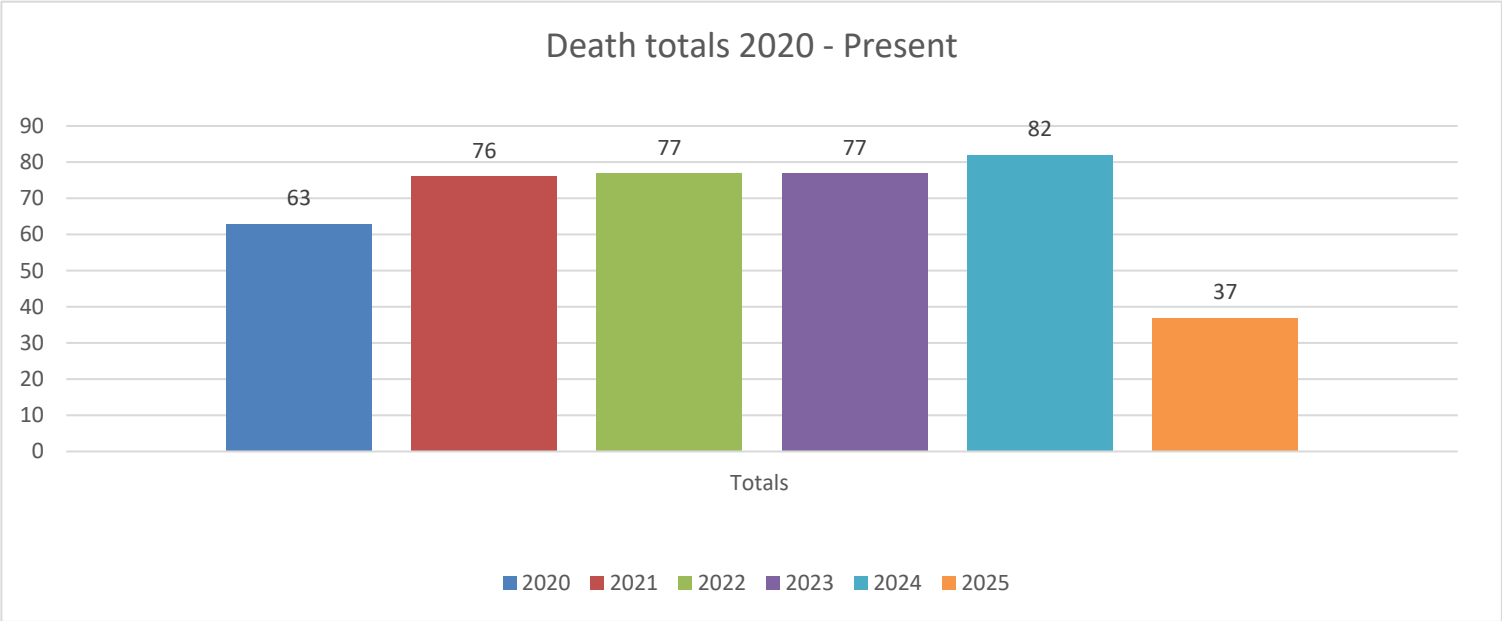


Figure 2

Core service updates:

The Child Death Review Process in the trust continues to evolve because of issues identified by HMRG members and bereaved families, plus external changes, here are the October 2025 updates on previous action points.

1) The AHCH pilot for the Medical Examiner (ME) process began in March 2024 and became a legal requirement in September 2024. ME scrutiny at AHCH is carried out by the Liverpool University Hospitals NHS Foundation Trust Medical Examiner Service, supported by two pediatricians (one actively working and one recently retired from AHCH). To date, approximately 110 paediatric deaths have been reviewed by the ME team. This quarter, there were no reported incidents.

2) One of the most significant issues that has been highlighted by a number of cases is the families' expectations when transferred from regional

neonatal units to Alder Hey and frequently to PICU. These expectations are unrealistic as the model of care, acuity, infrastructure, and staffing are completely different. Usually, neonates are transferred because they have deteriorated, and their care needs have escalated. Not infrequently, there are few, if any, treatment options left, and there is nothing the AHCH team can do. Going forward, it is important that the families are aware that their baby's situation is precarious and that it is not a reflection of AHCH/PICU management but of how unwell the babies are. There is work on-going to try and address this.

3) It is essential that when antenatal counselling is undertaken by multiple AHCH specialties, a consensus plan is agreed and communicated clearly.

4) The HMRG email is being used consistently, ensuring that families' voices are heard and included in the review process. We are also receiving an increasing number of feedback requests, indicating strong engagement and confidence in the process. The current system is robust, well-established, and functioning, but there is a delay in responding to parent/s due to capacity and increased demand for feedback.

5) Over this period, there has been a recurrent theme relating to inadequate documentation which then leads to confusion and breakdown in communication between the Trust and families resulting in complaints and unnecessary distress. This challenge has been escalated appropriately.

6) Currently, hospital discharge letters are only sent to the child's GP. It is vital that they can be sent to the patient's district general hospital to ensure they are updated should the child/YP need follow up or seek advice locally after discharge or on weekend leave ensuring optimal continuation of care.

7) Work on the neonatal audit has now begun. Data from the past five years has been collected, and the medical and nursing leads for HMRG are progressing to the next stages of the audit process. This baseline assessment will help measure the impact of the new neonatal surgical unit once it opens.

Current Performance of HMRG - Summary of 2025 Deaths

Number of deaths (Jan. 2025 – Sept 2025)	60

	+1 reviewed in LWH
Number of deaths reviewed	34
HMRG Primary Reviews within 4 months (standard)	34/36 (94%)

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

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

New InPhase Mortality Module

Members of HMRG have worked with InPhase developers to build the mortality module. This will enable more effective working in future and act as a repository for all mortality-related information. It is hoped this will go live in December.

Outcomes of the HMRG process 2025

Outcome table (figure 3):

Month	Number of Inpatient Deaths	HMRG Review Completed	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
					Internal	External		
Jan	6	6	6	6				1
Feb	4	4	4	4				1
Mar	8*1	7	7	7			1	1
April	6	6	6	6		1		1
May	6	6	6	6		1		
June	6	5	5	5				
July	6							
Aug	6							
Sept	8							

***1 death reviewed in LWH as deemed more appropriate than AHCH. Input provided from AHCH clinical teams.**

Potentially Avoidable Deaths

There have been 2 potentially avoidable deaths in the 2025 cases reviewed so far and both related to external causes and no reflection on care at AHCH.

Learning disabilities

The number of learning disability cases over the past four years has varied with no clear pattern, as illustrated in the graphs below. When compared to the total number of deaths, the percentage has ranged between 16% and 20%. However, in the 2025 cases reviewed so far there is a much lower number of LD cases than usual at 12%. This was the same pattern last year but then balanced out over the whole of 2024.

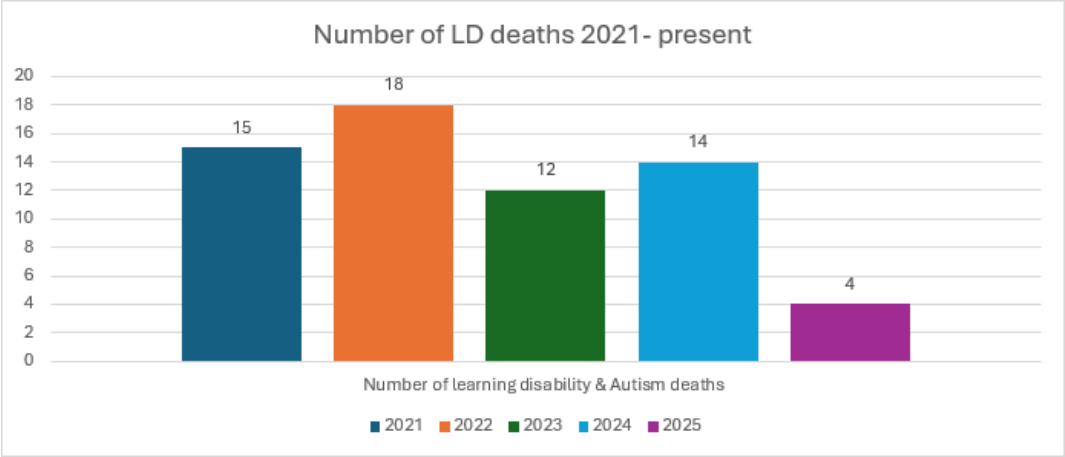


Figure 4

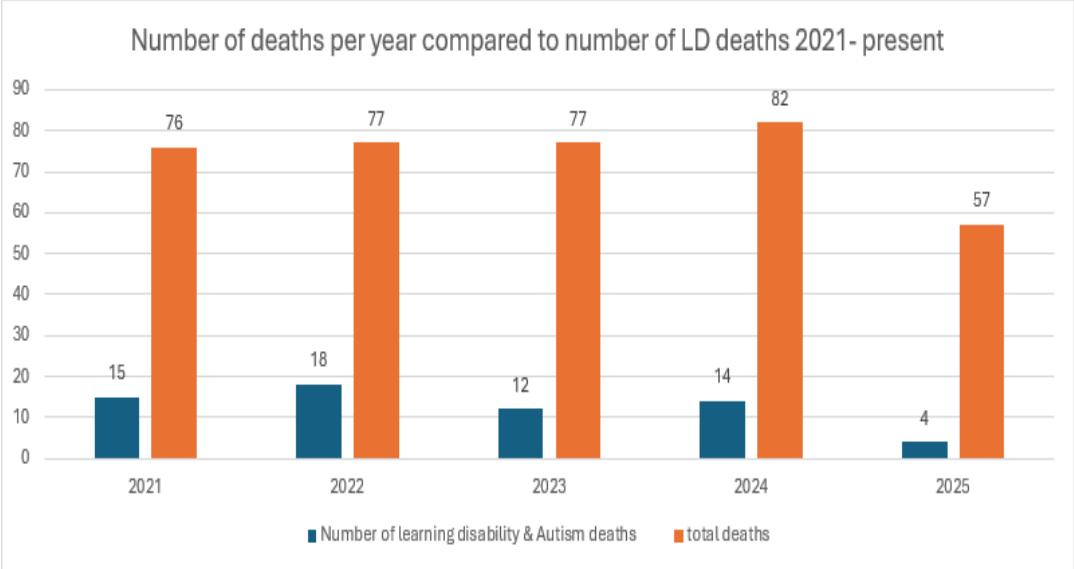


Figure 5

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

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

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

No concerning themes or trends have been identified within the LD patient group. The deep dive of this patient group is undertaken in the quarter 4 report each year. Cases will be further reviewed upon completion of any coronial processes to identify any additional learning and adjust coding (e.g. from SUDiC) where necessary. The review group maintains close collaboration with the Learning Disability services to ensure that any findings are shared and acted upon, supporting high-quality care for this complex and often high-contact patient population.

Neonates

The definition of a neonate is a baby less than 28 days old. Of the cases reviewed so far, there have been 12 neonatal deaths which is 35% of the total deaths. Of these cases, 67% had the diagnostic code of congenital, genetic, and chromosomal anomalies. The only other category was neonatal /perinatal causes which was 33%.

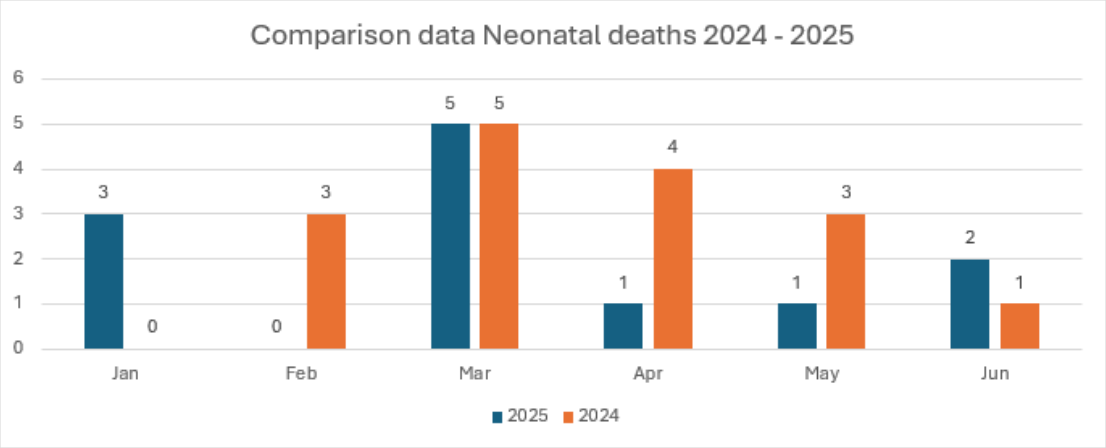


Figure 6

The graph below shows the breakdown of the caseload into complex congenital cardiac heart defects, surgical and other compared to the total number of neonatal deaths. The surgical cases are predominantly the premature babies with NEC (Necrotising Enterocolitis) which is a recognised complication in premature infants. Of these neonatal cases, it was decided in 58% that after investigations or due to their condition that there were no further treatment options available. They were then changed to palliative pathways after discussion with all relevant teams and with the agreement of the families.

In March all the deaths were neonatal with four being cardiac which were very complex cases where all possible treatment was given. There were no concerning features or themes with these cases.

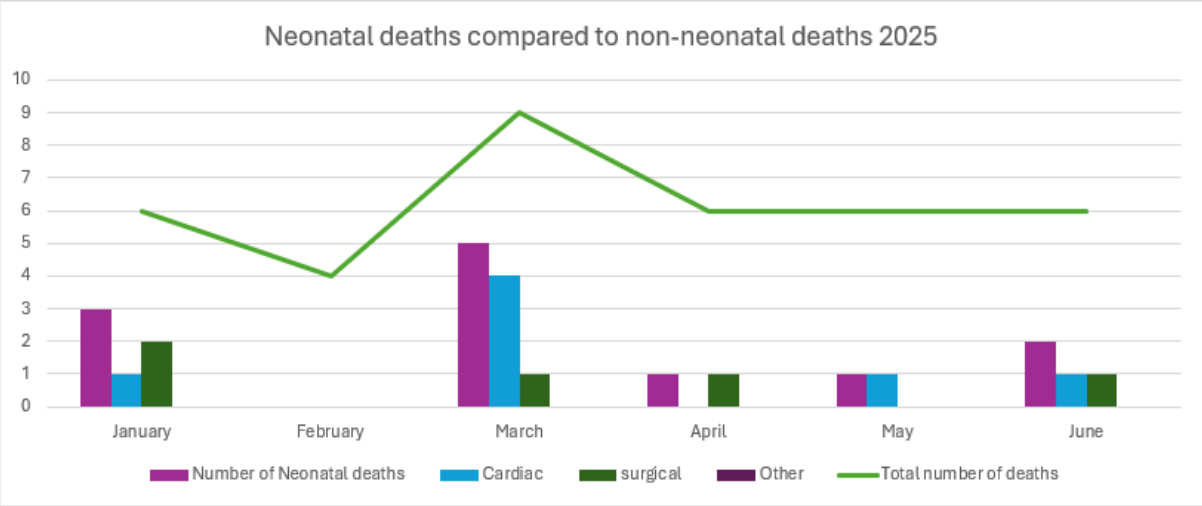


Figure 7

The Perinatal Mortality Review Tool (PMRT) recommends that reviews be conducted at the trust where the baby dies; however, at AHCH, this is not feasible due to the lack of obstetric services. Instead, the PMRT is completed by the hospital of birth and shared with AHCH, allowing HMRG members to review it prior to their own assessment. To ensure alignment between processes, the HMRG form will be updated to include PMRT findings and summaries for consistent and thorough review of all neonatal cases. It is also noted that some trusts do not complete a PMRT if the baby dies outside the hospital of birth; therefore, HMRG continues to advocate for the inclusion of obstetric history reviews using PMRT methodology in these cases and will collaborate with partner hospitals to promote robust and consistent review processes.

Family

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

There have been an increasing number of families who are asking for a summary of the HMRG review relating to their CYP. This is provided. We do

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

External Benchmarking

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

Primary and Secondary Categories

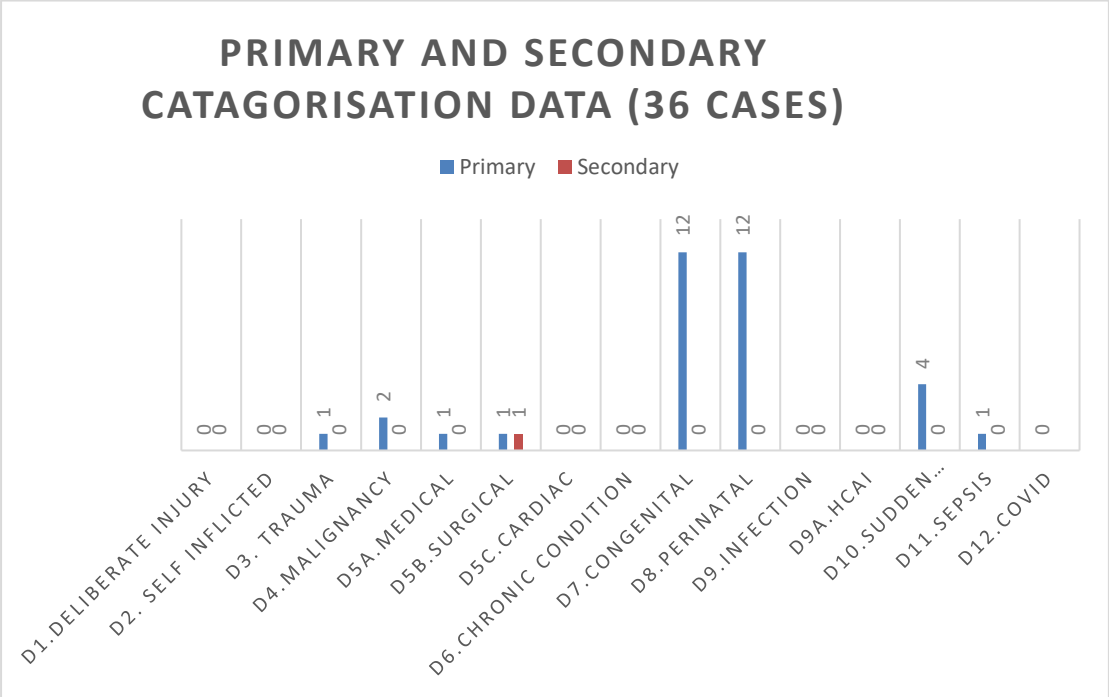


Figure 8

The cases reviewed so far in 2025, show that the highest diagnostic codes are jointly 'children with underlying chromosomal, genetic and congenital conditions' (33%) and Perinatal, when the cause of death is a complication of prematurity or neonatal causes. These are covered in more detail in the neonatal section.

The chromosomal, genetic and congenital conditions are often complex and vulnerable patients. These conditions, depending on the case, may be life-limiting or life-threatening and often the care they have received by AHCH, other health professionals and their families have enabled them to live longer than previously anticipated.

Recurrent Themes

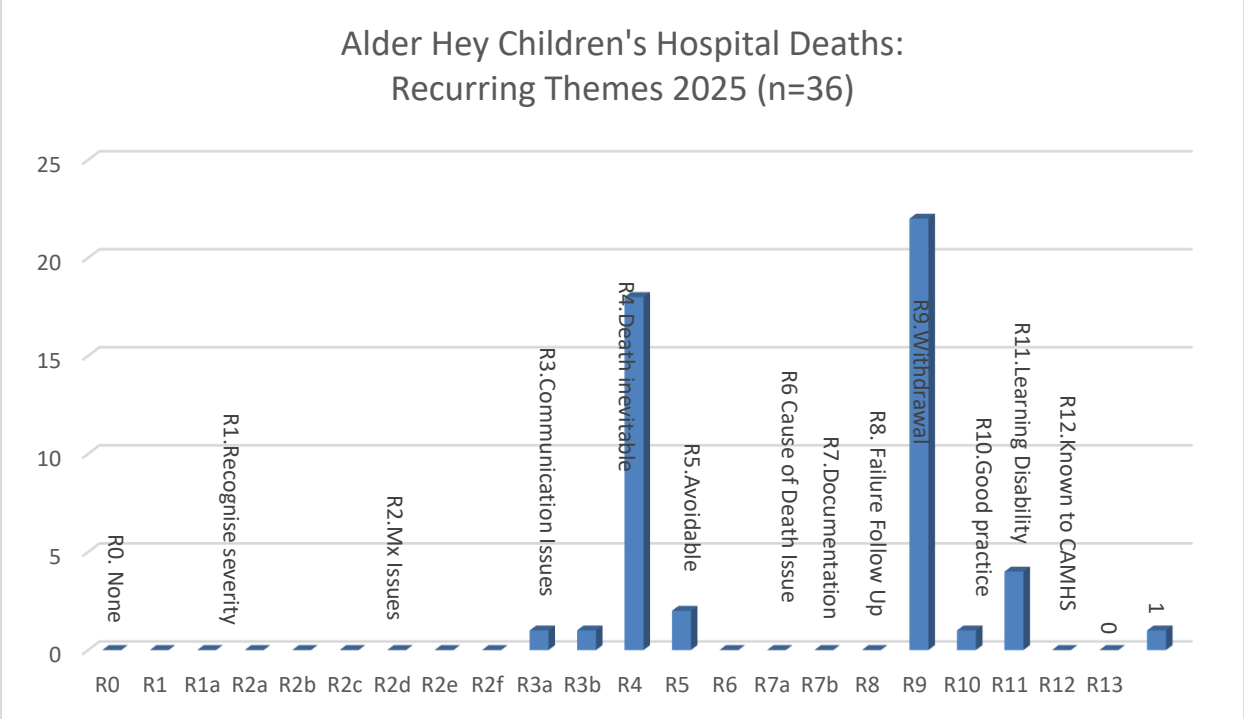


Figure 9

The main recurrent theme in 2025 to date, is withdrawal of life-sustaining care (61%). This demonstrates that the intensive care team are working with families to ensure that no CYP suffers unnecessarily when available treatment options or continuing treatment are no longer felt to be in the best interests of the CYP.

The next most common theme is when death was concluded to be inevitable in 50%, regardless of the care and expertise that was provided at AHCH. This category also includes the cases where death was inevitable with hindsight. These cases are included to highlight that it is not a reflection on the care AHCH provides as children are transferred for investigations which then indicate conditions which are life-limiting.

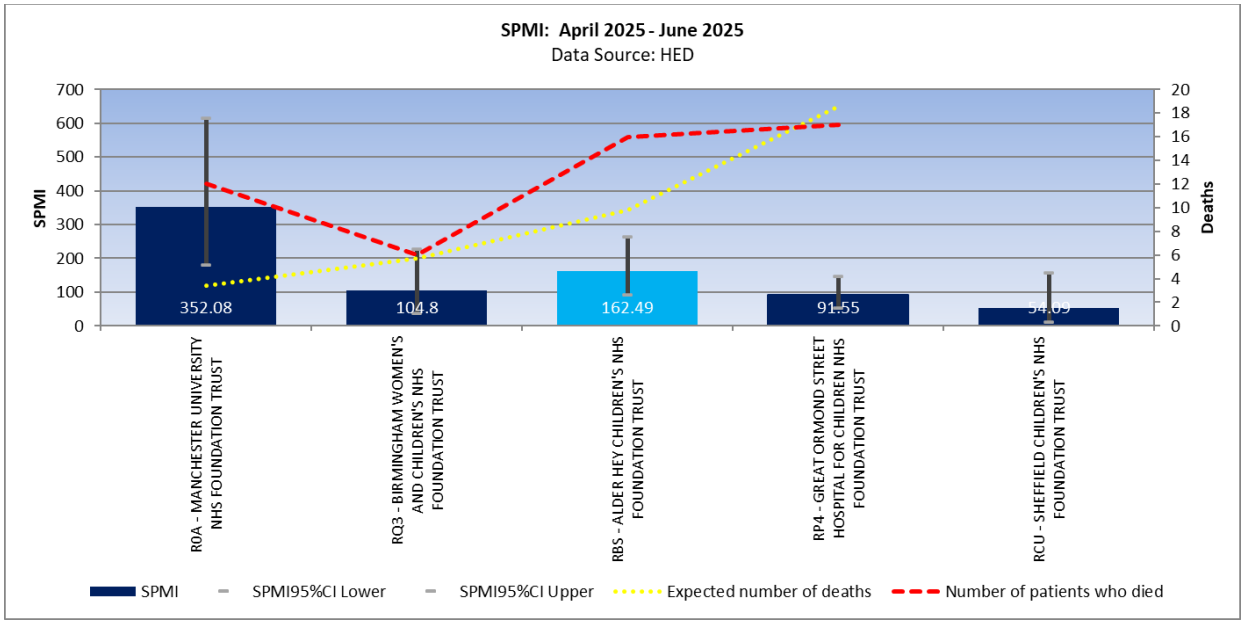
The LD and avoidable deaths have been discussed earlier in the report.

Section 2: Quarter 2 Mortality Report: July 2025 – Sept 2025

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the most recent available period covering April 2025 to June 2025.



The chart shows that Alder Hey recorded 16 deaths against 9.8 expected deaths. These figures as can be seen below are outliers in relation to the surrounding data. In November and December, the actual number of deaths was below the expected level. April through to June show higher expected numbers, and then July returns to normal. All the cases have been reviewed in HMRG and there were no concerning features and Birmingham as our best comparator for workload had no such variation. It meant that the data submitted to HED was reviewed and there were errors identified resulting in incorrect expected death value.

The funnel plot below shows that SPMI remains within the funnel plot indicating mortality is under control.

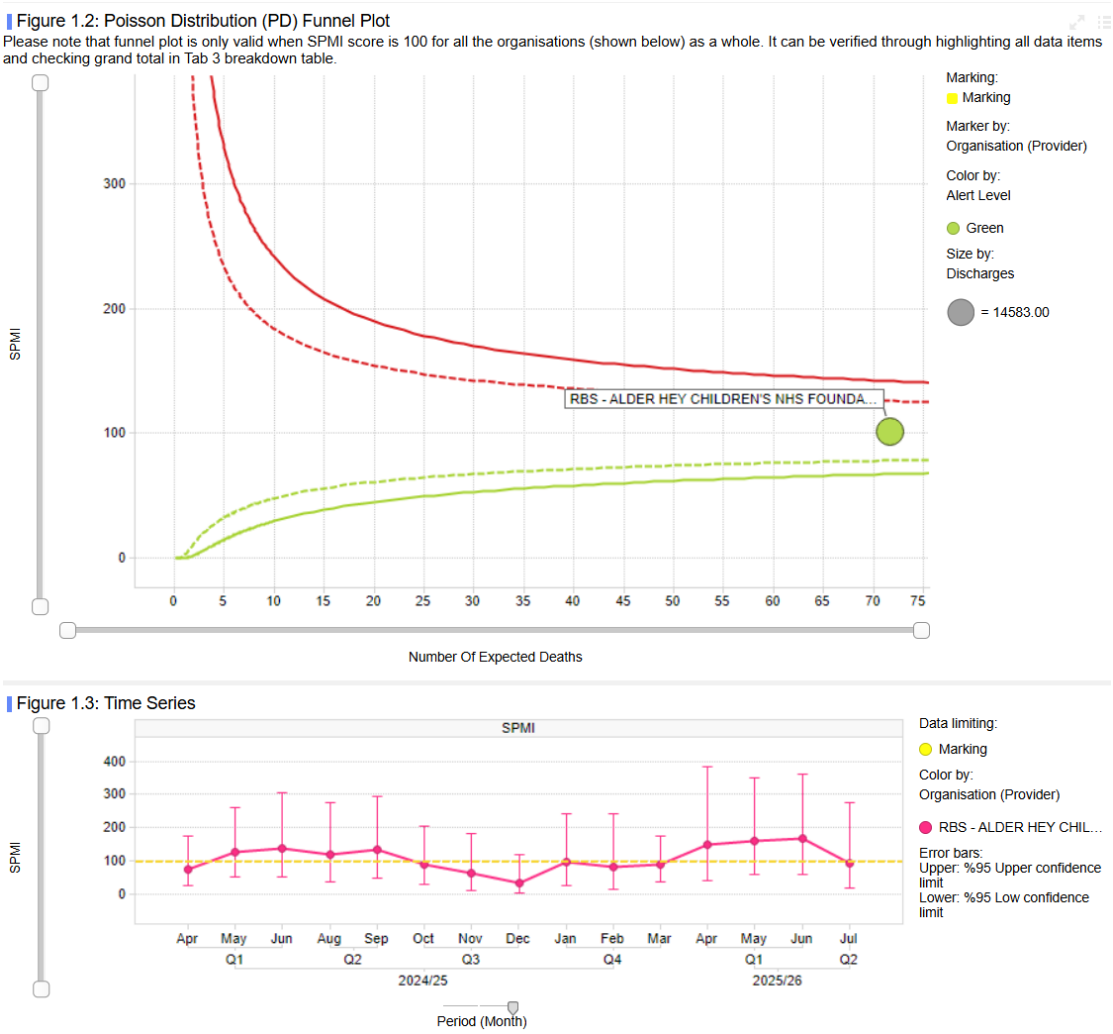


Figure 10

PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other Children's Trusts. In the most recent PICANet report (2024 2021-2023), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.

There was no evidence that any PICU had an excess mortality rate compared to what would be expected based on the level of sickness at the time of admission across the three-year reporting period. This is illustrated in Figure 11 based on inclusion of all SMR estimates being contained within the control chart limits.

Metric 5: Risk adjusted in–PICU mortality

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

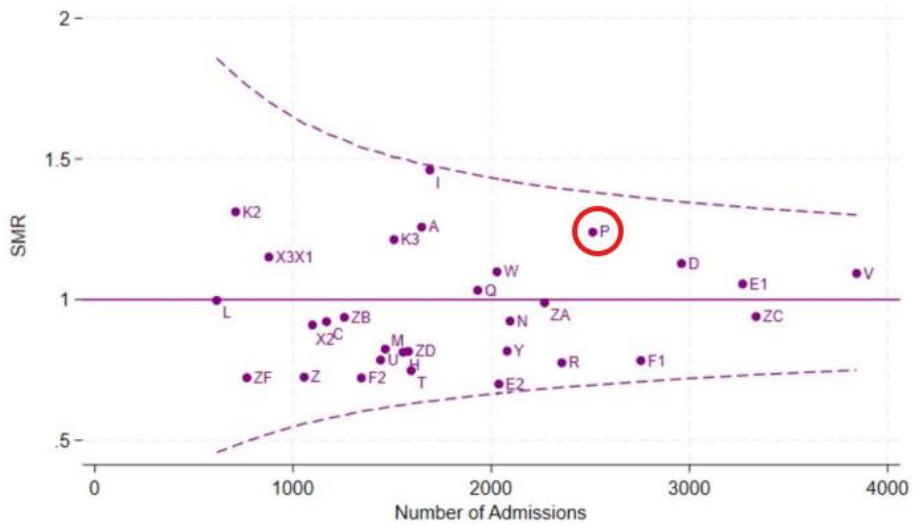


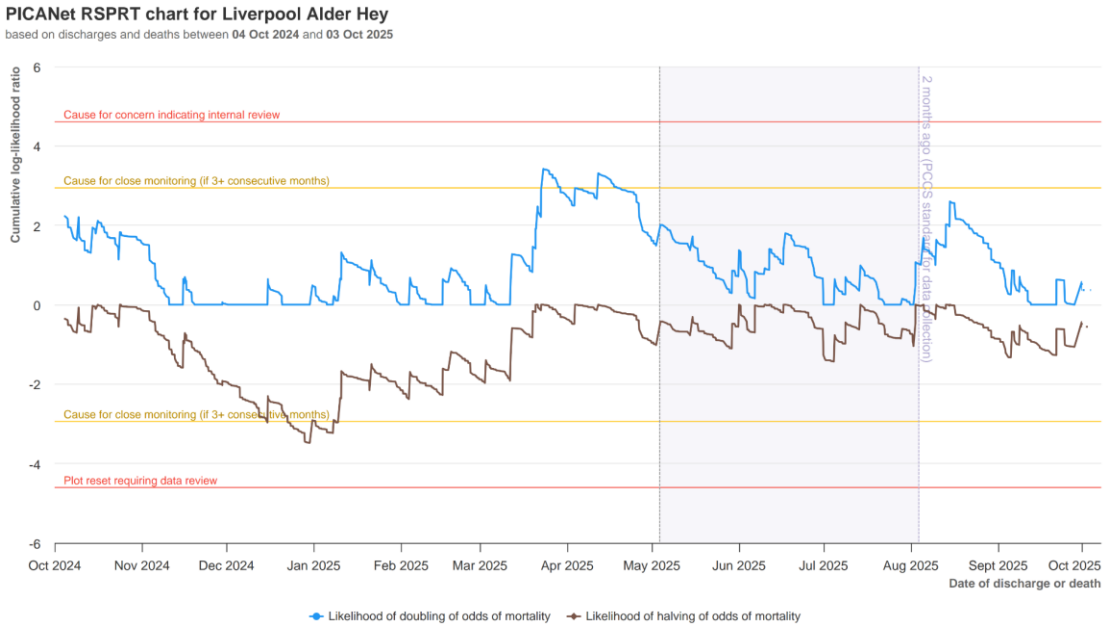
Figure 11

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

Statistical analysis of mortality:

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

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



https://laser-picanet.leeds.ac.uk/reports/RsprtChart.aspx

In the period Apr – June 2025 there were 13 deaths on PICU. There was one case that required legal process, with a prolonged length of stay >9 months. Outside of this, the median, mean and max length of stay was 2 days, 12.2 days and 71 days respectively. The RSPRT was observed to settled from a cumulative log-likelihood ratio of just above 3 back into the 'safe zone'. It did not remain elevated for a sustained period (<1 month, with trigger set at >3 consecutive months), reflecting expecting fluctuations. Most cases (54%) were categorised as multi-organ system failure (MOSF).

Real time monitoring of mortality

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

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

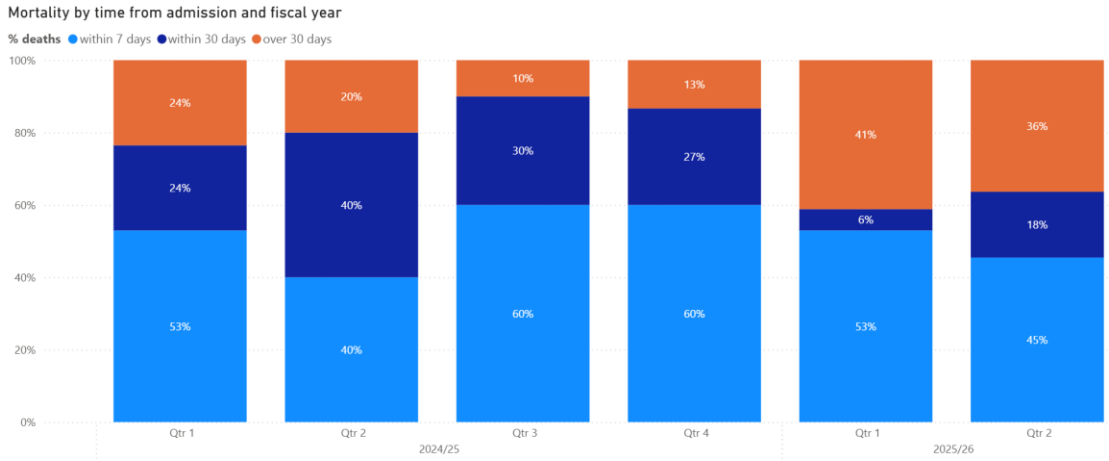


Figure 12

The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, 40-60% of deaths occur within this time frame. In the recent quarter April 2025 – June 2025, 45% of deaths occurred within 7 days of admission, 18% occurred within 8-30 days from admission, and 36% of deaths occurred over 30 days from admission. The fact that 36% of deaths occur over 30 days post-admission reflects the tumultuous recovery period many patients experience. During this time, we explore all medical options with input from a multidisciplinary team to provide comprehensive care. This underscores the complexity of recovery and the need for ongoing monitoring and support. The 45% within 7 days shows how unwell these CYP are and would include those that are coded as death inevitable regardless of care provided.

Conclusion

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

A broader analysis of mortality data, clinical governance, and thematic findings across Alder Hey Children's NHS Foundation Trust highlights a culture of transparency, learning, and continuous improvement. Mortality rates this quarter show an unexpected discrepancy between actual and expected deaths. However, it is likely that this can be explained by the inaccuracies of the data submitted to HED resulting in an unusually low expected death figure. The data submitted did not have accurate coding on relating to what the CYP died of thus resulting in the lowest category being assigned inaccurately. This has been

highlighted and should not happen again, but it may not be possible to correct the incorrectly submitted data that has already occurred.

The implementation of the Medical Examiner (ME) process and further integration of HMRG have enhanced oversight and multidisciplinary input into complex cases.

Efforts to improve cohesive specialist antenatal counselling and focus on accurate and timely documentation, demonstrate the Trust's commitment to safe, compassionate, and high-quality care.

Concerns regarding the variation regarding the expectations of families transferring out of the neonatal environment were highlighted and work is on-going to try and address the unrealistic expectations regarding staffing and environment. Other than this no other concerns or adverse trends have been identified across learning disability, neonatal, or general paediatric deaths. The Trust's proactive stance evident in initiatives like the neonatal audit and its decision to continue reviewing all relevant deaths beyond national requirements, demonstrates a forward-thinking, robust approach to mortality governance.

References

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

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

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

BOARD OF DIRECTORS

Thursday, 8th January 2026

Paper Title:	**Organ Donation 2024 - 2025**
Report of:	**Alder Hey Organ and Tissue Donation Committee**
Paper Prepared by:	Dr. Carla Thomas – Clinical Lead Organ Donation

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

Does this relate to a risk? Yes ☐ No ☑

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

Risk Number	Risk Description	Score

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

1. Executive Summary

Every family of a child who is approaching the end of their life and has the potential to donate organs, should be offered this choice and this choice should always be fully explored.

In 2024-2025 Alder Hey Children's NHS Foundation Trust referred 24 potential organ donors to NHS Blood and Transplant (NHSBT) organ donation service. There were no occasions where potential organ donors were not referred.

There were 4 medically suitable eligible donors. The families of 2 medically suitable eligible donors were approached for organ donation. 1 family was not approached due to the coroner and forensic pathologist refusing permission for organ donation. 1 family was not approached due to the patient subsequently being assessed to be medically unsuitable.

The specialist nurse for organ donation was present for 1/2 of the organ donation discussions.

Of the 2 families who were approached for organ donation in 2024/2025, 1 family gave consent for organ donation.

In 2024/2025, Alder Hey Children's NHS Foundation Trust had 1 DCD solid organ donor, resulting in 4 patients receiving a transplant.

2. Background and current state

Organ and tissue donation saves and improves the lives of thousands of UK citizens every year. It can offer comfort to the families of donors through the knowledge that something remarkable came from their loss.

National Strategic Plans

- **UK Paediatric and Neonatal Deceased Donation - A Strategic Plan [2019]**
  - Aim to significantly increase the rates of paediatric and neonatal deceased donation in the UK.
  - Aim to normalise practice, minimise variation and promote excellence in care, ensuring that donation is considered a routine part of end-of-life care, especially in the intensive care setting.
  - Aim to confidently assert that every family of a child who is approaching the end of their life and has the potential to donate organs, will be offered this choice and this choice will always be fully explored.
- **Organ Donation and Transplantation 2030: Meeting the Need - A ten-year vision for organ donation and transplantation in the UK [2020]**
  - Living and deceased donation will become an expected part of care, where clinically appropriate, for all in society.

3. Main body of report

Alder Hey Children's NHS Foundation Trust's Organ and Tissue Donation Committee (OTDC) was established in 2022. The primary remit of the ODTC is to influence local policy and practice to ensure that deceased organ donation is considered in all appropriate situations. Secondary roles include championing deceased donation within the Trust to hospital staff and visitors and promoting donation to the wider local community. These are the four domains of the ODTC which will be outlined in this report.

3.1. Performance – Ensure there are no missed donation opportunities.
3.2. Policy – Ensure the hospital policies and guidelines support organ donation, are up to date and are in line with national guidance.
3.3. Education – Ensure that any staff who may care for a potential donor are adequately trained.
3.4. Promotion – Ensure public engagement through opportunities within both the hospital (like the annual Organ Donation Week) and local community.

3.1 Performance

Every death on PICU is audited by NHS Blood and Transplant (NHSBT) to assess if best practice is followed in relation to the identification and referral of potential organ donors (Actual and Potential Deceased Organ Donation Audit).

Between 1 April 2024 and 31 March 2025, there were **58** audited deaths in Alder Hey Children's NHS Foundation Trust Paediatric Intensive Care Unit (PICU).

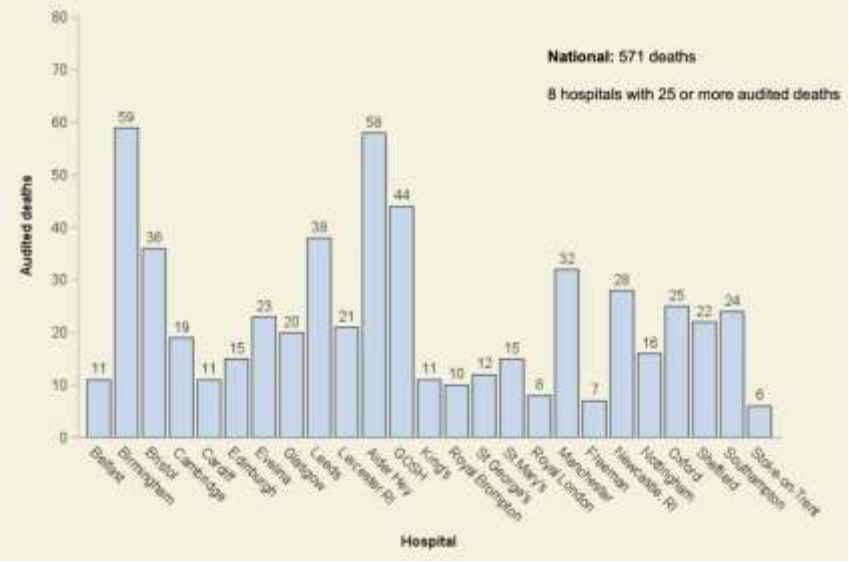


Figure 1.1 Audited deaths by hospital 1 April 2024 – 31st March 2025 [PICU benchmarking data]

3.1.1 Neurological death testing

Goal: Neurological death tests are performed wherever possible.

There was **1** patient in whom neurological death was suspected. This patient was tested for a diagnosis of death by neurological criteria. The 1 tested patient was confirmed to be deceased by neurological criteria.

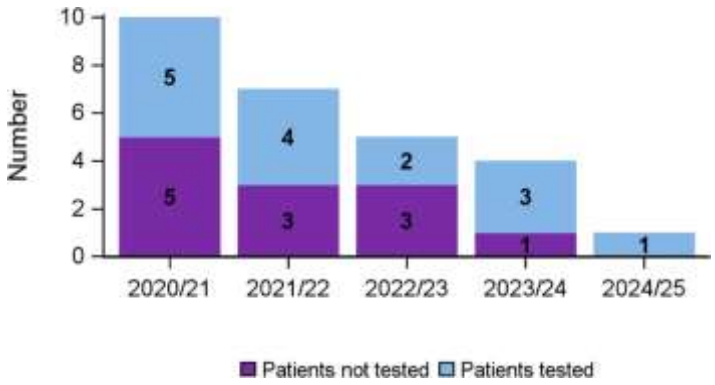


Figure 1.2 Number of patients with suspected neurological death at Alder Hey Children's NHS Foundation Trust

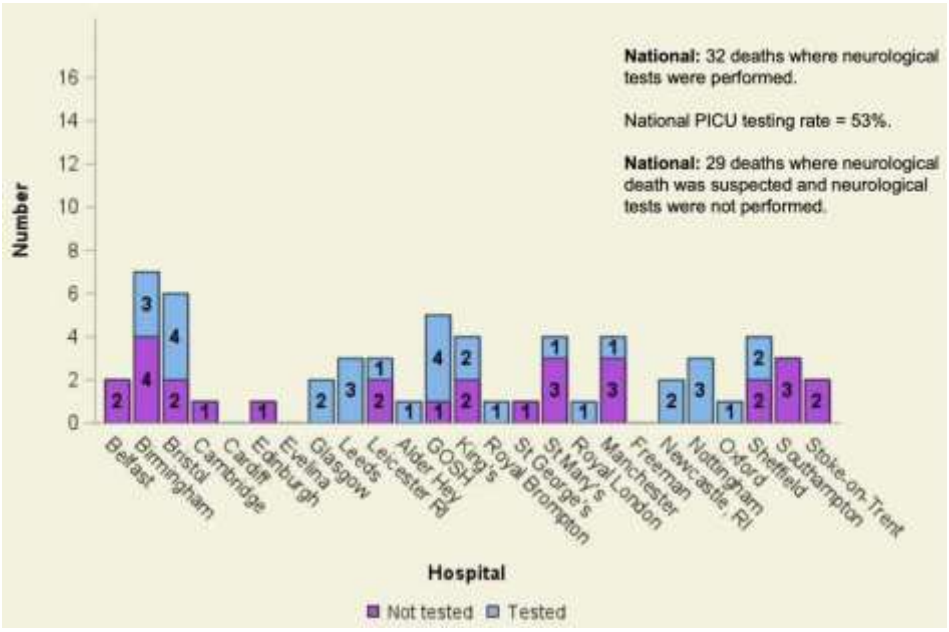


Figure 1.3. Number of patients with suspected neurological death by hospital 1 April 2024 – 31st March 2025 [PICU benchmarking data]

3.1.2 Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service.

Alder Hey Children's NHS Foundation Trust referred **24** potential organ donors to NHSBT during 2024/2025. 1 Potential DBD donor (a patient with suspected neurological death). 23 Potential DCD donors (a patient in whom imminent death following withdrawal of mechanical ventilation is anticipated). There were no occasions where potential organ donors were not referred.

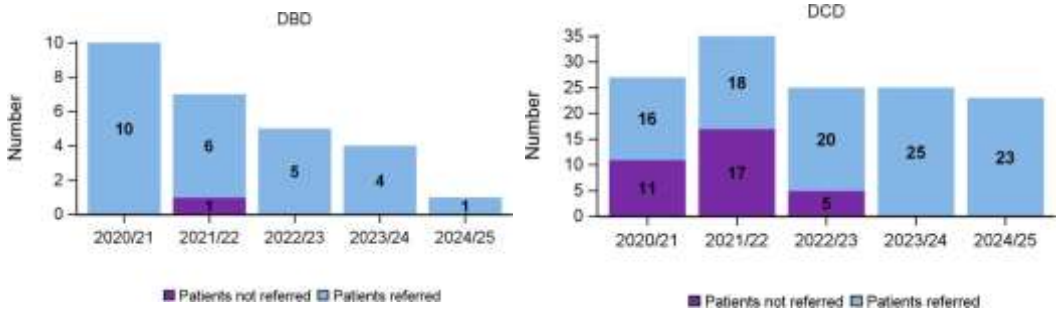


Figure 1.4. Referral of potential deceased organ donors at Alder Hey Children's NHS Foundation Trust.

15 of the referred potential donors were considered eligible donors (Eligible DBD donors – death confirmed by neurological tests and no absolute contraindications to solid organ donation. Eligible DCD donors – imminent death anticipated, and treatment withdrawn with no absolute contraindications to solid organ donation) by NHSBT.

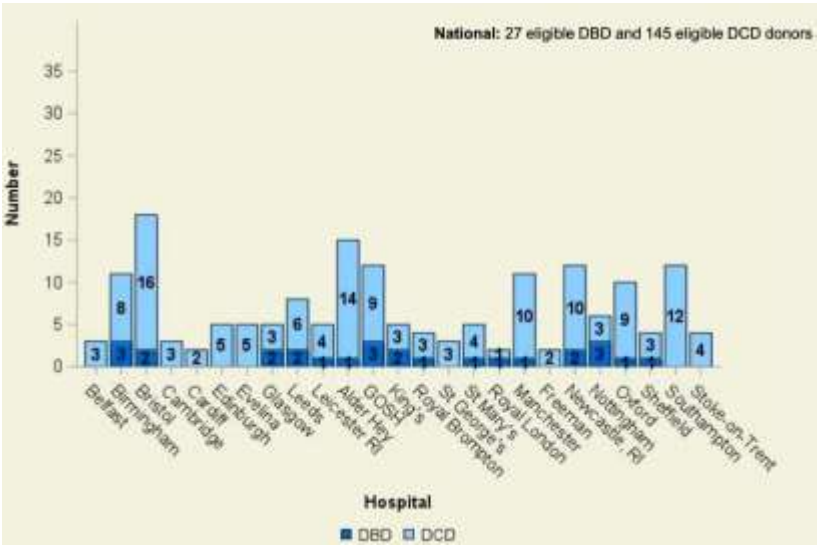


Figure 1.5. Eligible donors by hospital 1st April 2024 – 31st March 2025. [PICU benchmarking data]

3.1.3 Medically suitable eligible donors

There were 4 medically suitable eligible donors at Alder Hey Children's NHS Foundation Trust during 2024/2025. The families of 2 medically suitable eligible donors were approached for organ donation. 1 family was not approached due to the coroner and forensic pathologist refusing permission for organ donation. 1 family was not approached due to the patient subsequently being assessed to be medically unsuitable.

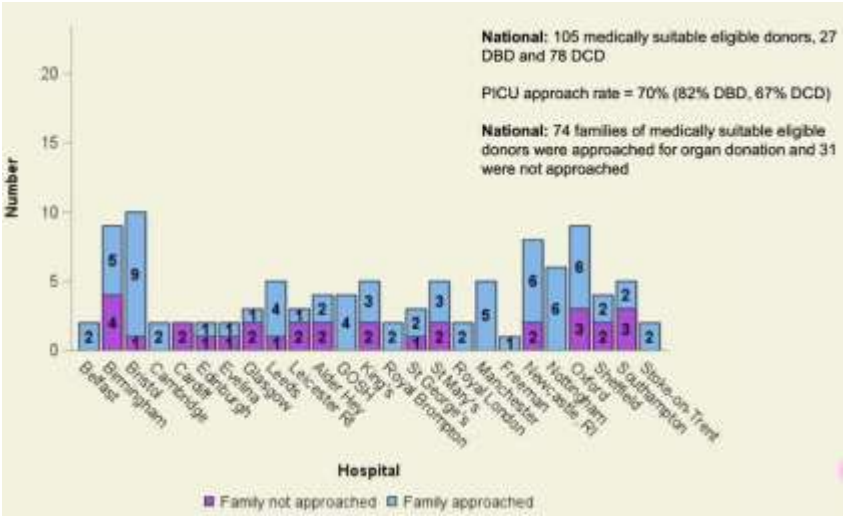


Figure 1.6. Medically suitable donors by hospital 1st April 2024 – 31st March 2025. [PICU benchmarking data]

3.1.4 Specialist nurse for organ donation (SNOD) presence at approach for organ donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

A SNOD was present for 1 organ donation discussion with family during 2024/25. There was 1 occasion where a SNOD was not present due to the SNOD not being able to attend within time frame that the family were willing to wait.

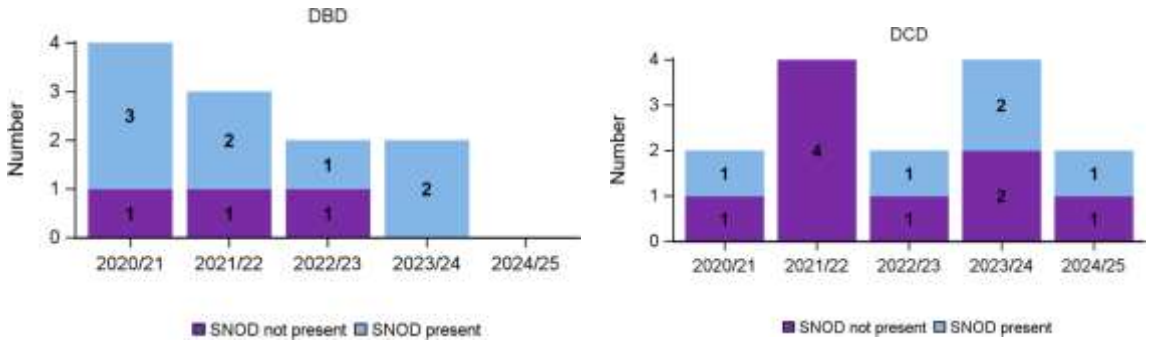


Figure 1.7. Presence of specialist nurse for organ donation during organ donation discussion with families at Alder Hey Children's NHS Foundation Trust

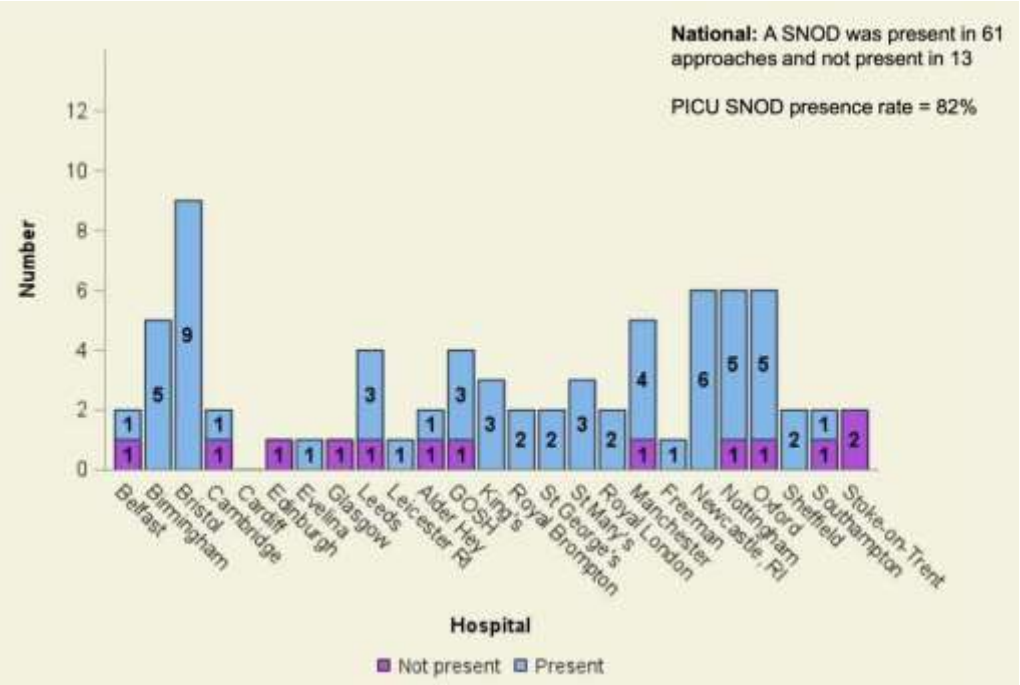


Figure 1.8. Presence of specialist nurse for organ donation (SNOD) by hospital 1st April 2024 – 31st March 2025.

3.1.5 Consent

Of the 2 families who were approached for organ donation in 2024/2025, 1 family gave consent for organ donation.

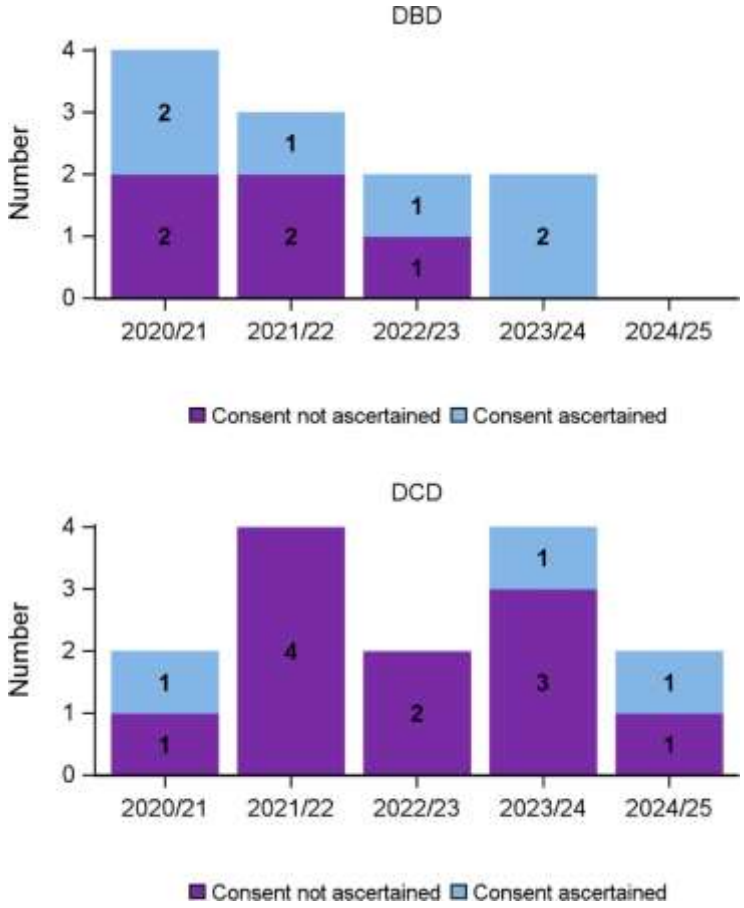


Figure 1.9. Consent for organ donation at Alder Hey Children's NHS Foundation Trust

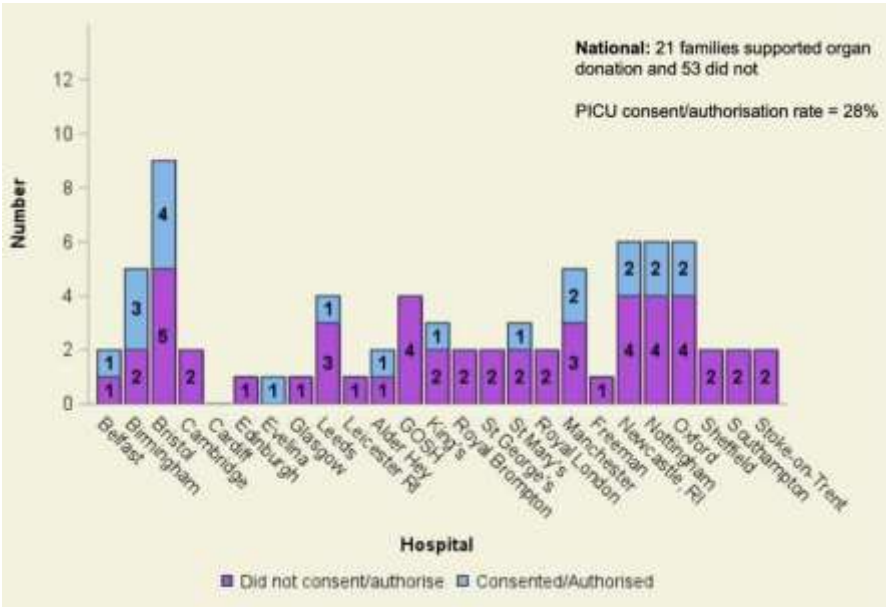


Figure 1.10. Consent for organ donation by hospital 1st April 2024 – 31st March 2025

3.1.6 Donor Outcomes

Between 1st April 2024 and 31st March 2025, Alder Hey Children's NHS Foundation Trust had 1 deceased solid organ donor, resulting in 4 patients receiving a transplant.

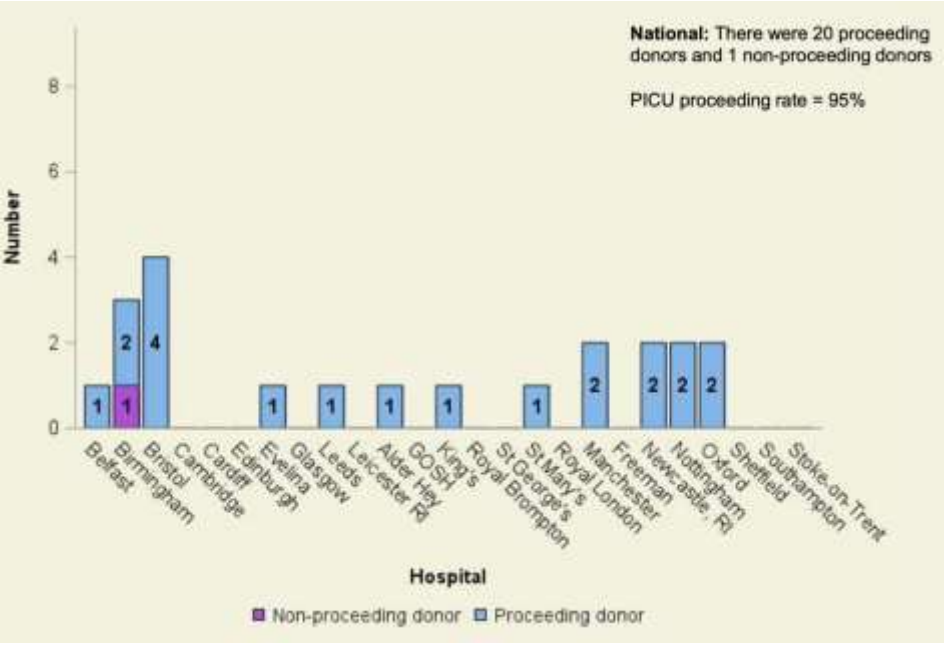


Figure 1.11. Proceeding organ donors by hospital 1st April 2024 – 31st March 2025.

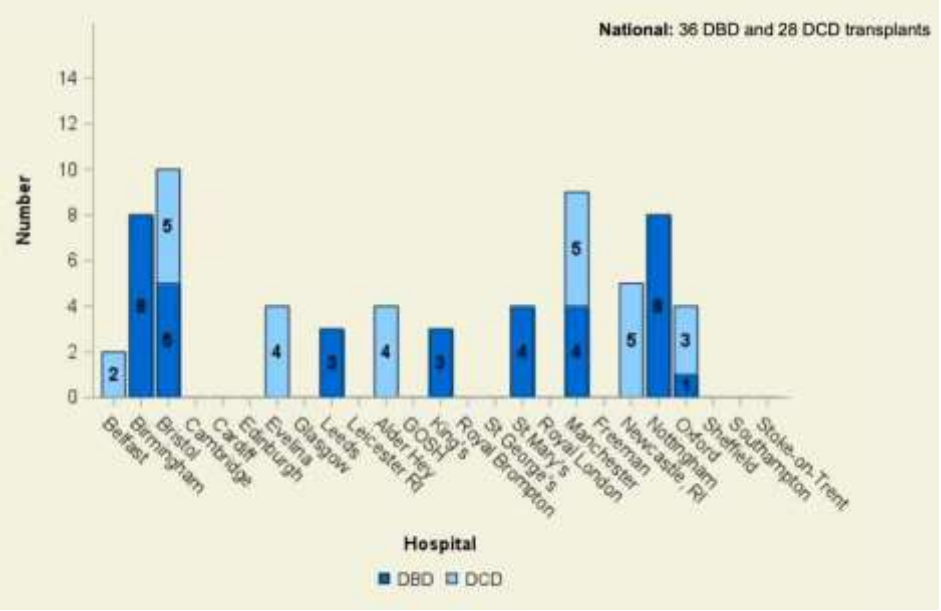


Figure 1.12. Transplants from proceeding donors by hospital 1st April 2024 – 31st March 2025.

3.2 Policy

There is an Organ and Tissue Donation Committee ratified clinical guideline, "Organ Donation [Paediatric intensive care]". This was updated in January 2025 to reflect the updates to the Academy of Medical Royal Colleges Code of Practice for the Diagnosis and Confirmation of Death and the Faculty of Intensive Care Medicine form for the diagnosis of death using neurological criteria.

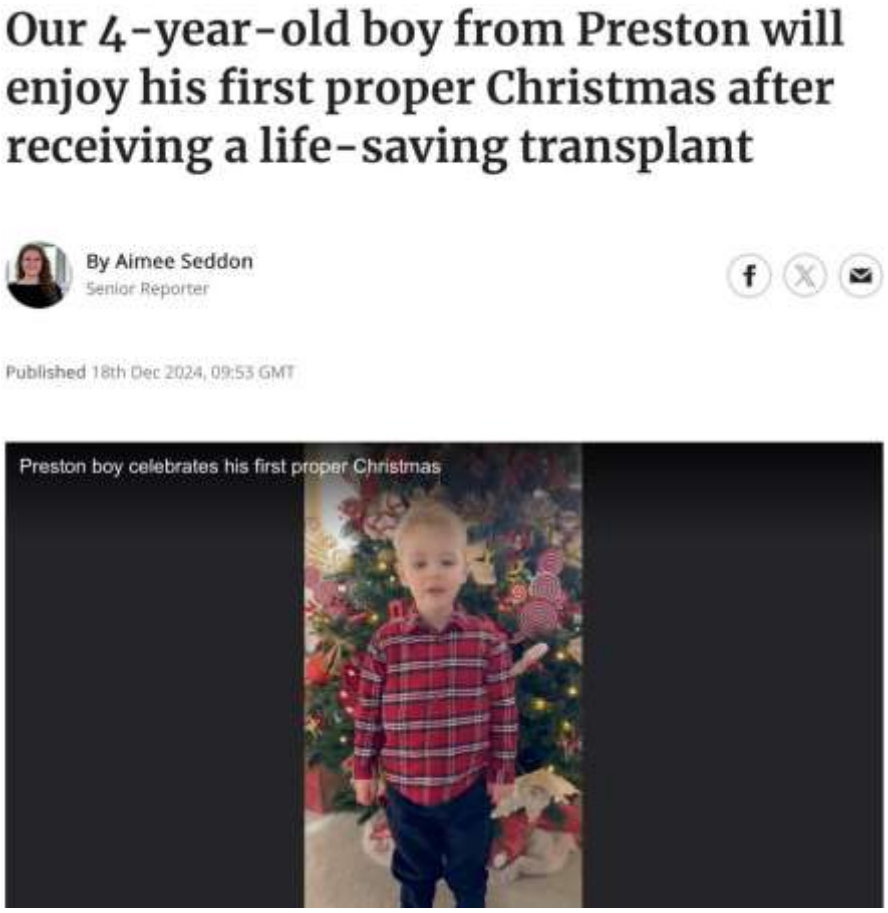
Additionally, there is an Organ and Tissue Donation Committee ratified standard operating procedure, "formal peer review of the process of organ donation as part of local PICU mortality review or other regular review meeting."

3.3 Education

In 2024/2025 the Organ and Tissue donation committee delivered education to Alder Hey PICU staff and theatre staff who may care for potential organ donors as part of a regular education programme.

3.4 Promotion

In 2024/2025 the Organ and Tissue donation committee promoted organ donation on the Alder Hey Children's NHS Foundation Trust website and across the social media channels.

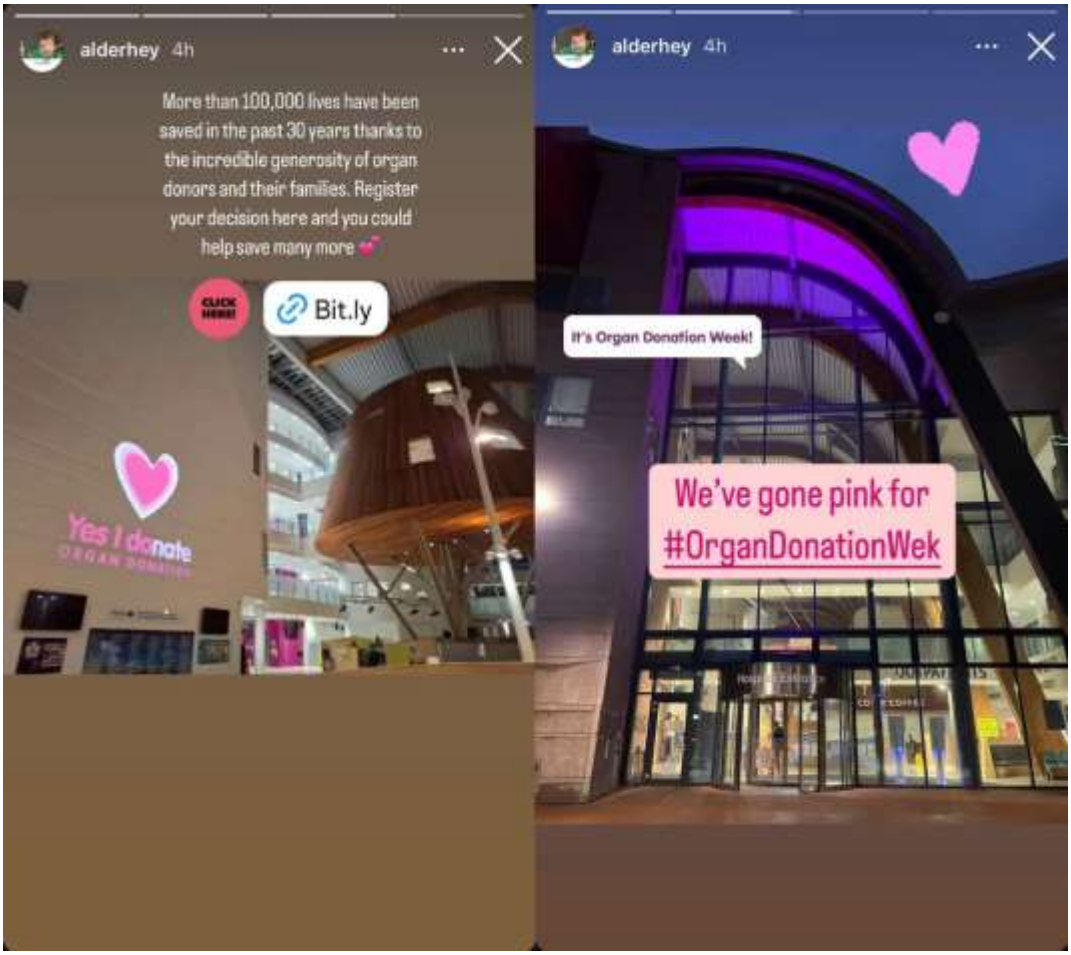


Our 4-year-old boy from Preston will enjoy his first proper Christmas after receiving a life-saving transplant

By Aimee Seddon
Senior Reporter

Published 18th Dec 2024, 09:53 GMT

We celebrated organ donation week Monday 23rd September to Sunday 29th September 2024.



4. Conclusion

The Trust Board can be assured that that every family of a child who is approaching the end of their life and has the potential to donate organs, will be offered this choice and this choice will always be fully explored.

5. Recommendations & proposed next steps

- Work with NHSBT to improve specialist nurse for organ donation (SNOD) presence during organ donation discussions with families.
- Champion and promote organ donation at Alder Hey Children's NHS Foundation Trust.
- Engage with national research to understand how we can support more parents to donate their children's organs after they die.

BOARD OF DIRECTORS

Thursday, 8th January 2026

Paper Title:	**Chair's Report from the Safety and Quality Assurance Committee meeting held on 17th December 2025**
Report of:	**Fiona Beveridge, Committee Chair**
Paper Prepared by:	SQAC Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information:	This paper provides a summary from the Safety Quality Assurance Committee meeting held on 17th December 2025, along with the approved minutes from the 26th November 2025 meeting.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑ **Strong Foundations** ☑
Resource Implications:	None

Does this relate to a risk? Yes ☑ No ☐

Risk Number/s	Risk Description	Score
BAF Risks 1.1 1.2 1.4	• Inability to deliver safe and high-quality services • Children and young people waiting beyond the national standard to access planned care and urgent care • Increased waiting and RTT times for children and young people to mental health services due to increased demand post Covid 19 and reduced support from partner agencies	3 x 3 =9 4x5=20 3x 5 = 15

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

1. Introduction

The Safety and Quality Assurance Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including clinical quality, clinical practice and clinical governance arrangements and activities within the Trust.

2. Agenda items received, discussed / approved at the meeting

Minutes of the meeting held on 26.11.25	Minutes Approved
Divisional updates	Reports x4 noted
Liverpool Neonatal Partnership Monthly update	Report noted
Risk relating to Pathways Trial of puberty-suppressing hormones for Gender incongruence	Report noted
QNCC Accreditation Alder Hey Community Eating Disorders Service	Report noted
Patient Safety update	Report noted
Patient Safety Incident Investigation (PSII) – Paralysis following Spinal Surgery	Report noted
Patient Safety Incident Investigation (PSII) – Never Event Wrong Route Medication	Report noted
Cleaning Standards Report	Report noted
Infection Prevention & Control Quarterly Report	Report noted
Fuller Recommendations Report	Report noted
AlderC@re Data Quality Demographic report	Report noted
Southport Incident Learning Review action plan	Report noted
Clinical Effectiveness and Outcomes Board Chairs Highlight Report	Report noted
Mortality Report Quarter 2 2025-26	Report noted
Board Assurance Framework	Report noted
Organ Donation Annual Report	Report noted
Improve My Life Chances report	Report noted
NICE Guidance Compliance Quarter 2 2025/26	Report noted
Bed and Bedrail Safety Policy	Policy Ratified
Clinical Audit & Service Evaluation Policy	Policy Ratified
C42 Dissemination of National Alerts Policy	Policy Ratified

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

None

4. Positive highlights of note

- SQAC engaged in substantive discussions on several key topics and acknowledged notable progress in various areas, while also recognising the presence of ongoing challenges.
- SQAC engaged in a thorough and comprehensive discussion concerning the risks associated with the Pathway trial of puberty-suppressing hormones for gender incongruence.
- SQAC welcomed the QNCC Accreditation Alder Hey Community Eating Disorders Service Report noted and noted the current progress made to date.
- SQAC engaged in a detailed and comprehensive discussion concerning the Patient Safety Incident Investigation (PSII) – Paralysis following Spinal Surgery.

- SQAC welcomed the Patient Safety Incident Investigation (PSII) – Never Event Wrong Route Medication and noted the current position
- SQAC welcomed the Patient Safety update
- SQAC Noted the Infection Prevention Control Report
- SQAC welcomed the Fuller Report and noted the progress made to date
- SQAC welcomed the Cleaning Standards report and noted the progress made to date
- SQAC welcomed the Alder C@re Data Quality Demographic
- SQAC welcomed the Southport Incident Learning Review Action plan and noted the current position, the progress to date and the next steps. For reference details of the completed actions associated with key recommendations to date is attached at Appendix 1
- SQAC welcomed the Organ Donation report and expressed thanks to C Thomas, for her continued support
- SQAC welcomed the Improve My Life Chances report and noted the ongoing progress
- SQAC welcomed the NICE Guidance Compliance Quarter 2 2025/26 report
- SQAC Noted the Board Assurance Framework
- SQAC Noted the Mortality report Quarter 2 2025-26
- SQAC received, Noted and Ratified the Bed and Bedrail Safety Policy
- SQAC received, Noted and Ratified the Clinical Audit & Service Evaluation Policy
- SQAC received, Noted and Ratified C42 Dissemination of National Alerts Policy

5. Issues for other committees

None

6. Recommendations

The Board is asked to note the contents of the report

Chair's Report from the Safety and Quality Assurance Committee meeting held on 17th December 2025

SQAC received the Action Plan following from the Learning Review into the Southport Incident and will receive monthly updates in the first place on implementation. The table below is shared with the Board as an overview of progress in implementation of the actions. Updated versions will be shared with the Board on a quarterly basis.

Progress on completion of actions associated with key recommendations to date

'AR' Internal Learning Review actions					
TOR	**No. Actions**	**No. Completed**	**No. on track**	**No. delayed**	**No. limited/no progress**
1 Engagement	**9**	**3**	**6**	**0**	**0**
2 Record keeping & Communication	**7**	**1**	**5**	**1**	**0**
3 Electronic Patient Records	**5**	**2**	**2**	**0**	**1**
4 Escalation	**3**	**0**	**1**	**0**	**2**
5 Safeguarding Supervision	**4**	**0**	**4**	**0**	**0**
6 Risk assessment	**6**	**0**	**5**	**0**	**1**
7 Prescribing	**5**	**0**	**5**	**0**	**0**
Totals	**39**	**6**	**28**	**1**	**4**

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 26th November 2025
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	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
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW
	Veronica Greenwood	Director of Allied Health Professionals	VG
In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
Observing	Jenny Devine	Governor	JD
Observing	Ava Kilbride	Governor	AK
	Jill Preece	Governance Manager	JP
25-26-172	Jacob Gray	Emergency Preparedness, Resilience & Response Manager	JG
25-26-173	Nichola Osborne	Associate Director for Safeguarding and Statutory Services	NO
25-26-182	Luke Oldland	Account Director, MITIE	LO
Apologies:	Nathan Askew	Chief Nursing Officer	NA
	Alfie Bass	Chief Medical Officer	AB
	Kelly Black	Interim Head of Nursing, Liverpool Neonatal Partnership	KB
	Susan O'Neil	Head of Neonatal Nursing, Liverpool Neonatal Partnership	SON

25/26/165 Welcome and Apologies
The Chair welcomed everyone to the meeting and apologies were noted.

25/26/166 Declarations of Interest - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

25/26/167 Minutes of the Previous Meeting
The Committee members were content to **APPROVE** the minutes of the meeting held on 22nd October 2025.

25/26/168 Matters Arising/Review of Action log
The action log was reviewed and updated.

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

25/26/169 Divisional Updates
Clinical Research Division
LR presented the Clinical Research Divisional update and drew attention to the following key points:-
Highlights:-
- The Division highlighted the effectiveness of band 6 deputies in filling nursing leadership gaps during October's half-term, showing the benefits of developing these roles.
- The long-standing risk regarding the CRF (Clinical Research Facility) door had been resolved with a full replacement; risk will continue to be monitored.

Challenges:
Division encountered challenges due to a loss of drinking water supply, which affected the provision of drinking water to patients, families and staff. The issue was fully resolved within 14 days.

- Research delivery team are under increased pressure due to vacancies not being replaced due to financial deficit connected to MRI and trying to close the gap. This issue had been escalated to the senior management team as the vacancies are not connected to the underperforming budgets and are going to limit the amount of income generation through commercial studies, as the Division would not have capacity to allocate research nurses. A risk had been added to Inphase, and progress is now being made to take these vacancies forward and explore alternative solutions for increasing MRI related activity across Futures.

Performance Metrics

- Three serious adverse events were reported, all related to oncology trials, with participants receiving chemotherapy, all children were monitored and reported to study sponsors, with no ongoing concerns noted.

GM requested confirmation that recruitment decisions are guided by clear business rationale, particularly in cases where staff contribute to income generation. LR affirmed that commercial study income and workforce levels are rigorously tracked, noting that failure to fill vacant positions would result in missed opportunities. LR advised of the establishment of a Steering Group for MRI finances, ensuring that challenges are proactively addressed.

Division of Medicine

CW presented the Medicine Division update and drew attention to the following few key points:-

Highlights:-

- The neurology risk profile and departmental culture demonstrated marked improvement, with high-risk in neurology decreasing to score of 16 following two years of targeted initiatives. Additionally, there was a notable increase in neurologist engagement.
- Two long-term, complex patients from Ward 3C had been discharged following a year of care.

Challenges:-

- The Metabolic service continues to be identified as a high-risk area with ongoing strategic discussions between Manchester and Alder Hey with the aim of establishing a sustainable service, addressing nurse and PCO appointments, general paediatric cover, and the review of SLAs and clinical pathways. Executive leadership is actively engaged in initiatives to mitigate these risks.
- Complication of Excessive Weight (CEW) Service – As a result of long term sickness there is significant pressure within the service. Therefore a review of the CEW service is under way within the medical division to establish the demand and capacity what clinicians are required and whether the service should sit under general paeds.
- Emergency preparedness training compliance had shown a gradual improvement; however, further training is scheduled for December 2025 to enhance progress.

GM highlighted the increasing demand on services due to excessive weights and sought clarity whether Public Health in the wider system is robustly addressing this. CW confirmed that there is joint collaboration and external engagement. AB suggested that it would be beneficial to obtain a view/input from R Isba to explore creative approaches to prevention and awareness.

FB noted the potential parallels between services across Cheshire & Merseyside and the Eating disorder services and suggested whether this may be for future cross-ICB conversations. CW agreed that system-wide progress is being made and welcomed further review to ensure all gaps are addressed.

Surgery Division

RP presented the Surgery Division update and drew attention to the following key points:-

Highlights:-

- Major trauma MDT meeting had led to a reset in governance and assurance processes, shifting the view of major trauma from a specialty to a support service and improving reporting and assurance mechanisms.
- A ward-based quality oversight report is being developed to centralise and triangulate key metrics, facilitating the identification of challenges and supporting enhanced data-driven decision-making. The launch is scheduled for the beginning of the new year.

Challenges:-

- A "Never Event" was reported involving a retained swab during a spinal procedure that required two incisions. The swab was identified and removed prior to the patient's awakening. This incident represents the third Never event occurrence involving separate teams, suggesting a systemic issue

with counting protocols across the surgical theatres. An external expert from the Walton Centre/AFPP has been engaged to conduct a comprehensive review of checking and counting procedures throughout all theatre areas.
- Challenges in monitoring neonates discharged from Liverpool Women's Hospital and ensuring appropriate follow-up when they are subsequently seen at Alder Hey. To address this, a new overview process had been implemented to support tracking and outcome follow-up during the initial four weeks of life.
- Challenges with EPR/SMOC-related training compliance, with a divisional training day planned to support the small number of staff who still require training.
- All BCPs (business continuity plans) are on trajectory to be completed and signed off by the end of the month.

KB expressed concerns regarding the increasing number of overdue incidents and investigations across Divisions, questioning the patient safety risk and suggesting a review of barriers to timely incident closure. KB also observed recurring references to illness, burnout, and fatigue, emphasising their connection to patient safety.

RP explained that many incidents remain open due to ongoing investigations or actions, and not neglect, and suggested a tolerance level for overdue incidents may be appropriate. RP highlighted the difficulty of coordinating clinician schedules for investigations.

JR concurred, noting staff capacity as a limiting factor and that urgent actions are prioritised for rapid implementation. The issue would be discussed at the Patient Safety Board.

GM asked if the three retained item Never Events were atypical and sought clarity regarding what had changed. RP clarified that retained items were not previously a trend and suggested the need for team-specific adaptation to counting standards. RP recommended reviewing near misses and no-harm events for further insight.

JD sought clarification on the procedure classification (one vs. two procedures) and the process for ensuring clarity pre-operatively. RP explained the specifics of the case and the need to revisit double scrub protocols and team-specific safety standards.

FB acknowledged the progress on emergency preparedness and the value of the new quality oversight approach.

Community and Mental Health Division

JP presented the Community & Mental Health Division report and drew attention to the following key points:-

Highlights:-

- Review of HCA positions across the Division for 13 HCA'S which had led to a successful adjustment to their pay scale which had contributed to improved workforce retention, particularly within Outpatients and Sunflower services.
- The new neurodevelopmental diagnostic pathway, Sunflower House, was launched on 1st September and would combine ASD and ADHD services with integrated digital support. Initial implementation had encountered some minor challenges; however, the key objectives are to enhance service delivery, minimise duplication of effort, and significantly decrease waiting times. A comprehensive review is scheduled for the conclusion of Quarter 4, following six months of data collection.

FB proposed that the Quarter 4 review be designated as a separate agenda item to facilitate broader organisational learning.

ES noted public inquiry interest regarding the new pathway and recommended ongoing SQAC oversight of the improvement plan.

Challenges:-

- Ongoing environmental and staff challenges at Sunflower House, with close collaboration with NHS England and Trust teams to resolve.
- Ongoing impact of the Public Inquiry on staff capacity and emotional wellbeing.
- Impact of vacancies in clinical services and administrative support, particularly within booking and scheduling.

Performance metrics

- October saw the highest number of incidents reported, linked to acuity challenges at Sunflower House.
- Business continuity plans: Following a quarterly data cleanse, Business Continuity Plans were designated as 'non-compliant' as they utilised an outdated template that has since been updated. Efforts are currently underway to migrate all plans to the new template.
- Significant improvement in complaint handling was noted.
- PALS responses remain in the 80% range.
- Increase in incidents of staff receiving racial abuse from the public, prompting an action within the Division to discuss with the REACH network and to monitor staff and seek ways to support and understand this issue. The Division have also had an increase of parents filming of staff and uploading to social media, the Division are liaising with the Comms team and the Information Governance Team in this regard. LR confirmed similar racial abuse incidents which had been received within the Clinical Research Division and hospital settings, with staff concerns about children's safety. LR contacted the Director of Culture & OD with liaison from staff in the SALS team who had also liaised with the Head of Equality, Diversity & Inclusion to seek wider input from across the Trust.

FB advised that the People & Wellbeing Committee had discussed this issue on 19.11.25 and that further work was planned following the discussion at the People & Wellbeing Committee.
Resolved: FB confirmed that she would inform the Chief People Officer and the Chair of People & Wellbeing of the concerns raised at SQAC. FB encouraged continued reporting and escalation, ensuring all of the incidents are separately recorded and raised.

AB highlighted that whilst the Respect at Work Policy exists, it is not sufficiently visible or brought to life for frontline staff. AB suggested raising its profile, improving support, and making expectations more visible via the Trust social media channels and via the Trust website, including narrative regarding a contract between practitioners and families. AB proposed that through AB, the Executive team and through SQAC to agree some actions to enable the visibility and support through training and awareness of the Respect at Work policy, through the REACH network and via the communications team to ensure visibility and confirm what is appropriate etc. FB requested AB to address the issue of recording of staff.

JD suggested involving the international nurses staff committee to involve these colleagues and potentially whether they could lead on this to enable a voice for colleagues experiencing racial abuse. FB confirmed that AB would feedback to the People & Wellbeing Committee and to ensure that the Chief People Officer is included in any discussions.

CW referred to previous incidents of filming of staff in 2024 on Wards 3C and 4C and stated that the Division of Medicine had implemented training and support for staff, a zero-tolerance policy was applied and on admission the policy was made clear for all for families, if families did not adhere to the expectations of the policy, this would be raised and addressed. CW highlighted the importance of clear expectations, escalation to senior staff as needed, and a focus on early training, support, and strict enforcement.

FB emphasised the importance of communicating this information effectively to all relevant parties, ensuring visibility for both outpatients and inpatients.
Resolved: AB and Exec colleagues to raise visibility and support for the Respect at Work policy, including comms and training.
AB requested further clarity regarding the Sunflower House risks, including safety culture and ongoing investigations.
JP explained the critical situation and stated that there is a new Head of Service in post. JP referred to an unhelpful culture within the unit and advised that the Senior Leadership Team are working closely with NHS England involvement.

Several individual investigations into incidents are currently underway, alongside direct inquiries from both HR and safeguarding perspectives, all conducted with thoroughness and diligence. The Divisional Director continues to keep the Executive Team fully informed of all developments. JP advised that at present, the unit is closed to new referrals, with only a small number of children remaining on the unit. The primary focus is on maintaining safety and providing support to staff.

GM referenced the ongoing "reset" at Sunflower House and discussed how the mix of clients can affect staff morale and unit stability. JP highlighted the importance of understanding the unit's purpose, as well as the need for greater awareness regarding child development and complex mental health needs in young children. Efforts are being made to avoid closing the unit during this reset by bringing in additional staff and collaborating closely with current team members. Clear communication remains a key priority throughout this process.
Resolved: SQAC **NOTED** that the Community & Mental Health Divisional leadership team is monitoring this issue very closely, and there is upward reporting to Executive team.
RESOLVED: SQAC received and **NOTED** the Divisional Assurance Reports.

25/26/170 Liverpool Neonatal Partnership update
Resolved: SQAC received and **NOTED** the Liverpool Neonatal Partnership update.

---- Safe ----

25/26/171 Patient Safety Update
JR presented the Patient Safety update and drew attention to a few key points within the report:-
Highlights:-

- Patient Safety Board met in October 2025; however, the meeting was not quorate, and no decisions could be taken. This update pertains to September data. There was a decrease in the number of incidents reported in September, the level of harm continues to decrease.
- The recent Never Event in the Surgery Division was reported to CQC and commissioners and is being investigated within timescales, with findings to inform a wider quality improvement project around NatSIPPs.
- An increase in restrictive practice incidents was noted, correlating with reports from Sunflower House.
- In September, two category 2 pressure ulcers were identified. One case was subsequently downgraded, while the other, occurring within the Surgery Division, remains under review.
- There was a decrease in complaints responded to within 25 working days, attributed to the complexity and length of complaints.
- Several quarterly reports were presented, including a comprehensive update on the Deteriorating Patient workstream, with extensions to some deadlines.
- The PEWS dashboard is now live, and an open forum is scheduled to update staff on progress.
- A trial of the HDU transfer nurse role is ongoing within existing budgets.
- No transfusion harms were reported.
- No gaps in action plan deadlines were noted

Challenges:-

- Challenges were noted regarding the use of multiple systems for maintaining compliance with Medical Device safety training, leading to complexity; a workstream had been developed with L&D to address this and would report back to Patient Safety Strategy Board.
- Shortage of wheelchairs in the Trust is affecting patient movement from entry to clinic and A&E; a scoping exercise is ongoing with the Medical Device team and would be reported back to Patient Safety Strategy Board.
- There had been a decline in consent documentation and risk assessment for transfusion; a working group is reviewing the pathway and would provide assurance to Patient Safety Strategy Board.
- Four-week timescale for completion of after action reviews is proving difficult due to lack of staff capacity; the timescale is under review.

KB commented positively on the momentum in the AMR workstream, noting improved data despite challenges with accuracy and the absence of IC Net; JR confirmed progress and ongoing work with the labs and data metrics.
Resolved: SQAC received and **NOTED** the Patient Safety update

25/26/172 EPRR Annual Report 2025
JG presented the EPRR Annual Report and drew attention to a few key points within the report:-

- Of the 62 relevant core standards, the Trust demonstrates full compliance with 48 standards and partial compliance with 14, with no instances of non-compliance identified. This assessment had been corroborated by the ICB's audit. This represents a significant improvement compared to previous years.

- Partial compliance gaps are detailed in the appendix and include resourcing of the EPRR function, some incident response plans, and a small section of hazmat/CBRN exercise reporting.
- Two main risks are maintained: Major incident disruption to statutory duties (risk will be reviewed after updated plans and exercises) and Business Continuity Incidents (scored higher due to ongoing divisional controls).
- Improvement focus for the next 12 months: include Robust incident response plans, inclusion of subject matter experts, and further development of the business continuity management strategy, including audits (currently limited by resourcing).

FB noted that regular EPRR updates improved visibility and assurance and expressed satisfaction with recent progress and upcoming plans and confirmed the report's submission to the Trust Board.

Resolved: SQAC received and **NOTED** the EPRR Annual Assurance Report and self-assessment assurance rating of partial compliance in line with the NHS England EPRR Core Standards for 2025 and **NOTED** this would be presented to Trust Board to fulfil ICB and NHS England transparency requirements.

--- Caring ----

25/26/173 Safeguarding Reports

Annual Safeguarding Report

NO presented the Annual Safeguarding Report and apologised for its late submission to SQAC. NO confirmed that the report provides a summary of information previously presented to SQAC and includes data from Quarter 4.

- 18 LADO processes were managed regarding allegations against staff.
- A total of 805 staff members had completed Level 3 Safeguarding training. However, 95 training slots were unfilled due to non-attendance, challenges with safeguarding training compliance persist.
- The Safeguarding team contributed to 24 rapid review requests, representing a 60% increase compared to the previous year. The team continues to observe a consistent upward trend in this area of work.
- Safeguarding Meditech Order Dashboard had been developed, with supporting information included within the Safeguarding Annual Report last year.

Highlights:-

- Significant assurance was noted from the MIAA review.
- Actions undertaken concerning the Fuller Phase One Inquiry Report
- Ensuring exemplary leadership in promoting sexual safety within the NHS.

Challenges:-

- The absence of certain named professionals had impacted the team's capacity. Following investment secured at the conclusion of the previous financial year, the team faced challenges ensuring that recruitment processes effectively brought new staff onboard.
- Alder Hey's engagement with the Local Authorities regarding their respective improvement processes, as well as contributions to the Local Safeguarding Children Partnership Boards, remains a complex challenge. The organisation interfaces with Liverpool, Sefton, and Knowsley—all of which are undergoing ongoing improvement efforts that require active participation from health partners.
- Ongoing challenges were noted regarding the Southport Response in terms of the Safeguarding response and the Safeguarding response to the contributions to internal review which had resulted in significant capacity challenges.
- Priorities for the Financial year ahead: Reviewing SOPs/policies, digitalisation of the service, improving patient experience improvement, and reviewing child death statutory processes.

FB noted the significant increase in the Safeguarding workload and the ongoing challenges.

Resolved: SQAC received and **NOTED** the Safeguarding Annual Report

Quarter 2 Safeguarding Report

NO presented Quarter 2 Safeguarding Report and drew attention to a few key points within the report:-

- The Safeguarding team received 8 Rapid Review requests within Quarter 2
- 255 people had been trained at Safeguarding level 3
- There had been 60 people who had failed to attend Level 3 Safeguarding training

- The Safeguarding Team had received 823 Multi-Agency Safeguarding Hub (MASH) requests in relation to 1640 children and young people, with 1% of those requests breached.
- The Safeguarding Specialist Nurse received 759 Meditech orders in Quarter 2. It is important to note that some Meditech Order activity was potentially lost in Quarter 2 due to initial technical difficulties experienced as part of the Safeguarding Team Digital Project Go Live on 1st July 2025

FB stated that SQAC had escalated to People and Wellbeing Committee the issues raised previously regarding staff failing to attend mandatory training. The People & Wellbeing Committee are considering what actions are required to address this issue, FB envisaged that detail would be provided in due course.

GM referenced the Families First Partnership and the establishment of multi-agency child protection teams, raising questions about the implementation at Alder Hey given the complexity of the multi-partnership environment.

NO indicated that the Families First agenda is newly introduced, with each Local Authority creating boards and subgroups. This development had raised concerns regarding the capacity to support all these structures effectively. NO further noted that meetings are typically lengthy and held in person, which presents additional challenges related to travel and resource allocation. She reported intentions to discuss these matters with the Divisional Director for Community & Mental Health and the Chief Nurse to evaluate whether it would be appropriate to add a risk to the Risk Register pertaining to multi-agency expectations. These requirements are statutory, and the Trust must engage with various structures; however, fulfilling these obligations across multiple areas remains highly challenging.
LC stated that the safeguarding capacity issue is a Trust wide issue and advised that she would continue to raise this issue with the Chief Nursing Officer given the significant investment required into the Safeguarding Team to meet requirements, especially with recommendations from the Public Inquiry regarding safeguarding supervision for staff. LC stated that both NO and LC would discuss this with Chief Nursing Officer with regards to the need for a large-scale business case to address these needs.
Resolved: SQAC received and **NOTED** the Quarter 2 Safeguarding Report

---- Safe ----

25/26/174 Compliments, Complaints & PALS Report Quarter 2 2025/26

JR presented the Compliments, Complaints & PALS Report Quarter 2 2025/26:-

- 48 complaints were received in Quarter 2.
- Main theme related to Treatment/procedure issues, accounting for nearly half of all complaints.
- Of the 44 complaints reviewed: 17 were fully upheld, 12 partially upheld, 15 not upheld.
- The Division of Medicine achieved 96% compliance for three-day acknowledgement; Surgery 81%; Community & Mental Health 73%.
- There were no new Ombudsman cases opened, and none ongoing within the reporting period

PALS

- 425 PALS contacts had been received in Quarter 2, which is an increase from Quarter 1
- Main themes related to access to appointments and communication.

Highlights:-

- 94% of PALS had been responded to within five working days.
- 85% of formal complaints responded to within 25 working days, though improvement is still required due to complexity and length of complaints.
- Community & Mental Health Division's complaint responses were noted as excellent.

Challenges:-

- The Trust was not fully compliant with the three-day acknowledgement target for complaints, averaging 75%, with variation across divisions.
- Divisions are struggling to respond to complaints within the required timeframes due to the complexity and length of some complaints.
- There is ongoing work to improve compliance and to review the complaints module for better identification of themes and trends, especially for patients with special educational needs and disabilities.

FB noted that the committee is well-sighted on the data through monthly Divisional reports and thanked the Director of Nursing for compiling the report.
Resolved: SQAC received and **NOTED** the Compliment, Complaints & PALS Report Quarter 2 2025/26

25/26/175 Patient & Family Feedback Quarterly Report

JR presented the Patient & Family Feedback Quarterly Report

Highlights:-

- Family Well-being Hub received 84 referrals in Quarter 2 and made 388 social prescriptions; details are outlined in the report.
- The hub expanded to accept referrals from oncology and general paediatrics, increasing support for more families.
- 93% of responses to the Friends and Family Test (FFT) rated care as good or very good during Quarter 2.
- Questionnaires for ED, outpatients, and community were streamlined to mandatory questions, improving response rates and making it easier for families and young people to participate.
- The NHS Experience of Care Improvement Framework was introduced, providing a structured approach to improving experience across five domains. Three stakeholder workgroups were held to baseline current state and map against these domains.
- Next steps include completing the self-assessment framework, developing an improvement plan, and aligning it with Trust priorities and governance.
- Continued engagement with stakeholders (youth forum, young volunteers, patient/carer forum) to inform the new patient experience strategy, due for publication next year.

Challenges:-

- External stakeholders were invited to the workgroups but did not attend, though the work was still completed.
- Ongoing work to ensure continued engagement and to produce a comprehensive strategy.

FB commented positively on the structure of the framework and its usefulness for scrutinising performance and thanked the Director of Nursing for compiling the report.

Resolved: SQAC received and **NOTED** the Patient & Family Feedback Quarterly Report

25/26/176 Quarter 2: Children & Young People Engagement Leads Report

LC presented the Quarter 2: Children & Young People Engagement Leads Report

Key Activities & Successes

- The Children and Young People's Forum was highly active during the summer holidays, engaging in several notable activities:
- Filming for CBBC Newsround.
- Conducting interviews ahead of National AHP Day.
- Collaborating with the Surgical Theatre team to enhance engagement with children and young people.
- Completing peer mentoring and barista qualifications, as well as life skills and basic car maintenance training.
- The forum continued to participate in quality ward rounds
- Children & Young People Forum hosted the Alder Hey Pride event in the atrium at the end of July.
- Looking ahead to Q3, the forum will launch a befriending programme (supported by the charity) for long-stay children and young people on acute paediatric wards, offering games, reading, and companionship tailored to each young person's wishes.

LC highlighted the significant and diverse engagement of the forum, noting the appeal and benefits for young people.

KB praised the clear split between Trust benefit and young person benefit in the report, suggesting that the latter may be driving increased interest in the forum.

KB recommended preparing a concise annual report on forum engagement, considering the significant contributions from the youth forum.

FB agreed with KB's feedback, noting the value of identifying benefits to young people and the lively membership.

Resolved: SQAC received and **NOTED** the Quarter 3 Children & Young People Engagement Leads Report

25/26/177 The Cheshire & Merseyside Best Practice Model for Children and Young Peoples' Community Eating Disorder Services Report

LC presented the Cheshire & Merseyside Best Practice Model for Children & Young People's Community Eating Disorder Services Report. SQAC noted that the Executive Summary report was omitted from the meeting pack and would be circulated following the meeting.

FB acknowledged the progress made in service development across the ICB footprint and requested clarification on two key points: the challenges faced by Alder Hey in implementing and resourcing the model, and the anticipated benefits along with their measurement for children and young people throughout the region. FB emphasised the need to clarify how the model aligns with the neighbourhood approach, particularly in relation to the ARFID service and physical health checks, and how various components of the service will integrate during implementation.
LC referred to the alignment with the neighbourhood approach and stated that services may not be delivered in a direct locality model due to the need for specialist skills and scale but noted that the eating disorders day unit at Blossom House is located in the neighbourhood.

- Alder Hey, led by Dr. Crosby, had developed a standardised model for community eating disorder services, including a dedicated ARFID pathway for children with neurodiversity
- Expected Benefits include consistent care standards and pathways across Cheshire and Merseyside; Improved access to specialist services, especially for ARFID and complex cases: Integration of physical health monitoring with mental health care, supporting holistic treatment; Enhanced service equity, ensuring all children and young people receive the same quality of care regardless of location & streamlined implementation of national guidance, reducing variation between providers.

Challenges:

- Regional alignment, resource requirements for expansion, and integration with local service models remain ongoing considerations.

Discussion focused on the compatibility of the model with the neighbourhood approach and operational implications for Alder Hey and other providers.
Resolved: The summary paper would be circulated to SQAC, and Trust Board would receive the appropriate documentation for review.
Resolved: SQAC received, **NOTED** and endorsed the Best practice model, noting onward presenting at Trust Board. SQAC agreed to proceed with system-wide approval and partnership with the ICB, pending further review of resource and financial considerations.

---- Effective -----

25/26/178 Clinical Effectiveness and Outcomes Board Chairs Highlight report

JR presented the Clinical Effectiveness and Outcomes Board Chairs Highlight report from the meeting held on 13th November 2025.

- Audit and Documentation Compliance: Continued improvement in oversight and learning from clinical audit, with research and corporate services maintaining 90% compliance in documentation.
- Work is ongoing to improve compliance with patient leaflets and to develop clinical audit apps for improved monitoring and assurance.
- National Epilepsy 12 Audit: Noted a potential workforce gap from January 2026 that may affect submission of cohort 7 data. Previous non-compliance with cohort 5 was rectified, and cohort 6 data had been uploaded. The issue had been escalated to the Medicine Division for review and is to be kept on the committee's radar.
- JR clarified that the National Epilepsy 12 audit issue is not an immediate escalation but should be noted due to past compliance concerns. CG confirmed the matter is under discussion within the team.

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

25/26/179 Board Assurance Framework

ES presented the Board Assurance Framework
ES reported that there are no specific comments regarding current SQAC risks for the month and noted the upcoming Extraordinary Risk Management Forum, co-chaired with the Chief Operating Officer/Deputy Chief Executive which is scheduled for 26.11.25. The forum will evaluate how external financial decisions impact quality, safety, workforce deployment, and risk management in clinical and corporate areas, using a workshop to analyse data and review past decisions. ES highlighted the need

for active participation and confirmed that session outcomes would be shared with the Trust Board, with reporting details to be finalised separately.
Resolved: SQAC received and **NOTED** the Board Assurance Framework update

25/26/180 **Clinical Audit Assurance Update**

JR presented the Clinical Audit Update

- 21 mandated audits are registered and are included in the Trust annual plan.
- The CKD audit data feed issue (from internal database/Meditech to the national database) had been resolved.

Challenges:-

- An issue with Life Arc remains and will be reported on in the next Clinical Audit update.

Trust Priority Audits:

- Consent audits for the Medicine and Surgical Divisions are pending registration. Divisions are requested to escalate this matter if registration has not already been completed.
- 5 registrations had exceeded their completion date; a process is in place to manage this.

Divisional Audits:

- 159 Divisional audits are on the plan; 26 were registered in October.
- 27% of Divisional audits had exceeded their completion dates; audit leads are to provide an update to the next CEOG meeting.
- Slides in the pack highlight learning from completed audits and the internal action tracker.
- Capacity issues within the audit team were escalated and may cause some delays in assurance reporting.
- MIAA audit had been completed; feedback would inform the 2026 work plan.

KB noted the report's improved format and suggested further refinement. KB observed that the report covers only October, and since SQAC does not receive monthly reports, some data (especially learning outcomes) may be missing; and suggested reviewing this.
KB recommended that each division determine an appropriate number of Divisional audits, considering staff time and efficiency, especially in the current environment.

KB positively noted the inclusion of a GDS audit.
JR stated that many Divisional audits are driven by resident doctors' requirements and confirmed that a significant data cleanse and streamlining of Divisional audits, with queries raised when new audits are registered.
JR advised that overdue divisional audits are sometimes cancelled due to lack of capacity, timeframes, or unavailable data, emphasising the importance of front-end planning.
Resolved: SQAC received and **NOTED** the Clinical Audit Assurance update Report

National Confidential Enquiries report: Quarter 2 2025/26 summary position report

25/26/181 JR presented the National Confidential Enquiries report: Quarter 2 2025/26

- The Trust participated in Four confidential enquiries during July–September:
- Stabilisation of the Critically Ill Child: Retrospective data collection began in September and is ongoing. Dissemination of clinical and organisational questionnaires and case note extracts starting in November.
- MBRRACE: Six neonatal deaths were eligible and submitted within the two-day target. The process for notification had changed from "cascade" to "SPEN" (perinatal event notification), now encompassing MBRRACE, maternity, newborn investigations, and NHS resolution notifications. The Trust is onboarded with SPEN, with no impact on notification submissions.
- Suicide in Children & Young People (CYP) National Confidential Inquiry into suicide and safety in mental health Thematic Report: One submission was made for a young person who died in 2021, completed after the inquest.
- NCEPOD Juvenile Idiopathic Arthritis: The report had been published in February, and the team are developing an audit plan to be signed off this month.

Resolved: SQAC received and **NOTED** the National Confidential Enquiries report: Quarter 2 2025/26 summary position report and **NOTED** the ongoing progress and compliance.

25/26/182 **Mitie theatre performance and dashboard update**

LO presented the Mitie theatre performance and dashboard update

- Mitie had increased its target operating model headcount by around 30%, with only two vacancies remaining. This has led to positive impact on response rates and fix times for reported jobs and planned preventative maintenance (PPM), though ongoing improvement is still required.
- A working prototype reactive repairs dashboard had been developed to allow all staff to view outstanding jobs in their areas. A meeting with the Trust data team is scheduled to address practicalities and IT/network issues for implementation.
- New dashboards had been developed to enable local temperature control adjustments (BMS dashboards) by area managers, reducing the need to log jobs for temperature changes. The main challenge is integrating the FM and Trust networks, which has proven difficult, but work is ongoing with IT and network teams.

LO emphasised that these developments are expected to provide tangible benefits for staff comfort and operational transparency.
AB acknowledged LO's efforts and noted the ongoing operational themes, such as persistent issues with doors and the need for improved cleaning of ventilation grills. AB stated these would continue to be addressed in the environmental and cleanliness group.
FB agreed that further issues should be managed through the Health and Safety Forum and the Environment and Cleanliness group, with escalation to SQAC only if necessary.

FB expressed her thanks to LO for the MITIE theatre performance and dashboard update.
Resolved: SQAC received and **NOTED** the Mitie theatre performance and dashboard update

25/26/183 Children & Young People's Gender Service (North) Quarter 2 Report (01 July 2025- 30th September 2025)

LC presented the Children & Young People Gender Service (North) Quarter 2 report

- 75 referrals were accepted from the national waiting list.
- The "was not brought" rate had reduced to 4.25%, attributed to the implementation of text reminders and full embedding of the Trust patient access policy.
- The report included data on children with autism, ADHD, learning disabilities, and looked-after child status. It was noted that some children fall into multiple categories, and work is ongoing with the BI team to improve data presentation and care plan tracking.
- Incidents and Safeguarding: Six incidents were reported for the service in the period, along with safeguarding referrals and one Prevent referral. The service is now well-embedded in terms of incident and safeguarding reporting.
- Workforce Update: A review of staff roles and time commitments was completed, with a draft report received. No estates risks were identified.
- Service Development: NHS England's National Pathways Horizon research trial went live, led by the research division in partnership with the service. Approval was received for five improvement projects, including consultation for paediatricians and community/mental health services, puberty groups for trans boys and girls, a parent group intervention, and psychosocial groups. Funding transfer is pending.
- Four Freedom of Information requests were received; no media requests were reported.

FB noted the FOI requests and anticipated possible future media interest but confirmed that the risk remains appropriately scored on the risk register. LC added that FOI responses are coordinated with other hubs for consistency.
Resolved: SQAC received and **NOTED** the Children & Young People's Gender Service (North) Quarter 2 Report (01st July 2025-30th September 2025)

---- Policy Ratification ----

25/26/184 Standard Operating Procedure for the Management of Safeguarding and Children in Care Special Indicators and Alerts

NO explained that the Standard Operating Procedure (SOP) was created following Care Quality Commission (CQC) concerns about CAMHS services. Previously, only the safeguarding team entered alerts, but now any staff member can add a temporary alert with daily safeguarding team oversight. Categories and terms for special indicators are now standardised. Changes have been communicated across all Divisions, supported by the communications team, and targeted training has been given to the CAMHS team. The SOP was reviewed by senior nursing and safeguarding staff and is currently on the Document Management System (DMS). After SQAC approval, it will be updated on the DMS and further communication will follow. Additional training on adding special indicators has also been introduced.

Resolved: SQAC received, **NOTED**, and **RATIFIED** the SOP for Managing Safeguarding and Children in Care Special Indicators and Alerts.

---- *Any Other Business* ----

25/26/185 **Any Other Business**
None received

---- *Board Assurance* ----

25/26/186 The key assurances and highlights report was presented to the Board meeting held on 2nd October 2025

Date and Time of Next Meeting: 17th December at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 8th January 2026

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

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

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

Risk number	Risk description	Score

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

LIVERPOOL NEONATAL PARTNERSHIP BOARD

Monday, 1st December 2025

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

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

1. Purpose

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

2. Overview of partnership & activities in month

Programme overview

There are several items to highlight including:

- The LNP Clinical Lead for Neonatal Surgery post has been advertised with several candidates expressing an interest. Interviews are scheduled for the 15th December.
- The LNP have successfully appointed a neonatal speech and language therapist. This post has been vacant for some time and therefore this is a fantastic enhancement for the partnership, a start date of March 2026 has been agreed.
- The LNP joint governance arrangements have been approved by the Trust Board at Liverpool University Hospitals Groups and Alder Hey Children's Hospital. The next steps will see the development of the LNP operational policy and governance

framework which will be developed with support from Corporate Governance Leads and NHS England / ODN. Third part assurance will be sought from the MIAA.

- The build programme continues to progress, but a number of potential issues and delays are being worked through with the Capital Projects Team and the Contractors. The current programme is now scheduled to complete in June, with full occupation by September 2026.
- The water safe workflows are progressing well, with a multidisciplinary approach adopted. The team are working closely with the national experts to develop the water safe workflows and supporting documentation and have created a network with colleagues from Leeds to share good practice.
- The LNP funding requirements aligned to the national specification will be discussed at the December Board following review and agreement to propose a phased approach to achieve the standards. The funding gap has been shared with specialist commissioners.
- The phase 1 integrated performance report has been developed and presented to the LNP Board, phase 2 is now under development
- The LNP has recruited to all medical and nursing posts and is hold a number of nurse vacancies at LWH in preparation for the 6 cot closure. This can be achieved by utilise the LNP workforce flexibly until the new unit opens.
- The simulation programme continues to run each week, with additional equipment added regularly to support the education plan
- There is a robust training and competency framework schedule in place that is reviewed on a monthly basis and remains 'on track'
- The Maternity and Neonatal Voices Partnership for a neonatal specific role is out -to advert.

LNP Partnership working

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

Development of the LNP Operational Policy and Governance Framework

AHCH, LWH, and LUHG have collectively determined that the remit of the LNP encompasses neonatal services across a total of 68 cots—comprising 46 cots at LWH and 22 at AHCH. The operational policy and governance framework will be drafted to reflect this arrangement.
Furthermore, at the Exec-to-Exec meeting, it was agreed that joint liabilities and responsibilities would be established for all 68 cots, further strengthening the partnership agreement.

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

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

Collaborative working, safety and culture

Meetings with surgical divisional leads to review pathways

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

The LNP culture review is well underway with regular updates presented to the LNP Board

Build

The SLT continue to meet with the Senior Capital Project Manager on a fortnightly basis to help provide timely input and direction to the new build. The build timescales are reviewed regularly and quick action can be taken through the effective communication channels developed. The current build timeframe is under review, although the current plans indicate full occupation by October 2026

Occupation of surgical NICU	Start date	End date
1st baby to transfer (1c cot)	18/08/2026	18/08/2026
Safety checks complete	18/08/2026	18/08/2026
8 cots transfer to NICU (1c cots)	18/08/3036	01/09/2026
SLT review and agree safe to increase capacity	01/09/2026	01/09/2026

4 cots transfer (PICU and HDU activity)	01/09/2026	08/09/2026
6 cots transfer (LWH transfer)	08/09/2026	22/09/2026
3 cots transfer (other wards)	22/09/2026	29/09/2026
Unit fully occupied	01/10/2026	01/10//2026

Changes to the senior leadership team

The senior leadership team would like thank Joanne Minford for the significant contribution made to the partnership over many years. Jo has guided the team and provided insight and direction to help maintain momentum and focus. Jo's enthusiasm and passion for the partnership, encouraged relationships to form and boundaries to be removed, which has helped shape the partnership that we work in today. We would like to wish Jo well in her retirement.

3. **Key risks / issues to escalate to LNP**

- The risk associated with the build timescales is being carefully managed by the senior capital projects lead and all key stakeholders will respond as required, to help mitigate any further delays that may be identified.
- Identification of additional funds to meet the neonatal critical service specification

4. **Recommendations**

The LNP Board are asked to:

- Note the content of the report and key updates

BOARD OF DIRECTORS

Thursday, 8th January 2026

Paper Title:	**Neighbourhood working for children & young people**
Report of:	**Dani Jones, Chief Strategy & Partnerships Officer** **Lisa Cooper, Director Community & Mental Health Services**
Paper Prepared by:	Jenny Dalzell, Associate Director of Strategy & Partnerships Rachel Greer, Associate Chief Operating Officer, Community & Mental Health Division

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

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

Risk number	Risk description	Score

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

1. Report Purpose

This report updates the Trust Board on the Alder Hey Neighbourhood Plan and details the 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 children and young people, both locally across the Trust's principal 'Places,' and more widely across the whole system through the Alder Hey-led Cheshire & Merseyside (C&M) "Beyond" children and young people's transformation programme.

2. Executive Summary

Neighbourhood working is a central element of UK health policy, as outlined in NHS England's Long-Term Plan and the 10-Year Health Plan. These policies prioritise community-based, integrated, and preventative care tailored to local needs. The neighbourhood model is the primary delivery mechanism for the 10-year plan's 3 shifts – hospital to community, sickness to prevention and analogue to digital.

While initially focused on adults, there is increasing emphasis on developing similar approaches for children and young people, through integrated 0–19 pathways and multidisciplinary teams (NHS England Guidance).

However, the following remains absent from national guidance:

- Currently, there is no national requirement or dedicated funding for Primary Care Networks (PCNs) to participate in neighbourhood multidisciplinary teams (MDTs) focused on children and young people, beyond what is included in the standard GP contract. Primary care faces significant workload pressures and competing priorities, which can limit involvement in neighbourhood-based MDT development for this population. While time spent on prevention and interagency work is not routinely recognised or funded unless part of a specific contract or pilot, the 2025/26 GP Contract continues to encourage neighbourhood working through PCNs. The details of additional financial support for neighbourhood initiatives in primary care are still to be confirmed. These challenges may well impact on scale and spread, however despite these challenges, local CYP neighbourhood approaches are developing with committed primary care leadership and expertise, who are critical, integral partners.
- There is acknowledged ambiguity regarding the practical alignment of NHS England and Local Authority neighbourhoods. This uncertainty arises from differences in their respective purposes, geographic coverage, and stages of development, as well as limited national guidance on establishing coterminous boundaries, leadership, or governance frameworks.

The Cheshire & Merseyside system (including Alder Hey as a partner) recognises these challenges and is addressing them by taking a structured, practical, and locally focused approach. Partners are focusing on aligning functions at the neighbourhood level, working together towards shared goals, using collaborative multidisciplinary methods, and ensuring coordinated leadership. In our capacity as system leaders for children and young people (CYP), Alder Hey is actively developing innovative

strategies to incentivise the achievement of the three key shifts outlined in the 10-Year Health Plan. To support this, we have made CYP neighbourhood working a priority, in part as a means to pilot and refine these potentially transformative approaches.

3. National Neighbourhood Health Implementation Programme (NNHIP)

Launched in July 2025, the NNHIP is a delivery mechanism for the NHS 1-Year Health Plan. Its focus is on moving care from hospitals to community settings, enhancing prevention, and integrating health and social care at a neighbourhood level.

The programme aims to address health inequalities and outcomes through multi-agency, place-based models that provide personalised and proactive care, especially for adults with multiple long-term conditions and individuals identified as being at increased risk.

Key features include:

- Integrated neighbourhood teams spanning NHS providers, local authorities, and the voluntary sector.
- Population health management to identify and respond to local needs using linked data.
- Scalable, hyperlocal models allowing flexibility to address differing community priorities.
- Digital enablement to improve access, coordination, and continuity of care.
- A national Community of Practice to share learning, with test-and-learn pilots to inform policy and spread effective models.

Participation in this initiative enables Trusts to contribute to national neighbourhood health policy, develop cross-sector partnerships, and implement established methods aimed at lowering hospital demand, enhancing patient experience, and supporting community-based care.

Liverpool, Sefton, and Knowsley Places have submitted applications to this scheme and Sefton was successful in their bid to become one of the 42 national sites. Alder Hey is engaged with Liverpool, Sefton and Knowsley Places in the development of their neighbourhood plans as a partner organisation amongst many (Place, Primary Care, Local Authority, VCSE, Community Services, Education).

Below is a summary of Sefton's national bid in the context of children and young people.

Theme	Sefton
Overall CYP Vision	Embed CYP support across the whole-life course, from early years to transition into adult services, with hyperlocal tailoring.
Core Models	**Team Around the School** – 9 school clusters linking health, social care, education, VCFSE; reduced exclusions (−22%) and improved attendance.
Targeted Health Areas	Mental health resilience, trauma-informed care, early identification of vulnerable families.
Flagship Programmes	Adverse Childhood Experiences (ACE) programme – nationally recognised; reduced mental health prescribing and improved wellbeing.

Theme	Sefton
Data & Insight Use	*Data Into Action* platform for early identification and neighbourhood-level outcome tracking.
Partnership Strengths	Mature PCNs, strong VCFSE sector links, existing trauma-informed workforce.
NHIP Aim for CYP	Scale trauma-informed and school-based models, expand neighbourhood dashboards, and tailor to local population needs.
Innovation / Test-and-Learn	Uses proven, evaluated local pilots (e.g., ACE, Team Around the School) as templates for scale-up and adaptation.
Financial Return Outlook for CYP MDTs	Strategic, long-term investment; expect 3–5 years before measurable savings through reduced crisis admissions, lower specialist demand, and better patient flow. Immediate value in outcomes and inequality reduction.

4. Cheshire & Merseyside (C&M) Context

National guidance regarding multidisciplinary teams (MDTs) for children and young people emphasises the importance of integrated collaboration yet does not clearly define leadership roles at the local level. This ambiguity may lead to dispersed accountability among health, local authority, and education stakeholders, while insufficient incentives exist for Primary Care to assume a leadership position for children and young people.

Local Primary Care Networks are at various stages of creating GP Federations, aiming to unify general practice, enhance neighbourhood coordination, and support new care models. Federations may also improve funding access, workforce development, and strengthen Primary Care's role in place-based care.

A C&M Integrated Care Board (ICB) neighbourhood working group is developing a scalable model for children and young people's MDTs in all nine areas, led by the "Beyond" programme at Alder Hey. Six out of nine areas have secured NHS England funding to launch local multi-disciplinary teams, following national guidelines while allowing for local adaptation.

Liverpool and Sefton are among the 6 successful bids, and both anticipate collaboration with Alder Hey in developing their service models. This includes, for example, the reconfiguration of existing community services to enhance cooperative working across education, social care, and public health at the neighbourhood level.

5. Alder Hey's role in neighbourhood working

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.

5.1 0–19 Model and the 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

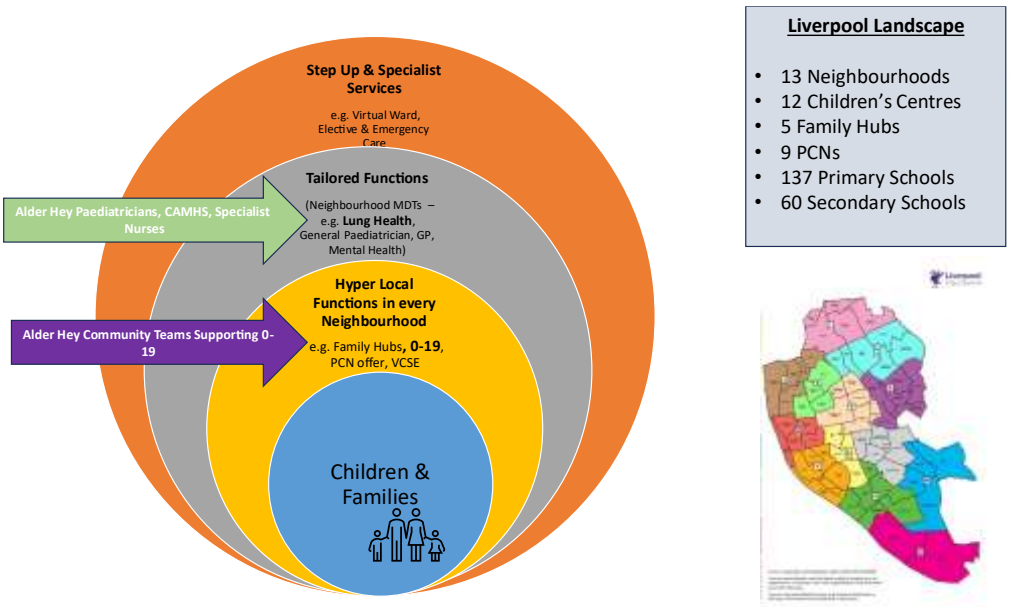
national strategies like *Start for Life*, *Family Hubs*, and *Family First* for better coordinated child and family support.

5.2 MDT Working: Progress and Challenge

An essential component of the neighbourhood approach involves establishing multidisciplinary teams (MDTs) focused on children and young people. Although education, social care, and voluntary sector stakeholders are actively participating, the integration of primary care remains challenging due to limited national incentives for Primary Care Networks (PCNs). This constraint has affected both the pace and progress of implementation. Nevertheless, 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.

5.3 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. The following diagram illustrates how service offerings may be coordinated at the neighbourhood level.



This 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. While the strategic fit is clear, it is important to acknowledge that there are no immediate financial savings for Alder Hey. Delivering this work will continue to require sustained investment in leadership, clinical expertise, and data support, with benefits realised primarily through improved outcomes for children rather than short-term cost reduction.

7. Conclusion

Whilst system challenges continue, Alder Hey is in a positive position to help shape the approaches for children & young people in neighbourhoods with our local ‘Places’, our key partners and by influencing practice throughout the region. With the Beyond programme, Alder Hey is paving the way for system-wide children & young people neighbourhood improvement and is recognised as a reliable collaborator in integrated care efforts. This moment offers a valuable chance to put children and young people at the centre of place-based services, making sure their needs guide decisions as neighbourhood models change.

By taking initiative for children & young people in neighbourhoods, Alder Hey is working to support the 10 Year Plan’s 3 shifts (hospital to community; sickness to prevention; analogue to digital), to exemplify leading practices for children, and to make the most of the Trust’s strategic partnerships and reach, both within the city and beyond.

MEETING OF THE GROWTH AND OPPORTUNTIES COMMITTEE

Confirmed Minutes of the meeting held on **Tuesday 7 October 2025 at 1:30pm. LT1**

Present:	Mr. M. Jennings	Non-Executive Director(Chair)	(MJ)
	Mr J. Kelly	Non-Executive Director	(JK)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mr. J. Chester	Chief Scientific Officer	(JC)
In Attendance:	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Mr. D. Hawcutt	Director Alder Hey Research Division	(DH)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Dr. K. Birch	Director of the Alder Hey Academy	(KB)
	Ms. L. Cooper	Divisional Director - Community/MH	(LC)
	Mrs. U. Das	Divisional Director - Medicine	(UD)
	Mr. R. Guerrero	Director of Global Health	(RG)
	Ms. F. Ashcroft	Chief Executive (AH Charity)	(FA)
	Mr. S. Leonard	Head of Marketing & Communications (AH Charity)	(SLe)
	Ms. N. Palin	Director of Transformation	(NP)
	Mr. A. McColl	Associate Director of Finance	(AMc)
	Mrs. S. Leo	Head of Research	(SL)
	Ms. L. Rad	Assoc Director of Nursing Research	(LR)
	Mrs. A. Prendergast	Assoc Director of Strategy and Partnerships	(AP)
	Ms. M. Ashe	Policy Advisor to the CEO	(MA)
	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Mr. S. Hosny (observing)	Senior Innovation Consultant	(SH)
	Mrs. E. Rees	Executive Assistant (Minutes)	(ER)
Apologies:	Mr. A. Bateman	Deputy CEO/ Chief Operating Officer	(AB)
	Mr. A. Bass	Chief Medical Officer	(Aba)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mr. N. Askew	Chief Nursing Officer	(NA)
	Mrs. R. Lea	Interim Chief Financial Officer	(RL)
	Ms. V. Greenwood	Director of Allied Health Professionals	(VG)
	Ms. G. Foden	Head of Learning & Development	(GF)

25/26/001 Welcome and Apologies

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

25/26/002	**Declarations of Interest** MJ is Chief Solutions and Services Officer at Strasys Ltd, who have some involvement from time to time across the Cheshire and Merseyside healthcare system in an advisory capacity.
25/26/003	**Minutes of the Futures Committee Meeting**

	The minutes of the last meetings held on 25 June 2025 were approved.
2526/004	**Introduction and Context** MJ, JG, DJ and JC introduced the GO Committee as the successor to the Futures Committee, highlighting its evolution into an even more action-oriented body. The Committee's main objective is to drive sustainable growth and positive impact for children and young people, with a particular emphasis on unifying organisational efforts, strengthening external influence, and amplifying the voices of children and young people throughout the organisation and beyond. Building on the foundations of the Futures Committee, the GO Committee has adopted a broader remit, focusing on identifying and prioritising the most pressing challenges and opportunities for children and young people. Rather than attempting to tackle every issue, the Committee aims to maintain a clear and immediate focus on areas where it can achieve the greatest impact. Initial challenges and opportunities were discussed and will be iterated to broaden the definitions around CYP challenges specifically. **Action:** **CSPO & CSO (DJ & JC) to oversee for each meeting (next Dec 25).** The Committee is committed to a balance between assurance and ambition, positioning itself as the least assurance-focused and most ambitious of the organisation's committees. Meetings are structured to include concise briefings and a clear emphasis on action, reducing lengthy discussions in favour of decisive progress. DJ and JC stressed the importance of breaking down organisational silos, coordinating responses to shared challenges, and ensuring the GO Committee acts as a convener within the organisation and externally. The Committee's mission is to place child health and well-being at the centre of all work, to grow Alder Hey safely and appropriately, to develop the world-leading ecosystem of CYP research, innovation, digital, education, global health, strategic partnerships, and to guarantee that all prioritised GO initiatives for children, young people, and families are digitally enabled and inclusive.
25/26/005	**Ambition** ***Horizon scan – An Integrated System for CYP*** The IHO was introduced as a strategic opportunity, potentially afforded to Alder Hey as a 'segment 1' trust in national performance rankings. The IHO is a contractual mechanism to enable integrated, accountable care for children across the region, replacing fragmented commissioning. This aims to support the NHSE 10 Year Plan '3 shifts' (e.g. sickness to prevention, hospital to community (shift left), analogue to digital +), and help to address multi-setting challenges from fragmented systems (e.g. ASD/ADHD backlogs). The IHO would require strong input from children, young people and families as well as a range of strategic partners, including NHS trusts, primary care, local authorities, academia, industry (etc). Alder Hey could hold an IHO contract for the CYP population, whilst not necessarily delivering all services directly. NHSE will announce a national pilot to

	launch April 2026, with a year of preparation before full implementation beginning April 2027. Clear communication will be vital. The Committee also discussed a further opportunity that is currently confidential in nature. GO representatives discussed how their leadership areas could best align with these opportunities, and where there are opportunities to leverage or scale their support / mitigate competing priorities. **Resolved:** The Committee recognised the prioritisation of these 2 areas from Trust Strategy Board and noted the update.
25/26/006	**How will we know GO is making a difference** **<u>GO Metrics & KPIs</u>** The committee emphasised the need for clear metrics and KPIs to measure the GO committee's impact, focusing on improving outcomes for more children, earlier and more fairly. Suggested metrics included activity outside hospitals, reducing inequalities, influence on standards, clinical engagement, strategic partnerships, Newsweek ranking, and GO-derived income. The group recognised challenges in measuring long-term and partnership impacts and agreed KPIs should balance short-term goals with long-term ambitions, with regular review. Both quantitative and qualitative measures, including the organisation's attractiveness to others, were seen as important indicators of genuine transformation and leadership. **Action:** **CSPO & CSO (DJ & JC) to oversee next stage of refinement of GO Metrics / KPI's (Dec 25).** **Resolved:** The Committee noted the update.
25/26/007	**Programme Updates – Assurance** **Futures** **<u>Research & Innovation</u>** The research and innovation update noted most activities are partner-driven and overseen by the Futures Management Board, with financial and operational challenges managed via improvement programmes. Key challenges include limited clinical time for research due to workforce constraints, despite strong training offers. Metrics are being aligned with GO priorities, and the committee welcomes input on specific research measures. Financial pressures persist, but recovery plans are underway and improvements expected as transactions are processed. Innovation training is being integrated into workforce plans, with emphasis on driving genuine transformation rather than replicating existing practices. The committee stressed the importance of avoiding double-counting automation efficiencies and ensuring accurate financial reporting. **<u>Education</u>**

Education and innovation training are available, but staff face difficulties attending due to workforce pressures. Training is being integrated into workforce plans and aligned with clinical divisions. Education risks are managed separately, but the committee recommended reviewing them for full coverage. Embedding education in workforce development remains key to supporting GO ambitions.

Digital

Digital was highlighted as both essential and challenging for integrating services across providers, particularly for the proposed opportunities discussed. The committee noted issues with system interoperability and stressed that integration is key to collaboration and innovation. They recommended a review of the digital risk register, especially regarding the technology platform's alignment with GO priorities. Automation is being pursued to free up manual hours, but financial and reporting difficulties persist. Creative solutions, such as AI for onboarding and policy harmonisation, were encouraged. Digital transformation remains fundamental, though technical and operational barriers continue.

Action:
CDIO (KW) to review relevant Digital risks and advise on optimal committee reporting route (Dec 25).

International (non-NHS) Private Patients (IPP)

The committee highlighted the need to prioritise and invest in private patient services as a key financial opportunity, provided this supports children's best interests and enhances NHS provision. Resource constraints mean reprioritisation is necessary, and private work should not impact NHS care or public perception. The group recognised private health insurance as a substantial market and discussed building organisational expertise, including possible joint ventures, to grow this area. The strategy for private patient services will be reviewed in future meetings to ensure a clear and aligned approach.

Action:
CNO (NA) – deeper dive item on IPP at December's GO Committee (Dec 25).

Global Health

The Committee was informed about the Alder Hey Global Health Programme, which was established to enhance our paediatric expertise globally and strengthen our reputation as a world-leading children's hospital.

Notable progress includes the establishment of a Global Health structure, which integrates the ICH department, strengthens governance and synergy in this area. This structure comprises forming a Leadership Board with a TOR, agreeing on KPIs that are being refined for flexibility amid changing circumstances, but remaining aligned to the GO strategy and Vision 2030.

Additionally, a Standard Operating Procedure (SOP) for Observership at Alder Hey and a Memorandum of Understanding (MOU) process have been developed, providing a single point process, including potential diversified income revenue.

Commercial value proposals for various clinical services, education, innovation, and infrastructure consultancy have been developed in collaboration with Healthcare UK. External funding has been leveraged to facilitate global networking, establish partnerships, and develop commercial proposals.

	Continued progress is being made with global sustainable partnerships with healthcare institutions in Vietnam, China, and Peru. The Committee was informed that RG has been appointed as a member of the Board of the LCR Health and Life Science Board, thereby strengthening Alder Hey's influence at regional, land, and national levels. **Action:** **Global Director (RG) to include refined Global Health KPIs in December highlight report.** **Resolved:** The Committee welcomed the progress being made, considering the limited team.
25/26/008	**Global Health Terms of Reference** **Resolved:** The Committee received and approved the terms of reference.
25/26/009	**Comms and Branding** The committee highlighted the need to clarify and strengthen the organisation's brand, particularly regarding external partnerships and international work. It was agreed that branding decisions should be led at Trust Board level (consideration of Strategy Board as possible home). Ideas from industry – such as concept of using the brand as a "kite mark" for endorsing socially responsible partners was discussed, but concerns were raised about potential risks. The committee noted the challenge of balancing the organisation's core specialism with ambitions to broaden its appeal. There was consensus on the urgency of developing a refreshed brand strategy, with a focused stakeholder group suggested. The upcoming GO committee meeting will address branding to ensure consistent business to business / industry messaging and global relevance. **Action:** CB to organise a stakeholder group to conduct a focused sprint on clarifying and updating the organisation's brand and messaging, involving charity and global/international representatives. **Resolved:** The Committee noted the update.
25/26/010	**Strategic Partnerships** Strategic partnerships will be reviewed in line with GO committee priorities, with biannual reporting and quarterly updates. Existing partnerships will be assessed for value, and new/emergent partnerships realigned with current opportunities. Work continues to define 'strategic partnership' and clarify governance. The GO forum will provide assurance, with agendas focused on decisions and actions. Alignment with the committee's evolving ambitions, particularly in regional leadership and innovation, remains key. **Action:** **CSPO/AD SP (DJ/AP) to oversee preparation of bi-annual oversight report on strategic partnerships for December GO Committee (Dec 25).**

	Resolved: The Committee noted the update and agreed the proposal for assurance rhythm.
25/26/011	**Growth and Opportunities (GO) Committee Terms of Reference** The GO committee reviewed its terms of reference, with members suggesting a delay in approval to ensure they reflect recent priorities, as outlined in 'ambition' section above. Updates will include adding DH as Director of the Institute of Child Health and Well-being, and future meetings will focus on actions related to these new directions. **Action:** **CSPO/AD SP (DJ/AP) To review and update the committee's terms of reference to reflect new near-term opportunities and recent developments before next approval at the next meeting (Dec 25).** **Resolved:** The Committee agreed to delay approval of the terms of reference until the next meeting, pending a reread and potential revision to ensure they are fit for purpose given the committee's current direction.
25/26/012	**Any Other Business** None raised.
25/26/013	**Review of the Meeting** The Chair thanked all participants for their preparation and attendance, noting that the session served as a valuable scene-setter for the GO committee's strategic direction. There was a need to prioritise future agenda items where decisions or actions are required, with particular focus on the 2 key strategic opportunities described in 'ambition' section above. The Chair encouraged ongoing engagement from all members and noted that future meetings would feature more contributions from all participants.
	Date and Time of Next Meeting: 16 December at 1.30pm, Lecture Theatre 1, Alder Hey

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th January 2026

Paper Title:	**Strategic People Update**
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Sharon Owen, Jo Potier, Katherine Birch, Angela Ditchfield
Purpose of Paper:	Decision ☐ Assurance R Information R Regulation ☐
Action/Decision Required:	To note R To approve ☐
Summary / supporting information	To provide a strategic update to the Board of the key people issues during December 2025.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience **Collaborate** for children & young people **Revolutionise** care ☐ **Support** our people R **Pioneering breakthroughs** **Strong Foundations** R
Resource Implications:	

Does this relate to a risk? Yes R No ☐

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

Risk Number	Risk Description	Score
#384	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	15
#395	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	12

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

1. Introduction

People issues are a strategic priority for the Board, and so the purpose of this report is to provide the Board with an overview of current and emerging issues and how the Trust is responding to those issues. This report will cover activity completed and insight and intelligence gathered during November and December 2025.

2. Colleague Engagement & Culture

Progress on the Thriving Culture programme of work was provided to the People Committee in November and Board in December with a focus on values & behaviours, safety culture, thriving teams, and thriving leaders.

With the new values now formally signed off in December, work is now underway to develop a values-in-action framework and toolkit. New lanyards have now been produced and will be distributed over the coming weeks along with the values statement to all areas.

Thanks to support from the Digital team, delivery of the Thriving Teams Index is now scheduled for Q3 2026 with a pilot "static" version of the dashboard due to be completed in the first quarter of this year. The Index will combine data on staff experience, safety culture, patient safety and HR metrics to help identify teams who are thriving and provide targeted and timely support for those who are struggling. This integrated approach will help us to identify strengths and areas for improvement, enabling timely interventions to enhance team performance and wellbeing.

Finally, with phase 1 of the Connected Leadership approach (leaders and all staff briefings) now operational, phase 2 has been agreed and will commence this year. Phase 2 comprises the roll out of the Team Connect/"Ask for an Exec" programme and the New Leader Connect/First 100 days programme. A monthly report to the executive team will give details of the Team Connect impact evaluation to include struggling teams and how they are being supported. The New Leader Connect programme will ensure that all staff in new leadership roles have a one-to-one session with an executive as part of their induction. Both the Team and New Leader Connect programmes will include questions relating to value congruence.

Staff morale & supportive interventions
Over the last month, as in previous months, staff morale continues to be affected by workplace stress and the pressures of winter. There is a trend towards an increase in sickness absence, with stress, anxiety and depression being the leading cause for absence and accounting for 35% of all absences. HR and SALS continue to work together in developing a targeted response to managing stress offering targeted support to those on sick leave and offering live Spotlight on Stress psychoeducation sessions with another Q&A focused on undertaking Stress Risk Assessments for managers in the Trust. We recognise the need to support managers with effective management as the most important intervention in reducing stress and protecting morale.

SALS, OD and People Services continue to support individuals, teams and leaders struggling with the impact of stress and a scarcity mentality contributing to inflexibility, incivility, and issues in interpersonal relationships. New referrals to SALS were higher in the last month than the previous quarter, receiving 94 new referrals vs an average of 80 per month in the quarter before. As expected, SALS continue to support staff affected by mental ill health, and mental health crises.

2025 Staff Survey
Fieldwork for the 2025 NHS Staff Survey closed on the 28th November (with a final 52% response rate) and the first results were made available for internal use only on the 15th December. Full results will be available in early 2026. The results are currently under

embargo and so cannot be shared publicly. We have, however, begun initial analysis of the data which we can use internally to shape our action planning and interventions

3. Equality, Diversity and Inclusion

Equality, Diversity, and Inclusion (EDI) remain a strategic priority, and we will continue to drive forward the EDI work to strengthen an inclusive culture where all staff feel safe, supported, and able to thrive, enabling us to deliver the best possible care for our children and young people.

We will continue to support our brilliant staff networks, recognising their vital role in providing safe and supportive spaces for staff, amplifying lived experience, and informing organisational improvement. We have recently launched new support groups, including a Carers Support Group and an Endometriosis Support Group, further broadening our offer and responding to identified staff needs.

Implementation of the NHS EDI Improvement Plan remains a key focus, with ongoing work aligned to the high impact actions. We are currently completing both the Gender Pay Gap Report and the Equality Delivery System (EDS22), which together provide important assurance and insight into progress, challenges, and areas of great practice.

Staff support activity has continued to increase, and collaborative working has been strengthened across teams including HR, Freedom to Speak UP, SALS, and OD. This joined up approach ensures staff can access the right support at the right time and that our responses are coordinated and effective.

Funding has been secured from the Alder Hey Charity to deliver Active Bystander Training. This investment will enable us to develop a team of Active Bystander champions who will support the delivery and embed learning across the organisation over this next year, strengthening our approach to tackling inappropriate behaviour and discrimination. In February, we will launch our Internationally Recruited Staff Development Programme, 'Grow to Lead'. This six-month programme will provide tailored support, development opportunities, and resources to enhance career progression, inclusion, and retention for internationally recruited colleagues. Looking ahead, we will be hosting a Day of Inclusion in April, working in partnership with the Youth Forum. This event responds directly to a challenge set by one of the members of the Youth Forum, to work collaboratively with internal and external partners to showcase our EDI work, with a particular focus on Anti-Racism and the actions being taken to support this agenda.

Overall, the work demonstrates continued progress, strong partnership working, and sustained commitment to making Alder Hey an inclusive organisation for our staff, children and young people, and our communities.

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 has been undertaken as reported to November's People Committee and Education Governance Committee. Although overall Trust compliance remains over 90%, currently at 92.75% for November 2025, there are pockets of non-compliance linked to staff groups, teams, individuals and topics. A mandatory training subcommittee has been established to undertake a deep

dive, identify barriers and solutions, then implement and monitor improvements. The initial meeting identified a number of areas to explore and work has already commenced with the SMEs for Safeguarding, Prevent and Sepsis and further updates will be provided as appropriate.

- Work to roll out the next stages of the professional development hub continues. As previously reported, skills support and guidance when applying for posts is live and feedback has been positive. A skill scan model and tool have been developed to facilitate self-assessment of learning needs and is currently being tested. The next step is to further enhance the learning needs signposting to support colleagues to 'fill' the learning gaps identified. Career pathways for some of the 'futures' workforce have been produced and a pathway for nursing and allied health professionals is underway. The intention is to launch early 2026/27.
- Our evolving work with Edge Hill University has led to us recently supporting delivery of their new flagship PGCE Primary (Mental Health and Wellbeing) programme and this work will also see sessions delivered for EHUs PGCE secondary trainees across January. A new strategic partnership with EHU agreement will be signed later this month. To note also, Alder Hey were invited to take part in the recent Ofsted pilot inspection of EHUs teacher training provision.
- The Masterclass series continues to receive very positive feedback, with further sessions in development.
- As we enter Q4, the focus will turn to forward planning for 26/27, and the TNA will go live shortly. Focused discussions will be held with all teams / services to understand both local training needs (reflecting local, regional and national priorities) with a view to then scoping how these can best be met across 26/27.
- Automation of the PDR paperwork / approach is scheduled to go live in January 2026. Work is underway to automate the Trust's Study leave process also, linked to the updated Study Leave Policy.

Resident Doctor Experience at Alder Hey

Ensuring we are supporting residents and improving the working lives of doctors in training at Alder Hey is a priority. A comprehensive report was presented to November People Committee, with highlights to last month's Board, detailing information about the GMC Survey, Improving Working Lives of Doctors in Training and NHSE Education Quality Review. Discussion with the CEO and CMO is ongoing in terms of ensuring that the Board is sighted on resident doctor experiences in line with national guidance.

Change in DME

To note also, Dr Lakshmi Ramasubramian has recently been appointed at the Trust's Director of Medical Education, replacing Dr Clare Halfhide whose tenure had come to an end.

5. Employee Relations & Wellbeing

Sickness Absence

The Trust current sickness position (in-month) as of November 2025 is 6.98% 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 4.10%, with a target of 2.5%, and STS at 2.88% with a target of 2%). This higher than target absence rate is impacting on the use of premium spend and service delivery, thus requiring specific interventions alongside the current management processes, and is being closely monitored.

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 or all appropriate cases.

In December 2025 in collaboration with SALS the first psychoeducation session took place, focusing on strategies to manage stress, (the top reason for sickness absence continues to be stress related absence). The session provided an insight and awareness into human stress responses, as well as practical ways to respond and reduce stress in self and others. The session was well attended with circa 150 staff and managers in attendance. This session will be repeated in January 2026.

Staff Flu vaccination

The flu vaccination clinics have now stopped. There was the requirement to substantially improve our rates of staff vaccination, to support the protection of our patients and staff, easing winter pressures and reducing the risk of avoidable disruption to our services. All Trusts were expected to achieve a 5% improvement of the previous year's uptake; therefore, the Trust target was set at least 50% of staff being vaccinated. At the end of the programme the Trust have achieved the target and vaccinated a total of 53% of front-line staff.

Resident Doctor Industrial Action in December 2025

Five days of Resident Doctors industrial action took place from 7am on 17th December to 7am on 22nd December 2005. During this period the Trust re-established the operational group responsible for managing the impact of the strike action, overseeing patient safety and activity during these five days. The table below shows the % of Resident Drs who were on strike each day over the five-day period.

	17/12/2025	18/12/2025	19/12/2025	20/12/2025	21/12/2025
Doctors available for work	113	96	96	19	20
Doctors on strike	55	58	47	18	18
% on strike (current action)	32.74%	37.66%	32.87%	48.65%	47.37%
% on strike (previous November action)	38.56%	45.45%	51.16%	41.72%	42.86%

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, 8th January 2026

Paper Title:	Emergency Preparedness, Resilience and Response, Annual Report - 2025
Report of:	Nathan Askew - Chief Nursing, AHP & Experience Officer (Accountable Emergency Officer)
Paper Prepared by:	Jacob Gray - Emergency Preparedness, Resilience & Response Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☑
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Alder Hey Children's EPRR Annual Core Standards.
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☐
Resource Implications:	N/A

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

Risk number	Risk description	Score
178	Major Incidents disrupting the Trusts ability to maintain statutory duties	12
173	Business Continuity Incidents disrupting the Trusts ability to maintain statutory duties	15

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

1. Executive Summary

This report summarises the Trusts overall preparedness in reference to NHS England Emergency Preparedness, Resilience & Response (EPRR) Core Standards from October 2024 to September end 2025.

The report outlines organisational plans, training and exercising, divisional business continuity compliance, and declared incidents over the previous year.

2. Purpose

This report is to provide an annual assurance statement to the Board of Directors on the current position of the Alder Hey Children's NHS Foundation Emergency Preparedness Resilience and Response (EPRR).

It also provides information of the year to date for EPRR including the assurance rating against the NHS England Core Standards for EPRR.

3. Background

The Civil Contingencies Act (2004) identifies the Trust as a Category 1 responder, as such the full set of civil protection duties apply:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place business continuity management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency.

Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England Guidance.

4. EPRR Annual Core Standards Assurance

NHS Cheshire and Merseyside ICB Integrated Care System (ICS) undertook an annual audit and review of the of the Trust's EPRR arrangements, 115 items of supporting evidence were provided to underpin the self-assessment. The audit outcome agreed with the Trusts assessment and noted the Trust was fully compliant with 48 of the standards and partially compliant with 14. Providing the Trust with an overall annual assurance statement of partial compliance.

The areas of partial compliance relate to governance, plans, response, business continuity and HazMat/CBRN, where arrangements are in place but require further development to fully meet the standards. These include updating of pandemic and infectious disease planning, mass casualty, lockdown planning, decision logging capability, business continuity maturity, and HazMat/CBRN exercising. Targeted improvement activity will be required to strengthen assurance and achieve full compliance.

The detail of partially compliant standards can be found within Appendix 1.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	6	5	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	4	6	0
Hazmat/CBRN	12	11	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	48	14	0

5. Policies, Plans, Procedures

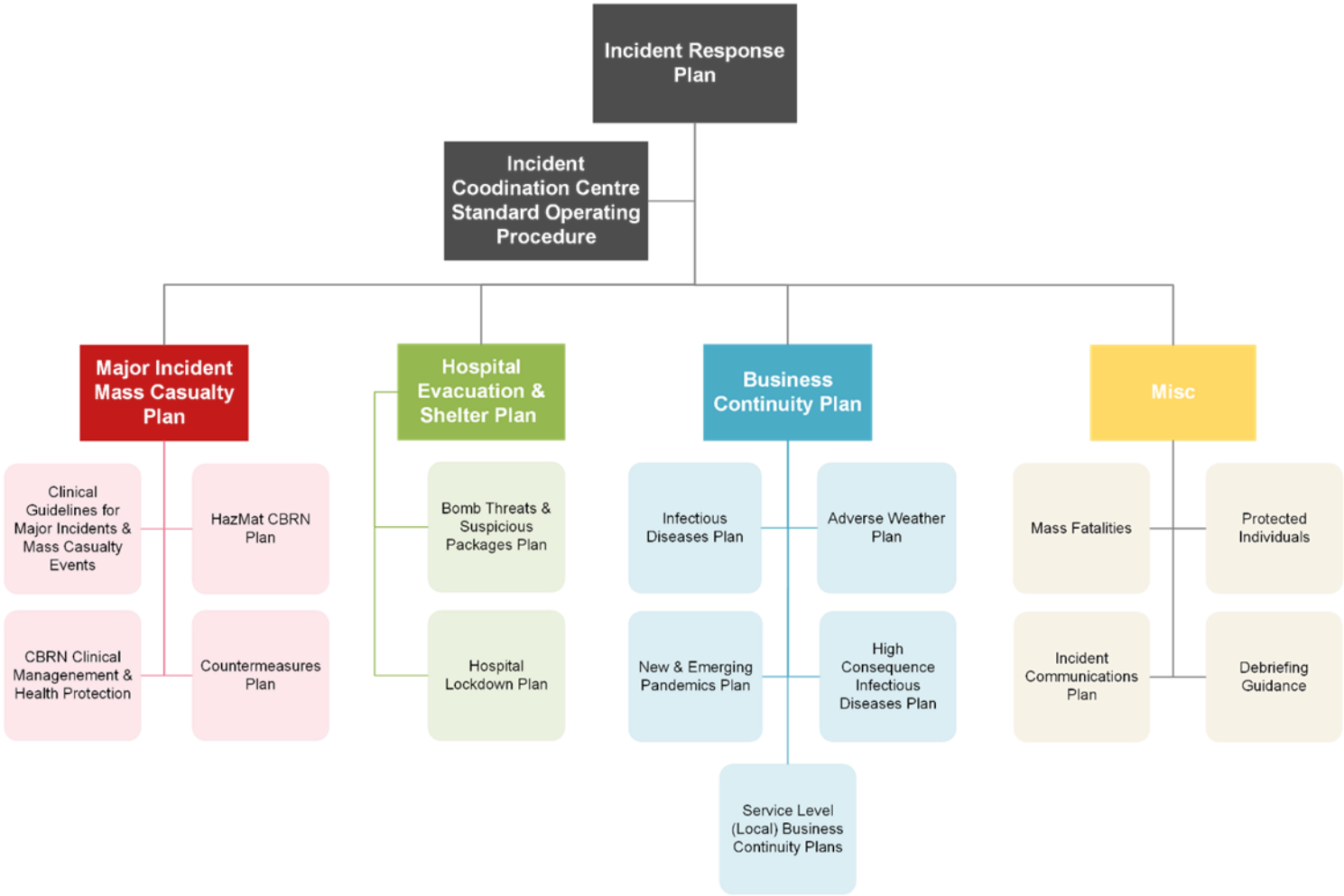
In line with NHS England's EPRR Core Standards and assurance process, it is considered good practice to review policy every three years and plans annually, unless significant changes occur.

The Trust maintains a broad suite of incident response plans. Most plans are current and within review date, with several newly issued in 2024–2025. A small number require additional attention due to being overdue. This highlights strong overall plan coverage but a priority need to update overdue documents.

Incident response and business continuity plans, are required to be reviewed annually to ensure they remain current, reflect updated risk, and incorporate lessons learned from incidents or exercises. The Trusts policies, plans and procedures are maintained on the Trusts Document Management System (DMS).

Title	Date Issued	Next Review
Adverse Weather Plan	Sep-25	Sep-26
Bomb Threat Plan	Sep-21	Sep-24
Business Continuity Management Strategy	Aug-24	Aug-27
Business Continuity Plan	Jul-25	Aug-26
Countermeasures Plan	Jun-25	May-26
Debriefing Guidance	Jul-25	Aug-26
Emergency Preparedness, Resilience and Response Policy	May-25	May-28
HAZMAT and CBRN Incident Response Plan	Jul-25	Aug-26
High Consequence Infectious Diseases Plan	Sep-23	Sep-26
High Profile Patients & Families (Protected Individuals) Policy	Dec-24	Dec-28
Hospital Evacuation & Shelter Plan	Oct-25	Oct-26
Incident Response Plan	Aug-24	Aug-27
Incident Communications Plan	Jul-25	Jul-26
Incident Coordination Standard Operating Procedure	May-25	May-26
Lockdown Plan	Not Authored	Not Authored

Major Incident Plan	May-23	May-24
Mass Fatalities Plan	Oct-25	Oct-26
On Call Manager Policy	May-22	May-25
Pandemic Plan	Jan-24	April-24



5.1 Divisional & Departmental Business Impact Analysis & Business Continuity Plans

Divisions are demonstrating clear progress in strengthening local Business Continuity Plans, with increased engagement in Business Impact Analyses and exercising activity across several areas. Multiple services now hold in-date plans, indicating improved document maintenance and version control. While 1 division has achieved full BCP compliance, the current position shows movement from plan ownership toward active testing and assurance, providing a stronger foundation for achieving full compliance in the next phase of BCMS development.

Medicine	Total
BIA's Conducted	11
# of BCP's	15
BCP's Exercised	9
BCP's in Date	2

Surgery	Total
BIA's Conducted	6
# of BCP's	7
BCP's Exercised	0
BCP's in Date	0

Community	Total
BIA's Conducted	0
# of BCP's	14
BCP's Exercised	0
BCP's in Date	8

Estates & Facilities	Total
BIA's Conducted	0
# of BCP's	7
BCP's Exercised	0
BCP's in Date	0

Digital	Total
BIA's Conducted	0
# of BCP's	4
BCP's Exercised	0
BCP's in Date	0

Research	Total
BIA's Conducted	1
# of BCP's	1
BCP's Exercised	1
BCP's in Date	1

Corporate Services	Total
BIA's Conducted	0
# of BCP's	5
BCP's Exercised	0
BCP's in Date	0

Misc	Total
BIA's Conducted	N/A
# of BCP's	1
BCP's Exercised	N/A
BCP's in Date	1

6. Summary of Incidents

During the reporting period, four formal live incidents were managed, two of which were formally declared and fully debriefed. The cyber incident (Nov 2024) and measles incident (July 2025) were led by Alder Hey with partner agencies and completed with lessons identified. The RTC standby (May 2025) and BMA industrial action (Aug 2025) were not formally declared, therefore do not have recorded debriefs.

Incident	Date	Type	Formally Declared	Response Led By	Completed With	Debrief Report / Lessons Identified
Cyber Incident	28/11/2024	Business Continuity	Yes	Alder Hey	NHS C&M ICB, CSOC	Yes
Liverpool Parade RTC	26/05/2025	Major Incident Standby	No	NWAS	-	No
Measles Incident	29/07/2025	Business Continuity	Yes	Alder Hey	NHS C&M ICB, UKHSA	Yes
Industrial Action BMA	25/08/2025	Business Continuity	No	Alder Hey	NHS C&M ICB	No

7. Training & Exercising

7.1 Training

The Trusts comprehensive EPRR training programme was delivered across the year, with a substantial focus on strengthening incident response awareness and capability, business continuity planning. Delivery of sessions available are a combination of face to face, remote, and self-led learning across the range of workshops, role-specific training, commander development, incident coordination familiarisation, and awareness sessions. Multiple sessions were repeated to build organisational coverage and support ongoing plan development.

Title	Date	Type	Description	Led By
Business Continuity Workshop	20/01/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
CBRN HazMat Commander	14/02/2025	Training	Plan specific training for Tactical Commanders	EPRR Lead
Commander Training	18/02/2025	Training	Generic incident response training	EPRR Lead
CBRN HazMat Commander	04/03/2025	Training	Plan specific training for Tactical Commanders	EPRR Lead
Incident Coordination Centre Awareness	17/03/2025	Training	Location training for Incident Commanders	EPRR Lead
Loggist Training	17/03/2025	Training	Incident role training	EPRR Lead
Business Continuity Workshop	08/04/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Business Continuity Workshop	09/04/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Business Continuity Workshop	09/04/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Business Continuity Workshop	16/04/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Business Continuity Workshop	22/04/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Business Continuity Workshop	28/04/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Business Continuity Workshop	08/05/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Commander Training	30/05/2025	Training	Generic incident response training	EPRR Lead
CBRN HazMat Commander	04/06/2025	Training	Plan specific training for Tactical Commanders	EPRR Lead
Business Continuity Workshop	20/06/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Students Workshop	26/06/2025	Awareness Session	Learner Forum: Major Incident Awareness	EPRR Lead
Business Continuity Workshop	23/07/2025	Workshop	Business Continuity Plan Author Workshop	EPRR Lead
Loggist Training	24/07/2025	Training	Incident role training	EPRR Lead

Incident Coordination Centre Awareness	24/07/2025	Training	Location training for Incident Commanders	EPRR Lead
Commander Training	28/08/2025	Training	Generic incident response training	EPRR Lead
CBRN HazMat Commander	04/09/2025	Training	Plan specific training for Tactical Commanders	EPRR Lead

7.2 Exercising

The Trust undertook all scheduled exercises during the 2025 period as set out in the 2025-2027 EPRR exercising programme, these exercises covered major incident, business continuity, cyber, and High Consequence Infectious Disease scenarios. This included both tabletop activities and communication cascade tests, led by either the EPRR Lead or C&M ICB. The exercises provided opportunities to test plans, coordination, decision-making, and communication pathways.

Title	Date	Type	Description	Led By
Exercise Ortho	26/11/2024	Tabletop	High Consequence Infectious Diseases Exercise	EPRR Lead
Exercise Gabriel	25/07/2025	Communications Cascade	Major Incident Cascade	C&M ICB
BC - Staffing Loss	11/06/2025	Tabletop	Business Continuity Exercise	EPRR Lead
Exercise Steer	16/06/2025	Tabletop	Cyber Incident Exercise	EPRR Lead
Exercise Polloi	04/07/2025	Tabletop	Major Incident Exercise	EPRR Lead
Exercise Mayday	04/09/2025	Communications Cascade	Major Incident Cascade	C&M ICB

8. Conclusion

Since September 2024 the Trust has continued robust development as part of its overall emergency planning and resilience arrangements.

Additional efforts into divisional incident planning, and subject matter expert ownership and contribution to incident response plans are required to further improve overall compliance.

The Trust should be undertaking internal audit and external audit specific to business continuity aligned with organisational audit framework, this requires suitable resource.

The current position of partial compliance reflects both the significant progress achieved and the work still required to meet all NHS England EPRR Core Standards. With focused improvement activity, strengthened governance and resourcing, timely review of key plans, and continued engagement in training, exercising and business continuity assurance, the Trust is well placed to move toward substantial compliance and further enhance organisational preparedness.

9. Recommendations

The Alder Hey Children's NHS Foundation Trust Board of Directors is requested to note the annual EPRR assurance report and self-assessment assurance rating of partial compliance in line with the NHS England EPRR Core Standards for 2025.

Appendix 1 – Partially Compliant Core Standards

Domain	Name	Detail	Compliance Assessment
Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Partially compliant

Domain	Name	Detail	Compliance Assessment
Duty to maintain Plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Partially compliant
Duty to maintain Plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Partially compliant
Duty to maintain Plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Partially compliant
Duty to maintain Plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Partially compliant
Duty to maintain Plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Partially compliant

Domain	Name	Detail	Compliance Assessment
Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Partially compliant

Domain	Name	Detail	Compliance Assessment
Business Continuity	Business Impact Analysis/ Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Partially compliant
Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially compliant
Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Partially compliant

Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Partially compliant
Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Partially compliant
Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Partially compliant

Domain	**Name**	**Detail**	**Compliance Assessment**
Hazmat/ CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Partially compliant

BOARD OF DIRECTORS

Thursday, 8th January 2026

Paper Title:	**Chair's Report from ARC meeting, 10th December 2025**
Report of:	**ARC Chair**
Paper Prepared by:	**ARC Chair**

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Minutes from the meeting on 18th September 2025
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☐ **Collaborate** for children & young people ☐ **Revolutionise** care ☐ **Support** our people ☐ **Pioneering** breakthroughs ☐ **Strong Foundations** ☑
Resource Implications:	None

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

Risk Number	Risk Description	Score

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

1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board and provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

2. Agenda items received, discussed / approved at the meeting

- Presentation on risk management processes within Surgery
- Update on the Roll Out of Risk Appetite and Tolerances
- Board Assurance Framework (ARC deep dive of workforce risks 2.1, 2.2 & 2.3).
- Risk Management Training Options Paper
- Risk Management Forum Update including Chair's Report and Minutes from most recent meeting
- Corporate Risk Register
- Trust Risk Management Report
- Risk Management Policy **(Approved)**
- Risk Horizon Scanning Discussion
- Internal Audit Progress Report, including the outcomes of audits of Clinical Audit (Moderate) and Divisional Clinical Governance (Substantial)
- Clinical Audit Progress Report
- Update on Oversight of External Visits, Inspections and Accreditations
- Q1 & 2 Assurance report on Compliance with the Freedom of Information Act
- Updated Corporate Governance Manual
- Q1 & 2 Tenders and Waivers Activity
- Proposed Questionnaires for Assessing the Effectiveness of Internal Audit, External Audit and the Anti-Fraud Service

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

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

- Loss of (need to maintain) Segment 1 status
- The "perfect storm" of increased pressure on the Trust and its employees due to the time and emotional demands of responding to the Southport Inquiry and the financial pressures resulting from the turnaround of the C&M system potentially leading (particularly workforce reductions) to poor morale at a time when the Trust is undertaking significant work in preparing for the application for Advanced Foundation Trust status, development of the paediatric chain and delivery of Vision 2030 and this may result in reduced performance and increased risks, incidents etc.

4. Positive highlights of note

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

- An Internal Audit of Governance of the Financial Improvement Programme was approved.
- The change in focus of the Risk Management Forum to enable understanding of the risk impact of decisions being made due to the Financial Improvement Programme.
- Following an unsuccessful request to the Education Governance Committee to reinstate Risk Management as a mandatory training topic, a revised proposal was received (and approved) from the Assistant Director of Nursing & Governance which recognises it as an essential (but not mandatory) topic for all Band 7s and above (1,426 staff) and provides training based on an off the shelf e-learning module supplemented by "drop-in" clinics with the Central Governance Team.

5. Issues for other committees

None.

6. Recommendations

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

Appendix 2 – 2025/26 Internal Audit Plan

Audit	Assurance Outcome	May be of interest to…
Assurance Framework Opinion		Board
Conflicts of Interest	Substantial	Board
Governance of the Gender Development Service		Board & SQAC
Key Financial Controls		FTPC
Asset Management Processes	Substantial	FTPC
Financial Measures (Grip & Control)		FTPC
Governance of Workforce Reduction Programme		People Committee
Clinical Audit	Moderate	SQAC
Theatre Management		SQAC
Data Security & Protection Toolkit		FTPC
Remote Access		FTPC
Balance Sheet Controls		FTPC
Governance of the Financial Improvement Programme		FTPC

The following audits related to 24/5 but were reported in 25/6:

Audit	Assurance Outcome	May be of interest to…
Cyber Assessment Framework Part 2	Limited	FTPC
Clinical Governance (draft report prep)	Substantial	SQAC

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

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 18th September 2025 via Teams**

Present:	Mrs. K. Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mr. G. Baines	Regional Assurance Director, MIAA	(GB)
	Mr A Bateman	Chief Operating Officer & Deputy Chief Executive	(AB)
	Ms. E. Kirkpatrick	Assoc. Director of Finance - Commercial, Control and Assurance	(EK)
	Mrs. R. Lea	Interim Chief Financial Officer	(RL)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
Item 25/26/75	Ms. B. Pettorini	Director of Surgery	(BP)
Item 25/26/75	Ms. L. Cooper	Director of Community and MH Services	(LC)
Item 25/26/75	Ms. C. Wardell	Assoc. Chief Nurse for Medicine	(CW)
Item 25/26/75	Ms. N. Pickard	Senior Manager, Division of Medicine	(NP)
Item 25/26/78	Ms. K. Birch	Director of Alder Hey Academy	(KBir)
Item 25/26/78	Ms. S. Leo	Head of Research	(SL)
Item 25/26/86	Ms. P. Fagan	Assistant Director of Digital, MIAA	(PF)
Item 25/26/88	Mr. P. Bell	Head of Anti-Crime Services, MIAA	(PB)
Item 25/26/89 & 90	Mr. D. Spiller	Senior Manager, Ernst & Young	(DS)
Item 25/26/91	Ms. M. Perrigo	Clinical Legal Services Manager	(MP)
Item 25/26/92	Mr. P. White	Chief Nursing Information Officer	(PW)
Observing	Mr. G. Bagnall	Governor	(GBag)
Apologies:	Ms. K. Stott	Senior Audit Manager, MIAA	(KS)
	Mr. H. Rohimun	Executive Director, Ernst and Young	(HR)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JRo)

*AB left the meeting after the risk element of the agenda.

25/26/73 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that had been received. A warm welcome was extended to new governor, Geoff Bagnall, who attended the meeting as an observer.

25/26/74 Declarations of Interest

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

25/26/75 Risks and Concerns Arising in the Current Financial Environment

The Committee was advised that Divisional Directors have been invited to the meeting to provide a current update on risks within their respective Divisions. The agenda item is intended to allow each Director to communicate any concerns to the Audit and Risk Committee (ARC) in light of the rapidly changing environment. The following points were highlighted:

Division of Surgery

The Director of Surgery, Benedetta Pettorini (BP), provided an update on risks within the Division of Surgery, pointing out that while the division is aligned with the Closing the Gap Programme, there are limits to what can be done without running risks. It was reported that the Division has already implemented significant reductions in bank spend, overtime, and Waiting List Initiatives (WLIs) resulting in a reduction in activity. Concern was expressed that further reductions or less selective management of MARS/vacancies will inevitably introduce clinical gaps, lower standards, and negatively impact patient experience.

The Chair asked as to whether colleagues would raise concerns if they felt that clinical risks were unacceptable. It was reported that current forums and processes within the Division allow staff to escalate concerns and discuss matters, with a number of MARS applications having been refused based on risk judgements. The Division is in the process of developing a consistent risk scoring mechanism that it can apply to any decisions made but it was felt that further pressure to reduce resources would necessitate active risk mitigation and possible escalation. It was concluded that while the Division is currently managing risks, any gaps in staffing would require additional financial resources to mitigate them, and if such mitigations cannot be implemented, the Division will escalate the risk to the Board.

Community and Mental Health Division

The Director of Community and Mental Health Services, Lisa Cooper (LC), provided an update on risks and concerns within the Division pointing out that clear documentation and robust governance processes are essential for recording decisions. It was felt that all decisions must be auditable as the long-term impact of current decisions, particularly in Mental Health and Children's Services, may not become apparent for a number of years.

It was reported that the Division is facing challenges due to its inability to recruit to vacant positions as a result of current financial constraints. This situation has raised concerns among frontline staff and emphasised the importance of clear communication and continued support during stressful times.

The Committee was advised that the Division has external investments that are expected to achieve growth and measurable outcomes, including the recruitment of personnel for these specific services, i.e. Gender Development Service, when recruitment is restricted in other services. Attention was drawn to the importance of maintaining equitable recruitment practices across all services to ensure that no cohort of CYP are disadvantaged or indirectly discriminated against.

Additionally, concerns were raised about the ongoing impact of the Southport Public Inquiry on staff morale and well-being. It was also reported that there are thirteen members of staff who will be affected by the recent changes in skilled worker visa regulations, potentially resulting in job losses and implications for the Division.

Division of Medicine

Nikita Pickard (NP) and Cath Wardell (CW) echoed concerns raised by the other Divisions and highlighted the vulnerability of specialist and highly skilled posts in Medicine, warning that recruitment restrictions could lead to the loss of expertise and result in issues (re)recruiting in the future which could make currently stable services fragile in terms of skill mix.

Both confirmed confidence that staff would escalate concerns, referencing processes in place and ongoing work to encourage communication and raising issues.

The need to document risk-related discussions and decisions for future reference during this challenging period was emphasised. The Chair confirmed that these conversations will feed into the Committee's horizon scanning discussion.

Attention was drawn to the concern raised about the potential for inadvertent discrimination between different cohorts of CYP when prioritising recruitment and resources, and it was queried as to whether more needs to be done to maintain equitable recruitment practices across all areas. It was reported that the decisions that the Trust is having to make are increasingly complex, necessitating a decision-making framework that considers factors such as vacancy, sickness rates, harm across specialities, etc. This process is still undergoing refinement with ongoing contributions from Executive leadership and divisional colleagues, to ensure fairness in resource allocation and that the prioritisation of services for onboarding new staff is appropriately determined. Additionally, it is essential to understand the consequences for all services in terms of the decisions being made.

The Chair referred to the placeholders on the 2025/26 Internal Audit Plan and suggested undertaking an audit to review the governance around the Workforce Reduction Programme with the aim to provide assurance on decision-making processes and how the organisation documents things now for the future.

Committee members expressed appreciation for the Divisional Directors' honesty and the value of open discussion, recognising the significant pressures faced by staff and leadership in balancing financial and clinical risks.

Resolved:
ARC noted the updates from the Divisions.

25/26/76 **Minutes from the Meeting held on 17th July 2025**
Resolved:
The minutes from the meeting held on the 17.7.25 were agreed as an accurate record of the meeting.

25/26/77 **Matters Arising and Action Log**

Matters Arising

There were none to discuss.

Action Log

Action 23/24/97.1: *Risk Tolerance and Appetite (advocacy)* – This action remains ongoing and is linked to broader strategic discussions and the Charity's advocacy project. It was noted that the topic will be further addressed as the new Growth and Opportunities (GO) Committee becomes established, with further updates expected after the inaugural meeting. It was decided to merge related actions (see 24/25/43.1 below) into this action and schedule a formal update in February, providing ample time for progress. **ACTION TO REMAIN OPEN**

Action 24/25/43.1: *Update on Risk Appetite and Tolerance (meeting to be arranged for KB, ES, JRO, Adam Bateman, John Chester and Shalni Aurora to further the discussion on innovation risks and risk appetite and how assurance can be provided to ARC on innovation activities)* – It was decided to merge this action into action 23/24/97.1 and schedule a formal update in February, providing ample time for progress. **ACTION TO REMAIN OPEN**

Action 24/25/108.1: *Risk Management Forum* (*RMF) update, minutes and Corporate Risk Register (CRR) (Include narrative in the report to indicate as to whether the mitigations are within or outside the Trust's control)* – It was confirmed that this information will be included in the next report. **ACTION TO REMAIN OPEN**

25/26/117.1: *InPhase Programme Update (Discussion to take place with the InPhase Project Board about the possibility of having InPhase Champions so that the organisation isn't solely reliant on one person)* – This action is addressed in agenda item **25/26/92. ACTION TO BE CLOSED**

25/26/117.2: *InPhase Programme Update (Look towards including feedback from the organisation's staff networks as part of the FTSU module as this is another source where the Trust is encouraging staff to raise incidents and concerns)* – As per agenda item **25/26/92** InPhase implementation has transferred into business as usual. This action to be passed to PW for consideration within the InPhase Operational and Development groups. **ACTION TO BE CLOSED**

25/26/44.1: *E&Y External Audit Year End Report on the Trust's Accounts (Schedule a Meeting with E&Y/Finance to discuss the additional audit fees in further detail)* - The discussion regarding additional audit fees is to be taken offline and the outcome will be reported back to the Committee once agreed. **ACTION TO REMAIN OPEN**

25/26/51: *Clinical Audit Annual Report for 2024/25 (Develop a process for monitoring and gaining assurance on the completion and embedding of actions from Trust-wide clinical audits)* – Work is taking place to develop a process for monitoring and gaining assurance on the completion and embedding of actions from Trust-wide clinical audits. The deadline for reporting into the Clinical Outcomes Programme is set for the end of September, and the work is currently in progress. **ACTION TO REMAIN OPEN**

25/26/62.2: *Review of BAF Risks (FPTC) – Undertake a piece of work to ensure that the 'Top 5 Risks' presented at FTPC are aligned with the strategic risks captured in the BAF* - This work is ongoing. **ACTION TO REMAIN OPEN**

25/26/78 Update on the Risk Management Process within Research, Innovation and Education

The Committee received an overview of the risk management process within Research, Innovation and Education. A number of slides were shared with the Committee that provided information on the following areas:

Education

- *The Academy* – The Academy oversees multiple teams responsible for internal and international learning, education, and opportunities for CYP and staff.
- *Risk reporting and assurance* – Risks are managed at team level, reviewed regularly, and reported to the Education Governance Committee (EGC), which includes internal and external (deanery, national college) representation.
- *Divisional governance structure* – The governance process is seen as an exemplar by NHSE and the deanery.
- *Risk profile* – Three new risks have been added to the risk register in September; inability to meet stretch income target, Learning and Development (L&D) activity and competence, professional nurse advocate Trust compliance. Anticipated risks include changes to the Apprenticeship Levy, placement provider expectations, and national concerns about newly qualified graduates' employment.
- Challenges:
  - Significant shift in national context/learner profiles.
  - Pressure to do more.
  - Multi-partner roles and responsibilities.
  - Recruitment (vacancies, national discussions).
  - International (lack of dedicated Business Development Delivery Team with expertise in respect of delivering education and training overseas).
- Key actions:
  - EGC focused reviews.
  - Monthly incident and risk review meetings with Heads of Departments.
  - Risk Appetite and Tolerance discussions.

The Chair queried the level of confidence across the teams to recognise risks and report them. The Committee was advised that some teams demonstrate a high level of understanding owing to the expertise in their team. However, there is ongoing development for newer team members to ensure consistent risk perception and escalation.

Research and Innovation

- Innovation risks (*summary position*): There are 5 risks currently open.
- Research risks (*summary position*): There are 6 currently open, with 1 under review.
- Key governance structures for assurance, approval, decision-making and monitoring;
  - Risks are managed by rea managers, added to InPhase, and reviewed by the Senior Team.
  - Risks are communicated to teams via monthly bulletins.
  - The governance structure includes a Futures Management Board (combining Research and Innovation), a Divisional Assurance Group, and an Operational Group for weekly risk review.
  - Research risks are well-governed; Innovation risks are generally lower but require clarity on clinical governance oversight, especially as Innovation is more risk-tolerant than Research.
  - Work is ongoing to bring clinical governance expertise into Innovation risk management.

The Chair inquired about the methodology for establishing appropriate risk targets for Innovation in the absence of a clearly defined Risk Appetite. It was explained that Innovation-related risks are generally not high, as pilots and evaluations are conducted in a controlled manner and operate in parallel with existing processes. The main risks identified relate to

financial implications or the integration of innovations into business as usual. It was confirmed that work is ongoing to provide greater clarity regarding clinical governance in the context of Innovation.

GBag asked about the risk scoring scale and the GO Committee. The Chair clarified the risk scoring and ES advised that all new Governors will receive a local induction covering the Trust's structure which includes the GO Committee.

Resolved:
ARC noted the update on the Risk Management Process within Research, Innovation and Education.

25/26/79 Board Assurance Framework (BAF) Report

The Committee received the BAF Report for August 2025. The Chair commended the notable enhancements in the clarity of the document, as well as the improved articulation of risks, controls, and actions, observing that the BAF is at its highest standard since her tenure with the Trust began. It was noted that current discussions predominantly focus on external factors, which remain the primary influence on the BAF, and that the organisation is also reviewing its Risk Appetite in the context of the current challenging environment. MIAA concurred with the Chair's observations, emphasising that the document continues to evolve and is actively utilised. ES acknowledged JP for her efforts in familiarising herself with the InPhase BAF module and for providing guidance to colleagues.

Board Assurance Framework Policy

The Committee was advised that the BAF Policy remains appropriate for its intended purpose, with the primary update being additional information regarding Risk Appetite. ARC approved the updates to the Policy and commended it to the Trust Board for ratification.

Focus on SQAC risks (1.1, 1.2 and 1.4)

The Committee reviewed the risks assigned to SQAC, noting recent updates and improvements. The Chair pointed out a potential gap in Actions related to transformational change in follow-up care under risk 1.2; clarifying that this is a gap on the BAF rather than a gap in practice.

The Trust remains in the process of implementing its Risk Appetite, which has resulted in some delays regarding alignment.

Risks 3.2 (System Risk) and 4.2 (Digital/Data Risk) were noted as having fewer robust updates compared to others. It was explained that this is more of a timing issue and that further reframing and updates were planned, especially for System Risks and Digital Actions.

Resolved:
ARC:

- Noted the BAF report for August 2025 and the review of the BAF risks allocated to SQAC.
- Approved the updates to the BAF Policy and commended it to the Trust Board.

25/26/80 Risk Management Forum Update; including Chair's Highlight Report and Corporate Risk Register

The Committee received an update from the RMF on the 5.9.25; the following key points were highlighted:

- The RMF reviewed the highest scoring operational risks, focusing on vulnerable services such as Metabolic, Radiology, and Biochemistry, and discussed action plans for these areas.
- A major theme was the relationship between financial pressures and people risks, particularly the rise in sickness absence and the challenge of maintaining staff engagement and wellbeing during difficult financial decisions. It was reported that the HR Team has undertaken sprint sessions/improvement work in terms of reviewing staff members who are on long-term sick leave. The RMF acknowledged that these situations pose a significant risk to the organisation.
- It was noted that only 11% of actions were overdue, while 65 risks have been closed in the last month, demonstrating significant progress in addressing and mitigating risks.
- An area for improvement was identified in the Community and Mental Health Division, where 60% of actions were overdue and 25% of risks lacked action plans. The leadership team has been asked to formally improve this for the next meeting.
- An Extraordinary RMF is to be scheduled to aggregate and assess the cumulative impact of financial decisions on quality, safety, and staff wellbeing, rather than considering these risks in isolation. This Extraordinary Meeting will provide a safe space for open discussion, enabling the organisation to revisit and understand the broader and dynamic consequences of ongoing cost-saving measures and to ensure that risk management remains holistic and responsive to the evolving financial environment.
- The RMF has agreed a new standardised risk review proposal, which recommends that risks with lower scores be formally reviewed every three months. A discussion took place and Forum Members provided feedback that this frequency should be considered the minimum standard, emphasising that risks must also be reviewed whenever there are changes or new developments. The Forum agreed that clear communication is needed to ensure the proposal is understood as a baseline for formal assurance, not as a limitation, and that Risk Owners remain responsible for ongoing, responsive risk management.

The Chair advised of her attendance at September's RMF and provided the Committee with assurance on the effectiveness of the RMF.

Corporate Risk Register (CRR)

The Committee received the CRR for the reporting period from the 1.6.25 to the 31.7.25.

The Chair provided feedback on the CRR, noting the addition of two new risks and emphasising the importance of reviewing the wording of new or escalated risks to ensure clarity regarding their meaning and implications. Attention was also drawn to the challenge of distinguishing, within the report, between risks that have robust action plans likely to resolve the issue and those where effective mitigation strategies are lacking. It was suggested that these two categories of risks require different approaches from the Committee, with the former monitored for timely action plan delivery and the latter warranting further discussion. It was proposed that these comments be fed back to JRO and discussed further with ES at their next joint meeting.

25/26/80.1 Action: KB/JRO/ES

Resolved:

ARC noted the RMF update and the CRR for the reporting period; 1.6.25 to the 31.7.25.

25/26/81 Risk Management Training Options

The Committee received a paper that presented options for the roll out of risk management training, for further discussion and agreement. Due to unforeseen circumstances the report owner was unable to attend September's meeting therefore it agreed to defer this item to December to enable a more informed discussion to take place.

A question was raised regarding whether the proposed e-learning module will be developed internally or acquired as an off-the-shelf package. It was noted that a package is available, which may require some modifications.

For noting
Risk Management Training Options Report to be re-submitted to ARC in December.

25/26/82 Risk Management Strategy

The Committee received the updated Risk Management Strategy. It was noted that the Strategy had been reviewed in conjunction with the more comprehensive Risk Management Policy, which is scheduled to be presented to the Committee in December. The Chair, having been actively involved in revising the Risk Management Strategy, expressed support for its approval, pending any further feedback from Members.

Resolved:
ARC approved the Risk Management Strategy.

25/26/83 Trust Risk Management Report
Resolved:
ARC received and noted the Trust Risk Management Report.

25/26/84 Fraud Risk Assessment Matrix

The Committee was advised that the Trust has taken the opportunity in H1 2025/26 to review the current status of the risks included on the Fraud Risk Assessment Matrix to ensure that fraud risks remain mitigated as far as possible. Named leads for each risk area have reviewed the risk assessment from the prior year to determine if the articulation of risk and mitigations remain relevant, and have updated where appropriate. It was reported that all risks scoring over 10 have specific risks logged on the Trust Risk Register.

In 2025/26 five out of eight areas showed improvement compared to the previous year; staff payroll, staff non-payroll, suppliers, systems, and third parties. The highest risks remain in time sheets/overtime/not working contracted hours, scams and cyber-crime. The bank mandate risk (previously risk ranked as 12 has reduced to 9) remains on the Matrix. It was reported that MIAA is currently updating the Matrix for 2025/26 and will issue an updated version in Q3 to reflect the Failure to Prevent Fraud Offence Act and any new guidance.

Questions were raised and responded to about whether the Fraud Risk Assessment Matrix should become a more live document for the Committee, and whether the target risk for bank mandate fraud should be lowered given the recent discussions on Risk Appetite and Tolerance.

Resolved:

ARC noted the update on the Fraud Risk Assessment Matrix.

25/26/85 Horizon Scanning

The Committee discussed emerging risks that may impact the organisation, with the aim of providing the Executive Team with a checklist of concerns for further consideration. The following points were raised:

- Attention was drawn to the importance of the Trust maintaining its position in the Segment 1 of the new regulatory performance framework for acute trusts as it was felt that this is critical for preserving the Trust's freedom, flexibility, and opportunities for expansion/development.
- A concern was raised about the potential impact of ongoing national negotiations between the Secretary of State and pharmaceutical companies regarding drug payment levels. From a long-term perspective it was felt that this could result in reduced medication quality which may pose risks for the Trust, given that innovation is central to the organisation's operations. There are also potential financial risks and cumulative effects on service quality and safety, all of which could substantially impact the organisation's resources.

As per the previously agreed process, JP will prepare a paper summarising the risks and concerns discussed for submission to the next Executive Team meeting.

Resolved:
ARC noted the emerging risks that may impact the Trust and requested JP prepare a paper for them to be escalated to the Executive Team.

25/26/86 Internal Audit Progress Report

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

- There have been two final reports issued:
  - Asset Management Processes – Substantial Assurance.
  - Data Security & Protection Toolkit (DSPT) – High Risk.
- Reviews in progress:
  - Divisional Clinical Governance – Draft report is being prepared.
  - Clinical Audit – This audit has been delayed slightly as MIAA have been asked to observe meetings. The report will be submitted to ARC in December.
  - Balance Sheet Audit – This review is in the planning stage.

PF provided an update on the DSPT audit, noting that this year's assessment was conducted under a new, more rigorous framework aligned with the National Cyber Security Centre's Cyber Assessment Framework (CAF). Of the 47 outcomes in the Toolkit, 12 were audited (eight mandated by NHS England and four agreed locally). The Trust met the minimum required profile for eight outcomes, with four areas identified as requiring further work (Supply Chain Management, Identity Verification, Authentication and Authorisation, Vulnerability Management, and Monitoring Coverage). It was advised that these themes are common across the sector and that NHSE anticipates Supply Chain Management will remain a challenge for the foreseeable future. The Committee was advised that the Trust's self-assessment closely matched the audit findings, and that the Trust has submitted an Improvement Plan to NHSE as required by the DSPT process. PF advised the Trust to

consider whether it has sufficient resources to meet the increasing demands of cyber risk management.

The Chair asked about the Trust's position on cyber risk management compared to other trusts. It was noted that Alder Hey is currently midway compared to peers, but that additional preparation ahead of the audit and implementing new tools will support improvement.

It was queried as to whether Supply Chain Management is the Trust's primary risk and if so, is there an established process in place to manage this complex area. PF advised that effective risk management involves evaluating all sources, including third parties, and developing a thorough understanding of suppliers. NHSE is currently undertaking pilot work in this area and will collaborate with trusts to enhance Supply Chain Management practices.

A discussion took place about the oversight and tracking of the Cyber Improvement Plan and it was decided that it should be monitored by FTPC as cyber falls within its Terms of Reference. It was agreed to submit the Plan to FTPC during October's meeting.

25/26/86.1 **Action: RL**

Attention was drawn to the two placeholders left on the Audit Plan. It was agreed to undertake a review of "Governance of the Workforce Reduction Plan", and a virtual decision will made about the remaining audit.

25/26/86.2 **Action: KB**

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

25/26/87 **Internal Audit Follow-Up Report**

The Internal Audit Follow-Up Report was submitted to the Committee to provide an update on the progress that has been made against the recommendations due for implementation during the period from July 2025 to August 2025. The following points were highlighted:

- Of the 14 recommendations due, 8 were implemented and 6 were partially implemented.
- It was reported that the Freedom to Speak Up (FTSU) recommendation still remains partially implemented with another extension requested for one month to end October 2025 to enable internal recruitment to complete. The three CAF recommendations were followed up as part of the DSPT audit and it was confirmed that one has been implemented whilst two remain partially implemented with another extension request to December 2025. Three of the Equality, Diversity and Inclusion (EDI) recommendations are partially implemented with an extension request to December 2025. The Chair provided rationale as to why the requests for extensions should be approved for the FTSU and EDI recommendations.

Reference was made to the CAF recommendations, and it was explained that this is a complex area, and the tasks involved require significant resources and effort to reach the necessary level, and establishing a realistic deadline for completing these actions is essential. The Chair agreed to liaise with the relevant leads before approving the requested extension to gain assurance that the new deadlines are achievable. The Chair also asked MIAA to advise as soon as possible of any requests they receive for extensions going forward.

25/26/87.1 **Action: KB**

ES advised the Committee of the upcoming Information Commissioner's Office (ICO) audit which will concentrate on children's data, and emphasised the importance of coordinating resources and avoiding duplication of efforts.

Resolved:
ARC received and noted the content of the Internal Audit Follow Up Report and approved the requests for extensions for the overdue recommendations relating to FTSU and EDI.

25/26/88 Anti-Fraud Progress Report

The Committee received the Anti-Fraud Progress Report for the reporting period from the 1.4.25 to 9.9.25. An overview of the content of the Report was provided, and attention was drawn to the following points:

- The Counter Fraud Functional Standard Return (CFFSR) submission against the national counter fraud, bribery and corruption standards was submitted by the deadline date of the 31.5.25. The Return was reviewed and approved in advance of the submission by the Interim Chief Financial Officer and the Chair of ARC. The Trust received a "green" rating overall, as well as across the 12 components which comprise the CFFSR.
- In July 2025, NHS Counter Fraud Authority (NHSCFA) provided a paper following the May 2025 submission of the CFFSR, which forms part of these papers for information and awareness to ARC members. The feedback document provided analysis from the last five years for England regarding frauds identified, frauds prevented, and frauds recovered as well as criminal, disciplinary and civil sanctions, which shows an increase from the previous year.
- The new Failure to Prevent Fraud Offence came into effect on the 1.9.25. The new legislation makes organisations criminally liable if an 'associated person' commits fraud for the organisation's benefit, unless it can prove it has reasonable fraud prevention measures in place. It applies to all NHS bodies. The NHSCFA has recently issued guidance to assist health bodies in preparing for the enforcement date. The AFS attended an NHSCFA webinar delivered on the 15.7.25 and issued a Client Briefing to key contacts on the 22.7.25. The AFS will update the Anti-Fraud, Bribery and Corruption Policy to reflect the new fraud offence in due course, as part of the planned Failure to Prevent Fraud Offence Gap-Analysis Local Proactive Exercise (LPE) work during 2025/26. The Terms of Refence for the LPE were agreed by the Associate Director of Finance on the 9.9.25.

  Two webinars are being hosted by MIAA and Hill Dickinson on the 30.9.25 and the 10.10.25 which will focus on the new Failure to Prevent Fraud Offence, its legislative implications, and how MIAA will assist the Trust with compliance.

- AFS has completed two proactive exercises (Contract Management NHSCFA National Procurement Exercise 2024/25 and Agency/Bank Staff ID Validation and Vetting LPE). It was noted that recommendations and management actions had been agreed and included in the progress report for information.

The Chair asked if there were any lessons learned, or changes required to internal controls as a result of recent fraud investigations. It was reported that HR undertakes internal reviews, and any relevant recommendations from AFS would be included in future reports. The Chair asked that actions arising from LPEs and their follow up be provided as a separate document for future meetings, since they are "lost" within the detailed Progress Report.

25/26/88.1 Action: VM

Resolved:
ARC received and noted the Anti-Fraud Progress Report for the reporting period from the 1.4.25 to 9.9.25.

25/26/89 Key Findings from Analysis of Data During the External Audit

The Committee was provided with a briefing on the key findings of the data analysis provided to the Trust by EY as part of the Year End Audit.

Subsequent to the initial report, EY supplied additional information using data analytics and AI tools which offered detailed insights into the Trust's financial transactions. The Finance Team is to be provided with the underlying data to review and validate the findings against the Trust's records.

Thanks were offered to DS for facilitating this analysis, noting that the information is valuable for identifying unusual transactions and potential efficiency improvements within the Finance Function. The Chair acknowledged the benefit of this value-added analysis, emphasising that while it is not intended for detailed discussion at ARC, it represents a positive outcome of the external audit process and supports ongoing financial oversight.

For noting
ARC:

- Noted the key findings from the analysis of data during the External Audit.
- Agreed that a regular report will be submitted to the Committee in July/September going forward.

25/26/90 Auditor's Annual Report Year Ended 31st March 2025

The Committee received the Auditors Annual Report for year ending the 31.3.25. It was noted that the Report primarily summarises the findings previously reported at Trust Board in June and the Council of Governors in September.

The Audit Opinion was Unqualified, and the Finance Team was commended for their performance under challenging circumstances. The report includes the Auditor's commentary on Value for Money (VFM), covering the Trust's arrangements for financial sustainability, governance, and improving economy, efficiency, and effectiveness. It was confirmed that there were no unexpected issues arising at June's Extraordinary Trust Board.

The Whole of Government Accounts (WGA) process is still pending final confirmation from the National Audit Office (NAO). Alder Hey was selected at random for additional review, and the External Auditors are awaiting confirmation that no further information is required. It was reported that the WGA process will not prevent the Trust from laying its accounts before Parliament, as all necessary certificates have already been provided.

The Committee was informed that a meeting will be held to discuss final 2024/25 audit fees.

Resolved:
ARC received and noted the Auditor's Annual Report Year Ended the 31.3.25.

25/26/91 Clinical Claims and Non-Clinical Claims

The Committee was provided with an update on the status of Clinical and Non-Clinical Claims reporting. Attention was drawn to the following points:

- It was reported that there are a number of ongoing issues with data clarity and discrepancies, though recent reports from NHS Resolution (NHSR) are considered more accurate.
- It was confirmed that progress has been made with the development of the InPhase Legal Module, which is now ready for testing. The Business Intelligence (BI) Team will support the production of claims reports, aiming for a 2-3 week turnaround once data is provided.
- The Trust will continue to use InPhase for both clinical and non-clinical claims, with cross-checking against NHSR data for accuracy, especially regarding claim costs. Historical data will be entered into InPhase as a minimum dataset to ensure continuity and reporting capability.

The Chair asked for clarification on the use of InPhase for both clinical and non-clinical claims and whether it would interface with NHSR systems or provide data extracts for reporting. It was confirmed that In-Phase will function as a Case Management System, with subsequent cross-referencing against live data from NHSR.

A question was raised about whether historical data will be incorporated into InPhase from the 1st of April or only used from a certain point in time going forward. The Committee was advised that a minimum dataset will be entered to cover the gap between previous and current systems. This will allow for reporting continuity with only essential data fields populated.

The Chair inquired about the expected timeline for the Committee to receive the new combined clinical and non-clinical claims report. The Committee was informed that the new reporting process will be in place by November/December, subject to the resolution of outstanding data assurance issues with NHSR and final confirmation from NHSR regarding data reliability.

Resolved:
ARC noted the progress that is being made on the data issues being experienced in producing the Clinical and Non-Clinical Claims Report.

25/26/92 In-Phase Programme (Phase 2) Update

The Committee was provided with an overview of Phase 2 implementation for the continued development, optimisation and support of the InPhase Risk and Incident Management system. The following points were highlighted:

- The recruitment of the In-Phase System Developer has significantly improved progress and system functionality.
- The majority of the modules are now live or in development, with the exception of the FTSU module. Work has taken place to scope out the module, and a meeting is scheduled for October between the FTSU Guardian and the InPhase System Developer to progress this area of work.
- Due to the progress that has been made in Phase 2, the project is now preparing to transition to business as usual (BAU). The Executive Phase 2 Team will be stood down, but the operational and development groups will continue to meet regularly to support ongoing system use and development.

The Chair raised a concern regarding the potential risk of sole reliance on the newly appointed In-Phase System Developer and queried as to whether there is a need to establish InPhase Champions or Super Users to mitigate this risk and ensure resilience. It was reported that work is underway to develop Super Users within the Divisional Governance Teams, and the System Developer is actively collaborating with these users to enhance their capability and knowledge of the system. Additionally, training materials and resources are being updated and improved to support broader system understanding and reduce dependency on any single individual. These measures are intended to strengthen organisational resilience and ensure continuity of system support.

PW thanked the Committee for its support and confirmed that should any challenges/issues arise in the future they will be escalated to ARC for consideration.

Resolved:
ARC noted the InPhase (Phase 2) progress report the recommendation to transfer into BAU.

25/26/93 Update on Progress Against Actions from Effectiveness Reviews

The Committee received an update on progress against actions arising from effectiveness reviews of Internal Audit, External Audit and the Anti-Fraud Service. It was confirmed that all actions are being addressed promptly, and the Chair reported no concerns.

Resolved:
ARC noted the update.

25/26/94 Review of Other Reports and Policies

Six-Month review of the changes made to the Corporate Governance Manual

Resolved:
ARC agreed to receive the Corporate Governance Manual in December 2025.

NHSE/ICB Controls Update

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

- Executive Summary;
  - ICB and NHSE have proposed various controls as part of the system turnaround.
  - Controls have been requested via various routes; Financial Control and Oversight Group (FCOG), ICB Turnaround Director to CEO/CFO and PWC.
  - A number of red risks requests are part of recent communication and are in discussion by the Executive Team prior responding to the ICB.
  - In addition, the Trust has recently agreed further controls as part of the Closing the Gap programme.
- NHSE/ICB Pay Controls and Non-Pay Controls: Update on controls that are not agreed due to being of high risk to the organisation, controls that are in progress, controls that have been implemented.
- Additional controls;
  - Pause all recruitment into corporate and managerial non-patient facing to March 2026. Would consider a 'break -glass' in exceptional circumstances.
  - Review all fixed term contracts, with a view to stopping where possible and exploring the feasibility of bringing any to a close earlier.

- Aim to reduce the number of new starters we recruit each month, with a target to reduce this by 50% of leavers.

The Chair felt that the information provided was valuable in clarifying both the requests and the level of detail that the Trust is being asked to consider by the ICB. It was further noted that while the ICB may seek implementation of all expected controls, thorough risk assessment and well-founded objections are expected and welcomed. GM pointed out that the Board is ultimately responsible for managing risks, regardless of external opinions. Evaluation will guide the Trust's decisions moving forward and though this may be a challenging message to convey, Alder Hey's priority remains the needs of CYP. The Trust is committed to doing everything possible within its means, but risk liability remains the responsibility of the Trust.

The Committee was informed that the processes the Trust has put in place has put it in a much stronger position than other organisations (*Financial Improvement Programme, Decision Documents, Impact Assessments*) and allows the Trust to assess risks thoroughly. While it is expected that the Trust's responses may be subject to scrutiny, its strong governance supports thorough, collective risk reviews.

Resolved:
ARC noted the update on NHSE/ICB controls.

25/26/95 Any Other Business

There was none to discuss.

25/26/72 Meeting Review

The Chair summarised the key themes and actions to be referred to the Executive Team, including feedback from the risk discussions with the Divisional Directors, and broader discussions on cyber security. It was confirmed that FTPC will monitor progress of the Cyber Improvement Plan.

Date and Time of the Next Meeting: Wednesday 10th December, 2:00pm-4:00pm, via Teams.

MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE COMMITTEE

Minutes of the meeting held on **Monday 24th November 2025 at 1pm**

Via Teams

Present:	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)
In Attendance:			
	Ms. A. Chindiya	Associate Finance Director	(AC)
	Mr. G. Wadeson	Associate Director of Finance	(GW)
	Ms. E. Kirkpatrick	Deputy Director of Finance	(EK)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Mrs J Halloran	Deputy Development Director	(JH)
25/26/125	Miss N Pickard	ACOO Medicine	(NP)
25/26/125	Miss L Simon	Business Accountant Medicine	(LS)
25/26/125	Miss C Lee	ACCO Surgery	(CL)
25/26/125	Mr G Montgomery	Business Accountant Surgery	(GM)
25/26/129	Mr M Upton	General Manager, Surgery	(MU)
	Mrs. J Tsao	Executive Assistant (Minutes)	(ER)
Apologies:	Mr A McColl	Associate Director of Finance	(EK)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mr. N. Askew	Chief Nursing Officer	(NA)
	Ms. N. Palin	Director of Transformation	(NP)

25/26/119	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted apologies received.
25/26/120	**Minutes of the Last Meeting** The minutes of the last meetings held on 22nd October 2025 were approved.
25/26/121	**Matter Arising and Action Log** **Strengthening TOM and supporting delivery in 2025/26** Rachel Lea and Kate Warriner confirmed that the TOM implementation is a key thread of the transformation programme for the coming year, with preparatory work ongoing. The plans are being reviewed and updated, with a focus on what can be brought forward for implementation from Q4, and further updates are expected in December. **Action: NP** **Pharmacy Outsourcing** Approval had been given to Pharmacy outsourcing at the November meeting. FTPC agreed to receive an update in January to clarify recurrent versus non-recurrent vacancies, as these are essential for closing the financial gap required for TOM. **Action: PS**

25/26/122	**Declarations of Interest** There were none to declare.
25/26/123	**Top 5 Risks** The committee received an overview of the top 5 risks for the month. **Trust Financial Performance** Rachel Lea reported a small surplus year-to-date. CIP is behind plan with emphasis on the need for divisions to deliver recurrent savings. Key highlights included coding issues due to Meditech downtime led to increased accruals and estimation, with ongoing actions to address coding issues through divisional meetings, targeted resource allocation, and exploration of internal AI solutions for coding improvement. **Campus and Capital Programme** The capital risk rating was reduced from high to medium due to improved in-year management and positive discussions with the ICB. An update was received on the NICU delays. Jane Holloran advised daily huddles and executive-level meetings are ongoing with contractors and partners to maintain progress and manage risks. Emily Kirkpatrick noted use of charity funding to provide flexibility in managing capital spend between years, as well as the importance of audit-proofing capital movements. **Transforming Alder Hey (ways of working, futures, AI & Digital** **Operational performance (productivity, access, targets, benchmarking)** The committee noted the latest position on operational performance. **Resolved:** FTPC noted the Top 5 Risks.
25/26/124	**Finance Report – M7 Financial Position** **Resolved:** FTPC received and noted the Financial Report.
25/26/125	**Plan Divisional Recovery Plan** **Medicine** Nikita Pickard described the division's efforts to reduce the forecast overspend by 25% through workforce controls, weekly activity and coding meetings, clinical engagement, and targeted mitigation of high-cost drugs and winter pressures. Ongoing risks included vacancies, sickness, and industrial action. Nikita confirmed that all clinical leads are engaged and aware of the need for urgent action, and that difficult conversations are ongoing to ensure delivery of required savings and operational improvements. **Surgery** Chloe Lee outlined the division's revised forecast, focusing on bed closures, increased weekend activity, supply cost reductions, targeted coding improvements, and discretionary spend controls. Continued risks include: vacancies, overbooking, and perfusion workforce gaps. Further actions included: theatre teams working on reducing physical supplies spend and improving procurement oversight.

	Coding improvements are targeted in cardiac and paediatric surgery, with clinical leads assigned and support from data managers. Discretionary spend is being tightly controlled with a new "break glass" process. **Resolved:** FTPC noted the updates on Medicine and Surgery recovery plan. Further updates will be received at the January FTPC.
25/26/126	**M7 Integrated Performance Report** Adam Bateman noted the following highlights: During recent industrial action, elective activity was maintained at around 95% of planned levels, the national target was an improvement over previous rounds. Participation in industrial action dropped to around 44–45% of eligible doctors, compared to around 60% previously. Alder Hey secured £3 million in elective transformation funding from the Northwest region, with additional funding expected for CYP, focusing on ENT and specialties with the longest waits. This is expected to enable treatment of an extra 400 children in Q4. The Trust is aiming to achieve less than 1% of patients waiting over a year by the end of March, with plans to transfer some patients to Manchester and increase weekend working. RTT and diagnostics standards are being met, and hospital occupancy has remained healthy, with winter pressures not yet causing cancellations. **Resolved:** FTPC received and noted M7 IPR.
25/26/127	**Medium Term Plan** Rachel Lea presented the medium term plan update, noting that national and regional guidance now requires a two-year revenue and four-year capital submission, with the first draft due in December and final submission in February. The underlying financial position is a £19.5m deficit, mainly due to unposted recurrent CIP and exclusion of technical PFI benefits. Capital allocation is higher than previous years, but prioritisation is needed due to a projected £13.8m gap next year and cash constraints. Next steps include locking in Q4 run rate, resolving PFI technical benefit, mitigating block income risks, and developing a cash strategy for future investments. **Resolved:** The December FTPC meeting will focus on reviewing the submission, with further board engagement planned before the February deadline.
25/26/128	**Board Assurance Framework** Erica Saunders reported on the new guidance for the Board Assurance Framework. The BAF now includes 16 statements, which are more detailed than previous years, covering areas from clinical leadership to contract management. Erica emphasized the need for the board to have a high level of detailed knowledge for assurance.

	John Kelly asked about the timing of assurance statements, expressing concern that they may be submitted after FTPC and before the next board meeting. Erica confirmed she would review the process and provide a briefing. Rachel clarified that the February submission will require more detailed assurance statements, and timing will be managed to ensure board oversight. Erica also noted the need to align the BAF with the top five risks for FTPC and to update the campus risk and segmentation risk in the BAF. **Resolved:** FTPC received and noted the changes to the Board Assurance Framework.
25/26/129	**NHS Oversight Framework – Sub Committee Themes** Alder Hey remains in Segment 1, with improvements in patient safety and care effectiveness. Increased sickness absence had seen a drop in the people and workforce metric. The override rule means that any unplanned deficit would move the Trust directly to Segment 3, so financial control remains critical. Actions are ongoing to address areas at risk, including a 90-day sickness absence improvement programme and continued focus on infection control metrics. **Resolved:** FTPC noted the Trust are in segment 1.
25/26/130	**Digital Futures Strategy** **Resolved:** Due to the meeting overrunning the above report was received.
25/26/131	**AlderC@re 2.2 Business Case** Kate Warriner presented the above, noting three options outlined in the paper. Following a comprehensive appraisal, the preferred and recommended option is to proceed with the upgrade to Expanse 2.2. This approach is fully aligned with the Trust's strategic objectives, offers access to advanced digital capabilities (including AI and modern APIs), and positions Alder Hey as a leader in digital paediatric care. It is envisaged the project will take 12 months from start to finish, with an anticipated go live date of October 2026. Kate responded to Dame Jo Williams query on no additional costs noting existing internal resources will focus on the project. The impact of this will be reduced capacity to develop in the current AlderC@re platform. Adam Bateman noted potential impact on clinical activity and asked if the aim could be to complete in summer 2026. Kate agreed to review the timeline and activity impact to ensure appropriate contingencies are considered in the implementation plan. **Resolved:** FTPC APPROVED the upgrade to AlderC@re 2.2 with further work to clarify benefits and risks for board reporting.
25/26/132	**Procurement Monitoring** John Kelly suggested expanding the scope of procurement to include high-value items and devices, aiming to achieve greater savings and better management of organisational spend, with plans to revisit the topic in future meetings.

25/26/133 **25/26/134**	**PFI contract monitoring** **ODN Network** **Resolved:** FTPC received and noted the three items above.
25/26/135	**Any Other Business** **FTPC 11th December 2025** It was agreed that the next meeting would be used to agree the Medium Term Plan. As the detail for a full finance report M8 won't be ready to submit a highlight Finance report will be included. **2024/25 National Cost Collection Index Review** As the meeting had overrun it was agreed that the above item would be discussed at the January FTPC.
25/26/136	**Review of the Meeting** FTPC noted the focus on the medium term plan for the next meeting.
	Date and Time of Next Meeting: Thursday 11th December at 1pm, via Teams.

25/26 FTPC Key Risks – Month 8 Position

Alder Hey Children's NHS Foundation Trust

	Initial Risk	Initial RAG	Latest Position	RAG M8
Trust Financial performance	Challenging 25/26 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time. Plan assumes delivery of £22.7m recurrent savings. Highest level set in any one year. Delivery contingent on both BAU and transformation savings	High	Month 8 position reported £0.3m surplus in month and £0.4m surplus YTD which is in line with plan YTD. ICB forecast (SW) at M7 reported likely forecast of £5m surplus position for the year and a best-case forecast of £7.2m surplus. PBR/ERF in month performance is estimated above plan by £0.6m in-month, plus a backdated loss of £0.3m. YTD PBR overperformance (£1.2m) sits within divisional positions. M8 position has been supported by non-recurrent benefit in relation to technical balance sheet (£0.5m), PBR/ERF overperformance (£0.3m) which offsets industrial action (£0.3m) and CIP non delivery. CIP is behind plan in M8 and YTD. Total savings of £19.3m have been transacted (green) , forecasting to deliver £20.3m (SW methodology). AH reported a £2m gap to the full year CIP target in M8 – with remaining gap to be mitigated through run rate savings, further rev to cap and elective recovery, the latter two are subject to ICB approval. There is a £14.9m gap (fully developed/amber/red/black) on recurrent plan as at M8.	High
System financial performance	Challenging 25/26 plan for C&M System plan is deficit and risk of further restrictions and controls that will retract resources/time.	High	TBC – M8 data not yet available.	High
Campus and Capital Programme	Limited CDEL allocation in 25/26 Complex campus programme across multi sites, with several key buildings opening in year (Neo/Alderpark).	High	Capital – M8 capital spend is slightly ahead of plan YTD (£17.9m spend against £17.7m plan. It is highly likely that the Trust will spend its full capital allocation in year due to prioritisation pressures with £0.3m remaining priority 2 high risk items to go ahead at risk. Current forecast (assuming all tbc funding is approved) shows a £0.2m overspend, however this may change subject to phasing of SDEC/NICU, Elective Hub and CT scanner costs following delays is being worked through. £5.1m of funding is still tbc - £2.1m of this relates to SDEC and is likely to be confirmed either way in Dec. Most recently £2m additional capital has been secured for spend in 25/26 or 26/27 as recognition for strong elective performance – this is likely to be primarily utilised in 26/27. Capital plan for 26/27 currently over subscribed therefore Capital prioritisation panel scheduled for 20th January. Bids being submitted for several national funding pots (£0.3m secured from 25/26 Estates Safety fund to date). 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.	High
Transforming Alder Hey	Transforming Alder Hey (ways of working, futures, AI & Digital)	High	Transformational work continues in line with the now-approved **2026/27 Transformation Plan**, alongside the ongoing development of a new **Target Operating Model (TOM)** that will define the future shape of Alder Hey. Collaborative actions are being prioritised to create greater simplicity, focus and accountability across delivery. The **Closing the Gap** 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 **Medium-Term Plan**, currently in development	High
Operational performance	National focus on productivity and benchmarking to drive down costs. Efficiency programme contingent on driving up productivity in order to	Medium	The trust's performance regarding patients waiting over 52 weeks continues to be a challenge. A proposal has been submitted and approved that includes strategies for increasing productivity and determining an optimal level of substantive recruitment to meet the standard and achieve CIP.	Medium

BOARD OF DIRECTORS

Thursday, 8th January 2026

Paper Title:	**Board Assurance Framework Report (November 2025)**
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Monthly BAF Reports
Strategic Context **This paper links to the following:**	**Outstanding** care and experience ☑ **Collaborate** for children & young people ☑ **Revolutionise** care ☑ **Support** our people ☑ **Pioneering** breakthroughs ☑
Resource Implications:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
As detailed in the report	This report provides an update against all Board Assurance Framework Risks for the month of November 2025.					As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2025/26

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 14 principal risks aligned to the Trust's strategic objectives and delivery of Vision 2030.

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

The Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people have timely and safe access to elective, urgent and follow up care.	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Finance, Transformation and Performance Committee
1.4	Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.6	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People Committee
3.1	Failure to fully realise the Trust's Vision for the 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 9th December 2025

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x1
1.2 AB	Children and young people not having have timely and safe access to elective, urgent and follow up care	FTPC / SQAC	**5x3**	3x3
1.3 RL	Building and infrastructure defects that could affect quality and provision of services ***(score increased in-month)***	FTPC	4x4	2x3
1.4 LC	Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.	FTPC / SQAC	**3x5**	3x3
1.6 LC	Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service.	Trust Board	4x3	4x2
STRATIC OBJECTIVE: Support our people				
2.1 MS	Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	People Cttee	**4x4**	3x2
2.2 MS	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Cttee	3x4	2x3
2.3 MS	Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	People Cttee	4x3	4x1
STRATEGIC OBJECTIVE: Collaborate for children and young people				
3.1 RL	Failure to fully realise the Trust's Vision for the Alder Hey Campus ***(score reduced in-month)***	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
STRATEGIC OBJECTIVE: Pioneering breakthroughs				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	GO	3x3	3x2
STRATEGIC OBJECTIVE: Revolutionise care				
4.2 KW	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	FTPC	**4x4**	2x4

4. Summary of November 2025 updates:

- ***Inability to deliver safe and high-quality services (NA).***
  Risk has been reviewed and requires no adjustment. Controls are in place to mitigate gaps in assurance. The risk is reviewed regularly by SQAC and Trust board.

- ***Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (LC).***
  Review of risk undertaken and actions remain in place with suitable controls.

- ***Children and young people not having timely and safe access to elective, urgent and follow up care (AB).***
  October performance against 2025/26 targets
  - Acute (78%) - ED performance remained above target at 87%
  - RTT (63% by March 2026) - remained the same as previous month (62% in month)
  - Pts >52 weeks (1% by March 2026) - Slight increase to 1.7% which was primarily due to patients under dentistry
  - DMO1 (95%) - Performance achieved 96%

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***
  Risk score increased to 16 in month.

  Settlement
  The Trust is awaiting a detailed project and implementation plan from Project Co Board. This has been escalated in correspondence and also raised at the last liaison meeting

  Water Safety
  Water Safety Group meetings continue to run in parallel with operational groups to monitor progress in addressing out-of-range water temperatures. A report from SPV Board has been received and is being reviewed.

  Tap Filters
  A formal notification concerning tap filters has been issued to Project Co. There has been no response.

  Chillers
  The chillers continue to experience performance issues. A project plan on the full reinstatement has been received.

  Combined Heat and Power (CHP)
  The CHP unit has been offline for nearly a year. The Trust continues to await an update from Project Co regarding the status of the unit and proposed next steps.

  Summary
  A formal notification covering the above matters has been issued to Project Co. No response has been received to date.

- ***Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services. (LC).***
  Review of BAF risk undertaken. Controls remain in place and actions are in date and ongoing.

- ***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. Impact and plans to mitigate associated risk are reviewed regularly and has been raised in a recent extraordinary Risk management meeting. 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. Updates made to actions to reflect progress in the connected leadership and new values programmes of work, with delay to progress in the development of the Thriving Teams Index.

- ***Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***
  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. Score to reduce to 6 (2x3) to reflect the completion of 2 out of 3 building demolitions (former gas governor located in the Park, and the Histopathology building). The final building due for demolition is the sub-station in Jan/Feb 2026. This final element of site clearance will allow the permanent ED car park to be built and the last area of the Park to be completed. Target date: Spring 2026.

- ***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 in the development of a Target Operating Model (TOM), which will define how the organisation is structured and operates to deliver the Vision 2030 ambitions sustainably. Alongside this, work is underway on the Medium-Term Plan, which will set out the three-year high-level transformational programme and associated benefits, bringing strategic, operational, workforce and financial priorities into a single, aligned framework.

  There remains a risk that the Vision 2030 Transformation Programme will not deliver the required in-year financial savings to meet CIP targets. While the programme is continuing to deliver strategic value across its seven goals, the pace of in-year benefit realisation has not met expectations, resulting in a residual financial gap and increasing pressure on operational budgets.

  To mitigate this, targeted actions within key programmes are being accelerated to maximise in-year savings. A single, aligned plan with strengthened governance is being developed to provide clearer delivery accountability and oversight. Monthly Transformation Board reviews are enabling dynamic

reprioritisation, and enhanced benefit tracking—with a stronger focus on recurrent savings—is being applied. Delivery models are being refined to bring together transactional efficiencies and longer-term transformation, supporting both short-term financial delivery and 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. The latest forecast for the in year is now showing a reduced gap to achieving the plan with a focus on the clear actions to mitigate the risk. Given the external scrutiny and oversight the risk score remains at 20.

  Continued work on the exit run rate from 25/26 and the future Target Operating Model with financial targets now assigned to each division and corporate area. The medium-term plan is due to be submitted mid-December following approval by FTPC on the 2-year plans. Alongside the submission a cash and capital plan and strategy will be submitted.

- ***System working to deliver 2030 Strategy (DJ).***
  Risk, control and actions reviewed and updated for December 2025.

  MIAA have supported Alder Hey to provide a totality view of system risks to ensure correlation across the system.

  No change to risk rating in month.

- ***Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People. (JC).***
  Risk score remains 9. Actions updated to reflect decisions made at FIP Strategic Command re closing the gap on MRI and RPA income targets.

- ***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. Network refresh business case in development. Good progress being made via Digital, Data and AI Collab. Target Operating Model work in progress and on track to meet deadlines. Cyber Improvement plan is also being progressed. Actions updated to mitigate gaps in control.

5. Corporate risks (15+) linked to BAF Risks (as at 1st December 2025)

There are currently 27 high rated risks on the InPhase system linked to the Board Assurance Framework risks as follows:

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
STRATEGIC OBJECTIVE: Outstanding care and experience						
1.1 Inability to deliver safe and high-quality services (3x3=9)						
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
432	Change to Working Visa rules and immigration status	5x4	Community	2.1	Sept 2025	Sept 2025
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
2677	Insufficient Capital funding due to ICS restrictions to support the Trust's Medical Equipment Replacement Program	4x4	Surgery	3.4	Aug 2022	Feb 2024
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 ***(NEW)***	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
349	Ongoing Beyond programme prioritisation and funding	4x4	C&M CYP Programme		Apr 2025	Sept 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 ID 2100)	4x4	Corporate Services	2.1	Jan 2020	*Apr 2023

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
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 & 1.6	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 ***(NEW)***	4x4	Corporate Services	3.1	Nov 2025	Nov 2025
496	NICU delay due to isolation of live services and service connections ***(NEW)***	4x4	Corporate Services	1.3	Nov 2025	Nov 2025
173	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties	3x5	Corporate Services		Mar 2024	Mar 2024
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
1.2 Children and young people not having timely and safe access to elective, urgent and follow up care (5x3=15)						
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
1.3 Building and infrastructure defects that could affect quality and provision of services (4x4=16)						
496	NICU delay due to isolation of live services and service connections ***(NEW)***	4x4	Corporate Services	1.1	Nov 2025	Nov 2025
1.4 Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services. (3x5=15)						
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
1.6 Impact of ADHD medication shortages on Children, Young People, Families and waiting time compliance of the service (4x3=12)						
458	Disruption in patient's supply of medication and / or treatment (legacy risk 2487)	4x4	Community	1.1 & 2.1	Oct 2025	Oct 2025
STRATEGIC OBJECTIVE: Support our people						
2.1 Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people. (4x4=16)						

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
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
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)						
464	Reduced Haematology consultant workforce (legacy risk 2684)	4x4	Medicine	1.1 & 2.1	Aug 2022	Jan 2024
2.3 Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (4x3=12)						
	None					
STRATEGIC OBJECTIVE: Collaborate for children and young people						
3.1 Failure to fully realise the Trust's vision for the Alder Hey Campus (3x2=6)						
496	NICU go live delay ***(NEW)***	4x4	Corporate Services	1.1	Nov 2025	Nov 2025
3.2 Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (4x4=16)						
	None					
3.4 Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments. (4x5=20)						

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
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 ***(NEW)***	4x4	Corporate Services	1.1	May 2025	Nov 2025
3.5 System working to deliver 2030 Strategy (4x4=16)						
	None					
STRATEGIC OBJECTIVE: Pioneering Breakthroughs						
4.1 Failure to deliver against the Trust's strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People (3x3=9)						
None						
STRATEGIC OBJECTIVE: Revolutionise Care						
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	P-MIP end-of-life server which is no longer supported by the supplier	4x4	Corporate Services		Jul 2024	Sep 2024
292	Inappropriate sharing of demographics	5x3	Corporate Services		Dec 2024	Dec 2024
368	Digital infrastructure capacity and age	4x4	Corporate Services		May 2025	May 2025

* risk movement data not available pre-move to InPhase

6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

Erica Saunders
Chief Corporate Affairs Officer

Inability to deliver safe and high quality services.					
Risk Number			Strategic Objectives		
1.1			Outstanding care and experience		
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
Safe		Nathan Askew	9	4	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 External: Care Quality Commission (CQC), MIAA
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC
Proactive programme of work in place to reduce medication errors	Monitored via Patient Safety Board
Programme of quality assurance rounds, ward and departmental accreditation is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC. Triangulation of data through Aggregated Analysis Reports to SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I)	Annual QIA assurance report and reporting into SQAC as directed by the Chair. Clinical Cabinet in place to review all EQIAs
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Internal: Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes. External: Care Quality Commission, MIAA, NHS Improvement

The Quality & Safety sections of the Integrated Performance Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
The Trust has a Patient Experience Group that reports against the workplan derived from the Patient Experience Strategy based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures. Chairs report to SQAC.
The Trust has a Patient Safety Incident Response Plan (PSIRP) in line with the requirements for the Patient Safety Incident Framework (PSIRF)	Incidents are investigated in line with PSIRP and the outcomes of Patient Safety Incident Investigations will be reported through SQAC and approved at Trust Board
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.

Gaps in Controls / Assurance

1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis
2. Robust reduction programme in the number of medication incidents and near misses
3. Emerging CQC oversight framework which may reduce our CQC ratings
4. The 2030 vision sees a shift towards and experience led organisation without additional resources for delivery of the plan
5. Increased oversight relating to the financial pressures resulting in inability to deliver 2030 Strategy

Action	Description	December 2025	
		Due Date	Action Update
1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	1. Continue to monitor KPI's at SQAC and within divisional governance structures (no further controls required, monitoring controls are in place)	31/03/2026	(no further controls required, monitoring controls are in place)
2. Medication Errors and Near Misses	2. Proactive programme of work in place to reduce medication errors (no further controls required, monitoring controls are in place)	31/03/2026	(no further controls required, monitoring controls are in place)
3. New CQC Assessment Framework	3. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2026	Trust continues to engage with CQC through regular engagement meetings
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
5. Delivery of 2030 Strategy	5. Revise EQIA process, establish a Clinical Cabinet. Oversight through SQAC, FTPC and Trust Board	31/03/2026	

Children and young people not having timely and safe access to elective, urgent and follow up care.					
Risk Number			Strategic Objectives		
1.2			Outstanding care and experience		
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
Effective		Adam Bateman	15	4	▪ Finance Transformation & Performance Committee ▪ Safety and Quality Assurance Committee

Description
With a growth in demand for elective, urgent and follow-up care maintaining timely access to high quality care and meeting national access standards is challenging. This is compounded by a tight financial environment and our NHS contract has limited scope for growth in income to fund additional capacity; productivity improvements are insufficient to meet demand and lower waiting times. Our approach is centred on providing enhanced support to departments with significant demand or service issues, helping them to create centre of excellence; innovating; seizing productivity opportunities; and collaborating with providers and system partners to modernise and optimise our patient pathways and service models.

Control description	Control assurance (How is this control monitored?)
Controls for improving access to follow-up care: - Real time report on the follow-up waiting list, waiting times and risk categories - Patient Initiated Follow Up (PIFU) pathway and system initiated - Patient portal for ISLA Care supports waiting list validation and PIFU	Weekly Executive Summary - Follow up metrics included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board - Safe Waiting List Management Group Chaired by Patient Safety Lead
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Monthly access to care with General Managers from the divisions - Activity plans for 25/26 adjusted to achieve national access targets - Real time reporting of RTT waiting list and tracking tool which highlights patients that could breach monthly / quarterly targets - Transformation programme to re-imagine elective care services to create centres of excellence	- Weekly Performance Report to Executive Directors - The NHSE weekly waiting time submission is reviewed and signed off by the Head of Performance - RTT performance is included in the IPR which reports to FTPC, Operational Delivery Board and Trust Board
Our controls for delivering timely care in the Emergency Department (ED) includes: - Acute response Team and Patient Flow - Emergency Department staffing rotas, establishment and skill mix reviews support staffing levels to meet minimum safe standards and align to demand - Safety huddles and patient handover huddles - A new Paediatric Assessment Unit and Urgent Care Centre - Winter Plan with flow and escalation procedures - Two transformation collaboratives driving service improvement: i) Neighbourhood Care supporting prevention and more care in the community - Ii) Acute, Diagnostics and Urgent Care	Daily reports to NHS England -Daily situational reports and patient flow meetings - Staffing reports reviewed at staffing huddle meetings - Daily Performance summary -@ monthly ED performance report to Operational delivery group -@ Performance reports to FTP Board Sub-@Committee

Gaps in Controls / Assurance

1. There is inadequate capacity in ENT and Paediatric Dentistry to have less than 1% of children and young people on the waiting list waiting over 52 weeks for treatment
2. In urgent care there are opportunities to further improve timeliness of care and experience through a Same Day Emergency Care Centre, expanded Paediatric Assessment Unit and virtual urgent care service.
3. To achieve a sustainable position in follow-up care, as measured by having no patients waiting 6 months beyond their target date, a more radical shift in follow- care pathways is required.

Action	Description	December 2025	
		Due Date	Action Update
Recruit a Locum Consultant in ENT	The executive board have approved a paper which allows the department to recruit a Locum Consutlant	31/10/2025	The department have a locum consultant post advertised and at least one interested candidate. However one of the locum consultants who is currently working for the department has resigned therefore the department may recruit however it may not lead to an increase in capacity
Restart weekend theatres in ENT	Weekend operating ceased when the AHP local pay rate was reduced from 1st July. The division have been working to reinstate weekend operating as it will increase capacity in ENT.	31/10/2025	The first weekend operating list since June is scheduled for 18th October.
Overbook outpatient clinic with new patients	Roll out overbooking to clinicians whose clinic utilisation consitute it requires an additional patient booked to increase actual clinic utilisation to as close to 100% as possible.	30/11/2025	The following services are now live with overbooking - Dentistry - Plastic Surgery - Community Ophthalmology and Ophthalmology The following services go live from 13th October - Urology - Paediatric Surgery - Gynaecology
2. Open Same Day Emergency Care Centre	Actions reviewed and action containing the below split into 5 separate actions on request. 1. Expanded Paediatric Assessment Unit 2. Open Same Day Emergency Care Centre 3. Deploy Ambient Artificial Intelligence to improve productivity 4. Move to a self-check in model for some patients, using a digital solution 5. Establish performance reports on the number of patients seen per clinician	30/03/2026	
3. Deploy Ambient Artificial Intelligence to improve productivity	Actions reviewed and action containing the below split into 5 separate actions on request. 1. Expanded Paediatric Assessment Unit 2. Open Same Day Emergency Care Centre 3. Deploy Ambient Artificial Intelligence to improve productivity 4. Move to a self-check in model for some patients, using a digital solution 5. Establish performance reports on the number of patients seen per clinician	30/03/2026	
4. Move to a self-check in model for some patients, using a digital solution	Actions reviewed and action containing the below split into 5 separate actions on request. 1. Expanded Paediatric Assessment Unit 2. Open Same Day Emergency Care Centre 3. Deploy Ambient Artificial Intelligence to improve productivity 4. Move to a self-check in model for some patients, using a digital solution 5. Establish performance reports on the number of patients seen per clinician	30/03/2026	

5. Establish performance reports on the number of patients seen per clinician	Actions reviewed and action containing the below split into 5 separate actions on request. 1. Expanded Paediatric Assessment Unit 2. Open Same Day Emergency Care Centre 3. Deploy Ambient Artificial Intelligence to improve productivity 4. Move to a self-check in model for some patients, using a digital solution 5. Establish performance reports on the number of patients seen per clinician	30/03/2026	
1. Expanded Paediatric Assessment Unit	Actions reviewed and action containing the below split into 5 separate actions on request. 1. Expanded Paediatric Assessment Unit 2. Open Same Day Emergency Care Centre 3. Deploy Ambient Artificial Intelligence to improve productivity 4. Move to a self-check in model for some patients, using a digital solution 5. Establish performance reports on the number of patients seen per clinician	31/03/2026	Action completion date aligned with new ground floor SDEC build completion. 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 Ownership of action will be transferred to ED Leadership and the action split into specific actions

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		
			Actual	Target	Assurance Committee
Safe		Rachel Lea	16	4	▪ Finance Transformation & Performance Committee ▪ Safety and Quality Assurance Committee

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. - 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 - Regular contact with Lawyers on the contractual status
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations.	-Review of the action plan takes place monthly to ensure all remains on track. - Where applicable, a team from the service provider is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact
Joint oversight by SPV and Trust through formal Liaison meeting	-Defects and action plan standing item on the monthly Liaison meeting attended by both Trust and SPV directors. - Minutes taken and circulated on key actions and risks
Regular oversight of defect issues by Trust committee (FTPC)	- Monthly report to FTPC on progress of remedial works through the PFI report - Escalation meetings when required with FTPC
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 - Lack of confidence in timescales for completion of remedial works - Lack of ownership / accountability by SPV on issues - Lack of transparency - Risk of issues escalated impacting on NHS services

Action	Description	December 2025	
		Due Date	Action Update
Defect Survey	Output from defect survey	31/12/2025	
Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	31/03/2026	
Appropriate Legal Advice	Continue to seek appropriate legal, commercial and technical advice	31/03/2026	

Since 2020, there has been a significant increase in demand for Specialist Mental Health Services across acute and community services. This has increased waiting times for children and young people accessing mental health services.	
Risk Number	Strategic Objectives
1.4	Outstanding care and experience

CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
▪ Caring ▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Lisa Cooper	15	4	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 is now being fully implemented.	Business case (attached)
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software
Existing BI Dashboard developed to support management of open caseload	Open caseload dashboard routinely reviewed by clinical leads and assistant clinical leads with practitioners
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required.	Monthly assurance processes include: ▯ Monthly contract statements ▯ Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Ongoing attendance at Cheshire and Merseyside Mental Health Workforce Planning groups	- Reviewed attendance across the range of meetings and Alder Hey lead/s identified - Feedback loop agenda item as part of Mental Health Business Meeting - Cheshire and Merseyside Lead attends Alder Hey business meetings.
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Trajectories developed to support improvement in access and waiting times	Monitored through - leadership meetings - weekly waiting times & access to care - regular meetings with divisional director - regular meetings with commissioners
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Week
Weekly performance monitoring in place for operational teams which includes: ▯ Weekly Tuesday/Wednesday meeting with PCOs ▯ Divisional Waiting Times Meeting each Thursday ▯ Trust Access to Care Delivery Group fortnightly This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes availa
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)

Monitored through
- leadership meetings
- weekly waiting times & access to car
- regular meetings with divisional dire
- regular meetings with commissioner

Action	Description	December 2025	
		Due Date	Action Update
Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	31/12/2025	work ongoing to streamline services, introduction of risk and triage calls to Liverpool CAMHS in Aug 2025 regular meetings to be scheduled with clinical leads to progress
MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/12/2025	work ongoing, crisis document development meeting now prioritised for Sept 2025 (delayed from July 2025) - meeting scheduled with developers for w/c 6.10.2025
ROMS collection and reporting	improve recording and reporting of routine outcome measures	31/12/2025	work ongoing -meeting scheduled with ROMS lead, CXIO, GM and Director for Oct 2025
Review of RTT performance trajectories and improvement plans for Liverpool and Sefton CAMHS	Performance trajectories and improvement plans to be produced and shared at Access to Care on a regular basis to track progress. Latest date for performance (Sefton) to be met end of September 2025. Liverpool's trajectory in progress - capacity and demand underway to be reviewed monthly as part of BAF Risk Review	31/01/2026	Trajectories for improvement are in place, and agreed with commissioners: **Liverpool CAMHS:** 92% CYP receiving urgent choice within 2 weeks of referral by 30.06.2025 - not achieved by end of June, but achieved and maintained from August onwards 0 CYP waiting over 52 weeks by 30.09.2025 - not achieved, but 0 expected by 31.10.2025 92% CYP receiving choice within 6 weeks of referral by 31.10.2025 - off track, but RTT improved in Sept. Expected to achieve. 0 CYP waiting over 40 weeks by 31.01.2026 - on track 75% CYP receiving partnership withing 18 weeks of referral by 31.1.2026 - on track 10% WNB rate by 31.12.2025 - off track, WNB rate for Aug higher than expected. Work ongoing **Sefton CAMHS:** 92% CYP receiving choice within 6 weeks of referral by 31.1.2026 - on track 92% CYP receiving partnership within 18 weeks of referral by 30.4.2026 - on track

Impact of ADHD medication shortages on Children, young people, families and waiting time compliance of the service.	
Risk Number	Strategic Objectives
1.6	Outstanding care and experience

CQC Domains	Linked Risks	Owner
Safe		Lisa Cooper

Risk Rating		
Actual	Target	Assurance Committee
12	4	Trust Board

Description
Risk that ADHD treatment will be interrupted due to unavailability of the prescribed medication, that commencement of ADHD treatment is delayed due to unavailability of medication and waiting times for assessment will increase, due to workforce being deployed to support the safety of prescribing activity.

Control description	Control assurance (How is this control monitored?)
Alder Hey external website updated to reflect the information we have	Website information is reviewed and updated as there are changes in medication availability.
High frequency huddles established with ADHD nurse team / developmental / paediatrics / pharmacist / prescription team / operational management.	ADHD medication stock levels monitored by the Pharmacy Team and uploaded to the ADHD /Developmental Paediatrics Drug Shortage Teams Channel and huddles are stepped up or down depending on stock levels.
Move to one item per FP10 so that partial fulfilment is possible.	Monthly report of PALS and Complaints relating to medication is presented at the Divisional Medication Safety Subgroup which would highlight any issues with inability to fulfill all or part of a prescription if this action isn't taken.
Registered with specialist pharmacy service, supply tool to gain direct intelligence Shortage of Methylphenidate prolonged-release tablets - SPS - Specialist Pharmacy Service - The first stop for professional medicines advice	ADHD medication stock levels monitored by the Pharmacy Team and uploaded to the ADHD /Developmental Paediatrics Drug Shortage Teams Channel and huddles are stepped up or down depending on stock levels.

Gaps in Controls / Assurance
• A shortage of raw ingredient • Issues with manufacturing across Europe • Significant (unexpected) increase in demand since 2020

Activity	Description	Stage
Risk 236 - Action 1	Engagement with suppliers to increase knowledge and seek support.	Completed
Risk 236 - Action 2	Increase capacity to the prescription rota to cover the additional work.	Completed
Risk 236 - Action 3	Engagement with the youth forum requested to help with messaging.	Completed
Risk 236 - Action 4	Escalation Regionally to ICB via Divisional Director and nationally via CEO	Completed
Risk 236 - Action 5	Two additional telephone lines ordered and awaiting installation to support the increased demand	Completed
Risk 236 - Action 7	Plan for Psychiatry support to increase number of complex assessment conclusions using voluntary additional hours	Completed
Risk 236 - Action 8 (carried over from Risk #70)	Daily reviews to take place to monitor progress against actions and monitor supply of relevant medications.	Completed
Risk 236 - Action 9 (carried over from Risk #70)	To review the medication of several children currently receiving ADHD medication, with a view to prescribing a suitable alternative if necessary	Completed

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.	
Risk Number	Strategic Objectives
2.1	Support our People

CQC Domains	Linked Risks	Owner
▪ Safe ▪ Well-Led		Melissa Swindell

Risk Rating		
Actual	Target	Assurance Committee
16	4	People Committee

Description
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time. 2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation. 3. Not developing inclusive recruitment and development practices to improve workforce diversity and progression 4. Not developing a Trust wide approach to succession planning and talent management 5. The Trust would be unlikely to successfully achieve the vision set out in both the People Plan and Vision 2030 if the right workforce is not available 6. Impact of national financial pressures on workforce numbers to deliver patient care 7. Not having a sustainable workforce will impact upon culture

Control description	Control assurance (How is this control monitored?)
Apprenticeship Strategy implemented	
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files
Engaged in pre-employment programmes with local job centres to support supply routes	Annual update to to PC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
Ensuring we have inclusive practices embedded throughout the organisation, is addressed in the People Plan 2030	reviewed at EDI steering group and monitored at People Committee also reported in the statutory WRES and WDES
Financial Improvement Programme	Monitored at FTPC
Health and Wellbeing Forum	Health and Well being Forum Terms of Reference - reporting through to People Committee
High quality mandatory training delivered and reporting linked to competencies on ESR. Online poral enables all staff to see their chosen IT device.	monthly reporting to the Board via the Integrated Performance Report - reporting at Ward level which supports Ward to Board
International Nurse Recruitment	Annual recruitment programme ongoing since 2019
Monthly monitoring through Ops Board, Board, Execs and People Committee	Regular reporting of delivery against compliance targets via divisional reports
Nurse Retention Lead	Bi-monthly reports to PC
Nursing Workforce Report	Reports to People Committee, SQAC and Board
PDR and appraisal process in place	Monthly reporting to Board and PC
People Plan Implementation - Apprenticeship workstream implementation - Leadership workstream implementation - Professional Development Hub - Thriving Workstream - Workforce Planning Workstream	People Strategy report monthly to Board

People Policies	All Trust Policies available for staff to access on intranet
Recruitment Strategy	progress to be reported PC
Training Needs Analysis linked to CPD requirements	Reports to Education Governance Committee, ToRs and associated minutes
Workforce Efficiencies Programme	Monitored at FTPC, and People Committee

Gaps in Controls / Assurance

1. Training/development
2. Sickness absence levels higher than target
3. Lack of workforce planning across the organisation
4. Lack of robust talent and succession planning
5. Lack of a robust Trust wide Recruitment Strategy
6. Lack of inclusive practices to increase diversity and progression opportunities across the organisation
7. The national and regional requirements to reduce NHS financial deficit, which is directly impacting on WTE

Action	Description	December 2025	
		Due Date	Action Update
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%
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
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)
6. Lack of inclusive practises to increase diversity across the organisation	A comprehensive EDI plan is in place, which is aligned to the NHS England high impact changes.	31/03/2026	EDI Plan monitored at People Committee
5. Lack of a robust Trust wide Recruitment Strategy	The next stage of the people Plan 24/25 there is a key work stream related to the Future Workforce, which addresses accessible and diversified recruitment and the Trust recruitment strategy. This action is addressed through the 24/25 People Plan.	03/03/2027	Action continues to be addressed through the People Plan, monitored at People Committee and reporting into Board.

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families					
Risk Number			Strategic Objectives		
2.2			Support our People		
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
▪ Caring ▪ Safe ▪ Well-Led		Melissa Swindell	12	4	People Committee

Description
- Failure to set up the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision and adapt well to other significant external and internal organisational changes. - Failure to create a happy, healthy, fair place to work for staff that is trauma informed and based on restorative, just and learning principles - Failure to communicate effectively with staff and have the right intelligence to be responsive to their unmet needs - Failure to design, develop and support compassionate and effective leadership at all levels

Control description	Control assurance (How is this control monitored?)
Action Plans for Staff Survey	Staff Survey Action Group, People Committee reports
Alignment of staff safety and patient safety work via developing safety culture training, developing Restorative Just & Learning culture strategy and focussed work on Avoidable Employee Harm with People Services	People Committee reports and Safety Culture reporting to Patient Safety Strategy Board
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Plan delivered moved into business as usual.
Celebration and Recognition Group	Celebration and Recognition Meetings established; reports to HWB Steering Group
Director of Culture in post focussed on staff experience, safety culture, leadership, & high performing teams	Director of Culture reporting to People Committee and Board
Freedom to Speak Up programme	Board reports and minutes
Network of SALS Pals recruited to support wellbeing across the organisation	Reported to People Committee
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic, People Committee reports
Occupational Health Service	Referral data, key themes and outcomes reported to People Committee as part of the People Paper
Partnership working with Staff Side representatives and FTSU Guardian	Staff Partnership Forum meeting minutes
People Pulse results available	People Committee reports
Regular communication channels including managers and leaders briefings and all staff Ask the Execs meetings	Internal Communication reports to People Committee
Regular Schwartz Rounds in place	Monthly Schwartz Steering Group meetings
Restorative just and learning principles embedded into key employment policies including Disciplinary Policy	People Committee reports

Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to People Committee as part of the People Paper
Staff Networks	EDI Steering Group and People Committee
Staff surveys analysed and followed up (shows improvement)	2024 Staff Survey Report - main report, divisional reports and team level reports
The People Plan Implementation	Monthly Board reports Bi-monthly reporting to People Committee
Thriving Leadership Programme	Strategy implementation as part of the People Plan
Thriving Teams MDT established comprising all corporate support functions who work with teams. Chaired by Associate Director of Organisational Development and enables shared thinking about teams in need of support and joint working where indicated.	Newly revised People Paper to include data relating to fragile teams
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered

Gaps in Controls / Assurance

- lack of embedded safety culture across the organisation
- lack of understanding about a just and restorative culture approach
- lack of consistent compassionate leadership
- Inconsistent application of Trust values and behavioural framework
- insufficient comprehensive "real time" culture data insights enabling earlier intervention in challenged areas
- insufficient OD resource available to fully address all culture tensions and challenges when they arise
- lack of aligned communications approach that is responsive to organisational needs
- lack of control of system decisions and pressures regarding the financial environment

Action	Description	December 2025	
		Due Date	Action Update
Restorative just and learning culture	Restorative just and learning principles to be embedded through patient safety work and all people practices. Consultation on approach to be provided to patient safety leads and investigators to support the implementation of PSIRF and to help to facilitate learning reviews where indicated. Work to be progressed about Avoidable Employee Harm with HR, staffside and other key stakeholders through workshops, consultation, policy review and training	30/01/2026	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
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.
2. Financial environment and culture	Attend Financial Improvement Programme tactical command meetings to reflect evolving understanding of the impact of financial controls on staff and work with the group to try and address these impacts. Ensure executive team are well briefed as to intelligence gathered from staff via listening routes such as SALS that pertain to the financial environment to help to shape communications and relevant interventions	31/03/2026	
OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/03/2026	
Responsive communications	Links to be strengthened with communications team to ensure that communications are responsive to organisational need, values based and aligned to the culture. To be achieved via attendance at newly developed Communications Board and via closer links with comms team in values working group and other relevant fora	31/03/2026	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.

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.	30/06/2026	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	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.		

Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation	
Risk Number	Strategic Objectives
2.3	Support our People

CQC Domains	Linked Risks	Owner
▪ Effective ▪ Well-Led		Melissa Swindell

Risk Rating		
Actual	Target	Assurance Committee
12	4	People Committee

Description
- Failure to attract, recruit, and retain a workforce which reflects the demographics of the local population. - Failure to foster an inclusive work place where staff feel respected, valued, and are able to contribution fully as an individual. - Failure to provide equitable access to career development, progression, and leadership opportunities. - Failure to meet statutory obligations under the public sector equality duty and wider equality obligations.

Control description	Control assurance (How is this control monitored?)
Actions taken in response to EDS22	Reported to EDI Steering Group, People Committee, and Patient Experience Group
Actions taken in response to Gender Pay Gap	Gender Pay Gap action plan, reports to People Committee and is part of the High Impact Actions
Actions taken in response to the North West BAME Assembly Anti-Racist Framework	Actions/activity reported to EDI Steering Group
Actions taken in response to the WRES/WDES	monthly recruitment reports provided by HR to divisions to incorporate WRES/WDES actions and report to People Committee
Collaborating across the Liverpool City Region to align regional and system wide practices	Building strong partnerships across the city region to ensure the EDI work aligns and that we share best practice, utilise opportunities and resources and relationships that will support the EDI work.
EDI Steering Group established - Chaired by NED	Minutes reported into People Committee. Membership has grown and will include Divisional Representation
Education and training for staff in relation to EDI	Mandatory EDI Training for all staff. current compliance above Trust target of 90%. Management Essentials Introduction to EDI Launched 2024, Thriving Leaders Programme includes module on EDI. Extensive online EDI training programme available for all staff to access. Anthony Walker Anti-Racism training provided as part of Thriving Leaders programme and also to certain identified areas. Neurodiversity training also delivered to certain areas and as part of the Thriving Leaders Programme.

Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives Policy just updated.
Full time Head of EDI now in place	Full time Head of EDI and part time EDI officer. HR advisors/managers identified to support each of the staff network and also support the implementation of EDI projects embedding EDI into HR practices.
Inclusive People Policies and training	People Policies (held on intranet for staff to access). Recruitment and Selection training launched incorporating inclusive practice. Staff Networks support policy develop and are invited to EPRG
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	Programme in year 6 of delivery, continues to include a focus on inclusive leadership. Development of a targeted leadership programme for our Internationally recruited staff
NHS England EDI Improvement Plan supported by Trust Board, and associated high impact actions	NHSE EDI Improvement Plan reported to Board
Organisational approach to equality analysis, which includes EDI audits and more robust demographic data collection process	Equality Impact Assessments undertaken for every policy & project the process is being reviewed and revised and a staff resource being developed to support application EDS 22 Publication working in collaboration with Patient service leads
People Committee ToR includes duties around equality, diversity and inclusion, and requirements for regular reporting.	- bi-monthly reporting to Board via People Committee on diversity and inclusion issues - monthly Corporate report (including Workforce KPIs) to the Board
Staff Networks, providing continuous support to grow and contribute to embedding EDI	All networks have appointed chairs, supported by Head of EDI are members of EDI Steering Group and report bi-monthly into the group. All staff networks have an executive sponsor

Staff Survey results analysed by protected characteristics and actions taken by Head of EDI	Monitored through People Committee. Staff Survey Action Group developed to support the implementation of initiatives that will support Staff Survey.
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.

Action	Description	December 2025	
		Due Date	Action Update
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
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.
Limited organisational awareness, training, and governance around legal duties	Review and revise the Equality Impact Assessment process, developing a toolkit to support staff in undertaking the process. Publication of Trust EDI objectives. HR advisors and managers to provide added resource and support to successfully embed EDI initiatives	15/07/2025	
Recruitment practices are not accessible and inclusive and do not target diverse communities	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. Accessible and Inclusive Recruitment Practices working group established. Recruitment and Selection training incorporating EDI throughout now launched.
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
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		
			Actual	Target	Assurance Committee
▪ Effective ▪ Safe		Rachel Lea	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	- Information provided to capital prioritisation on areas that require capital spend - Tracking of budget and spend in line with business cases through the development team and finance.
Delivery of Design and Access Statement (included in planning application)	- Compliance reporting from Park Project Team
Development monthly meetings with Divisions	- Monthly meetings held with Development Team and Divisions tracking progress of various schemes and escalation of issues - Outputs reported to FTPC via Project Update
Executive Design group to seek input into plans	- Quartely meeting to take place with key executives to share master plans, schemes and seek input - Feedback into Trust Board - NED sponsor
Funding availability and potential market inflation	Continual monitoring of market inflation
Handover of Park	Handover of Park now complete
Implement planning approval for full park development.	- Full planning permission gained in December 2019 for the park development in line with the vision - Tracking of works completed to ensure in line with planning approval - Regular updates and meeting with Liverpool City Council and the planning department to discharge pre-commencement conditions -

Neonatal Programme Board in place to ensure scheme delivers in line with business case and vision of clinical teams.	- monthly meeting in place with relevant teams including project highlight reports and any areas of escalation - Regular reports to LNP board on scheme
Planning permission granted for Neonatal and Urgent Care	- Regular updates on implementation of NICU scheme in line with planning permission granted
Regular updates to CEO, Executive Lead and Communications	Fortnightly Report submitted from DD on all areas of campus and any issues for escalation
Report monitoring progress on all areas of campus	- Monthly report to Board on campus - Campus highlighted as a top 5 risk at FTPC and reported through this mechanism with clear risk and escalation where required. - Stakeholder events / reported to Trust Board and CoG - Weekly tracking through Senior Development Team Meetings
Strategic Estates and Space Allocation Group to approve changes to the campus to ensure alignment to vision	- Monthly meetings from September chaired by exec lead and supported by DD

Gaps in Controls / Assurance
PARK: 1. Adoption of the SWALE by United Utilities 2. Weather conditions causing potential delays CAMPUS: 1. Stakeholder Engagement 2. Successful realisation of the moves plan.

Action	Description	December 2025	
		Due Date	Action Update
CAMPUS 1: Stakeholder Engagement	Engage with LCC, Friends of Springfield Park and community stakeholders and issue regular Comms	31/03/2026	Regular meetings in place with LCC, Friends of Springfield Park and community stakeholders. Regular Comms issued – newsletters/briefings.
PARK 2: Weather conditions causing potential delays	Continue to monitor throughout Autumn / Winter 2025/26	31/03/2026	All works now in accordance with revised programme and on target.
PARK 1: Adoption of the SWALE by United Utilities	Engage with planning consultants to assist with planning requirements.	31/12/2026	The developer (Step Places) are progressing the new surface drain and connection to the swale pond. This is due for completion Dec '25. Upon completion, United Utilities require a min of 12 months monitoring prior to adoption - anticipated date Dec '26.

Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment					
Risk Number			Strategic Objectives		
3.2			Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	Risk Rating		
			Actual	Target	Assurance Committee
Well-Led		Kate Warriner	16	4	Finance Transformation & Performance Committee

Description
Risk of failure to: - continue to deliver the ambitions of Vision 2030 given multiple competing demands of the system coupled with variable capacity, balancing short-term versus long-term decision making on priorities and investment.

Control description	Control assurance (How is this control monitored?)
Assurance and support mechanism framework for transformational collaboratives	
Executive Portfolios all incorporate elements of Vision 2030 delivery	
Executive sponsor roles within the programme	
Operational Plan incorporates Vision 2030 deliverables (2025/26)	Operational Plan
Portfolio Board	Portfolio Board
Reports to Board and FTPC	
Transformational collaboratives with Divisional SROs	Programme assurance framework

Gaps in Controls / Assurance
1. Shift of focus to meet demands 2. Failure to develop capacity for delivery 3. Failure to build capacity and skills within our workforce to deliver the 2030 Strategy 4. Failure to deprioritise to enable requisite focus on areas of need and transformational change 5. Risk of 'mission creep' associated to the Strategy

Action	Description	December 2025	
		Due Date	Action Update
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
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
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		
			Actual	Target	Assurance Committee
▪ Effective ▪ Responsive ▪ Safe ▪ Well-Led		Rachel Lea	20	4	Finance Transformation & Performance Committee

Description
Failure to deliver financial targets in particular the level of efficiency and cost reduction required. Inability to invest in the capital programme due to constrained capital and cash allocation. Detrimental impact due to system performance.

Control description	Control assurance (How is this control monitored?)
Active engagement within ICB, NHSE both regional and national.	- Attendance at system forums. - Cascade of system and national information on a regular basis. - Advocate for CYP - Hosting of Beyond programme
Capital Management Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend. Updated 5 year capital plan shared with FT&P and Trust Board. Oversight by FTPC through monthly updates at top 5 key risk
Divisional performance discussed at FT&P with Divisional Clinical/Management and the Executive	Quarterly Performance Management Reporting through Operational Board and FT&P with divisional leads ('3 at the Top'). Clear escalation to FTPC where required for high risk areas.
Financial Improvement Programme (FIP) in place to drive financial decision making whilst ensuring quality and safety impact is minimised subject to programme assessment and sub-committee performance management	FIP now in place with weekly strategic command meetings to approve financial decisions and drive cost reduction. Executive leadership through COO and CFO. Reported weekly through Exec Meeting and monthly through FTPC and Trust Board. All decisions will have a EIA/QIA approved before implementation.
Financial performance escalation framework in place	Any area/division that is off plan is expected to attend a financial review panel meeting with DOF with action plan detailing mitigation to bring back into budget. Quarterly divisional performance at Ops Board and FTPC along with deep dive into any high-risk areas. Divisional Directors report on performance at Trust Board.

Financial systems, budgetary control and financial reporting processes.	-@Daily activity tracker to support divisional Performance management of activity delivery -@ Full electronic access to budgets &@ specialty Performance results enhanced further with Finance App -@ Finance reports shared with each division/@department monthly and now readily available on Finance App -@ Financial in-month and forecast position reported through SDG, Exec team, FT&P, and trust Board including run rate analysis in detail -@ Financial recovery plans reported through SDG and FT&P -@ Internal and External Audit reporting through Audit Committee. -@ interactive financial dashboard rollout to all budget holders with all information readily available in one place.
Focused programme on closing the financial gap in year and realising the recurrent benefits.	8 key areas including in year transformation programme, with executive lead to drive financial benefits at pace to close the CIP gap in year Reporting into FIP and strategic command fortnightly with decision documents on financial savings.
Organisation-wide financial annual plan monitored throughout year by Board and sub-committee to ensure delivery.	- Specific Reports submitted monthly and annually as part of business plan process.(i.e annual plan reviewed by FTPC) - Monitored through IPR and the monthly financial report that is shared with FTPC and Trust Board.
Transformation Programme & benefits realisation	Weekly meetings are in pace for the transformation collaborative which includes benefits realisation and cost reduction and savings. Reported to FTPC as a top 5 key risk. Enhance reporting through FIP and strategic command for 2 of the areas to accelerate in year financial savings.
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

Action	Description	December 2025	
		Due Date	Action Update
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.
Changing financial regime	1. Close monitoring of financial directions from NHS England to ensure the Trust delivers its Plan 2. Working closely with the ICB	31/03/2026	Monitoring continues through Trust Board and FTPC
Delivery of 5 year capital programme	Risks around Capital Plan to be monitored closely. Capital management group established and regular reporting from capital leads. Reporting into FTPC and Board. Capital remains a key risk on FTPC	31/03/2026	Risks around Capital Plan continue to be monitored closely via Capital management group. Reporting into FTPC and Board. Capital remains a key risk on FTPC
Devolved specialist commissioning	Regular reporting to strategic execs and assurance to FTP and Trust Board Financial Analysis required to understand risk Financial analysis to be undertaken on impact of revision to allocations Regular exec to exec meetings with specialized commissioning	31/03/2026	Regular reporting to strategic execs and assurance to FTP and Trust Board Regular exec to exec meetings with specialized commissioning continues
High risk recurrent Efficiency programme	Transformation programme 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.
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		
			Actual	Target	Assurance Committee
Well-Led		Danielle Jones	16	4	▪ Growth and Opportunities Committee ▪ Strategy Board

Description
Risk of inability to control execution of 2030 Vision due to system complexities, constantly evolving statutory and political and system environment. Impact of membership of a system that is in national financial recovery. Risk of failure to keep CYP prioritised in the wider NHS context and competing priorities, and therefore risk to delivery of Vision 2030. Risk of constantly changing relationships and key personnel due to destabilisation of the commissioning environment.

Control description	Control assurance (How is this control monitored?)
Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually). Update: New CEO & leadership arrangements at RMCH - exec to exec scheduled for July 25 Sept 25 update: organisation change at RMCH has delayed NWPPB regrouping. New management is in post Sept 25, and we will now engage and progress this agenda. Oct 25 Update: No further update this month. 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, and management structures supporting the ODNs at RMCH are under change.
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	Beyond Programme recurrently funded by ICS - update funding confirmed for 25/26 March 25 Beyond Board fully established and reporting into ICS, North West region and Alder Hey Trust Board. Dec 25 Update: No change to arrangements
C&M ICS CYP Committee	C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy. Dec 25 Update: No change to arrangements
Capacity and capability building for the implementation of Vision 2030 is being captured in the forthcoming clinical strategies (blueprints) and target operating model work, to ensure Alder Hey have the ability to deliver in the new system environment. This requires both capacity in the central strategy team and wider distribution of system-working leadership and capability across divisions and corporate teams.	Incorporated into Executive Away Day planning discussions and development of 2025+ transformation plan Update Jun 25: Further embedding of the partnership priorities/leadership within the Tx Clinical Collaboratives Sept 25 update: capacity and capability building will be captured in the forthcoming blueprints and TOM work. Oct 25 Update: capacity and capability building continues to be built into the blueprints and TOM, which are in development and due for completion Dec 25. Control details updated. Dec 25 Update: A final version the clinical blueprints is developed. The target operating model work is ongoing.

Continual reflection of the impact of delegation of specialist services into ICBs. Routine reflection of the risks / opportunities for SYP.	Children's Hospital Alliance proposals (under development). On current CHA agenda in March 25 Sept 25 update: NHSE and ICB structural changes are causing uncertainty on timeframes: we continue to monitor and engage with the system on next steps. Oct 25 Update: No further clarity on structure or timeframes available. Dec 25 Update: Specialised services are due to be transferred to the ICB by March 27 (not delegated). Awaiting further clarity on structure and phases.
Engagement and working relationships with ICS and partners	For example peer to peer arrangement such as C&M DoF meetings. Feb 25 - System-wide CYP Neighbourhood engagement event with LCR and all key partners Oct 25 Update: Relationships with ICS and other system partners are active and Alder Hey continue to engage appropriately. Dec 25 Update: Relationships with ICS and other system partners are active and Alder Hey continue to engage appropriately.
Growth and Opportunities Committee oversight of growth element of Vision 2030, including	Oct 25 Update: New control Dec 25 Update: The first committee meeting took place in Oct, with the subsequent meeting due in Dec. The Committee is developing the workplan and metrics.
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	Regular Presentations to Trust Board & CoG, Strategy Board Oct 25 Update: continue to track developments and report back into the relevant forums. Dec 25 Update: continue to track developments and report back into relevant forums.

	Reporting through Strategy Board
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	Update Jun 25 : Strategic Pships governance within new 'GO' Committee developments Sept 25 update: Stakeholder management: An options paper on professionalising stakeholder management was completed for execs on Aug 25. Due to financial constraints, only no/low cost CRM tool options will be considered this year. The need for effective CRM tools is acknowledged, and the Strategy Board will receive an update in October as part of the broader GO review. Oct 25 Update: Strategic partnerships will report through the GO Committee, commencing in Oct, with Exec and non-Exec membership. Assurance continues to be provided through Trust Board also. Dec 25 Update: The first strategic partnership assurance piece will report through GO Committee in December 25. The breadth of partnership working has increased and this will need to be reflected into the Committee with the appropriate level of governance arrangements in place.
Joint development of new models of care on a wider footprint	Get me well: Lung Health respiratory co-created with partners across Liverpool. Sept 25 update: Recent Lung Health event took place, organised by Tripartite: Alder Hey, Merseycare and LUHG. Neighbourhood Model - system wide development with Place Partners Oct 25 Update: Joint models of care continue to evolve, for example 0-19 services and tripartite lung health. 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.
Maintain existing relationships and continually build new ones with system regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December Dec 25 Update: relationships are being maintained
Membership of CMPC Provider Collaboratives - to ensure CYP voice high on agenda	Membership of CMPC provider collaboratives. Dec 25 Update: Membership and engagement in place.
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	Engagement on Vision 2030 with PLACES Partnership Plans developing with CYP focus. Update Jun 25: High disruption of Places due to ICB new model - however Alder Hey continued commitment in all 3 Oct 25 Update: Alder Hey continue to represent at Place. Dec 25 Update: Alder Hey continue to represent at Place.

Gaps in Controls / Assurance
1. Uncertainty over future commissioning intentions (see BAF 3.4 re finance) 2. Impact of delegation of Specialist Commissioned services into ICBs – increased challenges getting things done for specialised services. 3. Executing the comprehensive Stakeholder Engagement Plan 4. National mandates, system finance and productivity challenges forcing us to prioritise unexpected programmes of work 5. System Threats: concerns about system threats to children's services, particularly the risk of being lost within a broader system focused on generic hospital services i.e. importance of maintaining a distinct focus on children's services.

Action	Description	December 2025	
		Due Date	Action Update
1. Uncertainty over future commissioning intentions	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2026	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.
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.
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.
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
▪ Caring ▪ Effective ▪ Safe ▪ Well-Led		John Chester

Risk Rating		
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.
Risk of not achieving a sustainable financial model for growth, including both income-generating and cash-saving activities.
Risk of exposure to ethical challenges and national and international reputational risks.

Control description	Control assurance (How is this control monitored?)
Clear management structures and operational accountability within Futures including the Clinical Research Division, Innovation team and Futures aspects of Education and Digital	Reports to Operational Board
Data governance via Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOP
External communications via internet, social media etc facilitated through Marketing and Communications team	Communications Strategy and Brand Guide
Futures Committee Additional oversight of financial and commercial aspects of R&I activity	Reports to Trust Board via Futures Committee
Futures Management Board Delivery and performance measurement of various R&I activities	Reports to Futures Committee
Protection +/- exploitation of intellectual property	Reports to Futures Committee
Risk registers	Reports to Risk Management Forum
Staff probity - via online declaration of interests portal (gifts & hospitality, sponsorship etc.)	Adherence to Trust Policies, Declarations of Interest Register and digital audit trail to audit committee
Strategic commercial partnerships with industry partners and commercial vehicles	Reports to Futures Committee

Gaps in Controls / Assurance

1. Integration of R&I activities into Futures not yet fully determined.
2. Levels of activity targeted at maintaining and enhancing reputation not yet sustainable.
3. Financial model and levels of income not yet consistent with growth and sustainability.
4. Capacity and capability of clinical staff and services to participate in R&I activities.
5. Comms Strategy for Futures not yet fully described.

Action	Description	December 2025	
		Due Date	Action Update
		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 New Futures Comms and Marketing officer starting in post on 14th July
5. Comms Strategy for Futures	Development of Futures comms approach		
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 performance reporting structure with data focus tested at Nov FMB - feedback will be actioned for Dec FMB
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.
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
▪ Effective ▪ Safe		Kate Warriner

Risk Rating		
Actual	Target	Assurance Committee
16	4	Finance Transformation & Performance Committee

Description
Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families.

Control description	Control assurance (How is this control monitored?)
Clinical and Divisional Engagement in Digital Strategy	Divisional CCIOs and Digital Nurses in place.
Digital Centre of Excellence in place & fully resourced - Chaired by Trust CCIO	Digital Centre of Excellence tracking delivery
Digital Data and AI Collaborative Established as part of transformation programme	Multidisciplinary leadership roles identified. Delivery programme in place.
Digital Strategy refresh underway to reflect changing environment. Digital Data and Insights key components of Vision 2030 and associated governance and plans	Digital Centre of Excellence. Relationship with Futures. Digital and Data Collaborative established.
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Executive level CIO in place	Commenced in post April 2019, Deputy CDIO in place across iDigital Service
External oversight of programme	Strong links to system, regional and national digital governance via internal and external relationships.
Formal change control processes in place	Weekly Change Board in place
High levels of externally validated digital services	HIMSS 7 Accreditation
Monthly digital performance meeting in place	iDigital performance meeting in place. Performance reported as part of Corporate Collaborative.
Regular update to Trust Board on digital developments, Monthly update to FTP	Board agendas, reports and minutes

Gaps in Controls / Assurance
1. Cyber security investment for additional controls approved - dashboards and specialist resource in place. Continual review underway to assess additional requirements. 2. Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs 3. Issues securing experienced resources in some services 4. Aging hardware/device estate and financial restrictions preventing all equipment being replaced, most notably in clinical areas 5. Capital investment anticipated lower than required 6. Optimizing user experience of digital systems review

Action	Description	December 2025	
		Due Date	Action Update
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.
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	
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.
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	
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.