

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 2nd April 2026, commencing at 10:20
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
YOUTH FORUM UPDATE (10:20am-10:30am)						
STAFF STORY (10:30am-10:45am)						
1.	26/27/11	10:45 (1 min)	Apologies.	Chair	To note apologies.	N For noting
2.	26/27/12	10:46 (1 min)	Declarations of Interest.	All	Board members to declare an interest in particular agenda items, if appropriate.	R For noting
3.	26/27/13	10:47 (2 min)	Minutes of the Previous Meeting.	Chair	To consider and approve the minutes of the meeting held on: 5th March 2026.	D Read enclosure
4.	26/27/14	10:49 (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.	26/27/15	10:50 (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.	26/27/16	11:00 (15 mins)	Vision 2030 Update; including: • Transformation Programme.	J. Grinnell/ K. Warriner N. Palin	To receive an update on progress.	A Presentation/ report
7.	26/27/17	11:15 (10 mins)	Neighbourhood Health Framework.	L Cooper	For information.	N Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action:		Preparation
					Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		
8.	26/27/18	11:25 (5 mins)	Advanced Foundation Trust Update.	J. Grinnell	To receive an update.	N	Verbal
9.	26/27/19	11:30 (10 mins)	C&M Financial Position Update.	R. Lea	To receive an update on the current position.	A	Presentation
10.	26/27/20	11:40 (10 mins)	Trust's Green Plan.	S. Ikomoni	For approval.	D	Read report
Performance Against Annual Plan							
11.	26/27/21	11:50 (35 mins)	Evidence of Our Performance: <ul style="list-style-type: none"> • Flash Report, M12. • Integrated Performance Report for M11, 2025/26: <ul style="list-style-type: none"> - 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
Lunch (12:25-12:55)							
Unrivalled Experience							
12.	26/27/22	12:55 (10 mins)	Acute Bed Base Review.	N. Askew/ A. Bateman	For approval.	D	Read report
13.	26/27/23	13:05 (10 mins)	Children and Young People's Gender Service National Provider Network - Annual Report 2025/26.	L. Cooper	To receive the children and young people's Gender Service National Provider Network Annual Report for 2025/26.	N	Read report
14.	26/27/24	13:15 (5 mins)	Mortality Report, Q3.	J. Grice	To receive the Mortality Report for Q3.	A	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action:		Preparation
					Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		
15.	26/27/25	13:20 (5 mins)	Safety and Quality Assurance Committee: <ul style="list-style-type: none"> - Chair's Highlight Report from the meeting held on the 25.3.26. - Approved minutes from the meeting held on the 25.2.26. 	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 25.2.26.	A	Read enclosures
Collaborating in Communities							
16.	26/27/26	13:25 (5 mins)	LNP Board: <ul style="list-style-type: none"> - Chair's Highlight Report from the meeting held on the 2.2.26. 	K. Black	To escalate and key risks and receive updates.	A	Read enclosure
17.	26/27/27	13:30 (10 mins)	Collaborating for Children and Young People: Partnerships Update.	D. Jones	To receive an update on the current position.	N	Presentation
Supporting our People							
18.	26/27/28	13:40 (10 mins)	Strategic People Update.	M. Swindell	To receive an update on the current position.	A	Read report
19.	26/27/29	13:50 (10 mins)	2025 NHS Staff Survey Results; including: <ul style="list-style-type: none"> • Update on cultural work linked to Staff Survey data. 	M Swindell/ J Potier	To formally receive the 2025 NHS Staff Survey Results and to receive an update on the cultural work linked to Staff Survey data.	A	Presentation
20.	26/27/30	14:00 (5 mins)	People Committee: <ul style="list-style-type: none"> - Chair's Highlight Report from the meeting held on the 26.3.26. 	M. Swindell	To escalate any key risks, receive updates and noted the approved minutes from the 29.1.26.	A	Read enclosures

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- Approved minutes from the meeting held on the 29.1.26.				
Strong Foundations (Board Assurance)							
21.	26/27/31	14:05 (5 mins)	Finance, Transformation and Performance Committee: <ul style="list-style-type: none"> - Chair's verbal update from the meeting held on the 25.3.26. - Approved minutes from the meeting held on the 23.2.26. - 2025/26 top key risks (M11) 	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 23.2.26.	A	Read enclosures
22.	26/27/32	14:10 (5 mins)	Board Assurance Framework Report; including: <ul style="list-style-type: none"> • Corporate Risk Register. 	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	A	Read reports
23.	26/27/33	14:15 (5 mins)	Directors' Register of Interests.	E. Saunders	To note.	R	Read enclosure
24.	26/27/34	14:20 (5 mins)	Election Results.	E. Saunders	To note.	N	Read enclosure
25.	26/27/35	14:25 (4 mins)	Any Other Business.	All	To discuss any further business before the close of the meeting.	N	Verbal
26.	26/27/36	14:29 (1 min)	Review of Meeting.	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	N	Verbal

Date and Time of Next Meeting: Thursday, 7th May 2026, LT1, Institute in the Park.

REGISTER OF TRUST SEAL
The Trust seal was not used in February 2026

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M11, 2025/26	R. Lea
Neighbourhood Health Framework	L. Cooper
Communications Report, Q4	C. Beaver

PUBLIC MEETING OF THE BOARD OF DIRECTORS
Confirmed Minutes of the meeting held on Thursday 5th March 2026 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)
	Mrs. R. Lea	Chief Finance Officer	(RL)
	Mr. G. Meehan	Non-Executive Director	(GM)
	Dr. B. Owolabi	Non-Executive Director	(BO)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Chief Scientific Officer	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)
	Mrs. K. McKeown	Board Administrator (minutes)	(KMC)
	Ms. R. Pennington	Assoc. Chief Nurse for Surgery	(RP)
	Mr. D. Powell	Director of Development	(DP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Observing	Ms. J. Potier	Assoc. Director of Organisational Development	(JP)
Apologies	Ms. S. Almond	Consultant Paediatric Surgeon	(SA)
	Mr. C. Beaver	Deputy Director of Marketing and Comms	(CB)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Ms. C. Lee	ACOO, Division of Surgery	(CL)
	Ms. B. Pettorini	Director of Surgery	(BP)

25/26/350 Welcome and Apologies

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

25/26/351 Declarations of Interest

The following declarations were made:

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

25/26/352 Minutes of the previous meeting held on 5th February 2026.

Resolved:

The minutes from the meeting held on the 5.2.26 were agreed as an accurate record of the meeting.

25/26/353 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

It was confirmed that all actions are on track.

25/26/354 Chair's and CEO's Update

John Grinnell (JG) informed the Board about the commencement of the Trust's organisational change programme, 'How We Will Work in the Future'. It was confirmed that a series of staff briefings and interactions are currently underway.

On the 18.3.26 the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) are hosting a system leaders' event with local authorities to think about the challenges ahead. Children and young people (CYP) are central to the agenda. It was confirmed that the Trust will be sharing its aspirations for CYP during the event.

The Chief Digital and Transformation Officer, Kate Warriner (KW) provided an overview of the recent Foreign Office co-ordinated visit to Sick Kids in Toronto. The delegation was hosted at the hospital and the Consulate General, with the Memorandum of Understanding for the AI partnership being formally signed during the trip. Learning was shared during the visit shared along with AI initiatives that are being undertaken. It was reported that plans are underway to coordinate a reciprocal visit, enabling representatives from Sick Kids to visit a number of trusts, including Alder Hey.

The Board received an update regarding the external assessment conducted on the 4.3.26 of the Trust's digital and data services by the Digital Skills Development Network. After the assessment, the assessor described the Trust as an exemplar of exemplars and praised the organisation's workforce and talent management. It was confirmed that the Trust has been recommended for Level 3 reaccreditation. The Chair congratulated all those involved in this achievement.

Resolved:

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

25/26/355 Vision 2030 Update

The Board received an update on the progress of delivering Vision 2030 and the Trust's strategy for its Transformation Programme for the period 2026–2029. A number of slides were shared outlining key information in the following areas:

- Medium Term Plan ambitions, transformation outcomes, and programme enablers.

- Programmes and enablers to deliver Alder Hey's Transformation Programme.
- Programme governance structure.
- Managing risk and protecting delivery.
- Support from the Board

The Board was informed that the approach to the Transformation Programme has developed substantially since last year, incorporating lessons learned from previous successes and challenges. Resource and leadership plans are currently being formulated, and support for these initiatives will be sought in the coming weeks. The importance of quickly accelerating the Transformation Programme was emphasised.

It was reported that work is taking place to understand the potential benefits of the Transformation Programme. Project Initiation Documents (PIDs) are due to be submitted on the 6.3.25 and will be reviewed via the Financial Improvement Programme (FIP) to assess the current position. It was highlighted that the scope of challenges and associated figures are considerable; therefore, in conjunction with the resource plan, it is important to consider how to improve the tracking of financial benefits this year from a leadership perspective and a project governance structure perspective. FIP will see notable changes compared to the previous year as demands will be greater due to the scale of the Trust's expanding efforts. The Board was advised that it's crucial to avoid under-resourcing the programme and ensure the right people are involved, therefore having the appropriate resources is essential. It was confirmed that upon receipt of the PIDs, an evaluation will be conducted to identify any gaps.

Reference was made to the programme's pace, and it was agreed that acceleration is important as is the monitoring of the programme via the Finance, Performance and Transformation Committee (FTPC). It was proposed that resources for the CYP outward-facing initiatives be developed independently from those required for internal organisational transformation, although some coordination will remain necessary. The need for additional roles to support the Transformation Programme was acknowledged, while also emphasising the critical importance of strong clinical leadership to prevent an approach driven solely by management. Attention was drawn to the importance of being able to demonstrate to the Board in April that the necessary resources have been secured and that the Trust is fully prepared to accelerate progress in alignment with the benefits plan, which must be clearly articulated at that meeting.

Non-Executive Director, Bola Owolabi (BO) reflected on the lessons learned from organisational transformation. BO referred to the organisation's cultural changes and Digital Operating Model which is recognised as the right thing to do. However, the sequencing in which these changes are made matter, and there are a number of reports in the public domain that highlight the pitfalls of organisations who attempted to undertake significant transformation in parallel. BO felt that it is important to be aware of challenges from the outset.

Resolved:

The Board noted the Vision 2030/Transformation Programme update.

25/26/356 Advanced Foundation Trust Assessment Update

The Board was advised that the Board-to-Board meeting with NHS England, which is part of the Advanced Foundation Trust (AFT) assessment, has been

arranged for the 23.3.26 with a pre-meeting scheduled with the AFT Assessment Team for the 12.3.26. Following the pre-meeting all relevant information will be shared with Board members.

It was reported that work is underway to prepare a presentation ahead of the Board-to-Board session, and an internal pre-meeting has been scheduled for the 17.3.26 with Board members to ensure they feel adequately prepared. The CEO of the C&M ICB is also joining the pre-meeting on the 17th.

Results of Provider Capability Assessment

The Trust received a letter from NHS England North West (NHSE) confirming that each provider capability rating has been signed off via the region's governance and a national moderation process resulting in Alder Hey's overall capability rating being assessed as 'Green' for 2025/26.

Resolved:

The Board noted the AFT assessment update and the results of the Trust's Provider Capability Assessment.

25/26/357 North Mersey Provider Partnership (Tripartite) Memorandum of Understanding

The North Mersey Provider Partnership (NMPP) is a collaboration between five NHS Foundation Trusts across North Mersey, serving nearly one million people, established to improve population health, reduce inequalities, and deliver more integrated, preventative, and person-centred care. Formed in response to national and local policy drivers including the Liverpool Clinical Services Review, the Darzi Review, and the Fit for the Future 10-year Health Plan, the Partnership is intended as a strategic asset for the system, enabling aligned planning and delivery across organisations.

A non-binding Memorandum of Understanding (MoU) sets out shared purpose, principles, governance, and ways of working, while maintaining organisational sovereignty. For 2026/27, partners will focus on neighbourhood health delivery, support for people with complex needs, development of a shared population health strategy, creation of a single care record, and maximising opportunities for joint research and innovation.

The Board of each trust involved has been asked to approve the MoU and associated Terms of Reference (ToR). It was confirmed that to date the MoU has been agreed by the Liverpool University Hospitals Group.

Reference was made to paragraph 3 of the ToR, which specifically mentions adults but lacks any reference to CYP. It was agreed that this omission needs to be addressed before confirming approval of the ToR.

25/26/357.1 Action DJ

Resolved:

The Board approved the MoU and the ToR subject to the amendment to paragraph 3 in the ToR.

25/26/358 Cheshire and Merseyside System Wide Update

There continues to be significant movement within the C&M system, especially as the ICB's operating model remains under consultation. Providers are working in collaboration on the strategy and becoming embedded with the commissioners at the ICB. Additionally, efforts are underway to co-design the CYP system. Further progress is necessary regarding the needs assessment, and a clear set of priorities has been established for year 1.

Preparations continue for the system-wide event scheduled for 18.3.26, with much of the agenda dedicated to CYP. It was reported that the overall system wide outlook is positive in terms of the work that is taking place, although certain elements remain complex.

C&M Financial Position update

The year end C&M position is expected to show a deficit of £289m. This represents an improvement of £45m compared to the position at M9; however, the overall plan will not be achieved. Additionally, six providers are projected not to meet their respective targets and are required to adhere to the established protocol.

The ICB will transition into its new role next year; as a result, providers will need to independently manage their understanding and sharing of information without the input of the ICB. It was reported that a number of collaborative groups are currently emerging to support these efforts.

Resolved:

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

25/26/359 Infection, Prevention and Control, Q3

The Board was provided with oversight of Infection, Prevention and Control (IPC) activity for the reporting period from the 31.10.25 to the 31.12.25. The following points were highlighted:

- The IPC Team is working extensively with staff, CYP, and families to promote a safe and clean environment via education.
- The incidence of *C. difficile* infections has decreased; however, efforts remain necessary to fully address the issue. There are three key components to the Trust's approach: 1. Manual cleaning - ensuring staff receive appropriate training and that cleaning protocols are consistently implemented; 2. Disinfection - verifying the use of suitable disinfectant solutions for specific purposes; and 3. Deep cleaning - utilising an improved UV light system that surpasses previous equipment. A Standard Operating Procedure (SOP) has been compiled and determines when each of the two systems should be applied.
- Work is taking place to improve water safety management across the Trust and rectify an ongoing issue. The Board was advised that the Clinical Water Safety Group has been relaunched, providing a renewed opportunity for colleagues across the organisation to collaborate, share expertise, and strengthen a collective approach to water and wastewater safety.

A question was raised about whether Gram-negative bloodstream infections (GNBI) are preventable. It was reported that many cases are linked to long term

drain access, often due to challenging venous access and ongoing treatment needs. The Board was advised of the work that is being undertaken related to touch tech areas and management principles. Efforts are also underway to promote more frequent replacement of lines.

The information leaflet for families and visitors containing IPC guidance was discussed, and a query was raised regarding its availability in multiple languages. It was noted that all leaflets can be accessed online and are supported by translation software for 28 of the most commonly used languages.

Resolved:

The Trust noted the IPC update for the reporting period; 31.10.25 to the 31.12.25.

25/26/360 Evidence of Our Performance

The Board received the Flash Report for M11. The following points were highlighted:

- Currently the Trust's referral to treatment (RTT) performance is at 64% which marks significant progress since the start of the financial year when it was 54%. As a result of a national priority to increase the number of patients seen in 18 weeks and receiving sprint funding, the Trust has set an ambitious RTT goal of 68% and anticipates seeing approximately 3,500 additional patients between January and March.
- A recent national briefing highlighted RTT and the Emergency Department (ED) 4-hour standard as being critical to NHS credibility. It was reported that Alder Hey has consistently met the 78% ED standard target all year, with January reaching 86% and February 80.3%. Discussions have taken place with the ED Team to look at the possibility of achieving a 95% via a number of initiatives.
- There has been an improved performance of diagnostic under six weeks (93.7%).
- Attention was drawn to the challenges being experienced around transcription and the sign-off of clinical letters. It was reported that additional resources were agreed in February and since then the backlog of letters has reduced significantly. The way in which the Transcription Team works has also been restructured to enable AVT letters to be prioritised as they total 40% of the letters being submitted to the team. Currently, letters are being produced within 24 to 48 hours, reflecting notable performance improvements.

Further short term solutions are also being considered to help improve the position, including discontinuing voice recognition and the audio route by the end of March and transferring these processes to AVT with support for clinicians. Additionally, legacy tasks performed by the team are being reviewed for potential removal. With regards to long-term strategies, outsourcing is an option, though it presents certain risks that will require careful consideration. The Trust is also aiming to increase the rate of clinical sign-off of letters in clinic.

- There are 4,000 children waiting over two years for follow-up care, mainly concentrated in three surgical specialties. The Trust plans to eliminate this backlog within six months by increasing the utilisation of Patient Initiated

Follow-Ups (PIFU) and validating every child who is overdue a follow-up appointment.

Integrated Performance Report

Outstanding Care and Experience – Safe and Caring

- The outputs for deteriorating patients will be included in the IPR from April onwards.
- All inpatients (100%) and 92% of ED patients with suspected sepsis received antibiotics within 60 minutes.
- Formal complaints increased significantly during the month, which has affected response timeliness, with compliance falling to 76%. Although no specific trends have been identified, continued monitoring of this area will remain a priority.

Pioneering Breakthroughs

- The Innovation Hub will host its 10-year celebration on the 12th and 13th of March combined with the launch of the Paediatric Open Innovation Zone (POIZ). Metro Mayor, Steve Rotherham, Children's Commissioner for England, Rachel de Souza, and representatives from a number of countries will be attending the event.
- It was reported that the Liverpool Institute of Child Health and Wellbeing will be launching a series of lectures at the end of March.

Workforce

- While long term sickness absence has reduced, short-term sickness has increased in month.

Financial Sustainability - Well Led

- The Trust is reporting in line with plan of a £2.2m surplus at the end of M11.
- Expenditure is in line with the projected forecast.
- *Activity:* The Trust is expecting to deliver a high income in March, partly due to the extra sprint funding provided to help achieve a 68% RTT, with teams making every possible effort.
- *Coding:* If coding is not finalised within the last two weeks of the financial year, there is a risk that this may impact the Trust's income.
- *Divisions:* Certain challenges have been identified within the Divisions which will be discussed by the Executive Team on the 10.3.26. In relation to potential deteriorations being forecast, separate discussions will take place with the Divisions to ensure that there are no changes to the forecast at this point in the year.

Community and Mental Health Division

- A meeting is taking place to hear about the proposed recovery action plan for addressing the ADHD medication backlog.

Division of Medicine

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

A question was raised about Lyrebird in relation to the increase in patients being seen in the Gastro service. It was noted that using Lyrebird allows clinicians to save time on dictating letters, which makes it possible to see more patients. The Gastro department has six consultants who are able to see an additional patient each as a result of using Lyrebird.

Division of Surgery

- It was reported that the complexity of complaints means the Division is spending additional time to resolve them.

Resolved:

The Board:

- Noted the Flash Report for M11.
- Noted the content of the IPR for Month 10.

25/26/361 PALS and Complaints Report, Q3

The Board received an update on performance against complaints and PALS targets in Q3, 2025/26 and a thematic analysis of the top reasons for complaints and PALS. The following points were highlighted:

- It was confirmed that performance in Q3 was strong across the three main metrics in terms of responsiveness to complaints and PALS.
- During the reporting period, three PHSO cases were open; however, two of them have since been closed.
- The Board was advised that following an in-depth discussion at SQAC about how the organisation can start to triangulate some of its patient experience data against demographic data, it was agreed to undertake an analysis to identify any disproportionately represented demographic groups and to assess the effectiveness of FFT reporting by protected characteristics. This information will be fed into the Patient Experience Strategy.

A question was raised and responded to about the process for sharing lessons learned across the Trust. Reference was made to the actions outlined in the Lessons Learned Action Plan relating to record keeping audits, and it was queried as to whether the Trust will undertake a record keeping audit as part of its Internal Audit Plan. It was explained that the auditing of records will be addressed as part of the Southport report, with the intention of developing an automated audit process. This approach it is believed will have a bigger impact Trust wide.

Resolved:

The Trust noted the content of the PALS and Complaints Report for Q3.

25/26/362 Safeguarding Children and Adults at Risk Annual Report, 2024/25

The Board received the Safeguarding Children and Adults at Risk Annual Report for 2024/25 which provided an overview of the Trust's safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team from the 1.4.24 to the 31.3.25.

The Safeguarding Annual Report notably indicates a continued increase in referrals, and the work of the team continues to be challenging. However, it is important to celebrate the full digitisation of the Safeguarding Service this year, which has had a big impact on the team. The report also outlines the key areas of

focus for the next twelve months. It was confirmed that the report has been shared with SQAC.

Resolved:

The Board received and noted the content of the Safeguarding Children and Adults at Risk Annual Report 2024-2025

25/26/363 Children in Care Annual Report, 2024/25

The Board received the Children in Care Annual Report for 2024/25 which provided an overview of the Trust's Children in Care governance arrangements and a retrospective view of the work completed by the Children in Care Team from the 1.4.24 to the 31.3.25.

It was reported that the Trust is challenged with recruiting safeguarding named and designated professionals across both functions. Alder Hey has reached out to the ICB and a meeting has been scheduled for the 8.4.26 to discuss a possible interim solution as well as a long term system wide resolution for these roles that are often quite difficult to recruit to.

It was noted that the Children in Care Annual Report is usually presented to the Board later in the year; however, it has been confirmed that measures are being implemented to ensure the report is available earlier next year.

The Chair emphasised the importance of having appropriate staff in place and questioned if Alder Hey is doing enough for CYP in the care system. It was pointed out that as the Trust moves into a system leadership role, filling key positions is essential. Because each organisation requires a designated professional, it was suggested that someone from the wider system might be able to offer support to Alder Hey by taking on this responsibility.

Resolved:

The Board received and noted the content of the Children in Care Annual Report for 2024/25.

25/26/364 Safety and Quality Assurance Committee

Resolved:

The Board noted the Chair's Highlight Report from the meeting held on the 25.2.26 and the approved minutes from the meeting held on the 21.1.26.

25/26/365 Growth and Opportunities Committee

The approved minutes from the meeting held on the 16.12.25 were submitted to the Board for information and assurance purposes.

During February's meeting the Committee focused on the progress achieved with centralising observerships and discussed the report on robotic surgery. The Trust's global presence was highlighted, including the prospect of a summer school in 2027 from China. Key risks were noted, particularly regarding the better use of the Trust's MRI scanner. It was confirmed that efforts are underway to look at how the scanner can be more effectively integrated with development research.

Resolved:

The Board noted the Chair's update from the meeting held on the 26.2.26 and the approved minutes from the meeting held on the 16.12.25.

25/26/366 Strategic People Update

The Board received the Strategic People Update Report that provided an overview of current and emerging issues and how the Trust is responding to those issues. The following points were highlighted:

- On the 25.2.26 the Trust welcomed representatives from the Department of Health who are developing the 10 Year Workforce Plan. The visiting team received an extensive overview of ongoing initiatives across various services, professions, and workforce development areas. They provided reassurance that some of the issues raised by the Trust will be addressed as part of the 10 Year Plan. The team acknowledged and commended the central focus of CYP throughout all discussions, noting that Alder Hey was the first trust where they felt that their strategy was being driven by patient needs. The team requested follow-up on a couple of items, which the Trust will address accordingly.
- The Trust's new values are live, and work is currently progressing on the development of a values action framework. This framework will be submitted to the People Committee in May.
- It was reported that the Trust's dedicated HR sickness support team continue to provide tailored support to improve levels of absence across the organisation. There has been a significant focus by the team on sickness in terms of pathways and pre-emptive work. The Board was advised that a large number of staff who are absent due to sickness are presenting with stress and mental health issues.
- On the 12.2.26 the government announced a 3.3% pay award for staff on Agenda for Change NHS terms and conditions. The pay award will be paid in April, in line with ESR lead times.

The Chair offered thanks for the update and noted that it is encouraging to learn that despite ongoing organisational changes, CYP remain at the core of Alder Hey's focus which provides significant reassurance to the Board.

Resolved:

The Board received and noted the content of the Strategic People Update.

25/26/367 Gender Pay Gap Report

The Board received the 2025 Gender Pay Gap Annual Report, for information purposes. The following points were highlighted:

- The gender pay gap is 25.1% on mean pay and 17.0% on median pay. The data indicates that female employees earn 17% less per hour than male employees, representing a 1% reduction compared to 2024.
- Analysis shows that the gender pay gap at Alder Hey is primarily driven by the Medical and Dental workforce. Although females now represent a greater proportion of this staff group than males, with females making up 52.95% of the Medical and Dental workforce, the highest paid clinical roles continue to be held by males due to higher length of service and national/local award holding. This reflects long-standing national and historical workforce trends, including an ageing male consultant cohort. Recent

recruitment trends show an increasing number of female consultants, which is expected to positively reduce the gap.

- The report presents the Trust's gender pay gap data in line with Government reporting requirements but there are still a number of actions that the Trust is taking to reduce the gender pay gap (*1. Promoting a flexible working culture, 2. Driving behavioural and cultural change, and 3. Embedding fair and inclusive recruitment and talent management*), which will be embedded within the Trust's workforce equality objectives, incorporated into the People Plan, and monitored through the People Committee.
- It was confirmed that the Gender Pay Gap Report will be published on the 31.3.26.

Resolved:

The Board received and noted the content of the 2025 Gender Pay Gap Report.

26/26/368 Audit and Risk Committee

Resolved:

The Board noted the Chair's Highlight Report from the meeting held on the 12.2.26 and the approved minutes from the meeting held on the 10.12.25.

25/26/369 Finance, Transformation and Performance Committee

Resolved:

The Board noted the approved minutes from the meeting held on the 21.1.26 and the Committee's top key risks in M10.

25/26/370 Board Assurance Framework Report (BAF)

The Board was provided with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 13 principal risks aligned to the Trust's strategic objectives. The following points were highlighted:

- End of year updates are being undertaken with all risk owners with varying degrees of movement being seen.
- Improvement is being seen in BAF risk 3.5 (*system working to deliver 2030 Strategy*).
- It was reported that strategic risks have undergone significant changes recently, and it was confirmed that the Board will receive a comprehensive report on risk appetite in May 2025.

Resolved:

The Board received and noted the contents of the Board Assurance Framework Report for January 2026.

25/26/371 Any Other Business

It was acknowledged that this is John Chester's final Board meeting as the Trust's Chief Scientific Officer. On behalf of the Board, the Chair expressed thanks to John for his significant contributions to Alder Hey and for advancing initiatives such as POIZ/Institute for Child Health and Wellbeing, which will leave a lasting legacy.

25/26/372 Review of the Meeting

Non-Executive Director Gerald Meehan (GM) was invited to review the meeting. GM commented that the strategic context was strong and that the Board is looking outwards rather than inwards, whether through initiatives involving a visit to Canada or welcoming international visitors, which is positive. Significant time was dedicated to discussing the system and Non-Executive Director, Bola Owolabi provided valuable guidance, emphasising the importance of appropriately sequencing multiple parallel and complex change to ensure their interconnections are understood.

Outcomes were notable, particularly regarding their implications for CYP. There was also a lot of discussion about processes. The Board talked about the ICB, and it was felt that improvements can be seen, and that greater cohesion can only benefit Alder Hey.

GM noted that learning about CYP in the care system was valuable, in terms of the child-focused discussion on how strategic decisions can support them and improve their lives.

The Chair acknowledged the Board's productive discussions and thanked members for their contributions during the meeting.

Date and Time of Next Meeting: Thursday 2.4.26, 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 May 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	May-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	May-26	
8.1.26	25/26/293.1	Mid Term Plan	Discussion to take place to determine/formalise Assurance Committee responsibility for the new national performance standards.	A. Bateman/ F. Beveridge/ E. Saunders	Apr-26	May-26	
8.1.26	25/26/296.1	Organ Donation Annual Report, 2024/25	Invite Dr. Carla Thomas to a future Board meeting to share an insight into the complexity and importance of the work that the Organ Donation service undertake.	K. McKeown	7.5.26	On track May-26	
Status							
Overdue							
On Track							
Closed							

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

Date	Ref	Item	Action	By whom?	By when?	Status	Update
5.3.26	25/26/357.1	North Mersey Provider Partnership (Tripartite) Memorandum of Understanding	Include reference to CYP in paragraph 3 of the Terms of Reference.	D. Jones	Apr-26	Closed	1.4.26 – This action has been addressed. ACTION CLOSED
Status							
Overdue							
On Track							
Closed							



BOARD OF DIRECTORS
Thursday, 2nd April 2026

Paper Title:	2026/27 Transformation Programme Mobilisation
Report of:	John Grinnell, CEO Kate Warriner, Chief Transformation and Digital Officer Natalie Palin, Director of Transformation and Change
Paper Prepared by:	Natalie Palin, Director of Transformation and Change

Purpose of Paper:	Decision <input checked="" type="checkbox"/> R Assurance <input type="checkbox"/> Information <input type="checkbox"/> Regulation <input type="checkbox"/>
Action/Decision Required:	To note <input type="checkbox"/> To approve <input checked="" type="checkbox"/> R
Summary / supporting information	N/A
Strategic Context This paper links to the following:	Outstanding care and experience <input checked="" type="checkbox"/> R Collaborate for children & young people <input checked="" type="checkbox"/> R Revolutionise care <input checked="" type="checkbox"/> R Support our people <input checked="" type="checkbox"/> R Pioneering breakthroughs <input checked="" type="checkbox"/> R
Resource Implications:	As detailed within the paper

1. Executive Summary

This paper sets out the current position of the Transformation Programme as it moves into mobilisation for 2026/27, alongside the emerging benefits and delivery risks for assurance by FTPC.

The programme represents the most significant and complex change undertaken by the Trust in recent years, combining service redesign, operating model transformation and financial recovery within a single portfolio.

The FTCP discussion was constructive but also highlighted a clear and shared concern: that the programme has not yet translated ambition into demonstrable delivery at the pace required. There was a view that, as a consequence of the scale and sequencing of HWWWITF, progress across the wider transformation programme has at times lacked momentum, due to insufficient, resource and prioritisation.

Three themes emerged consistently:

1. **The need to move decisively from design into delivery**, with a sharper focus on a smaller number of high-impact priorities
2. **The need for a clearer and more granular line of sight from plans to delivery**, including how programmes translate into measurable activity, workforce change and financial benefit
3. **The need to strengthen leadership, capacity and delivery infrastructure**, particularly at programme and divisional level

In response, the Transformation Board agreed to:

- **Refocus the programme on a small number of priority delivery areas**, led through Revolutionising Care and supported by HWWWITF Phase 2
- **Develop a single, integrated delivery plan**, with clear milestones, ownership and dependencies across all programmes
- **Strengthen alignment between transformation activity, workforce assumptions and financial plans**, ensuring consistency with the Medium-Term Plan while improving granularity and transparency
- **Bring forward proposals to address leadership and delivery capacity gaps**, including programme and clinical leadership

For the next FTPC cycle, a key requirement is to provide **greater granularity and clarity on delivery**, including a clearer line of sight from programme activity to outcomes, workforce impact and financial benefit.

2. Purpose and Context

The Transformation Programme is the mechanism through which Alder Hey will deliver Vision 2030. It brings together service redesign, workforce transformation, digital enablement and financial sustainability into a single, connected system of change.

The ambition remains clear: by 2030, Alder Hey will be part of a fully integrated CYP system, delivering care that is more joined-up, more personalised and more sustainable.

The Board recognised that this ambition is well understood and supported. The challenge now lies in **execution at pace and scale**.

Delivering transformation alongside organisational redesign introduces complexity. To manage this effectively, the programme now requires:

- Greater prioritisation and sequencing
- Clearer accountability for delivery
- Stronger alignment between strategy, operations and finance
- A more disciplined approach to programme management and reporting

There was also agreement that reporting should be simplified, with a single, coherent paper providing both narrative and assurance, enabling clearer oversight by FTPC.

3. Transformation Programme Overview

The programme is structured around five interconnected programmes, each playing a distinct role but designed to operate as a single system.

Programme	Focus	Contribution
Future CYP System & Futures	System and long-term horizon	Shapes the future model of care, partnerships and innovation
HWWWITF	Operating model	Strengthens clinical leadership, workforce model and organisational design
Revolutionising Care	Service model	Delivers tangible improvements through pathway and service redesign
Digital, Data & AI	Enabler	Provides the infrastructure for integration, insight and innovation
Financial Improvement Programme	Sustainability	Ensures financial resilience and reinvestment. This programme is not responsible for all financial improvement but rather the oversight and tracking.

These programmes are deliberately interdependent. Progress in one area enables progress in another, for example, digital capability underpins pathway redesign. The programme is sequenced over three years to ensure delivery is manageable and sustainable:

Year	Focus	What this means in practice
2026/27	<i>Reset & Align</i>	Stabilising services and creating the conditions for change
2027/28	<i>Build & Embed</i>	Scaling new models of care and standardising pathways
2028/29	<i>Sustain & Grow</i>	Embedding change and strengthening system leadership

This approach reflects a conscious decision to balance ambition with realism, ensuring that improvements are sustained rather than short-lived.

4. Delivery Focus and Programme Position

While the structure of the programme is well understood, the Board was clear that we are currently trying to move too much at once. The consequence is a risk that progress becomes diluted and difficult to evidence.

There was a consistent message that we now need to narrow our focus and demonstrate tangible delivery in areas that matter most to children, families and staff.

The immediate priority is to accelerate delivery within Revolutionising Care, and the safe completion of HWWWITF – phase 1 & 2.

Priority Area	Focus of Delivery
Urgent & Emergency Care	Improving flow, reducing delays and stabilising performance
Outpatients	Reducing unnecessary follow-up and improving access and utilisation
HWWWITF Phase 2 (Pathway Redesign)	Enabling service transformation through standardised pathways

This is not a shift in ambition, but a shift in emphasis—from planning what we will do, to delivering change where it will have the greatest immediate impact.

The expectation is that this will translate into visible progress within the next three to six months, supported by a clearer milestone plan set out in the appendices.

5. Emerging Benefits and Value

The programme is expected to deliver a combination of improvements in experience, outcomes, workforce sustainability and financial performance. However, the Transformation Board and FTCP recognised that:

- Current benefit assumptions are **largely derived from the Medium-Term Plan**
- There is **insufficient granularity linking benefits to specific delivery actions**
- Workforce, activity and financial assumptions are **not yet fully aligned**

In some areas, particularly within Revolutionising Care and elements of Digital, there is a clearer line of sight to impact. In others, CYP System programme, the benefit profile is less developed and requires further work, and will not be delivered in the same trajectory of programmes solely under organisational control.

Benefit Area	Emerging Direction
CYP Experience & Outcomes	More personalised care, fewer unnecessary steps and improved experience
Access & Flow	Reduced waiting times, improved clinic utilisation and more reliable pathways
Our people - thriving	Better use of skills, more sustainable staffing models and improved productivity
Financial Sustainability	Contribution to £21m–£24m CIP, with further work required to confirm full programme value

A key theme in the discussion was the need to bring these elements together into a single, coherent view. At present, financial, workforce and activity assumptions are not always aligned, and this limits our ability to clearly describe the total value of the programme.

There was a clear expectation that we move towards a more integrated approach, linking activity, workforce and finance in a way that provides confidence in both delivery and sustainability.

6. Integrated Oversight and Scorecard

The Board supported the development of a single, integrated transformation scorecard to bring greater clarity and consistency to how progress is tracked. Please see appendix 2 for more details on capabilities and benefits.

VISION 2030 **Transformation Score Care**

Outcome 1: Right care, right time, right place – first time
 Delivering timely, equitable and high-quality care through redesigned pathways and integrated services.

Outcome 2: Thriving people delivering sustainable services
 A clinically led, empowered workforce operating within a sustainable and productive model.

Outcome 3: Advancing care for the next generation
 Leading innovation in child health through digital, data, research and system partnerships.




Driver Measures:

RTT Performance (18-week standard / incomplete pathways)

4-Hour Emergency Care Performance Outpatient Follow-Up to New Ratio

Thriving staff index Workforce Productivity (Activity per WTE)

Workforce Productivity (Activity per WTE) CIP Delivery (£ and % Recurrent)

The intention is that this becomes the primary mechanism for tracking transformation at a strategic level and is aligned with the Trust’s Integrated Performance Report.

However, the discussion highlighted that further work is needed to ensure that measures are meaningful, clinically owned and clearly linked to delivery plans. Without this, there is a risk that the scorecard becomes a reporting tool rather than a driver of improvement. Benefit cases will also be created in accordance with the established benefit framework.

7. Leadership, Resources and Delivery Risk

There is agreement on the overall leadership model for the programme, with the CEO acting as Executive Sponsor, supported by the Chief Transformation and Digital Officer and the Director of Transformation.

Role	Responsibility
CEO	Executive Sponsor
Chief Transformation & Digital Officer	Coordination across programmes
Director of Transformation	Integration, oversight and delivery discipline

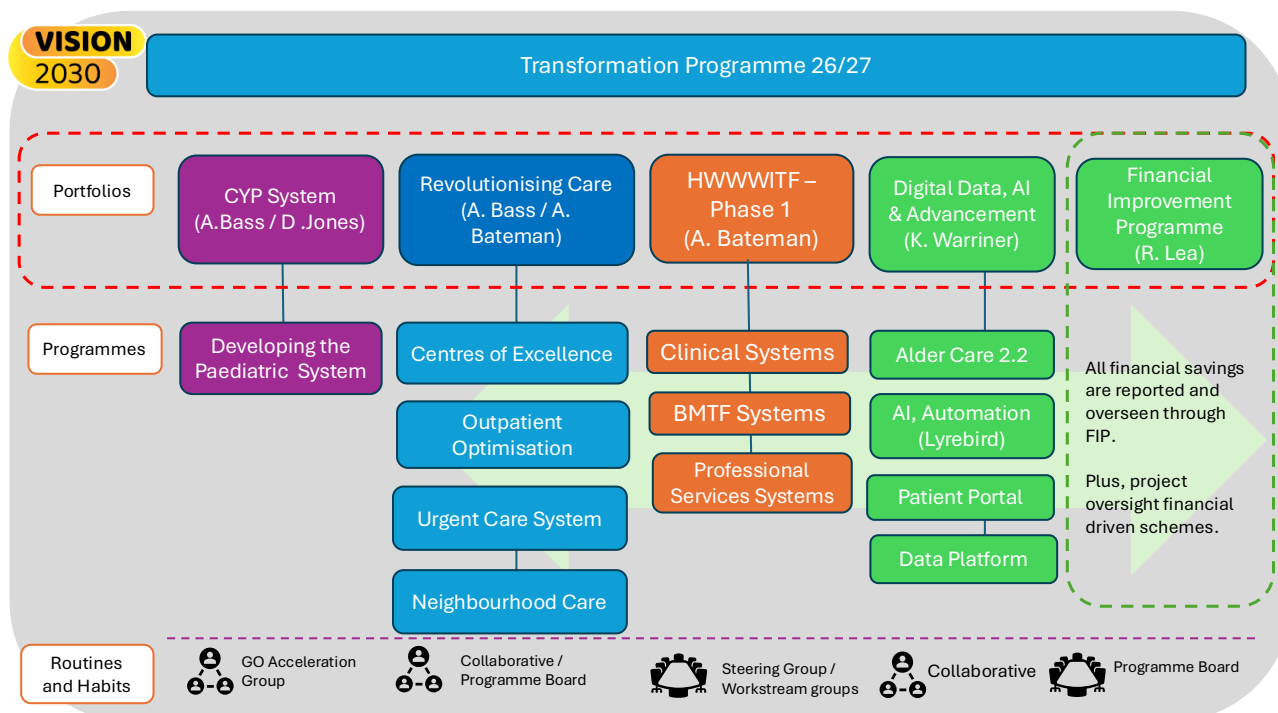
The Board identified a number of areas where clarity and capacity need to be strengthened.

Area	Current Position	Agree outcome
Leadership clarity / capacity	Not all programmes have clearly defined ops leads / gap in programme delivery	Roles and responsibilities to be confirmed. Support investment in Programme Director.
Clinical leadership	Gap in across programmes – risks of not clinically led	Support investment in Clinical Leadership

These gaps represent a material delivery risk. Without addressing them, there is a likelihood that the programme will remain well designed but not fully deliverable. Whilst the investment in additional capacity was supported its subject to the approval of a decision document by the Executive Team.

8. Governance

The overall programme will be governed through the newly established Transformation Programme Board chaired by the CEO. The establishment of a Revolution Care Programme delivery group was agreed as a priority action.



9. Next Steps

The focus over the coming weeks is to strengthen delivery discipline and create the conditions for successful mobilisation.

Priority	Action
1. Programme clarity	Finalise scope, milestones and measures
2. Benefits	Develop a clearer and fully aligned benefit profile
3. Leadership	Confirm accountable and clinical leads
4. Resource	Bring forward targeted resource proposals
5. Scorecard	Finalise and embed within reporting
6. Delivery	Accelerate priority areas within Revolutionising Care
7. Granularity	Provide FTPC with clearer, more detailed reporting on delivery and impact

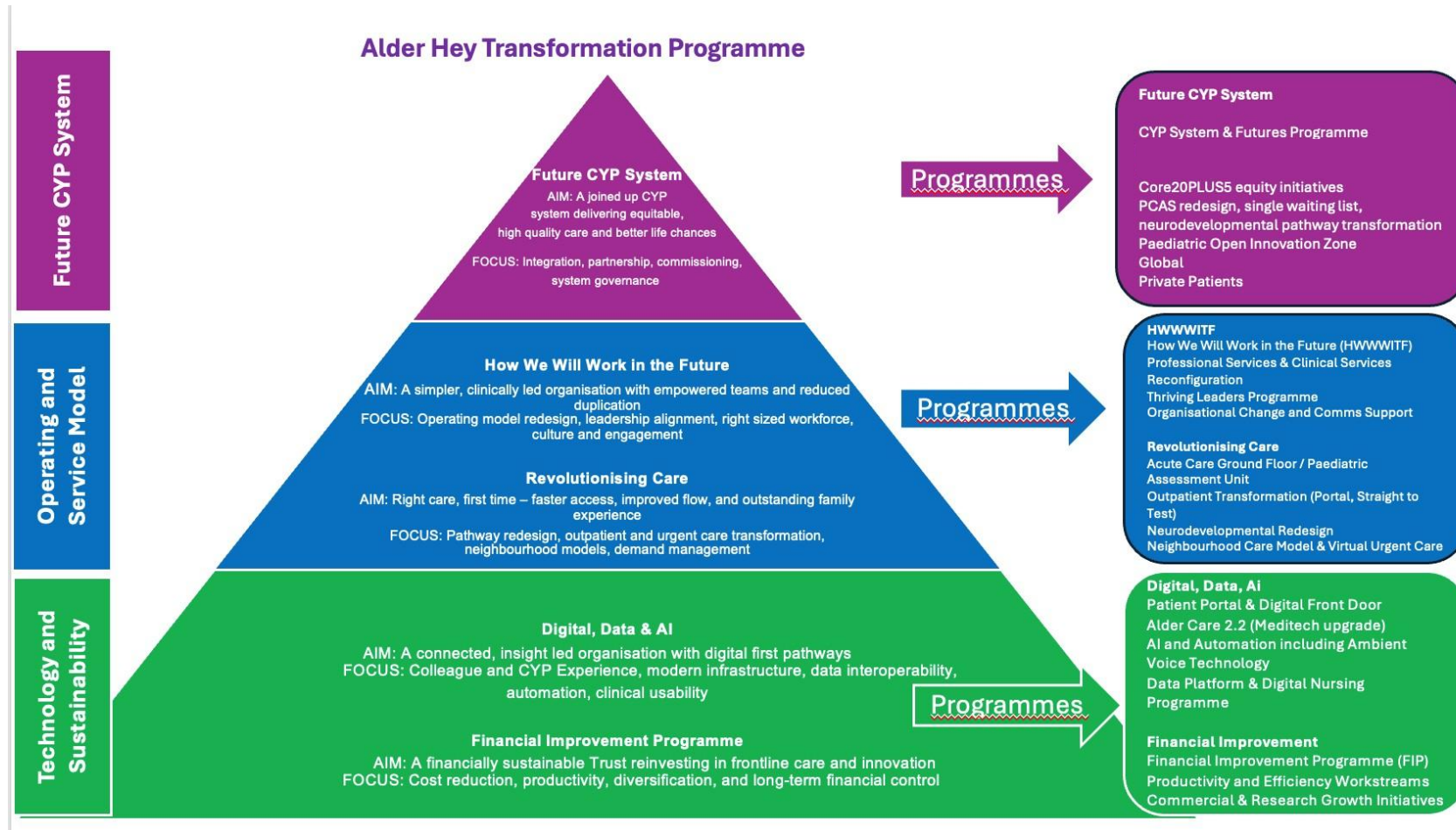
Appendices

Appendix 1: AH Transformation Programme

Appendix 2: Programme, Capability, Measure and Driver

Appendix 3: Transformation Delivery Plan

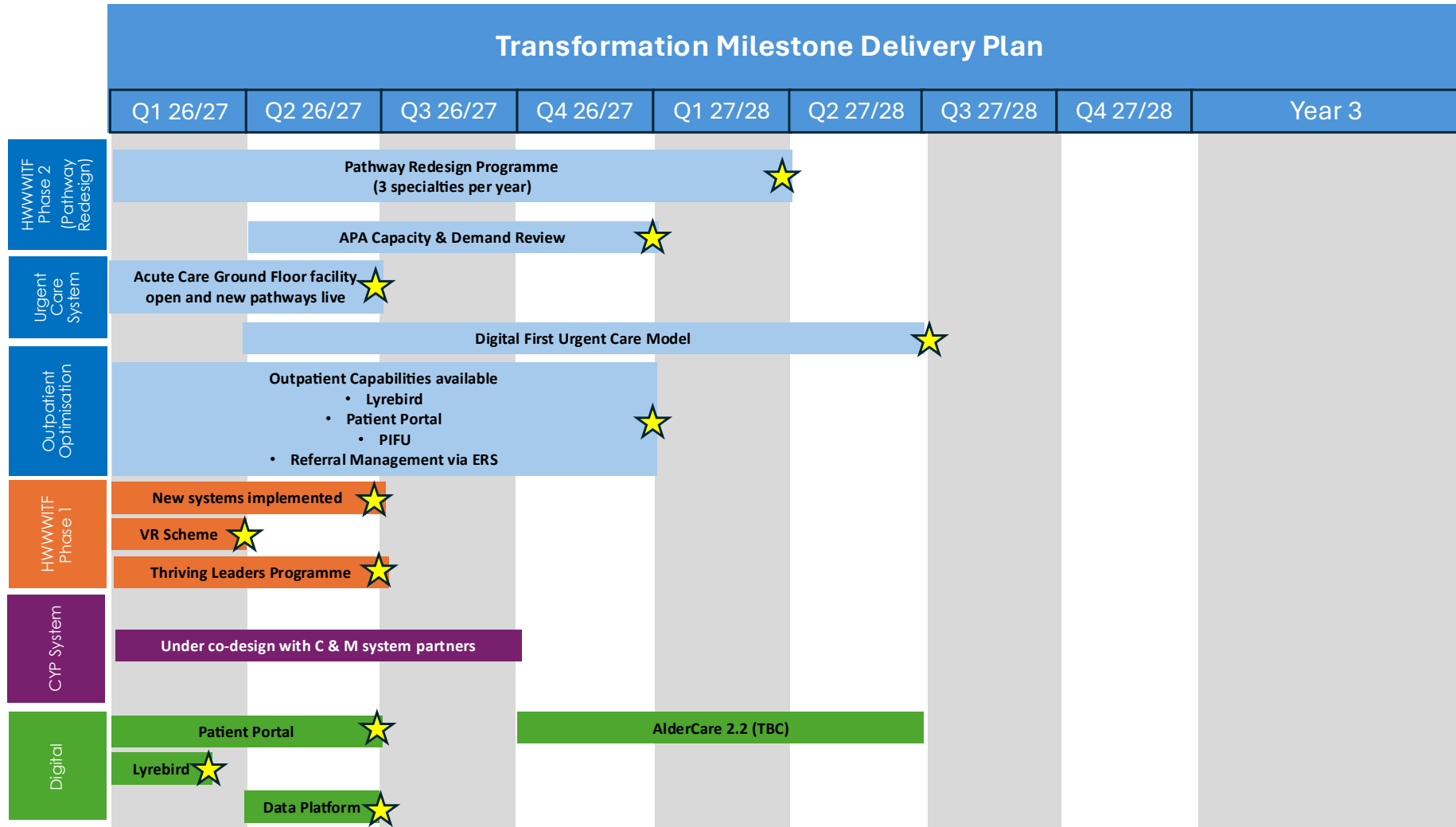
Appendix 1: AH Transformation Programme



Appendix 2: Programme, Capability, Measure and Driver

Transformation Portfolio	Transformation Programmes	What we will deliver (Capability)	Measures (Output)	Driver Measures (aligned with Medium Term Plan)
Revolutionising Care	HWWWITF Phase 2 – Pathway Redesign	<ul style="list-style-type: none"> Pathway Redesign APA Demand and Capacity Review 	<ul style="list-style-type: none"> £4M contribution to CIP target Deliver new national access standards Wait list size reduction Increase cases per list Reduction in cancellations within 24 hours Numbers of Clinical PAs Numbers of staff Numbers of teams with team based job planning 	<ul style="list-style-type: none"> Improved ED flow – 95% 4hr performance Year 1 RTT – increased to 70% 4000 WTE employed XX CYP impacted by BMTF development 0.7M Control Total Surplus Achieve £24M CIP Target
	Urgent Care System	<ul style="list-style-type: none"> Acute Care Ground Floor facility implemented (<i>SDEC unit/increase PAU/EDU beds</i>) Digital First Urgent Care Model 	<ul style="list-style-type: none"> £1M-£2M bed closure contribution Increase in care episodes delivered on the day XX reduction in reattendances within 72 hours Reduce length of stay in PAU to 4 hours Reduce Gen Paeds length of stays to 48 hours 	
	Outpatient Transformation	<ul style="list-style-type: none"> Outpatient Transformation (Including Portal / Lyrebrid) Referral management through ERS 	<ul style="list-style-type: none"> 10% reduction of follow ups in Year 1 Reduce WNB by 2% Increase PIFU/A&G by 1% Improve outpatient productivity by 2% 	
HWWWITF	HWWWITF Programme Phase 1	<ul style="list-style-type: none"> New systems implemented Clinical leadership Introduction of Thriving Leaders Programme VR Scheme 	<ul style="list-style-type: none"> £4.75M contribution to CIP target Voluntary redundancy applications (50 Phase 1?) Numbers of Clinical APAs 	
CYP System	Developing the CYP system	<ul style="list-style-type: none"> Create a CYP Health System for children and young people in Cheshire and Mersey 	<ul style="list-style-type: none"> Pilot initiated 	
Digital, Data and AI	Digital, Data and AI	<ul style="list-style-type: none"> Patient Portal Lyrebird (<i>AVT</i>) Data Platform Aldercare 2.2 	<ul style="list-style-type: none"> Improved data literacy Reduce cognitive load for clinicians Reduction in calls to booking and scheduling team System consolidation (Isla Care, Airelogic, HCC, Iqvia) 	
Sustainability	Financial Improvement Programme	<ul style="list-style-type: none"> Pharmacy Outsourcing Inventory Management System Lab Testing Programme 	<ul style="list-style-type: none"> Contribution towards £24M CIP target 	

Appendix 3: Transformation Delivery Plan





Department
of Health &
Social Care



Neighbourhood Health Framework

25/03/26



What is 'Neighbourhood Health'?

"Neighbourhood health puts the **person at the centre** of how we deliver their health and care, by organising **services** so they can **work together** to **serve a defined local population.**"

Neighbourhood Health Framework,
March 2026

What is 'Neighbourhood Health'?

This includes:

The services which people rely on close to home and on the high street, such as...



GPs



Community Services

and where appropriate...



Urgent Care



Diagnostics



Outpatients

and related public services such as...



**Adult and Child
Social Care**



**Public Health
Services**



**Housing,
employment
support, welfare**

Our ambition is for a Neighbourhood Health Service that...

Brings care into local communities



Delivers convenient, personalised care



Improves people's outcomes and system efficiency



Convenes professionals from different services to form multi-disciplinary, patient-centred teams

Is fully digitally enabled (with the NHS App as a "doctor in the pocket")



Moving from a National Health Service to a Neighbourhood Health Service is central to delivering the **three shifts** detailed in the 10 Year Health Plan:

Hospitals to community:



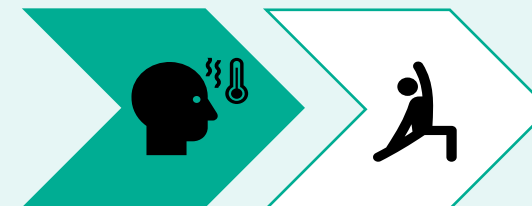
More care will be available on people's doorstep and from the comfort of their own homes

Analogue to digital:



New technology will liberate staff from time-consuming admin and make booking appointments and managing care easier

Sickness to prevention:



Reaching patients earlier, to catch illness before it spreads and prevent it in the first place, by making the healthy choice the easy choice

We are supporting systems with the first foundational steps

Guidance documents are setting expectations and supporting systems with implementation:

Medium-Term Planning Framework

Published October 2025. Sets out the high-level requirements for the NHS over the next 3-5 years. Describes the priorities to establish a Neighbourhood Health Service at pace. Sets out the steps that ICBS and relevant NHS providers should take from April 2026.

Neighbourhood Health Framework

Published March 2026. Set national expectations on the minimum aims all ICBs will need to focus on for the next three years, working in partnership with local government and others. Sets out the actions local systems will need to take in 2026/27 to develop the foundations for neighbourhood working. Defines what should be included in neighbourhood health plans and who should be involved.

Fit for the future: towards population health delivery models

Published March 2026. Sets out how ICBs and providers will work together differently to deliver models of care that are personalised, proactive and joined-up. Describes three new population-based delivery models that will be rolled out from this year.

We are accelerating progress through the National Neighbourhood Health Implementation Programme

National Neighbourhood Health Implementation Programme

A large-scale change programme designed to help systems (NHS, LAs and wider partners) to accelerate progress in implementing neighbourhood health on the ground. Currently covering 43 places with an initial focus on transforming care delivery for adults with multiple long-term conditions and rising risk.

On 17th March, we published the Neighbourhood Health Framework

The **purpose** of the Neighbourhood Health Framework is to:

- **Empower local leaders to develop and scale neighbourhood health** by setting out how ICBs, local authorities, Health and Wellbeing Boards and other partners should collaborate to deliver neighbourhood health services.
- **Provide immediate clarity and consistency** to support joined-up partnership working between ICBs and local authorities and their partners.
- **To set national expectations on the minimum aims and objectives of Neighbourhood Health Services.** Whilst it is important that reforms are locally-led, as local authorities and ICBs are best placed to design services for their local populations, we have heard that there are many common-sense actions that could work well everywhere.

The framework sets out the **actions local systems will need to take in 2026/27**, to build the foundations for developing local neighbourhood health plans

It outlines **what should be included** in neighbourhood health plans, and **how local systems should work in partnership** to develop these plans.

We know that delivering a Neighbourhood Health Service will be an **incremental process** as local understanding develops and national reforms progress.

We plan to update the framework in future, to reflect this learning.

The framework sets out five national minimum goals and objectives to deliver successful neighbourhood health services.

1) Improve health outcomes with a focus on high-priority cohorts*

- helping people to stay healthier, manage escalating conditions and maintain greater independence for longer
- better identification of people coming to end of life and improved access to services
- better diagnosis and treatment for people with long-term condition
- improving quality and access to care for children and young people

2) Improve access to general practice

- making sure clinically urgent patients are seen on the same day
- faster access for routine GP care; Improved patient satisfaction with access

3) Improve experience of planned care

- reduce variation in referrals to outpatient services
- better co-ordination of outpatient activity

4) Better urgent and emergency care performance

- better co-ordination of reactive care for high-priority cohorts
- Reduced need for hospital admissions
- better co-ordination of discharge process and capacity planning

5) Improve patient and staff satisfaction with NHS services

- take a proactive approach, where the patient feels in control of their care
- ensure teams working within neighbourhoods feel more motivated in their work

*High priority cohorts:

- people with frailty
- care home residents
- housebound patients
- those receiving end of life care
- those with:
 - CVD
 - Diabetes
 - COPD
 - Dementia
 - Mental health conditions
- children and young people
- any other cohort identified by local areas

Neighbourhood health is central to the government's wider agenda of public service reform.

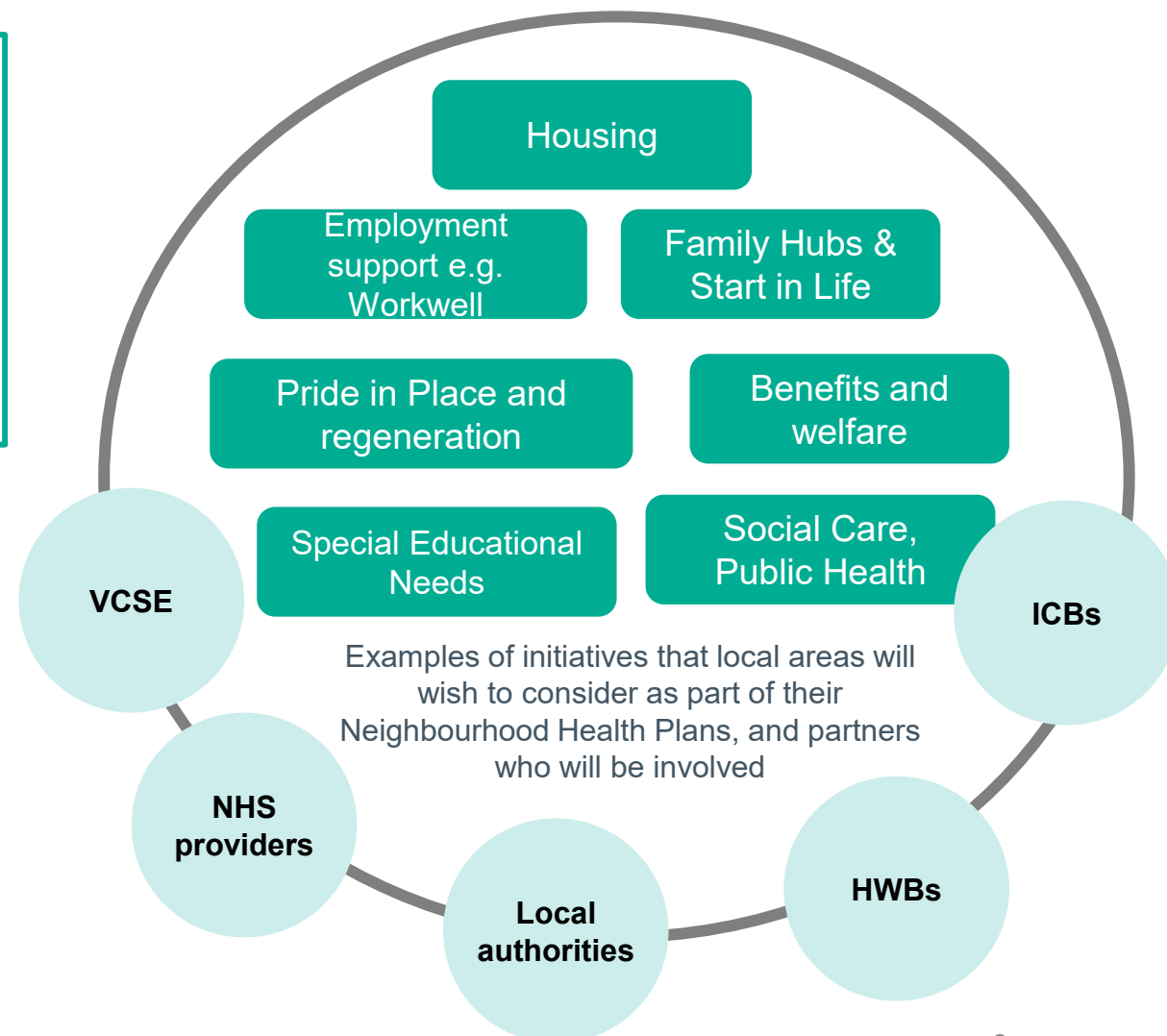
Through Health and Wellbeing Boards, ICBs and local authorities will work in partnership to:

- Plan for their local populations
- Address local priorities and health inequalities set out in their local joint strategic needs assessment
- Agree how neighbourhood health can deliver additional benefits beyond those national minimum goals.

The framework details how systems can establish local metrics

For neighbourhood health to be truly successful, **services must join up across the full spectrum of public services that will impact people's ability to live a happy, healthy life.** This will include housing, employment, education and much, much more.

Health and Wellbeing Boards should build strong links between neighbourhood health and other reforms and consider opportunities for further integration of services. Local authority leaders will play a critical part in this.



The Framework outlines **ten foundational steps** we are asking local areas to prioritise in **2026/27** to lay the groundwork for more fundamental reform

In 2026/27, ICBs and local authorities, working through their Health and Wellbeing Boards, should start developing and embedding new ways of working, to start jointly developing their approach to neighbourhood health services.

Priorities for **all partners**

- Agree neighbourhood footprints
- Agree plans to establish integrated neighbourhood teams focussed on high priority cohorts
- Increase urgent, rehabilitation and reablement services capacity, reduce non-elective admissions and bed days
- Confirm plans to spend pooled funding under the Better Care Fund, in line with BCF guidance
- Confirm the organisational ownership, governance and partnership arrangements to enable delivery
- Confirm plans for having appropriate data-sharing arrangements in place to do patient identification and evaluation

Priorities with a more specific ICB focus

- Agree a plan to improve GP access and reduce unwarranted variation
- Reforming elective pathways for outpatients
- Improving primary and secondary care interface
- Confirm plans to cut community health services waiting lists – meeting 18-weeks and eliminating 52-weeks

For implementation from at least 2027/28, ICBs and local authorities should work with partners to develop a locally owned neighbourhood health plan

The framework sets out what should be included in neighbourhood health plans.



Systems can and should go beyond these measures, in line with what is right for their populations. Once the plan is agreed, it will be incorporated into the ICB's refreshed 5-year strategic commissioning plan. This will be the formal NHS commissioning strategy for neighbourhood health.

The success of neighbourhood health hinges on the health and care system, local authorities and partners transforming how they work together by working collaboratively to agree a joint vision.

Overview of the framework



Introduction

Sets out the aims of neighbourhood health and the challenges we want to address



Measuring success:

Describes the five minimum national goals and objectives we want to achieve. Establishes national success metrics and maps out the process for systems to establish local metrics.

Highlights the importance of and linkages to wider public service reform



Delivering Neighbourhood Health

Describes actions systems need to take in every community over the next three years, across three reform agendas: improving services for people who need routine healthcare; improving proactive care; and delivering better alternatives to hospital care.



Providers of Neighbourhood Health

Describes the impact on providers and commissioners. Outlines new types of contracts we will roll out.



Estates and locations

Discusses the crucial role of Neighbourhood Health Centres



Workforce

Covers the vital role of the workforce, including new integrated neighbourhood teams



Finances

Outlines the financial mechanisms and frameworks supporting the establishment and scaling of neighbourhood health



Next Steps

Sets out the ten immediate steps we are asking ICBs and local authorities to take in 2026/27 to lay the foundation for neighbourhood health, and the longer-term direction for April 2027 to March 2029. Outlines what should be in neighbourhood health plans, for implementation from 2027/28

Fit for the future: towards population health delivery models – published March 2026 - sets out how the population-based delivery models introduced in the 10 Year Health Plan can be used by integrated care boards and providers to overcome these obstacles

Commissioning for a population will align objectives across providers and incentivise the shift of care into the community and towards prevention

The three contracts have complementary roles:

- **Single neighbourhood providers (SNPs)** will deliver services for people with similar needs.

- **Multi-neighbourhood providers (MNPs)** will deliver and coordinate consistent services across multiple neighbourhoods.

Leading to



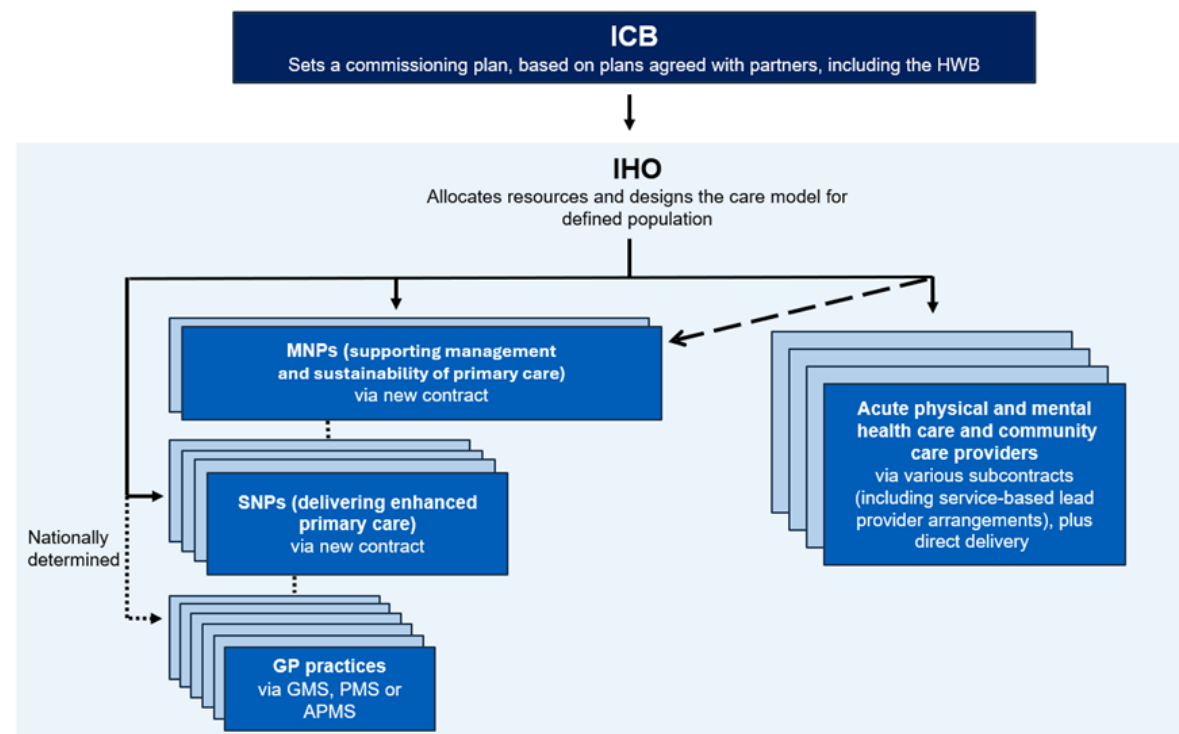
Greater integration of care delivery

- **Integrated Health Organisations (IHOs)** will allocate resources and design services to support implementation of new models of person-centred care that will improve health outcomes, patient and staff experience and efficacy of care.

Leading to



Alignment of incentives and allocative efficiency



Delivering the three shifts requires us to overcome historic barriers to change.



Multiple organisations deliver care along the same pathway

The services we provide through primary, community, mental health and acute care can be disjointed and poorly co-ordinated, creating frustration for both the communities they serve and the staff that deliver them.



Organisational infrastructure and capability tied up in acute settings

We struggle to move activity, staff and money between organisational boundaries, limiting the ability of primary and community services to adapt to an at scale shift of activity.



Misalignment of incentives

Spend incurred in one area leads to savings accrued in other. Contracting, payment and oversight mechanisms encourage organisations to focus on their part of the pathway.

Future model



Greater integration of care delivery – bringing together professionals of different backgrounds, who work in different organisations to make care of people with complex needs more efficient and effective



Alignment of spend and outcomes – Through new population-based delivery models that align providers into arrangements that incentivise allocative efficiency, with all organisations in a geography working to an aligned single set of outcomes, enabled by a payment model and clear accountability.

The **workforce** is a key enabler: The shift to neighbourhood health will entail a fundamental reimagining of the roles, skills and ways of working across health and social care

In most cases, this is about **existing staff working differently**. Neighbourhood Health Services will bring together **integrated neighbourhood teams** of professionals and partners closer to people's home – nurses, doctors, social care workers, pharmacists, health visitors, employment support, children's services, and more – to work together to support people and places to improve their health and wellbeing.

In some cases, we will be setting up new services, and this will require new staff roles at local level.

We are developing proposals for the **10 Year Workforce Plan**:

- This will deliver our aim to make neighbourhoods great places to work, with strong leaders and teams skilled at delivering proactive, preventative and personalised care
- Staff will work together as part of multidisciplinary integrated teams. Their careers will develop fluidly through different parts of the system.
- People will experience better care, that is easier for staff to deliver. This care will improve health outcomes and stop need escalating.

Neighbourhood Health Centres are a crucial part of the neighbourhood health delivery model



Neighbourhood Health Centres will be seen as the place to go for most health needs in every community. They will bring together GP services with a mix of community, LA and voluntary sector services, allowing staff to join up care which is better for patients. They will be open at a minimum from 8am to 8pm - 6 days a week.



The 10 Year Health Plan sets out that NHCs may:

- Be based in every community, focussed on places where healthy life expectancy is lowest.
- Be a 'one stop shop' for patient care
- Be a place from which multidisciplinary teams operate;
- Co-locate NHS, LA and voluntary sector services, to help create an offer that meets population need holistically;
- Bring hospital-based services such as diagnostics, post-operative care and rehabilitation into the community;
- Offer services like debt advice, employment support and smoking cessation or weight management services; and
- Help ensure, through co-location, convenient access to services, particularly for those with complex needs, and support more integrated working by professionals.

At the Autumn Budget:

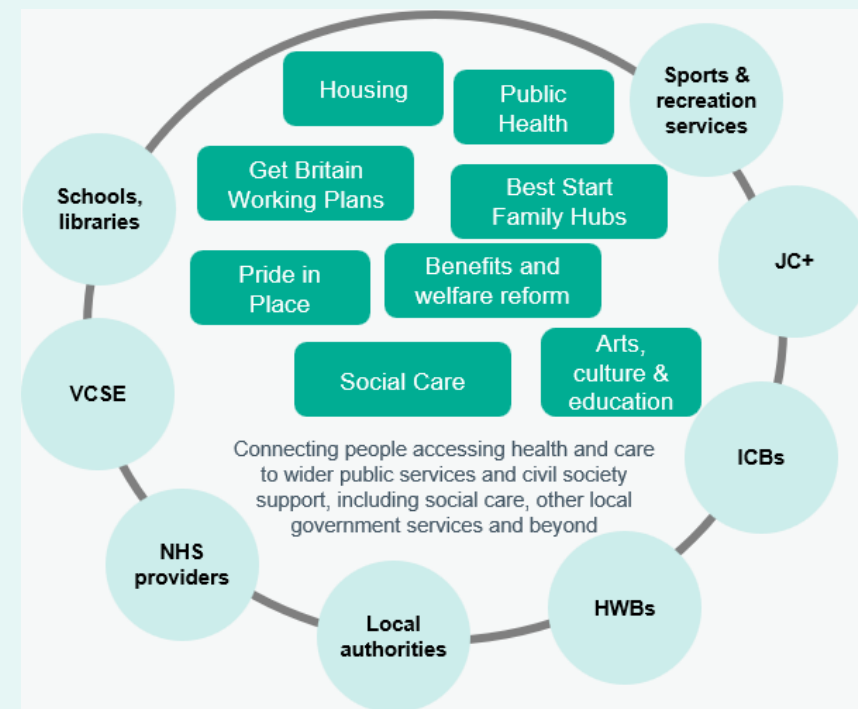
- 250 Neighbourhood Health Centres by 2035
- 120 by 2030: 50 repurposing underused estate (£50m pa FY26/27-29/30), 70 constructing new facilities (advising on SR prioritisation)
- New builds: 80% public-private partnerships (starting 28/29) / 20% public sector investment

These publications build on existing work being done by the National Neighbourhood Health Implementation Programme to pilot new approaches on the ground

“rethinking how we work together and how we deliver care to support the health and wellbeing of our communities, recognising that health is wider than healthcare.”

- **a large-scale change programme** that builds on existing knowledge from Places already progressing Neighbourhood Health and seeing results
- **spreading learning systematically to other Places across the country**, while supporting each Place to shape Neighbourhood Health in ways that work for their communities - a **“tight-loose-tight”** approach
- **creating the enabling conditions** for fulfilling the Government’s commitments to neighbourhood health for all
- **outcomes and partnership focused** – whole person outcomes for a joined-up system response, increasing community agency and integrated working
- **test bed to shape levers to hard wire changes** e.g. funding flows, digital, contracts, policy
- **rapid feedback loops to unblock barriers** coproducing solutions with national teams and spreading through a national community of practice
- **aligning neighbourhood health across government**

Alignment with X-HMG programmes



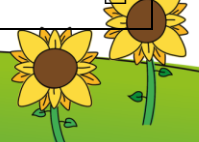
Examples linking neighbourhood health & PSR agendas:

Impact Economy/social investment | Test Learn & Grow accelerators | Community Help Partnerships

BOARD OF DIRECTORS
Thursday, 2nd April 2026

Paper Title:	Alder Hey Green Plan 2025–2028
Report of:	Chief Operating Officer – Board-Level Lead for Sustainability / Net Zero
Paper Prepared by:	Sustainability & Net Zero Lead

Purpose of Paper:	Decision <input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Information <input type="checkbox"/> Regulation <input type="checkbox"/>
Action/Decision Required:	To note <input type="checkbox"/> To approve <input checked="" type="checkbox"/>
Summary / supporting information	<p>The Alder Hey Green Plan 2025–2028 sets out the Trust's strategic approach to delivering the NHS Net Zero commitments and embedding sustainability across clinical care, estates, digital transformation, procurement, workforce and governance. The plan aligns with the updated NHS Green Plan Guidance (2025) and the requirement for all NHS Trusts to submit a refreshed plan.</p> <p>Key achievements to date include:</p> <ul style="list-style-type: none"> • 11% reduction in carbon emissions from energy use since 2021/22 • Elimination of desflurane across theatres • Waste improvements and reusable theatre textiles • LED lighting upgrades, BMS optimisation and estate-level energy efficiency • Expansion of digital workflows and the PaperLite programme <p>Stronger governance arrangements are established through:</p> <ul style="list-style-type: none"> • COO as Board-Level Lead for Sustainability / Net Zero • CFO as Executive Sponsor – Sustainable Finance & Supply Chain • Sustainability Oversight & Assurance Board • Clinical Sustainability Group • Sustainability Operations & Delivery Group • Sustainability Engagement & Champions Network
Strategic Context	<p>This paper links to the following:</p> <p>Outstanding care and experience <input type="checkbox"/></p> <p>Collaborate for children & young people <input type="checkbox"/></p> <p>Revolutionise care <input type="checkbox"/></p> <p>Support our people <input type="checkbox"/></p> <p>Pioneering breakthroughs <input type="checkbox"/></p> <p>Strong Foundations <input checked="" type="checkbox"/></p>



Resource Implications:	<p>The plan highlights future capital and operational requirements across:</p> <ul style="list-style-type: none"> • Estates decarbonisation (LED completion, BMS/HVAC optimisation, heat pumps, solar PV) • Digital transformation and cloud modernisation • Electric vehicle charging infrastructure • Waste and water-efficiency initiatives <p>Financial benefits are anticipated through:</p> <ul style="list-style-type: none"> • Reduced energy consumption • Lower clinical waste volumes • Lower-carbon anesthetic practice • Reduced paper and printing costs <p>All investment proposals will be developed into business cases and taken through FTPC.</p>
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<p>Does this relate to a risk? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If "No", is a new risk required? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
--

Risk number	Risk description	Score
	Delivery of national Net Zero requirements may be compromised without a Board-approved Green Plan and associated investment strategy.	Moderate

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

1. Executive Summary

The Alder Hey Green Plan 2025–2028 provides a clear roadmap for achieving the NHS Net Zero goals (2040 for Scopes 1 and 2; 2045 for Scope 3). It outlines a phased approach focused on energy efficiency, estate decarbonisation, digital transformation, waste reduction, greener theatres, sustainable food, travel and supply chain improvements.

The plan strengthens governance, sets a pragmatic carbon-reduction trajectory, aligns with regional ICS priorities, and positions Alder Hey as a leading trust for sustainable paediatric healthcare.

2. Background and Current State

The 2022–2025 Green Plan established strong foundations including:

- Sustainability governance structures and a Green Champions network
- Reductions in energy use and estate-level carbon
- Digital-first pathways and virtual care expansion
- Greener theatre practices (desflurane elimination, reusable gowns, reduced glove use)
- Food sustainability improvements and reduced waste

The updated national NHS Green Plan Guidance (2025) now requires:

- Annual measurement and reporting
- Integration with corporate, clinical and financial planning

- A strengthened Net Zero trajectory

3. Main Body of Report

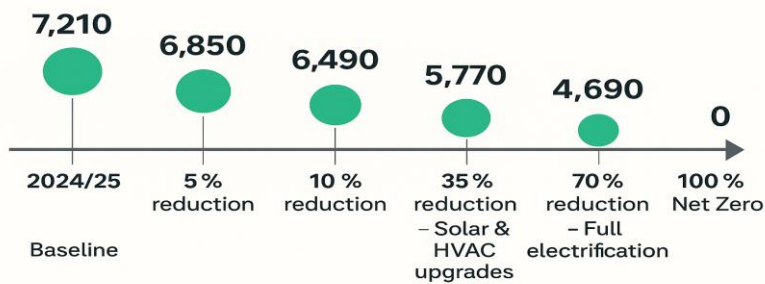
3.1 Key Delivery Themes (2025–2028)

- **Estates, Energy & Resources:** LED programme completion, HVAC/BMS optimisation, heat-decarbonisation planning and solar PV expansion.
- **Clinical Sustainability & Theatres:** Maintain desflurane elimination, reduce nitrous oxide wastage, expand reusable textiles and embed the Green Theatre Checklist
- **Digital Transformation:** Paper-lite processes, cloud modernisation, automation and improved data quality
- **Travel & Transport:** EV charging expansion and greener travel options.
- **Procurement:** Evergreen supplier assessment and circular procurement.
- **Food:** Reduced food waste and increased fresh/local sourcing.
- **Adaptation:** Heat, flood and storm resilience measures.
- **Workforce:** Strengthening training and Green Champions network.

3.2 Carbon Reduction Trajectory

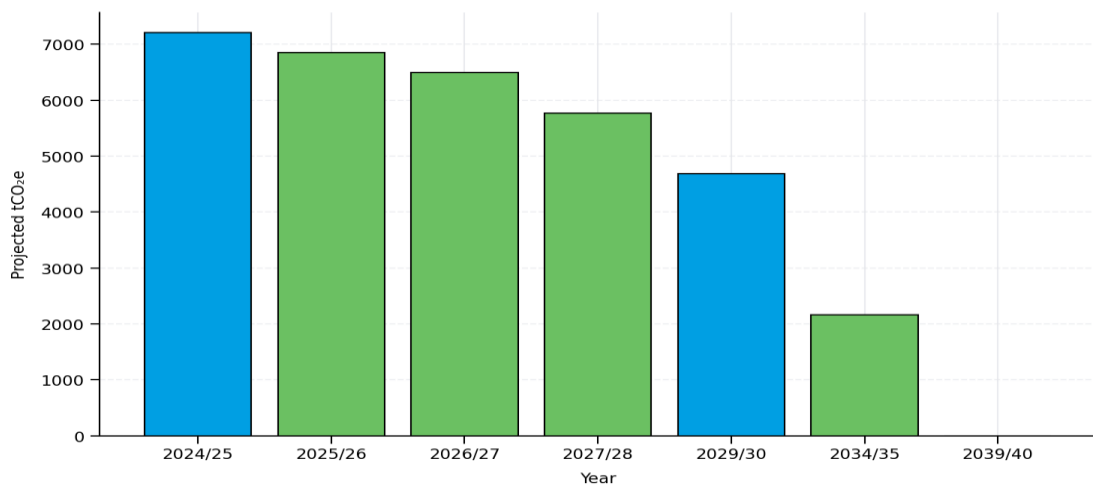
- 7,210 tCO₂e baseline (2024/25)
- Directional reductions aligned to NHS milestones: 5% → 10% → 20% → 35% → 70% → Net Zero (Scopes 1 & 2) by 2039/40

Carbon Reduction Roadmap



-

Alder Hey Net Zero Carbon Trajectory



3.3 Risks & Mitigations

Key risks: capital constraints, supply chain pressures, workforce capacity, operational pressures, climate-related disruption.

Mitigations: phased planning, external funding bids, strengthened governance, embedding

sustainability into business cases and EPRR alignment.

4. Conclusion

This Green Plan offers a credible, achievable and NHS-aligned sustainability roadmap. It supports operational resilience, financial stewardship and improved environmental outcomes for children and families. It is ready for Board approval and submission to NHS England.

5. Recommendations & Proposed Next Steps

The Trust Board is asked to APPROVE:

- ✓ Alder Hey Green Plan 2025–2028
- ✓ The updated governance structure (COO as Board Lead; CFO as Executive Sponsor)
- ✓ Submission to NHS England

The Trust Board is asked to NOTE:

- Annual progress reviews and the need to update the plan each year
- Future investment requirements subject to FTPC approval
- Ongoing monitoring through the Sustainability Oversight & Assurance Board

GREEN PLAN

2025-2028

Alder Hey Children's
NHS Foundation Trust

BRAND



ALDER HEY GREEN PLAN 2025 - 2028



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John Grinnell
Chief Executive Officer

1. INTRODUCTION

1.1 Foreword

Climate change is one of the greatest public health challenges of our time. Its effects are already being felt by children and young people worldwide, with rising rates of asthma, heat-related illness, infectious diseases, and the worsening social determinants of health. As a leading children's hospital, Alder Hey has a duty to protect the health of young people not only today, but for generations to come.

We therefore embrace our responsibility to take bold, evidence-based action. Delivering world-class paediatric care must go hand-in-hand with protecting the planet that children will inherit. Our Green Plan sets out how we will play our part in achieving the NHS's Net Zero commitments:

Net Zero for our NHS Carbon Footprint by 2040, and

Net Zero for our NHS Carbon Footprint Plus by 2045.

Alder Hey has already demonstrated strong leadership in sustainability. We were the first UK children's hospital built within a park, embedding nature, wellbeing and climate adaptation into our estate from the start. We have delivered major energy-efficiency improvements, reduced waste, transformed clinical practices such as anaesthetic gas reductions, and expanded digital transformation to reduce unnecessary travel.

But there is much more to do. This refreshed Green Plan for 2025–2028 sets out our route forward—practical, measurable actions across estates, care pathways, workforce development, supply chain, travel, biodiversity, food, and digital transformation.

Sustainability is not a separate programme; it is an essential part of delivering high-quality, safe, equitable care. I am proud of the commitment shown by our staff, partners, volunteers, and community. Together, we will continue to lead, innovate, and inspire—ensuring a healthier, happier, fairer and greener future for every child.

1.2 Foreword

At Alder Hey Children's NHS Foundation Trust, we are committed to delivering outstanding care for children and young people — today and for generations to come. Protecting health means protecting the environment on which health depends. Climate change and air pollution present significant risks to children's wellbeing, and as an NHS organisation we have both a responsibility and an opportunity to lead meaningful action.

As the Trust's Board-level lead for sustainability, I am proud to support the delivery of our Green Plan 2025–2028. This plan sets out how we will contribute to the NHS ambition to reach Net Zero for our direct carbon footprint by 2040 and our wider carbon footprint by 2045, while continuing to provide safe, high-quality and equitable care. It builds on the progress we have already made — reducing emissions from our estate, embedding sustainable clinical practice, and strengthening a culture of sustainability across our workforce.

Sustainability is fundamental to good governance, operational resilience, and responsible financial stewardship. The actions set out in this plan will help us reduce carbon, minimise waste, strengthen resilience, and deliver efficiencies that can be reinvested directly into patient care. Achieving our ambitions will require collaboration across the Trust and with our partners, suppliers, and local communities, and I would like to thank colleagues and teams who are already driving this work forward.

This Green Plan represents an important step in embedding sustainability as business as usual at Alder Hey. By working together, we can reduce our environmental impact, strengthen the resilience of our services, and help create a healthier, happier and fairer future for the children and families we serve.



Adam Bateman

Chief Operating Officer &
Board-level Lead for Sustainability

1.3 National and Local Climate Context

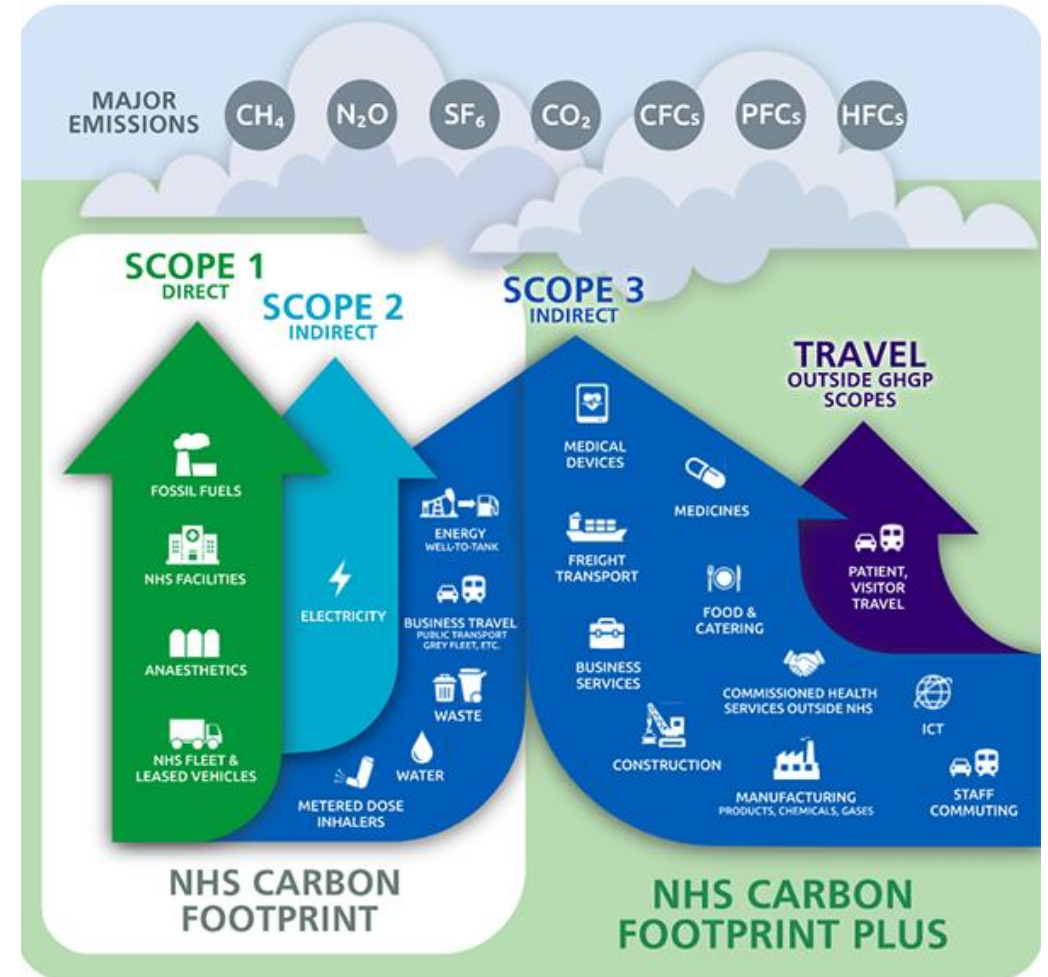
Climate change is a global health emergency. UK legislation requires Net Zero by 2050. The NHS is responsible for around 5% of the UK’s total carbon emissions—about 27 million tonnes each year. While this makes us part of the problem, it also means we can be a major part of the solution.

1.4 NHS Net Zero Targets

In 2020, the NHS became the first health system in the world to commit to reaching Net Zero. The *Delivering a ‘Net Zero’ National Health Service* report set two clear targets: Net Zero by 2040 for the emissions we directly control (NHS Carbon Footprint), with an ambition of reaching an 80% reduction between 2028 and 2032.

Net Zero by 2045 for the emissions we can influence (NHS Carbon Footprint Plus), with an ambition of reaching an 80% reduction between 2036 and 2039.

These national commitments provide the framework for Alder Hey’s own Green Plan and sustainability ambitions.



<https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/>

1.5 Cheshire & Merseyside ICS Context

We collaborate with:

- Cheshire & Merseyside Integrated Care System (ICS)
- University Hospitals of Liverpool Group
- Local authorities, universities, VCSE partners

Alder Hey’s unique park environment supports recovery and biodiversity. This plan strengthens our role as an anchor institution supporting green jobs, skills, education and community resilience.

The ICS has sustainability as a core strategic priority, with commitments to:

- Reduce health inequalities
- Enhance air quality
- Improve active travel networks
- Build resilience to climate change
- Support Net Zero across all member trusts



Cheshire and Merseyside Health Care Partnership Vision and Mission

Vision
We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer

Mission
We will prevent ill health and tackle health inequalities and improve the lives of the poorest fastest. We believe we can do this best by working in partnership



1.6 Liverpool City Region Climate Priorities



METRO MAYOR
LIVERPOOL CITY REGION

Liverpool City Region

Local priorities include:

- Improving air quality
- Reducing traffic emissions
- Increasing green space accessibility
- Encouraging active travel
- Supporting local climate adaptation
- Alder Hey's Green Plan supports and accelerates these regional ambitions.

2. GOVERNANCE, OVERSIGHT & CORPORATE APPROACH

2.1 Sustainability Governance Structure

Strong governance is essential for delivering sustainability.

2.2 Board-Level Accountability

Strong governance is essential for delivering sustainability.

- CEO accountable for delivery
- COO as Executive Lead for Sustainability and oversees operational delivery
- CFO as Executive Sponsor – Sustainable Finance & Supply Chain
- Non-Executive Director chairs sustainability oversight

2.3 Operational Delivery Groups

1. Oversight & Assurance (Board-Facing) - Sustainability Oversight & Assurance Board
2. Operational Delivery (Estates, Facilities, Green Delivery) - Sustainability Operations & Delivery Group
3. Clinical Sustainability (Clinical Leadership Focus) - Clinical Sustainability Group
4. Engagement (Green Champions Network) - Sustainability Engagement & Champions Network

2.4 Corporate Sustainability Commitments

Alder Hey commits to:

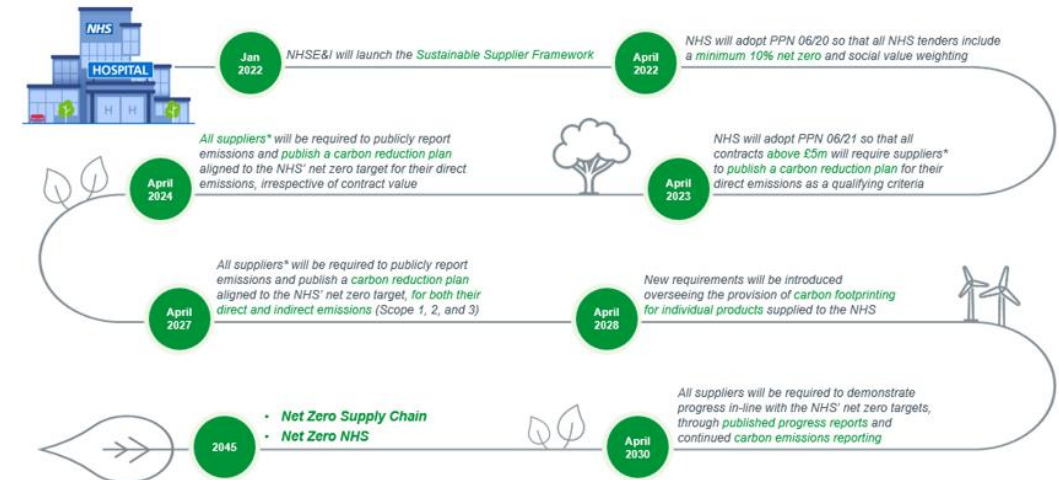
- Embedding sustainability into decision-making
- Annual reporting to the Board
- Transparent monitoring and evaluation
- Integrating sustainability into appraisals, training, and business cases
- Reducing carbon emissions across all areas of activity

2.5 Frameworks Guiding the Green Plan .

Aligned to national and NHS frameworks including:

- NHS Green Plan Guidance 2025
- Delivering a Net Zero NHS
- NHS Estates Net Zero Carbon Delivery Plan
- Net Zero Building Standard
- Net Zero Supply Chain Roadmap
- Adverse Weather & Health Plan
- HM Treasury sustainability reporting
- Greener NHS Travel & Transport Strategy

Building net zero into NHS procurement



*To account for the specific barriers that Small & Medium Enterprises and Voluntary, Community & Social Enterprises encounter, a two-year grace period on the requirements leading up to the 2030 deadline, by which point we expect all suppliers to have matched or exceeded our ambition for net zero.

3. OUR JOURNEY SO FAR

3.1 Progress Since the 2022–2025 Strategy

Alder Hey has already taken significant and measurable steps towards achieving its Net Zero ambitions. Since publishing our first Green Strategy in 2022, sustainability has become increasingly embedded across governance, workforce, clinical practice, estates, and digital transformation.

- Strengthened sustainability governance with Board-level leadership, an operational delivery structure, and an active Green Champions network.
- Eliminated desflurane and progressed nitrous oxide reduction work across theatres.
- Improved theatre sustainability through better waste segregation, reduced clinical waste, reusable sterile gowns, and reduced single-use items.
- Delivered LED upgrades, BMS optimisation and energy-efficiency works contributing to reduced energy use and lower carbon emissions.
- Expanded digital workflows (e-prescribing, paper-lite processes) and increased virtual care to reduce travel and paper use.
- Introduced AI-enabled tools and removed legacy systems to improve efficiency and reduce digital resource demands.
- Improved waste management, including enhanced recycling and responsible disposal of electronic equipment.
- Strengthened food sustainability through reduced single-use plastics, better forecasting, and more fresh, healthy menu options.
- Supported greener staff travel through active-travel initiatives and virtual meeting adoption.

4. Sustainability Themes and Delivery Plans

The 10 Green Commitments

Corporate Approach Secure Board-level support and embed sustainability across all Trust activities. 	Care Models Develop and deliver efficient, environmentally sustainable of healthcare. 	Workforce & Digital Transformation Create a culture of sustainability, empowering our staff to help achieve Net Zero. 	Travel and Transport Reduce emissions from travel by promoting low-carbon transport options and business mileage. 	Energy Improve the energy efficiency of our buildings and transition from fossil fuels to renewable energy. 
Waste and Water Reduce waste, increase reuse and recycling, manage unavoidable waste sustainably, and improve water efficiency. 	Food, Catering and Nutrition Provide healthy, nutritious, and sustainable food choices while reducing food waste across the Trust. 	Green Spaces and Biodiversity Enhance green spaces to support biodiversity, improve air quality, and capture carbon. 	Suppliers and Partners Work with suppliers and partners aligned with our sustainability goals and delivering social value. 	Adaptation Ensure our estate and services are resilient and prepared for the impacts of climate change. 

Committed to a Sustainable Future



4.1 Corporate Approach

What we want to do

Keep sustainability visible at Board level and embedded as a routine consideration in planning, decisions and service development in Alder Hey.

How we'll do it

- Maintain clear executive roles (COO/CFO) and simple reporting.
- Include sustainability in business cases and procurement considerations.
- Share short updates trust-wide and highlight local wins.

How we'll measure progress

- Evidence of sustainability in Board/committee papers and business cases.
- Qualitative progress updates and periodic carbon reporting.



4.2 Care Models (Sustainable Clinical Practice)

What we want to do

Promote lower-carbon clinical practice where safe and appropriate; reduce waste in care pathways; keep anaesthetic gases under review.

How we'll do it

- Support clinical leads and QI teams to identify opportunities in theatres and pathways.
- Encourage low-flow anaesthesia and continue to reduce nitrous oxide losses.
- Review consumables to reduce unnecessary items and switch to reusable options where safe.
- Maintain desflurane elimination and monitor alternatives.

How we'll measure progress

- Trends in anaesthetic gas use and wastage (directional reduction).
- Fewer disposables and improved segregation in theatres.
- Number of clinical QI projects with sustainability benefits



4.3 Workforce & Green Champions

What we want to do

Encourage, equip and recognise staff who make sustainable choices in their roles.

How we'll do it

Continue to grow and support Green Champions.
Keep learning simple (micro-learning, quick guides).
Share easy, practical behaviour changes that staff can adopt.

How we'll measure progress

Engagement with Champions network and staff-led projects.
Uptake of short sustainability learning and comms.



4.4 Digital Transformation & Sustainable IT

What we want to do

Make paper-lite the default and use digital tools to reduce waste and save time.

How we'll do it

- Expand e-forms, e-consent, digital checklists and digital letters.
- Explore automation and simple analytics to remove duplication.
- Consolidate platforms where appropriate to reduce digital “waste”.

How we'll measure progress

- Directional reduction in paper use.
- Qualitative evidence of time released via automation/digital.



4.5 Travel & Transport

What we want to do

Support greener travel choices and lower-emission fleet options over time.

How we'll do it

- Explore EV charging expansions and car-share options.
- Encourage virtual meetings where practical.
- Review staff commuting patterns and barriers.

How we'll measure progress

- Directional reduction in business mileage.
- Usage of greener travel initiatives and EV points.



4.6 Energy & Estates (Decarbonisation)

What we want to do

Reduce energy consumption and work towards decarbonising the estate.

How we'll do it

- Identify further efficiency opportunities (controls, HVAC, set-backs).
- Explore suitable renewable options (e.g., solar) where feasible.
- Ensure refurbishments meet modern sustainability standards.
- Improve sub-metering and dashboards to inform action.

How we'll measure progress

- Directional reduction in energy use and associated emissions.
- Evidence of completed efficiency upgrades and estate standards applied.



4.7 Waste & Water

What we want to do

Generate less waste, improve segregation and recycling, and reduce water use where appropriate.

How we'll do it

- Standardise bins, signage and simple guidance.
- Promote reuse and remanufacture where safe (e.g., textiles, trays).
- Improve data and feedback to clinical areas.
- Identify water-saving opportunities during refurbishments.

How we'll measure progress

- Directional reduction in clinical waste and improved segregation.
- Increased reuse/circular practice; better audit outcomes.



4.8 Food, Catering & Nutrition

What we want to do

Offer healthy, freshly prepared and sustainable options; reduce food waste.

How we'll do it

- Increase use of seasonal/local ingredients where feasible.
- Use digital ordering/monitoring to minimise waste.
- Encourage reusable cups/containers where practical.

How we'll measure progress

- Directional reduction in food waste; menu options maintained or improved.



4.9 Green Spaces & Biodiversity

What we want to do

Enhance green spaces for wellbeing and biodiversity, recognising estate constraints.

How we'll do it

- Identify small-scale planting and habitat projects within existing spaces.
- Work with partners (local groups, charities) where on-site space is limited.
- Encourage staff-supported micro-projects.

How we'll measure progress

- Qualitative improvements in green areas and small biodiversity initiatives.



4.10 Suppliers & Partners (Procurement)

What we want to do

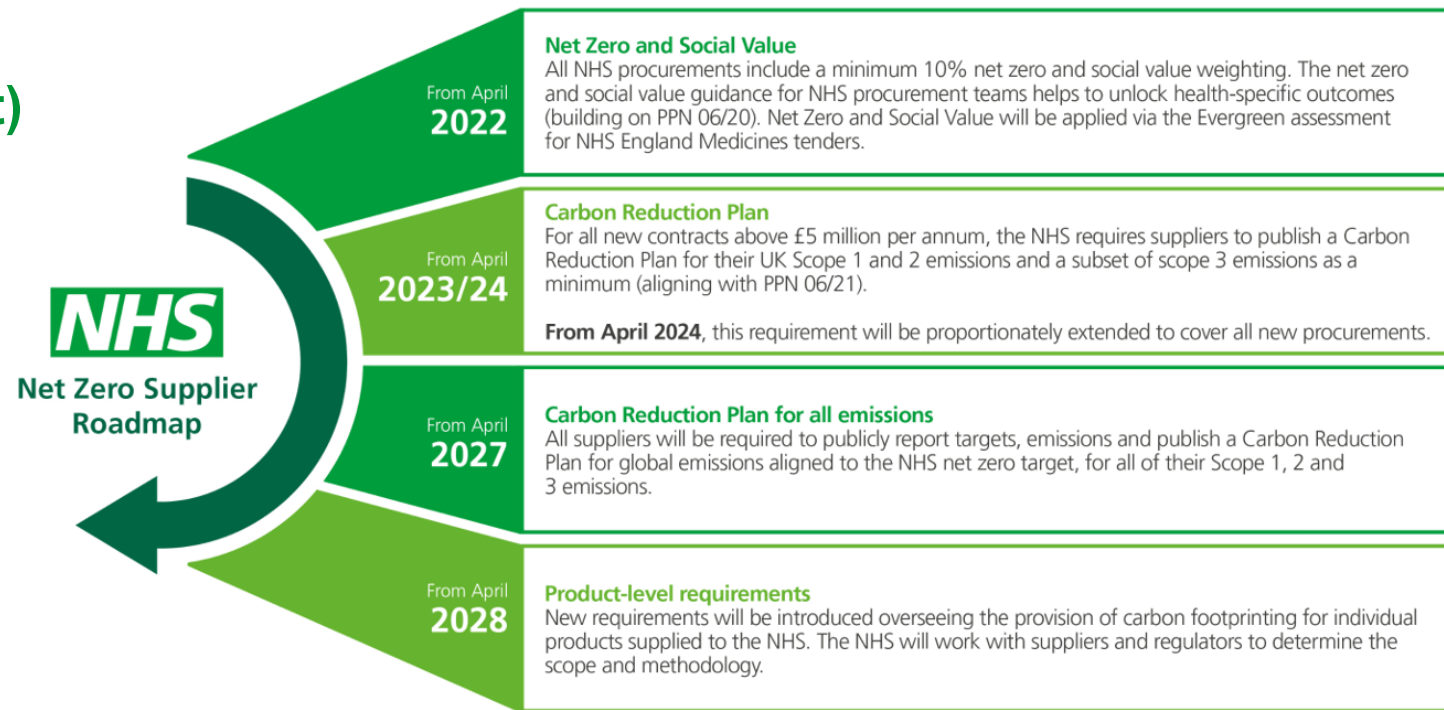
Encourage suppliers and partners to align with our sustainability goals.

How we'll do it

- Include sustainability & social value in procurement considerations.
- Encourage supplier engagement with recognised sustainability assessments.
- Share learning and explore group opportunities with system partners.

How we'll measure progress

- Evidence of sustainability criteria used in tenders and supplier discussions.



ADAPTATION STRATEGIES

4.11 Climate Change Adaptation

What we want to do

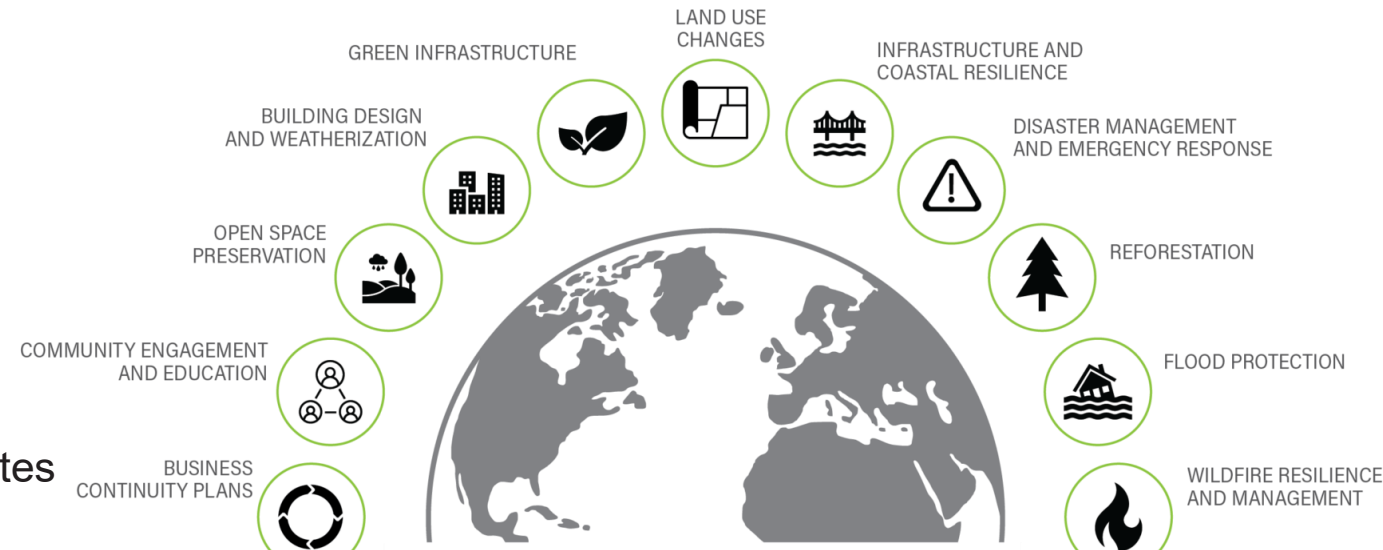
Understand climate risks to our services and estate and improve readiness.

How we'll do it

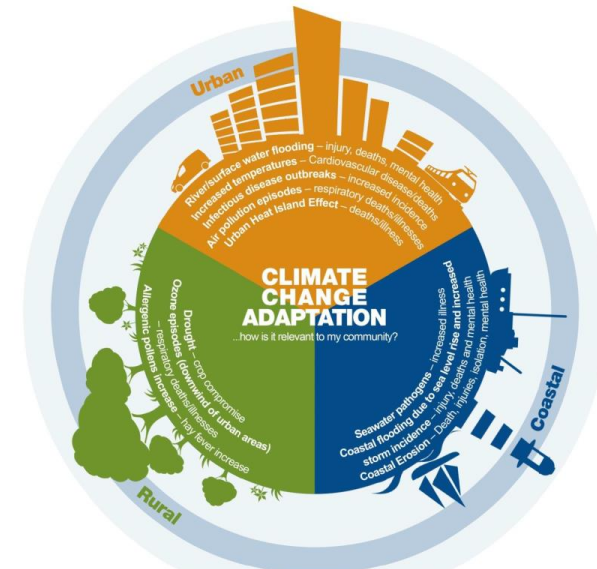
- Review heat, flood and storm risks and plan proportionate actions.
- Embed adaptation within business continuity and estates works.
- Coordinate with EPRR standards and system partners.

How we'll measure progress

- Qualitative evidence of resilience improvements and exercises.



Climate Change: Vulnerability, Risk, and Adaptation vs Mitigation - EA



How is the UK adapting to climate change? Spotlight on health

5. ENABLERS

5.1 Governance & Reporting

Keep reporting lean and meaningful: short dashboards, narrative progress notes and periodic carbon updates to Executive groups and Board.

5.2 Funding & Finance

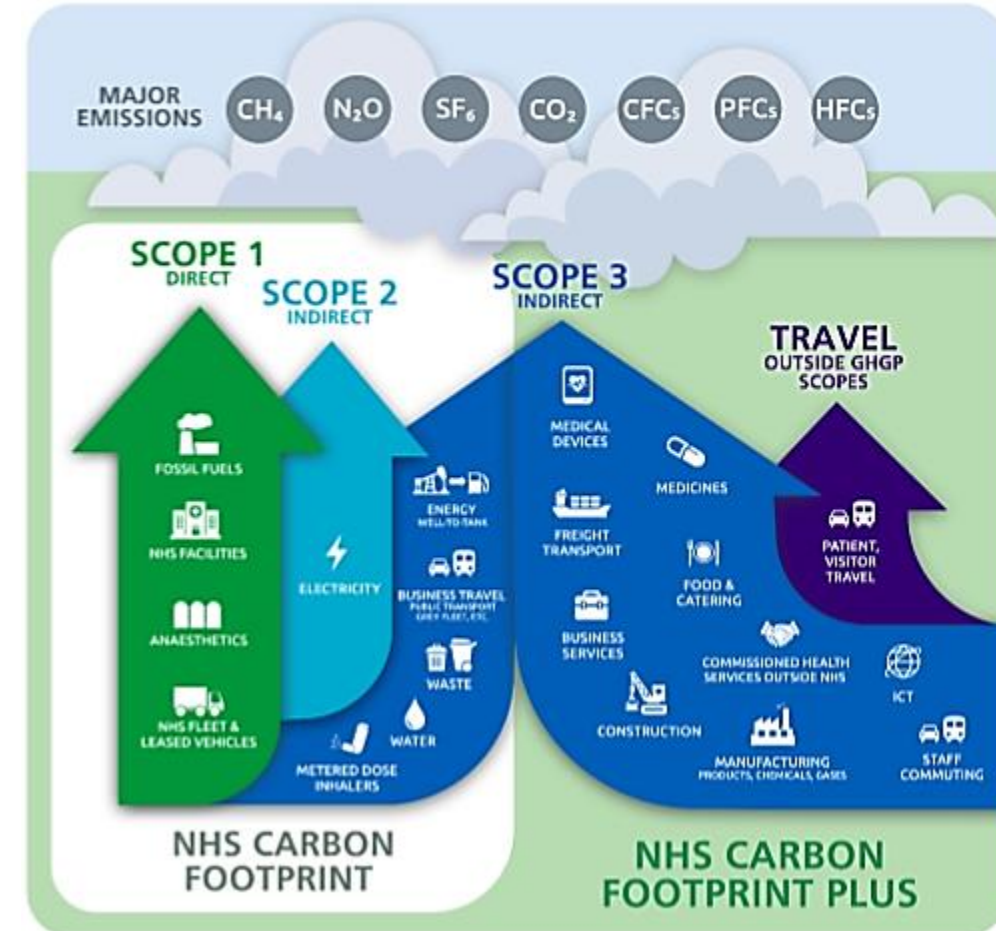
Work with Finance to phase investments, pursue external funds where suitable, and use whole-life thinking in cases, balancing affordability with benefits. (Finance owns modelling/assurance.)

5.3 Communications & Engagement

Share simple, positive stories and how-to tips; support local teams to showcase wins; keep staff informed on small actions that add up.

5.4 Data, Tools & Measurement Systems

Use pragmatic data that helps decisions: energy meters, waste audits, simple digital dashboards; avoid burdensome measurement unless it directly supports improvement.



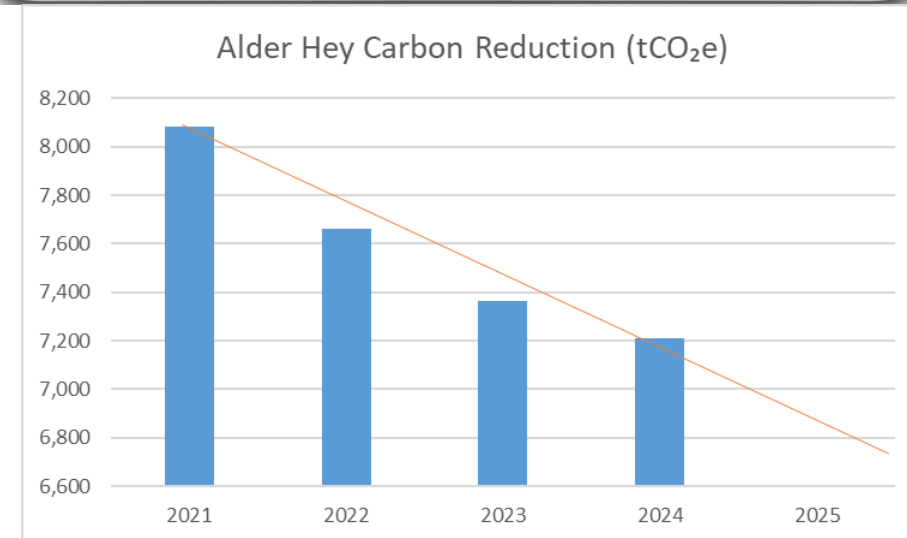
6. KPIs AND PERFORMANCE FRAMEWORK

6.1 KPI Summary

We will monitor direction of travel rather than fix many numeric targets:

- **Carbon & Energy:** reduced energy use and associated emissions over time.
- **Gases & Theatres:** reduced nitrous oxide wastage; desflurane elimination maintained; wider adoption of low-flow techniques where appropriate.
- **Waste & Resources:** reduced clinical waste per case; improved segregation; increased reuse/circular practice.
- **Digital:** reduced paper use; more digital workflows and automation in use.
- **Workforce:** growing Green Champions and staff engagement in micro-actions/training.
- **Food:** reduced food waste; continued availability of healthy, sustainable options.
- **Travel:** reduced business mileage; more use of greener options.
- **Adaptation:** practical resilience steps completed within estates and EPRR work.

April–March	Year	Other Sites (tCO ₂ e)	Main Building (tCO ₂ e)	Total (tCO ₂ e)
2021/22	2021	809	7,275	8,084
2022/23	2022	664	6,999	7,663
2023/24	2023	597	6,766	7,363
2024/25	2024	567	6,643	7,210



7. LONG-TERM NET ZERO TRAJECTORY

7.1 Scope 1 & 2 Decarbonisation Pathway

We will reduce our energy-related emissions through practical, phased improvements. This includes continued LED upgrades, building optimisation, improved control of heating and ventilation, and ongoing reductions from the decarbonising national grid. Further gains will come from replacing gas-reliant systems with low-carbon electric alternatives, following a clear, modelled pathway showing steady reductions over time.

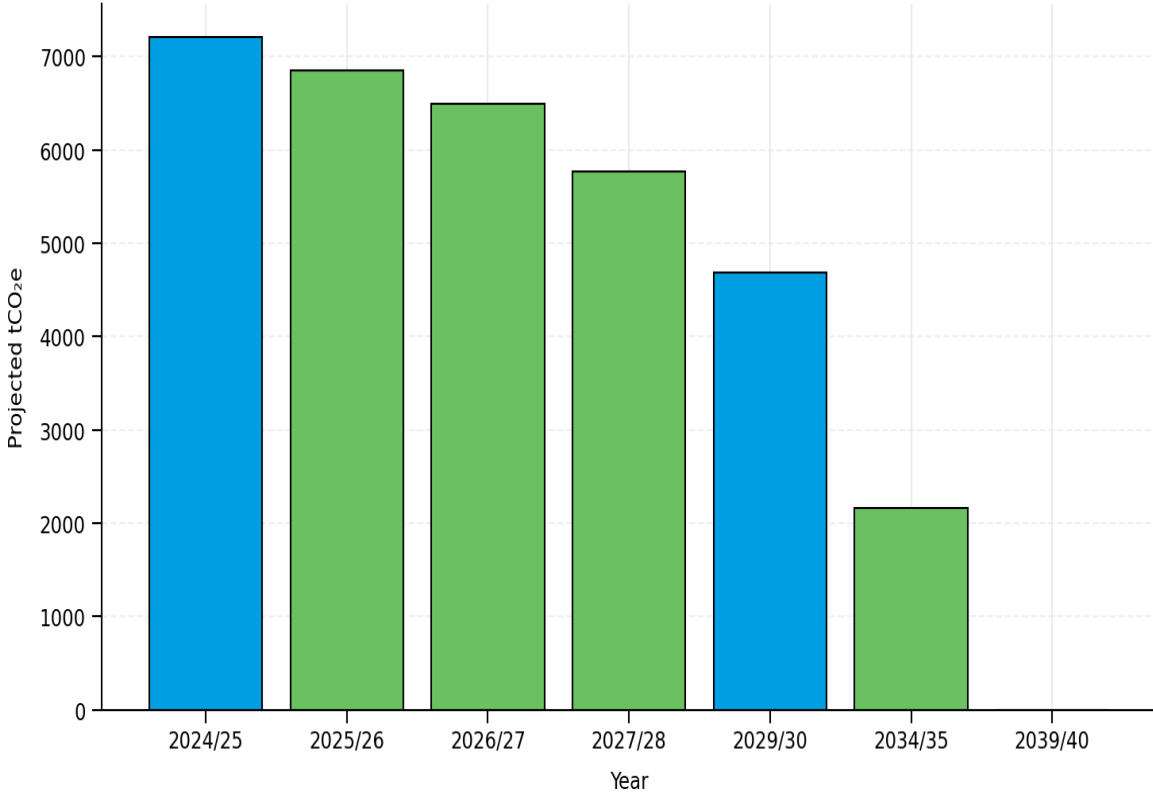
7.2 Renewables, Electrification & Heat Decarbonisation

Over the long term, we will move towards a fully electric, low-carbon estate. This includes expanding on-site solar generation, preparing buildings for low-carbon heat, replacing boilers with heat pumps, and phasing out the CHP system. These actions form the core of our shift away from fossil-fuel heating towards clean, renewable energy.

7.3 Scope 3 Roadmap & Future Priorities

Because most NHS emissions sit in Scope 3, we will progressively widen our approach to include procurement, medicines, travel, waste, food, construction and supply chain activity. Our focus will be on embedding sustainability criteria, reducing resource use, strengthening reuse and circular practices, and improving data so Scope 3 can be fully integrated into future plans.

Alder Hey Net Zero Carbon Trajectory



8. MONITORING, REPORTING & EVALUATION

To ensure delivery, Alder Hey will implement a robust monitoring plan:

8.1 Annual Reporting

We will publish:

- Carbon footprint updates (Scopes 1, 2, and 3)
- Progress against each of the 10 sustainability themes
- Updates on the Climate Adaptation Plan
- ERIC returns
- NHS England Greener NHS Dashboard data
- Green Plan Progress Dashboard

8.3 Data Tools, Audits & Modelling

Greener NHS Dashboard

- ERIC reporting
- Emissions modelling
- Sub-metering
- Waste audits
- Travel and commuting surveys
- Supply chain performance reviews
- QI sustainability metrics

8.2 Governance Oversight & Dashboards

Board Oversight

- Quarterly sustainability reports
- Annual Board review of Green Plan

Executive Leadership

- COO — Executive Lead for Sustainability

Committees

- Sustainability Oversight & Assurance Board
- Clinical Sustainability Group
- Sustainability Operations & Delivery Group
- Green Champions Network

9. RISKS, DEPENDENCIES & MITIGATIONS

Alder Hey recognises key risks to delivering the Green Plan:

9.1 Financial & Strategic Risks

Risk	Mitigation
Insufficient long-term funding	Multi-year capital planning & external bids
Competing operational priorities	Embed sustainability into business-as-usual
National supply chain constraints	Work with NHS Supply Chain Sustainable Procurement team
Policy changes	Maintain horizon scanning; flexible planning
Staff capacity	Training, job planning, Green Champions

9.2 Operational Risks

Risk	Mitigation
Equipment failure during heatwaves	Climate Adaptation Plan + EPRR strengthening
Inconsistent waste segregation	Staff training, audits, standardised bins
Limited EV charging capacity	Staged installation plan
Digital adoption challenges	Digital literacy support + blended models

9.3 Reputational Risks

Risk	Mitigation
Failure to meet Net Zero deadlines	Annual reporting + proactive correction
Suppliers not meeting standards	Evergreen compliance, contract management

10. CONCLUSION

Cleaner air, greener spaces and resilient services benefit children most. We will keep communications accessible and inclusive and ensure changes support equitable care and experience.

10.1 Implementation & Review

The Sustainability Oversight & Assurance Board will oversee delivery with support from operational groups and Green Champions, reporting into Executive governance and Board via short progress updates. We will refresh annually, keeping actions practical and achievable.

10.2 What Staff Can Do

Choose a small action this month: switch-offs, print-less, reuse where safe, greener travel once a week, share a tip with a colleague.

- Join or support your Green Champion; suggest one change in your area.
- Use the digital option when it works for patients and teams.

11. REFERENCES AND DATA SOURCES

National Strategy and Policy Framework

1.NHS England (2022) – *Delivering a ‘Net Zero’ National Health Service*. London: NHS England.

<https://www.england.nhs.uk/greenernhs/>

(Defines NHS Net Zero targets for 2040 and 2045 and the carbon footprint methodology.)

2.NHS England (2025) – *How to Produce a Green Plan: Guidance for NHS Trusts and Integrated Care Boards (ICBs) 2025–2028*. London: NHS England.
Published February 2025.

Available at: <https://www.england.nhs.uk/publication/green-plan-guidance/>

(Sets out the updated structure, reporting cycle, and metrics required for the 2025–2028 NHS Green Plan submissions, including integration with ERIC data, Greener NHS dashboards, and Net Zero delivery trajectories.)

3.NHS Estates and Facilities (2024) – *NHS Estate Returns Information Collection (ERIC) Data 2024/25*.

<https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection>

(Primary dataset used for Alder Hey’s energy, water, waste and carbon baselines.)

4.Department for Business, Energy & Industrial Strategy (BEIS) (2024) – *UK Government Greenhouse Gas Conversion Factors for Company Reporting*. London: BEIS.

<https://www.gov.uk/government/collections/government-conversion-factors-for-company-reporting>

(Emission factors used to convert gas and electricity consumption to tCO₂e for Scopes 1 and 2.)

5.UK Health Security Agency (2023) – *Adverse Weather and Health Plan: Adapting to Climate Change*. London: UKHSA.

(Provides guidance on resilience, heat, flood, and climate risk adaptation planning for NHS Trusts.)

6.Department for Environment, Food & Rural Affairs (DEFRA) (2023) – *Environmental Reporting Guidelines: Including Streamlined Energy and Carbon Reporting (SECR)*.

(Framework for energy and environmental disclosure consistent with NHS requirements.)

7.The Clatterbridge Cancer Centre Green Plan (2025 - 2028) – *Creating a Greener Clatterbridge Cancer Centre 2025 – 2028*.

8.Cabinet Office & HM Treasury (2023) – *Net Zero Strategy: Build Back Greener*.

<https://www.gov.uk/government/publications/net-zero-strategy>

(Sets the national strategic direction for decarbonisation across UK public services.)

Regional and NHS System Sources

- 9. Cheshire and Merseyside Integrated Care System (ICS) (2023)** – *Greener Cheshire and Merseyside Programme Framework.*
(Regional sustainability priorities aligned with NHS England’s Net Zero commitments.)
- 10. Liverpool City Region Combined Authority (2024)** – *Pathway to Net Zero Carbon 2040.*
(Supports alignment with local authority climate emergency targets.)
- 11. Liverpool University Hospitals NHS Foundation Trust (2023)** – *Green Plan 2023–2026.*
(Used as a comparator for group collaboration and governance model examples.)

Alder Hey Children’s NHS Foundation Trust – Local Sources

- 12. Alder Hey Children’s NHS Foundation Trust (2022)** – *Alder Hey Green Plan 2022–2025.*
(The Trust’s first Green Plan, used as the baseline for this 2025–2028 update.)
- 13. Alder Hey Estates and Facilities Management (2024)** – *Energy and Utilities Data Return 2021–2025 (ERIC Submission).*
(Source of building-level gas and electricity data for SPV Main Building and Retained Estate.)
- 14. Alder Hey Sustainability Oversight & Assurance Board Minutes (2023–2024).**
(Governance evidence for policy integration, training, and progress tracking.)
- 15. Alder Hey Research and Innovation Division (2024)** – *Sustainable Clinical Practices and Low-Carbon Care Pathways Report.*
(Evidence base for low-carbon clinical transformation and research-led innovation.)
- 16. Alder Hey Digital Transformation Programme (2024)** – *Electronic Document and Records Management System (EDRMS) Implementation Report.*
(Demonstrates digital sustainability improvements and paper reduction metrics.)
- 17. Alder Hey Procurement Department (2024)** – *Sustainable P*
- 18. Procurement and Social Value Statement.**
(Details supplier engagement and application of NHS Evergreen Supplier Framework.)
- 19. Alder Hey Green Champions Network (2024)** – *Annual Sustainability Survey and Staff Engagement Summary.*
(Qualitative and quantitative insights into workforce engagement and awareness.)
- 20. Alder Hey Building Management System (BMS) Reports (2024)** – *Energy Performance and Optimisation Data.*
(Used to support interpretation of energy efficiency improvements and gas reduction trends.)

Technical and Analytical Sources

20.DEFRA/BEIS (2024) – *Annual Emission Conversion Factors (kWh → kgCO₂e): Natural Gas 0.182 kgCO₂e/kWh; Grid Electricity 0.199 kgCO₂e/kWh (UK Average 2024).*

(Conversion methodology used for carbon footprint calculations.)

21.Health Technical Memorandum (HTM) 07-02 (2021) – *EnCode: Sustainable Health and Social Care Buildings.*

(Guides design and operational efficiency for NHS estates.)

22.Health Building Note (HBN) 00-08 (2023) – *Strategic Framework for the Design of Sustainable Healthcare Facilities.*

(Informs Alder Hey's infrastructure planning and refurbishment programmes.)

23.NHS Digital (2024) – *Sustainable Digital Transformation Guidance.*

(Supports inclusion of sustainability criteria in IT infrastructure and systems.)

24.NHS England (2024) – *Greener NHS Annual Progress Report 2024.*

(National update on progress, benchmarking, and case studies across NHS Trusts.)

Supporting Scientific Literature

25.Watts, N. et al. (2023) *The 2023 Report of The Lancet Countdown on Health and Climate Change*. The Lancet, 402(10419), pp. 2050–2083.

(Evidence on the health implications of climate change and NHS adaptation requirements.)

26.Haines, A. and Ebi, K. (2019) *The Imperative for Climate Action to Protect Health*. New England Journal of Medicine, 380(3): 263–273.

(Key academic basis for understanding climate change as a public health emergency.)

27.World Health Organization (2022) – *Operational Framework for Building Climate-Resilient Health Systems.*

(Guidelines for health system adaptation integrated into the Alder Hey adaptation strategy.)

Data Management and Tools

28.Microsoft Power BI & NHS Data Warehouse (2024) – *Used for data visualisation and carbon tracking dashboards.*

29.NHS Greener Metrics Portal (2024) – *Emission reporting interface used for annual monitoring.*

30.Alder Hey Energy Manager Software (2024) – *BMS and smart meter data collection system supporting Scope 1 and 2 emissions tracking.*

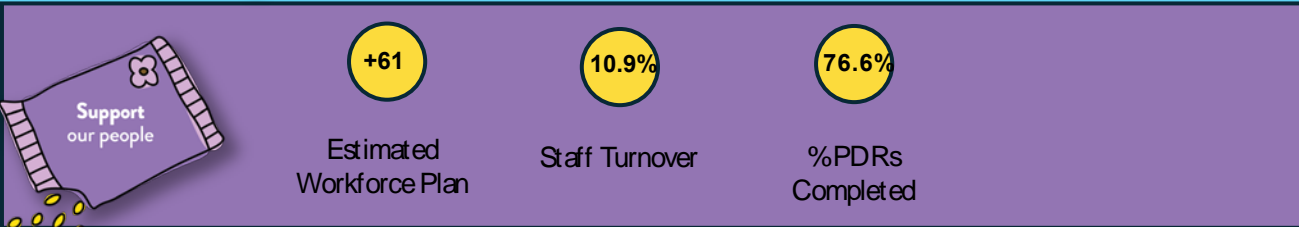
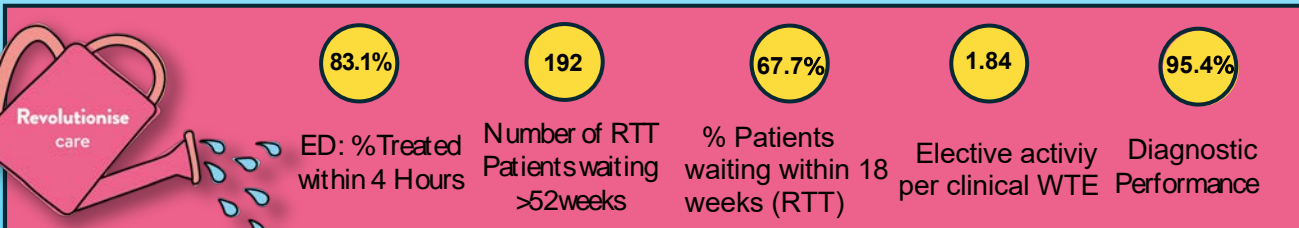
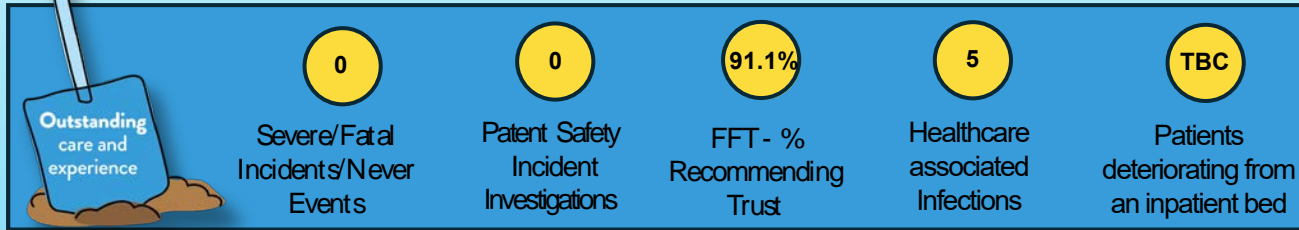
Acknowledgements

Alder Hey Children's NHS Foundation Trust acknowledges contributions from:

- **NHS England – Greener NHS Programme Team**
- **Liverpool City Region Combined Authority Climate Team**
- **Cheshire and Merseyside Integrated Care System (ICS)**
- **Alder Hey Green Champions Network and Sustainability Oversight & Assurance Board**
- **Alder Hey Estates, Facilities, and Clinical Leadership Teams**

Flash Report March 2026

Performance is subject to change



People data as of 26th March

HIGHLIGHTS

- Sustained performance for time to be seen and treated in ED - 12th consecutive month 80%+. 2025/2026 performance 85%.
- Improved performance for % patients waiting under 18 weeks for treatment - validation ongoing.
- Improved performance for 52 week waits
- Improved performance of diagnostic under six weeks.
- 0 PSII's, Severe Incidents or Never Events
- Good patient experience scores.

CHALLENGES

- Estimated Workforce above plan.
- Selected infections - x2 E.COLI, x3 MRSA (1 Community onset)

Integrated Performance Report

Published: March 2026

Performance: February 2026

VISION
2030


Our Journey
To 2030

A Healthier, Happier and Fairer Future for Children and Young People

OUR ASPIRATION
To be world-leading

The Needs
of Children,
Young People
and Families

Get
me well

Personalise
my care

Improve my
life chances

Bring me
the future

Outstanding
care and
experience

Collaborate
for children
& young
people

Revolutionise
care

Support
our people

Pioneering
breakthroughs



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Pioneering Breakthroughs	Page 13
Financial Sustainability	Page 16
Risk Management	Page 18
Divisional Summaries -	
Community & Mental Health	Page 20
Medicine	Page 23
Surgery	Page 26
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Corporate	Page 31
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IPR – Executive Summary



Outstanding Care and Experience

	Value	Target	Trend
Patients deteriorating from an inpatient bed admitted to PICU	20	n/a	
Number of Incidents per 1,000 bed days – No Harm	72	77.4	
Number of Incidents per 1,000 bed days – Low Harm and above	19	19.6	

Executive Summary

The Trust continues to report strong quality and safety performance. PALS responsiveness remains high at 97% within five working days, achieving a fourth consecutive month above the 90% standard, with a slight reduction in concerns received. There were no cases of C. difficile, while sepsis compliance remained strong, with 94% of inpatients and 91% of ED patients receiving antibiotics within 60 minutes. Restrictive interventions continue to reduce significantly, and there were zero Category 2 or above pressure ulcers. Areas of concern include one new PSII commissioned, although duty of candour was met, an increase in parent and carer concerns in February, and two cases of potentially preventable deterioration identified on review. Complaint performance remains below target at 80% within 25 working days. Priority action is to complete the cleaning equipment review, update policy, and deliver staff training.

Support Our People

	Value	Target	Trend
Workforce Plan	4,273	4,213	
Staff Turnover	12.2%	10%	
Sickness Absence (Total)	5.9%	4.5%	

Executive Summary

Workforce indicators remain broadly positive, with mandatory training compliance sustained above 90% and targeted work underway to improve completion in lower-performing modules. Long-term sickness absence has reduced by more than 1% since its December peak. However, workforce levels remain above plan, with the voluntary redundancy scheme now launched and further reduction plans submitted for 2026/27. Short-term sickness absence also increased in month and continues to require focused management action, in line with reporting to People Committee. Looking ahead, PDR compliance continues to improve, with B7+ completion at 89% and overall completion at 75%. Learning and Development colleagues are supporting managers to improve performance further, alongside rollout of the new PDR App to strengthen recording and monitoring.

Revolutionise Care

	Value	Target	Trend
ED % Treated Within 4 Hours	80.3%	78%	
% RTT Patients Waiting >52 Weeks*	1.45%	1.04%	
RTT Waiting List Within 18 Weeks*	63.5%	62.9%	

Executive Summary

Performance remains strong across several key operational measures. In February, 80.3% of patients were treated within four hours, DM01 improved from 90% in January to 95%, and there has been sustained improvement in time to first attendance, with 68% of patients seen within 18 weeks. The Trust's 18-week RTT position also remained ahead of year-end target at 63.5% against 63.1%. Areas requiring continued focus include an increase in CAMHS 52-week breaches from 30 to 36, a slight reduction in capped theatre utilisation to 79%, and growth in follow-ups overdue by more than two years, now exceeding 4,000. The proportion of neurodevelopmental waits over 65 weeks remains below 20%. Priority actions include delivery of the Community and Mental Health plan to eliminate 52-week waits by the end of March, continued focus on RTT improvement, and ongoing development of the patient portal to help reduce WNB rates.

Financial Sustainability

	Value	Target	Trend
I&E Year End Forecast	£7.1m	£7.1m	
Recurrent Efficiency Plans Delivered	£5.4m	£20.6m	
ERF Income (YTD)	£90.6m	£91.6m	

Executive Summary

The Trust reported a £0.9m surplus in month and £2.1m surplus year to date, in line with plan. Following post month-end discussions with the ICB, the year-end forecast has improved to £7.2m, reflecting confirmation of one-off income support including PFI credit, prior year income, MARS funding and specialised commissioning over-performance, materially reducing delivery risk. CIP delivery remains on plan year to date, with £22.3m transacted, £13m recurrently. Capital is ahead of plan due to over-profiling and confirmed additional funding, including £2m elective capital and £2.1m SDEC funding. Key risks remain around delivery of recurrent CIP and cash performance, with cash lower than plan due to non-cash CIP and higher capital spend. Continued cost control through FIP, divisional challenge, recurrent savings support, development of Target Operating Models, a cash strategy and a five-year capital plan will be critical to longer-term sustainability.

*RTT Targets based on trajectory

Outstanding Care and Experience - Safe & Caring

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

Highlights:

- Sustained high performance in responding to PALS concerns within 5 working days at 97%; 4 consecutive months of compliance above 90%. Slightly decreasing trend in the number of PALS concerns received
- No cases of C-diff. Trust liaising with UKHSA to review cleaning practices and products
- 94% and 91% compliance respectively for in-patients and ED patients receiving antibiotics within 60 minutes for sepsis
- Continued significant downward trend in the need for restrictive intervention
- Zero pressure ulcers of Category 2 and above

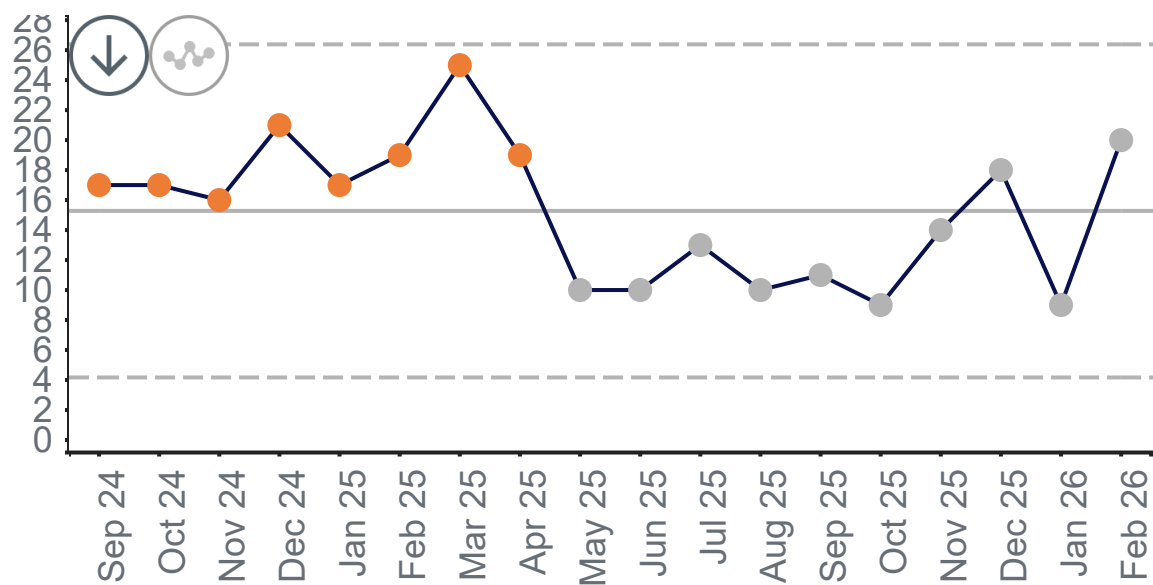
Areas of Concern:

- One new PSII commissioned by the PSIRI panel. Duty of candour met
- Increase in the number of concerns activated by parents / carers with six reported in February; two related to the same patient therefore 5 patients in total. Two cases of potentially preventable deterioration identified on review of cases
- 80% of complaints responded to within 25 working days

Forward Look (with actions)

Complete the review and purchase of cleaning equipment with associated update in policy and training programme for staff

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



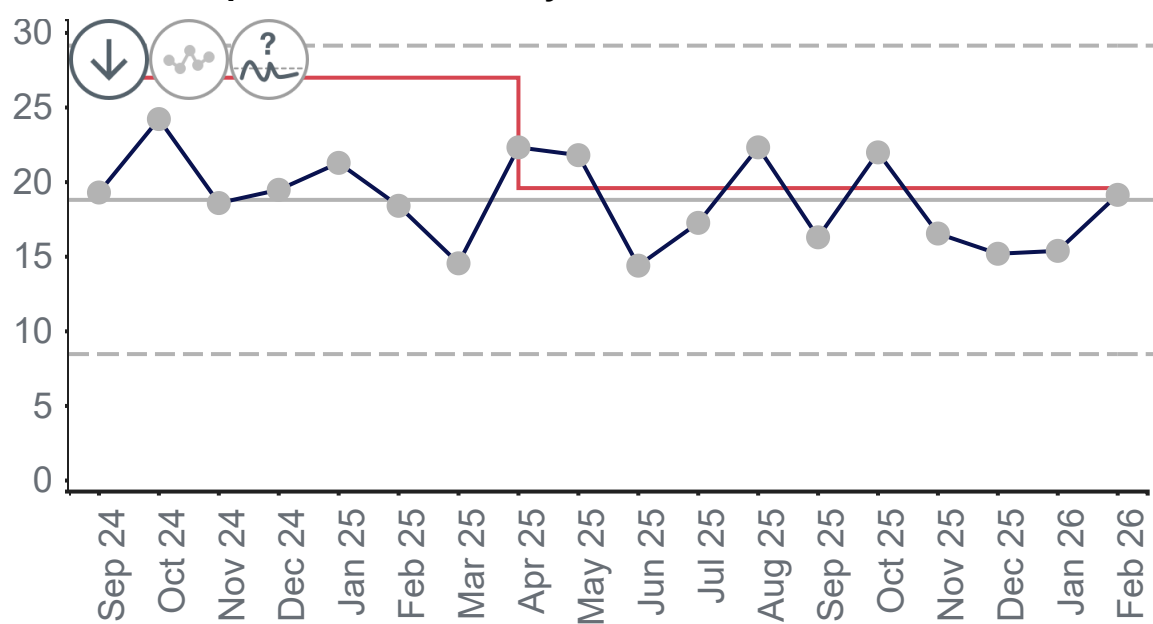
Technical Analysis:

Common cause variation observed with 20 patients deteriorating from an inpatient bed to PICU with an average of 15 a month during the last 18 months.

Actions:

Increased number in month associated with the high acuity of patients in winter. Deteriorating Patient working group continues to progress action plan and all cases are reviewed for any learning and / or themes

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



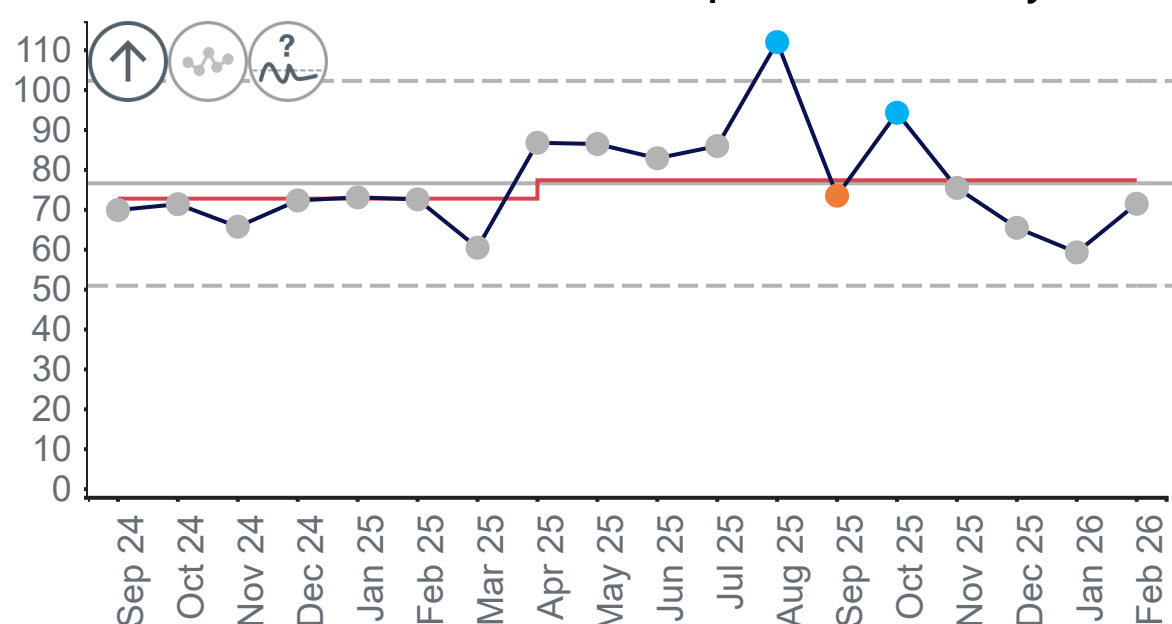
Technical Analysis:

Common cause variation with performance of 19 incidents of harm per 1,000 bed days, with a monthly average of 19 incidents during the period. Incidents are assessed on Physical and Psychological Harms. The target is set on a 5% reduction of 24/25, with a monthly target of 19.6

Actions:

Decreasing number of incidents resulting in harm in the last four months. Robust process for review and multi-faceted dissemination of learning in the Trust

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



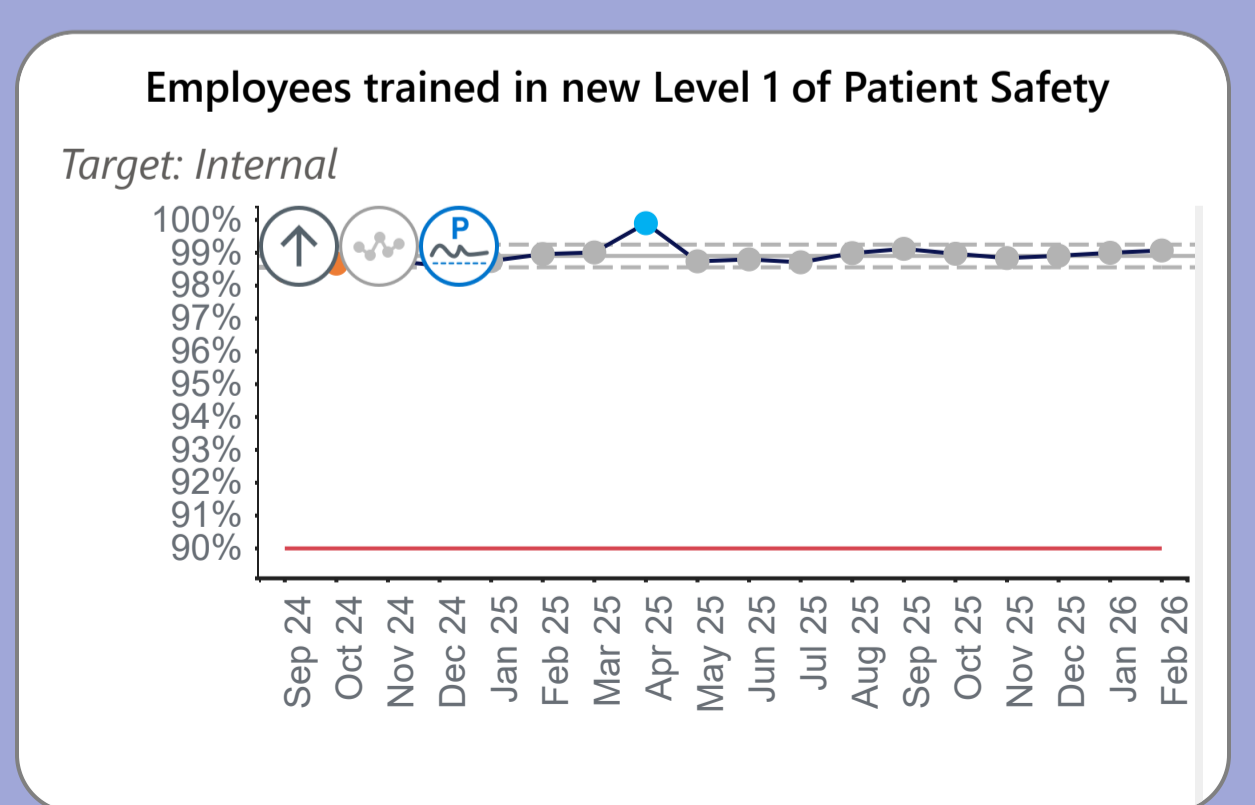
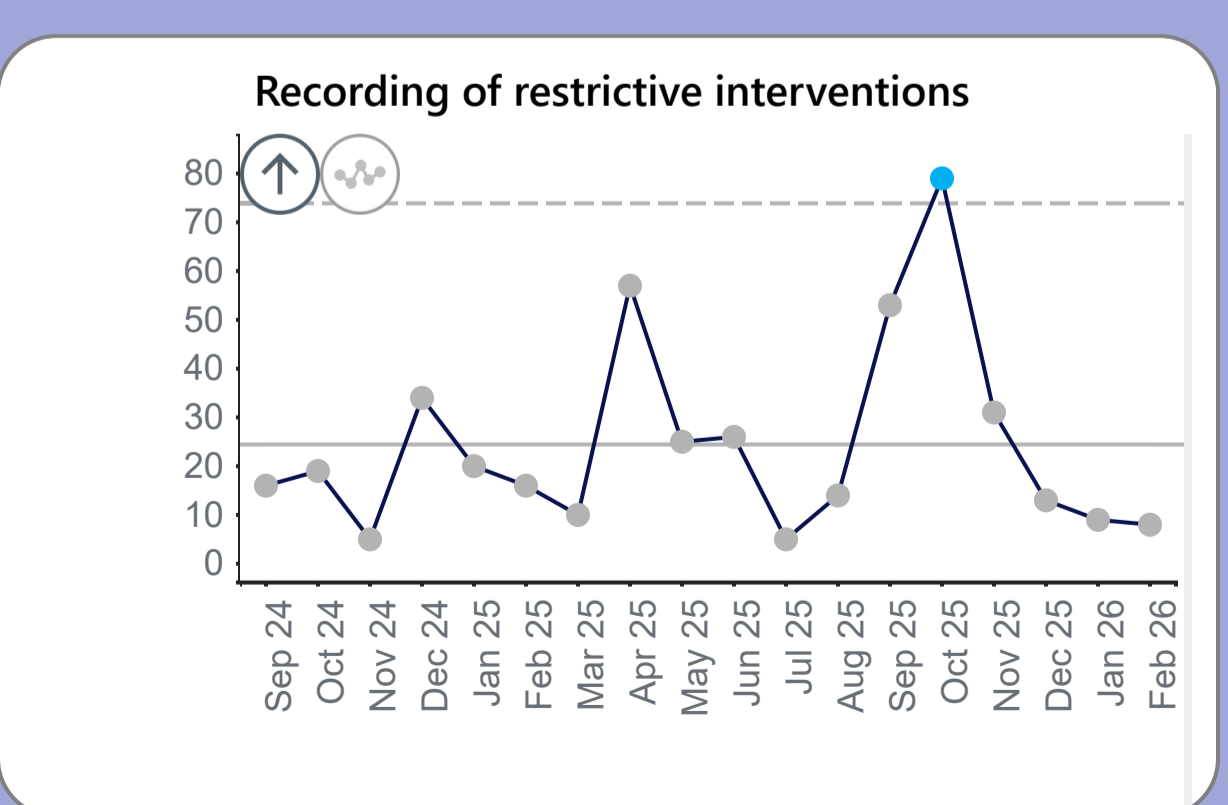
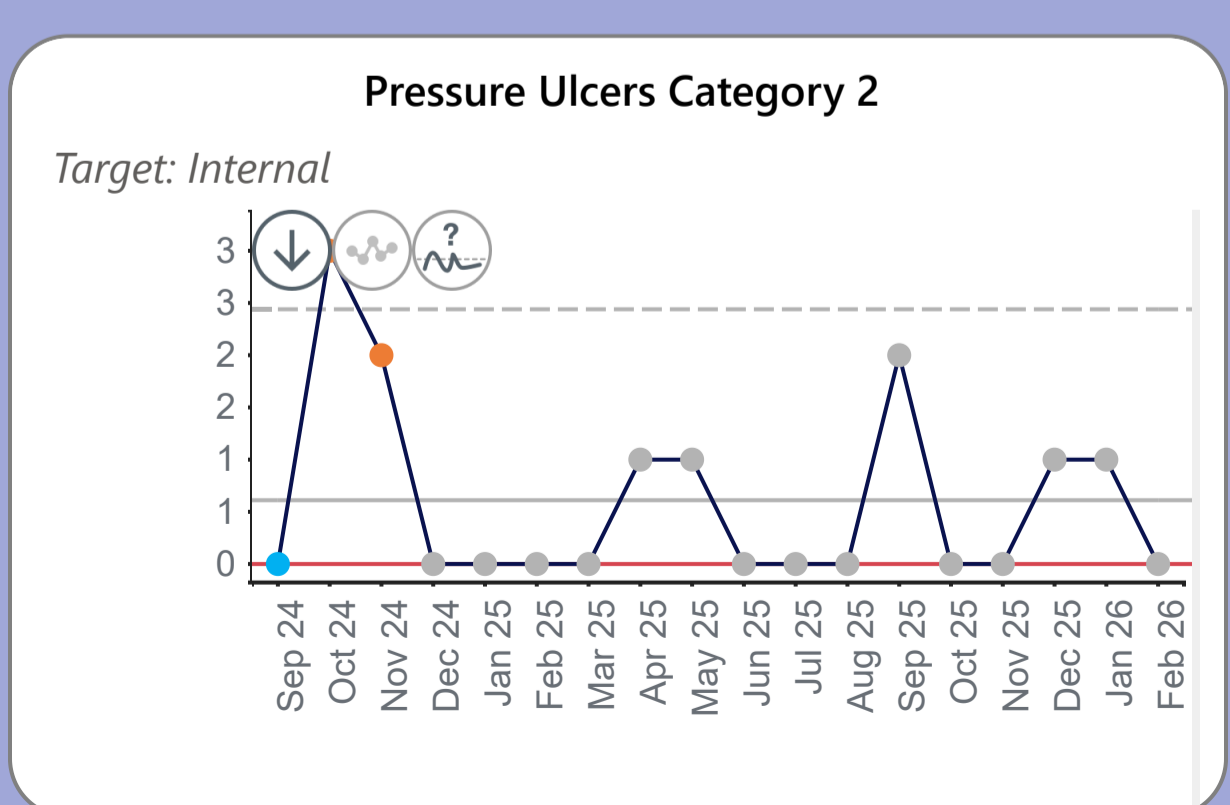
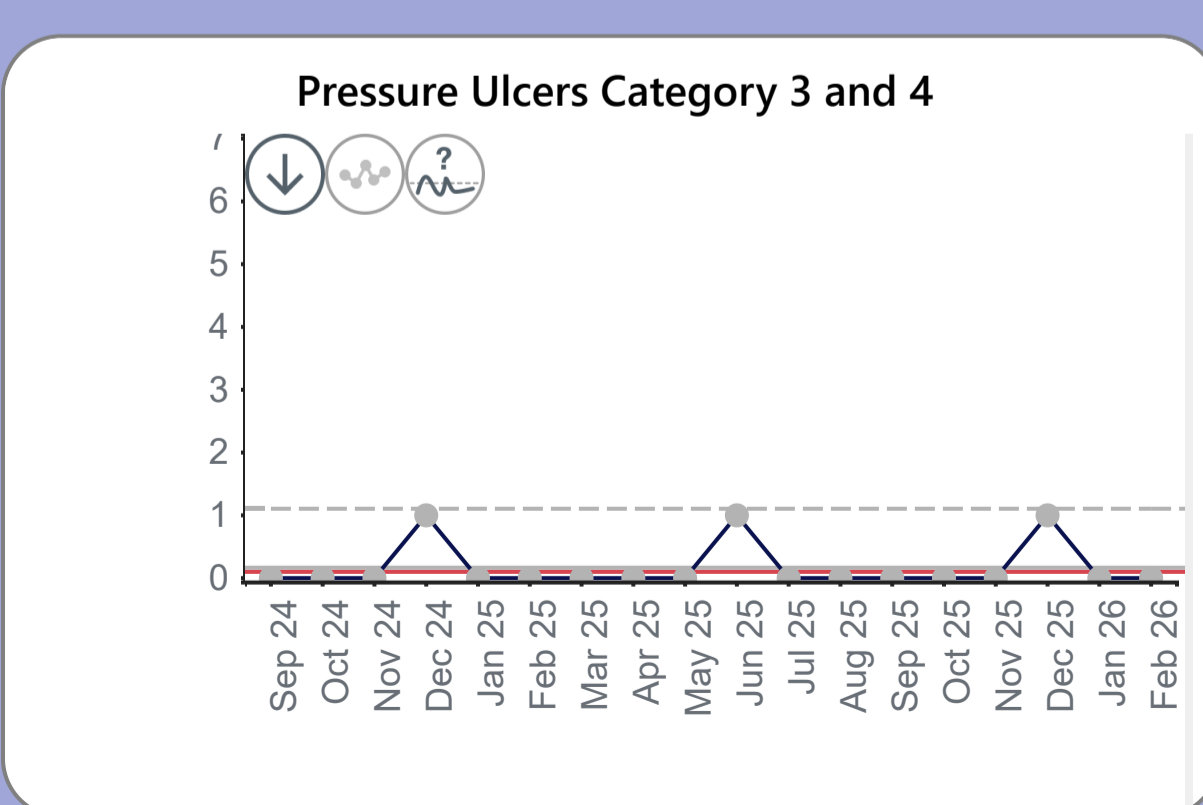
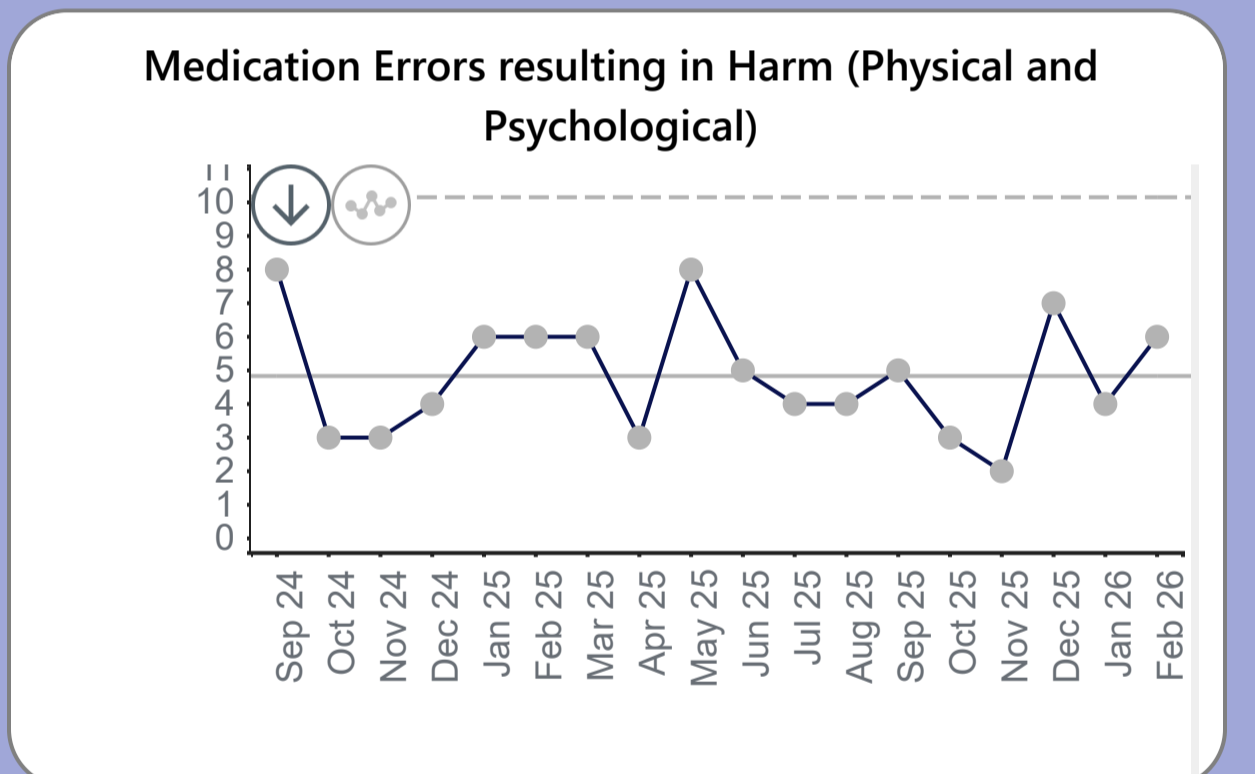
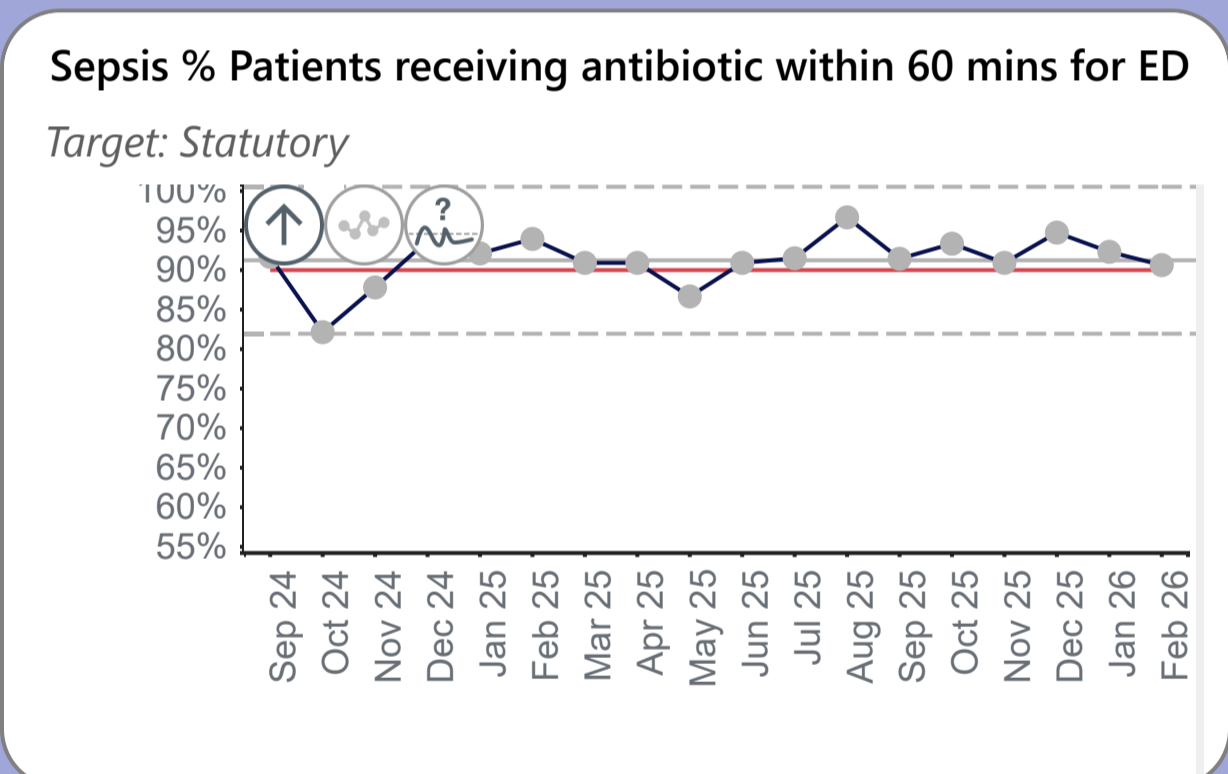
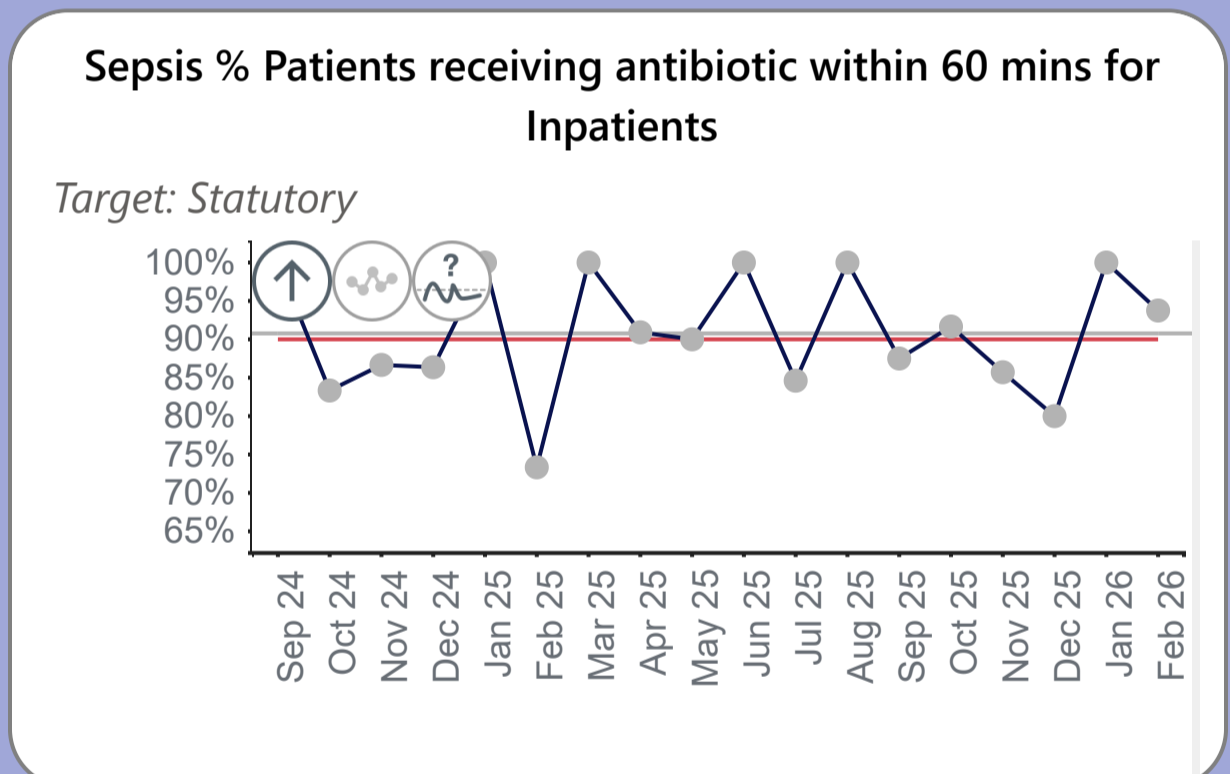
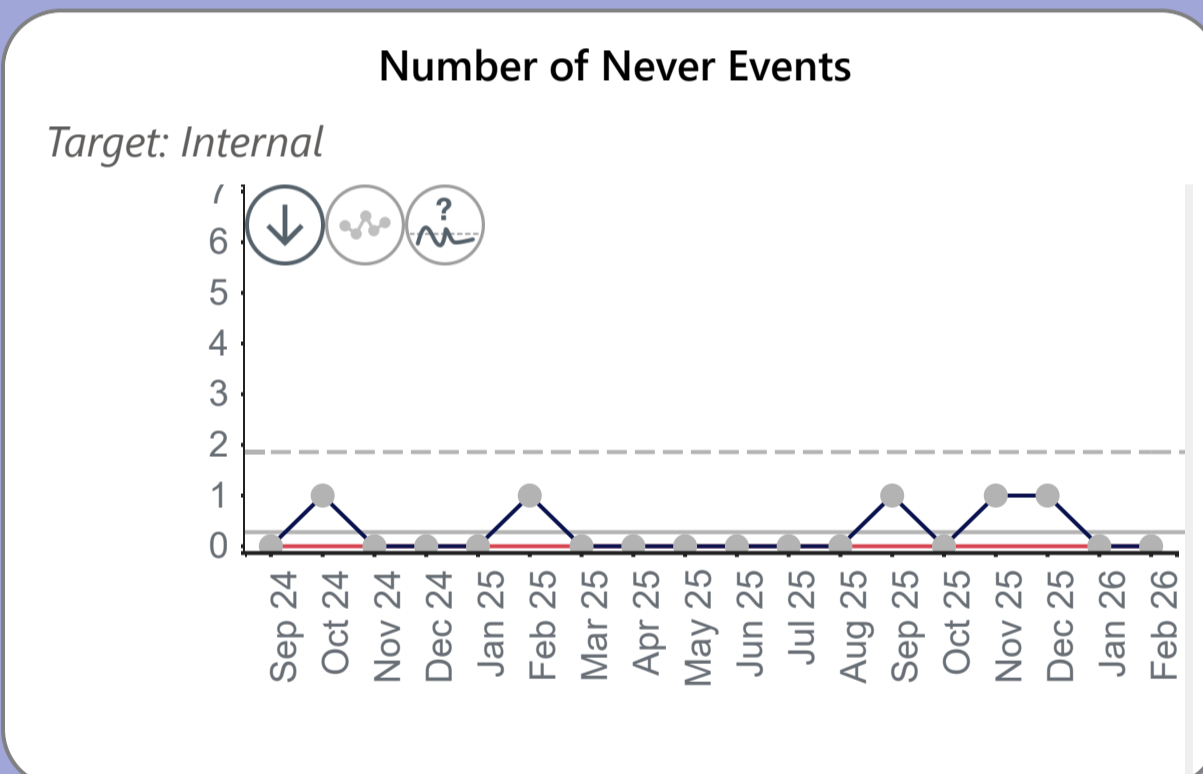
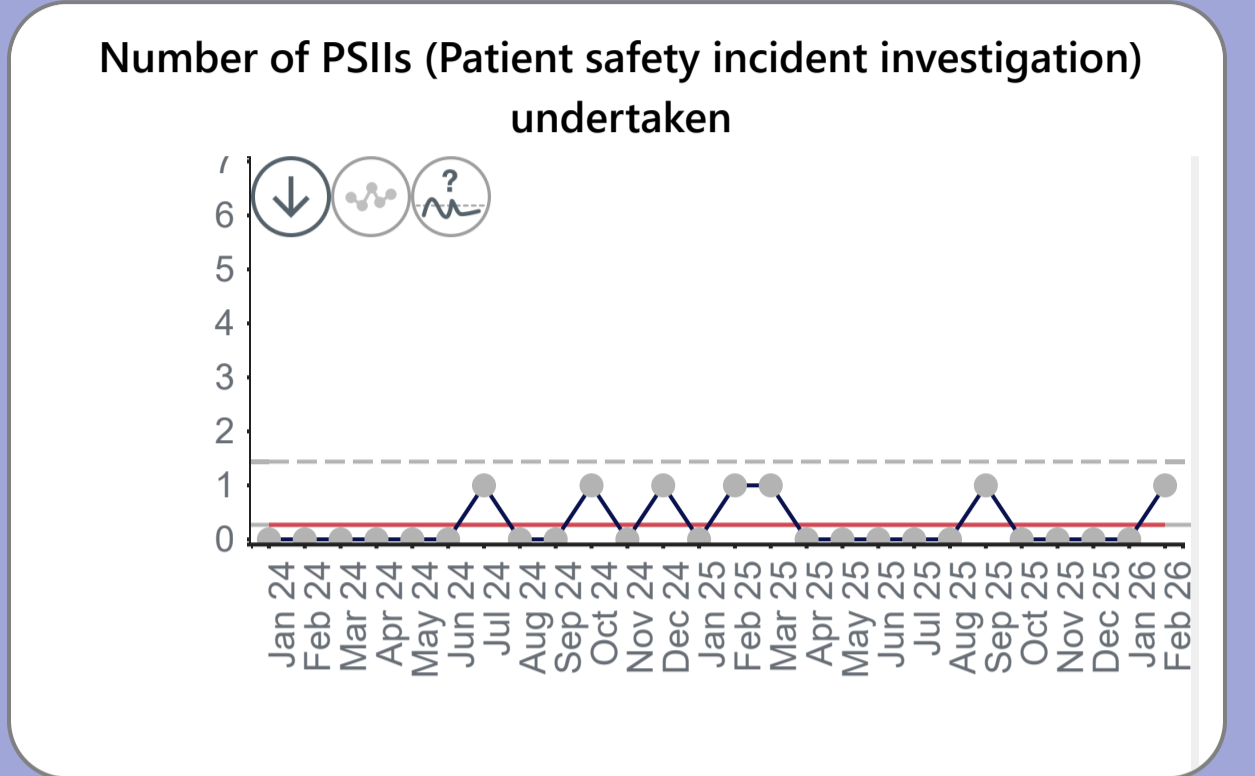
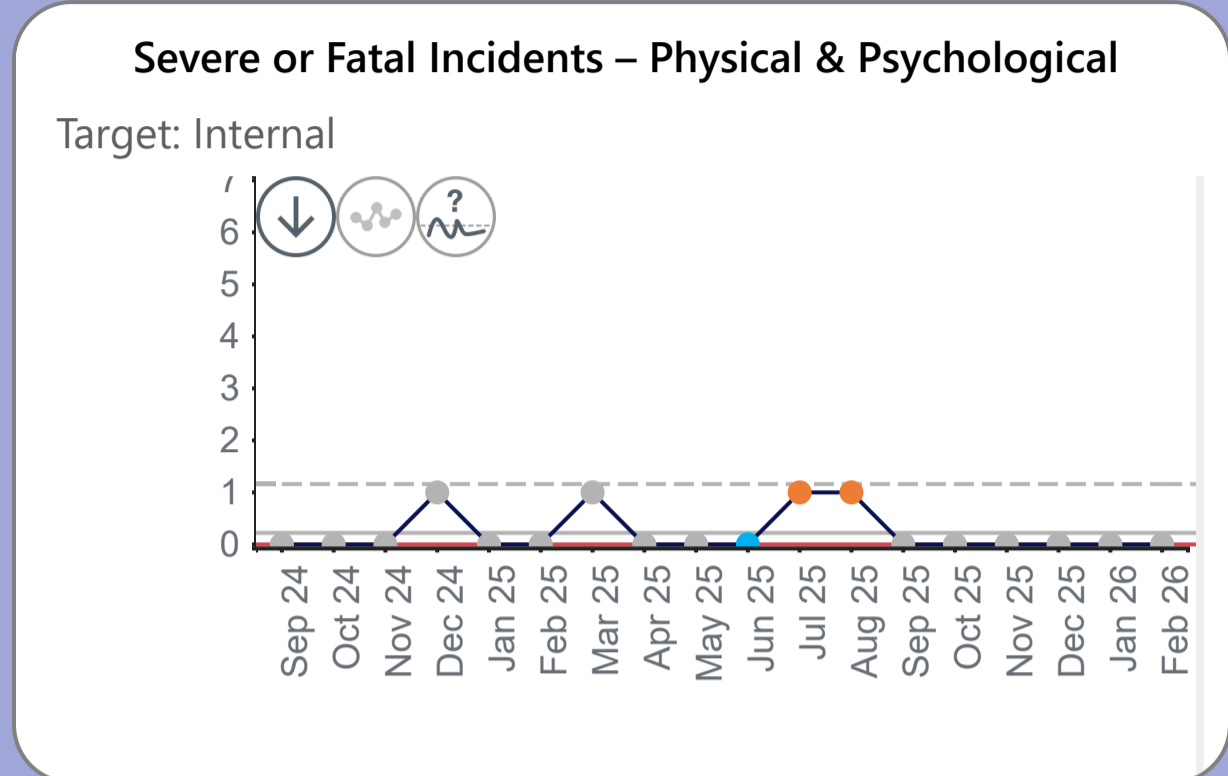
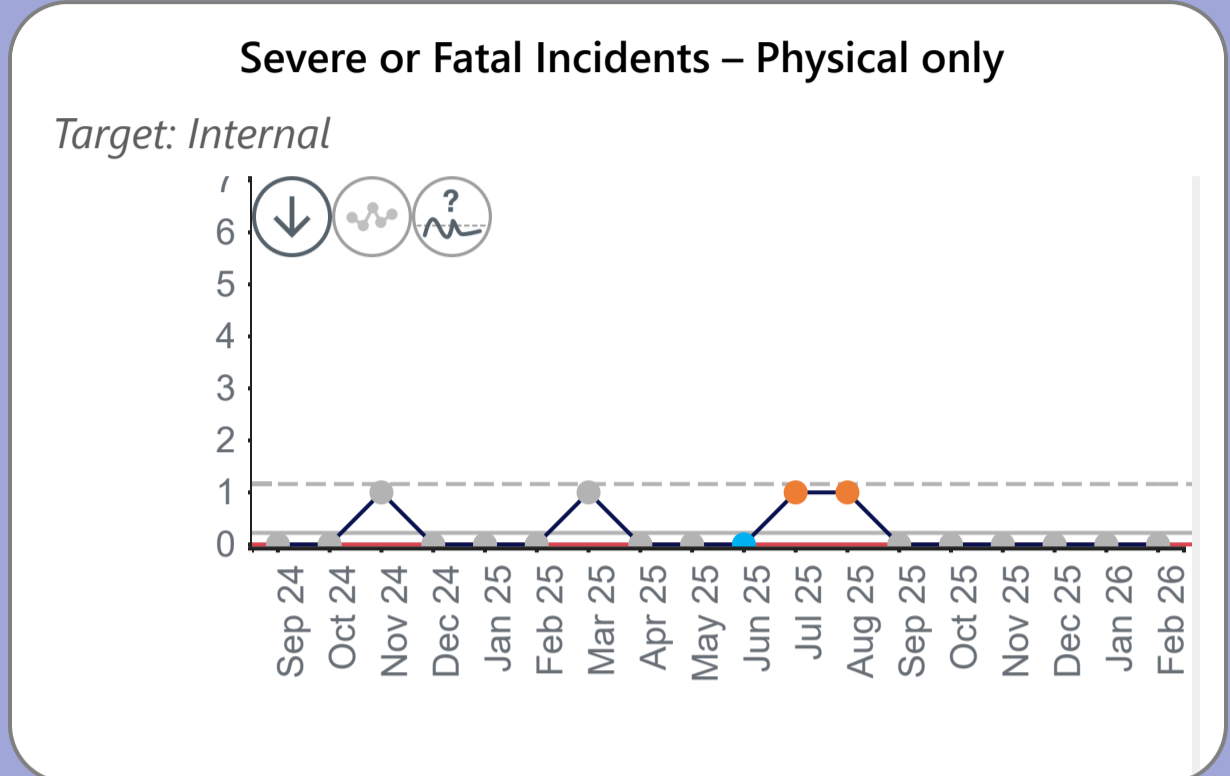
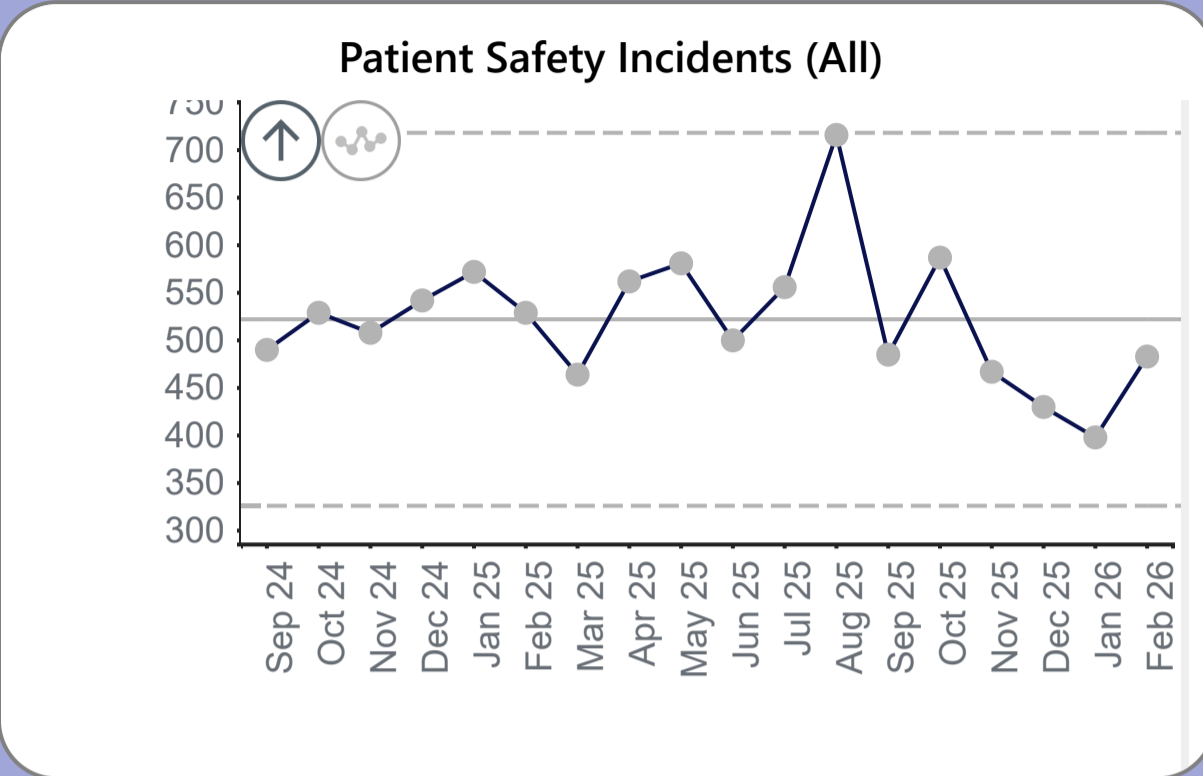
Technical Analysis:

Common cause variation observed with 72 incidents of no harm per 1000 bed days, with a monthly average of 77. Incidents are assessed on both Physical and Psychological Harms. The target is set against a 5% improvement on 24/25 with monthly target 77.4. 4th consecutive month the below target however meeting target year-to-date with 81.2.

Actions:

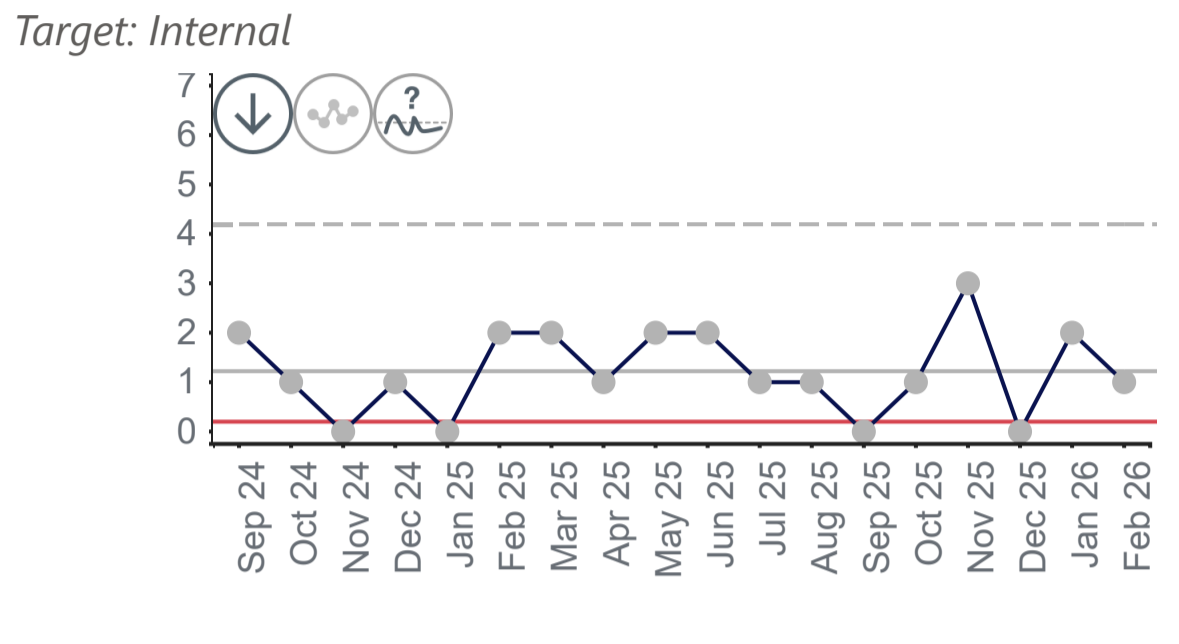
Decreasing number of no harm incidents in the last four months. Staff are encouraged to continue to report

Outstanding Care and Experience- Safe & Caring - Watch Metrics

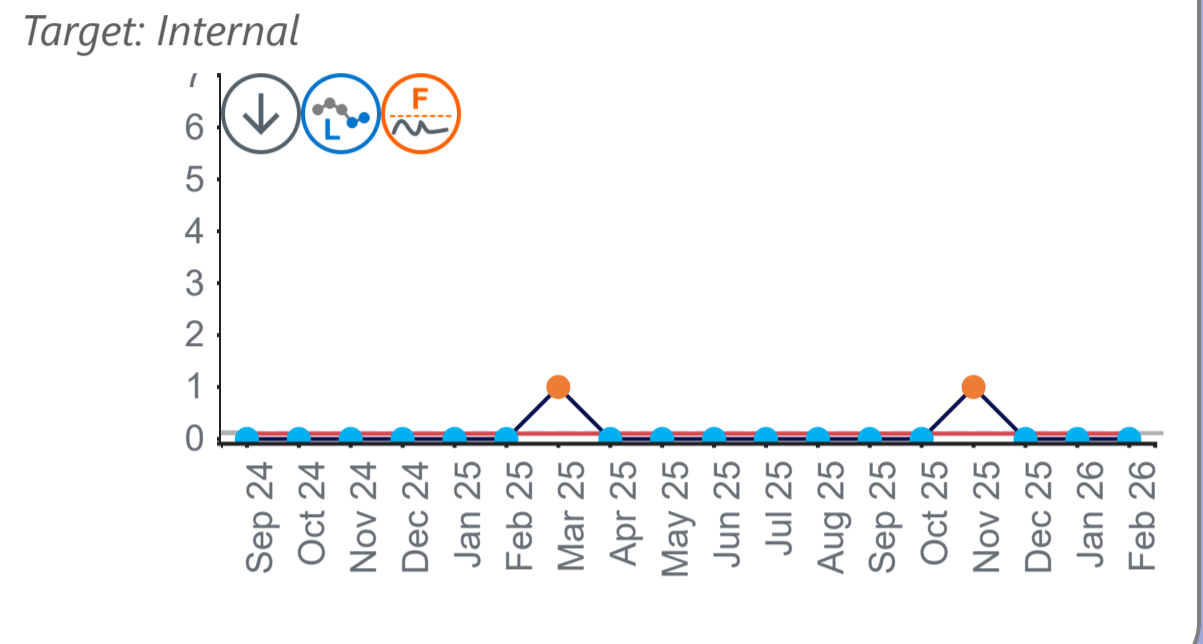


Outstanding Care and Experience - Safe & Caring - Watch Metrics

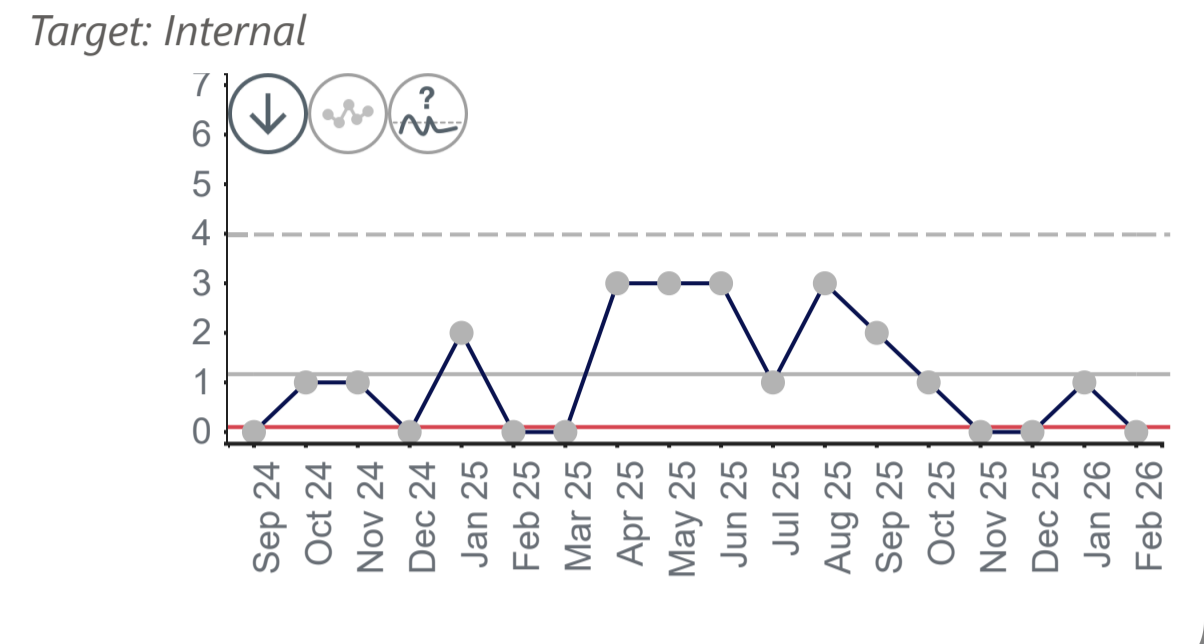
Hospital Acquired Organisms - MSSA



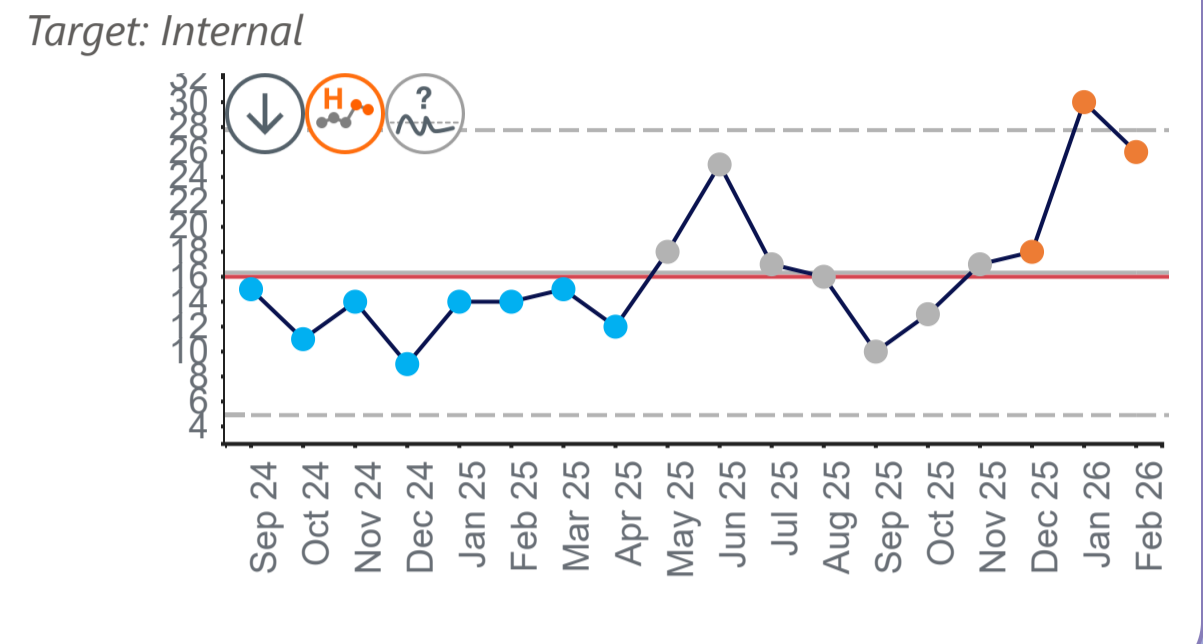
Hospital Acquired Organisms - MRSA (BSI)



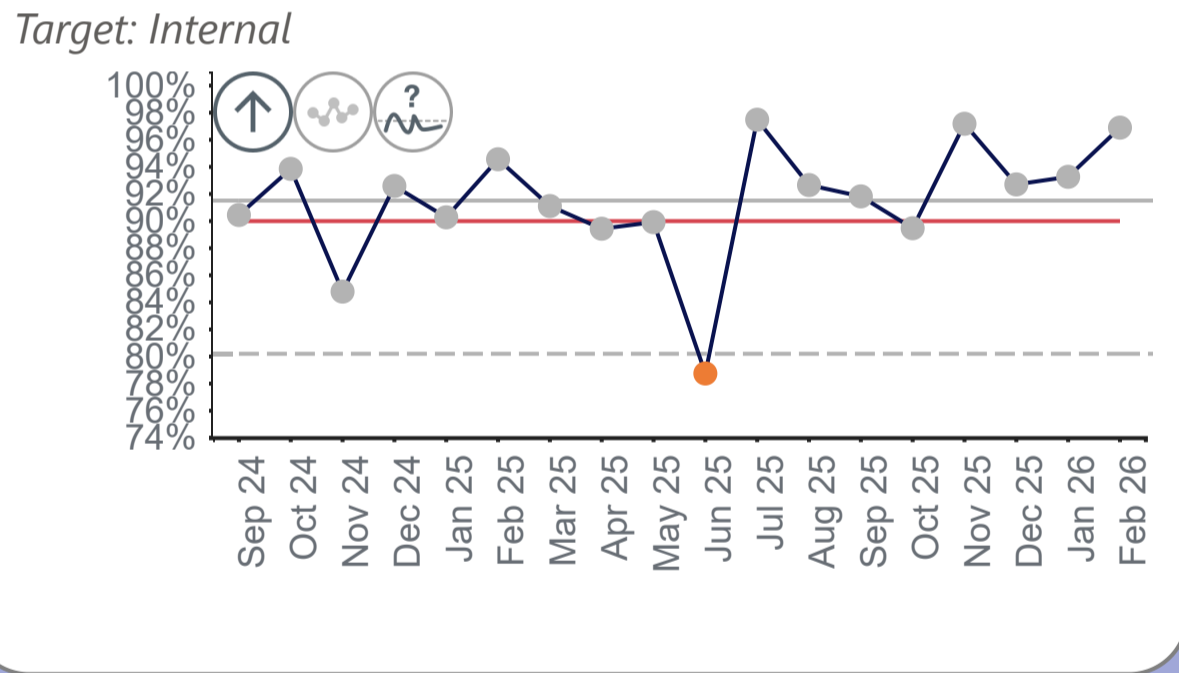
Hospital Acquired Organisms - (C.Difficile)



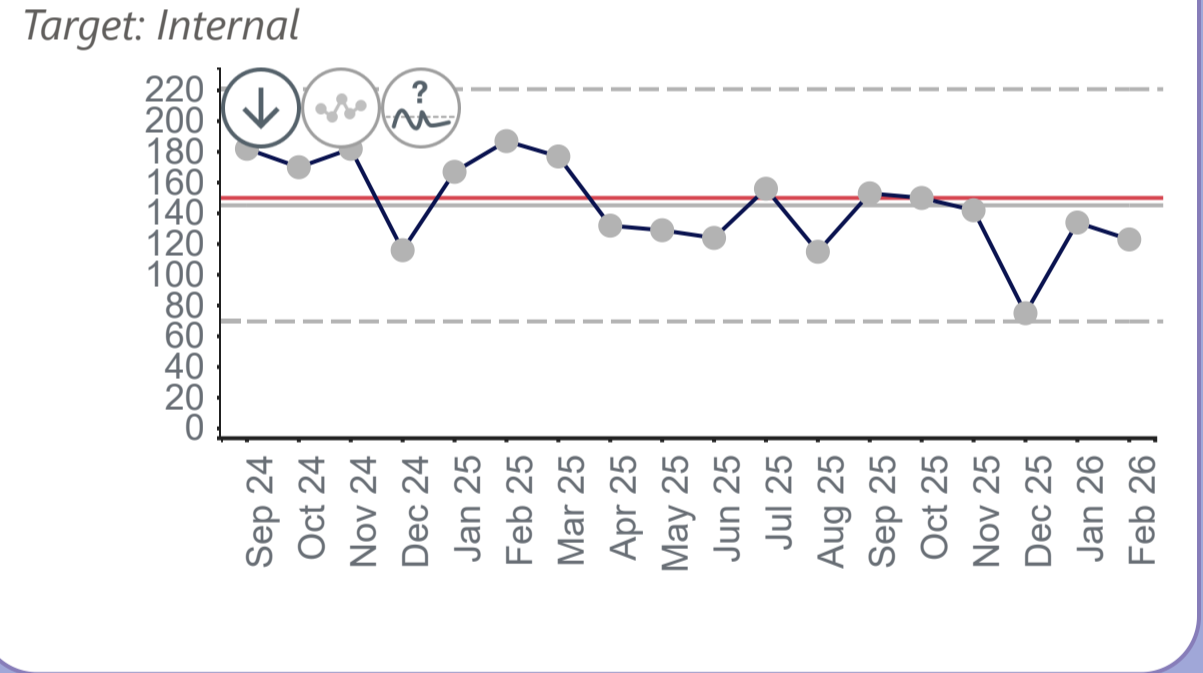
Number of formal complaints received



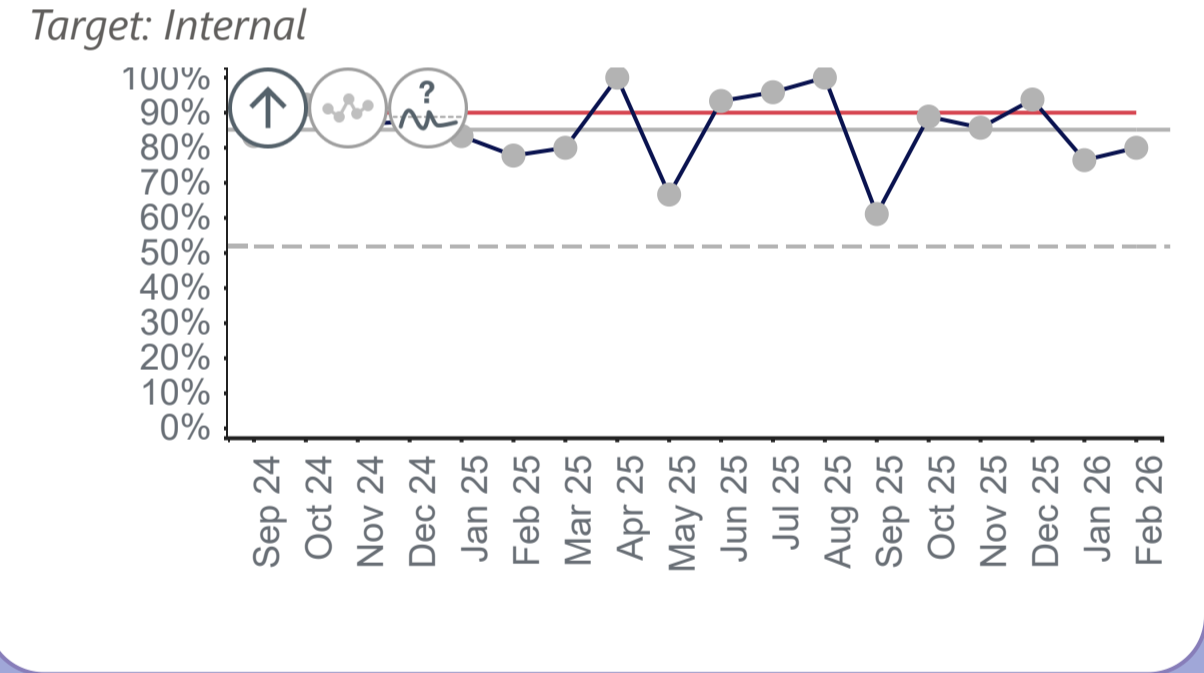
% PALS Resolved within 5 Days



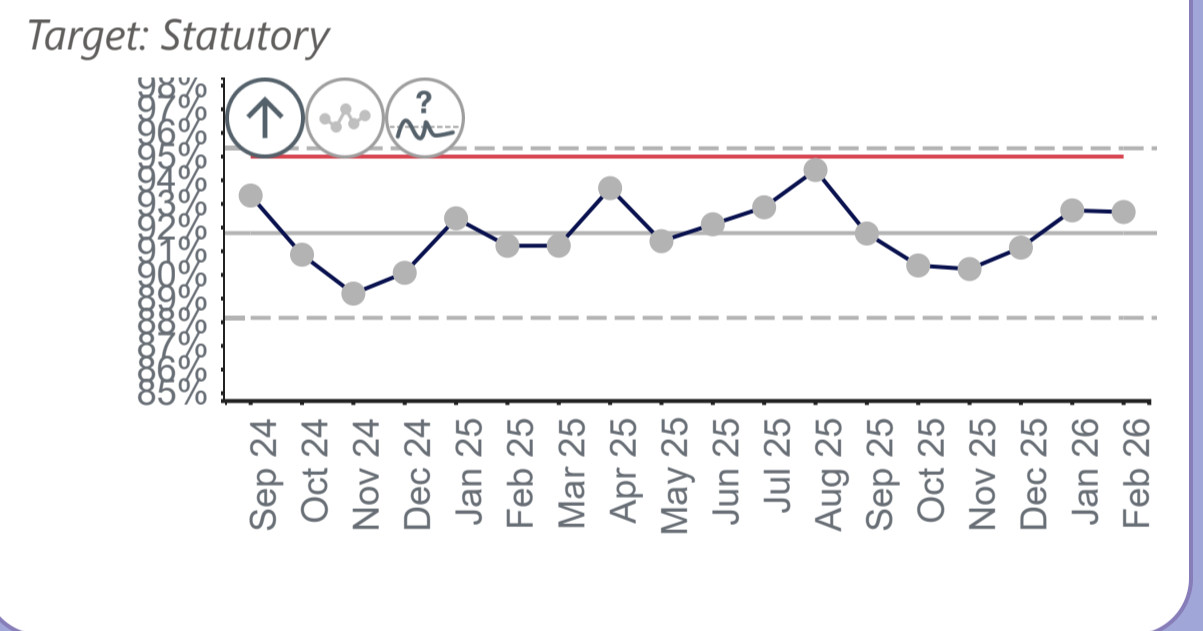
Number of PALS contacts



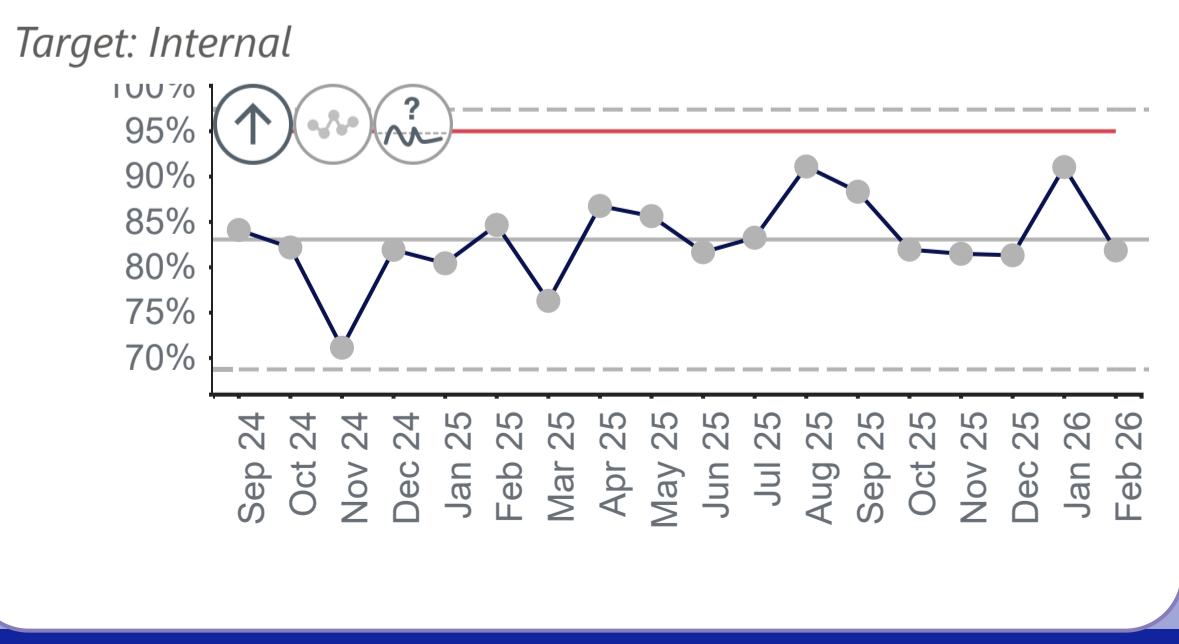
% Complaints Responded to within 25 working days



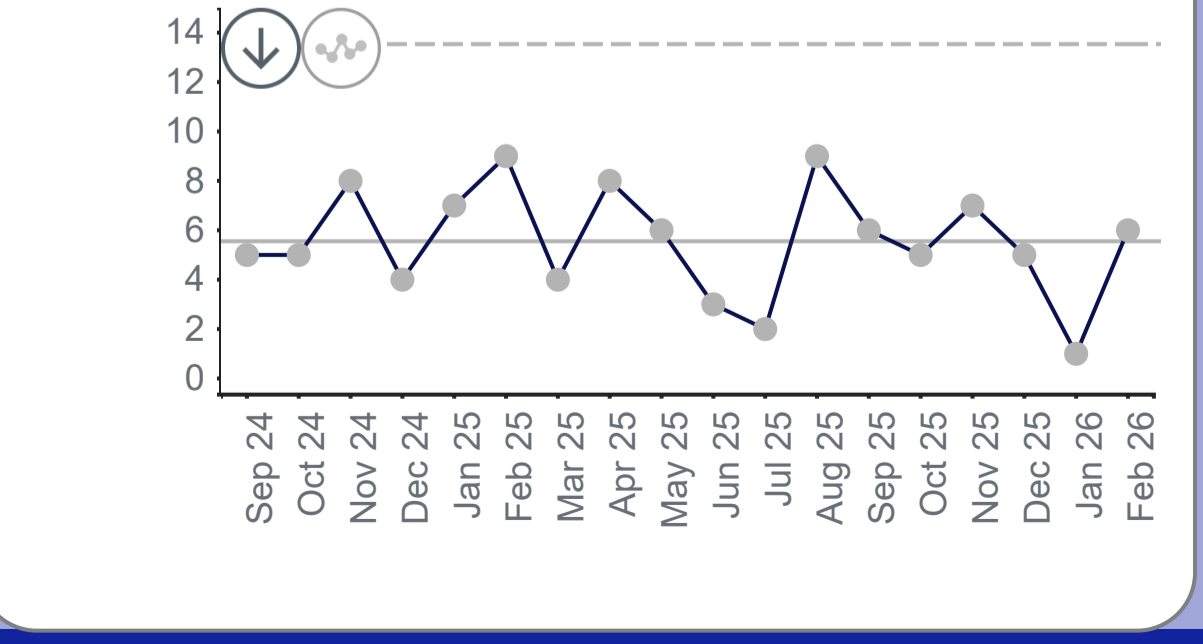
Trust: % of very good/good ratings for 'Overall, how was your experience of our service'



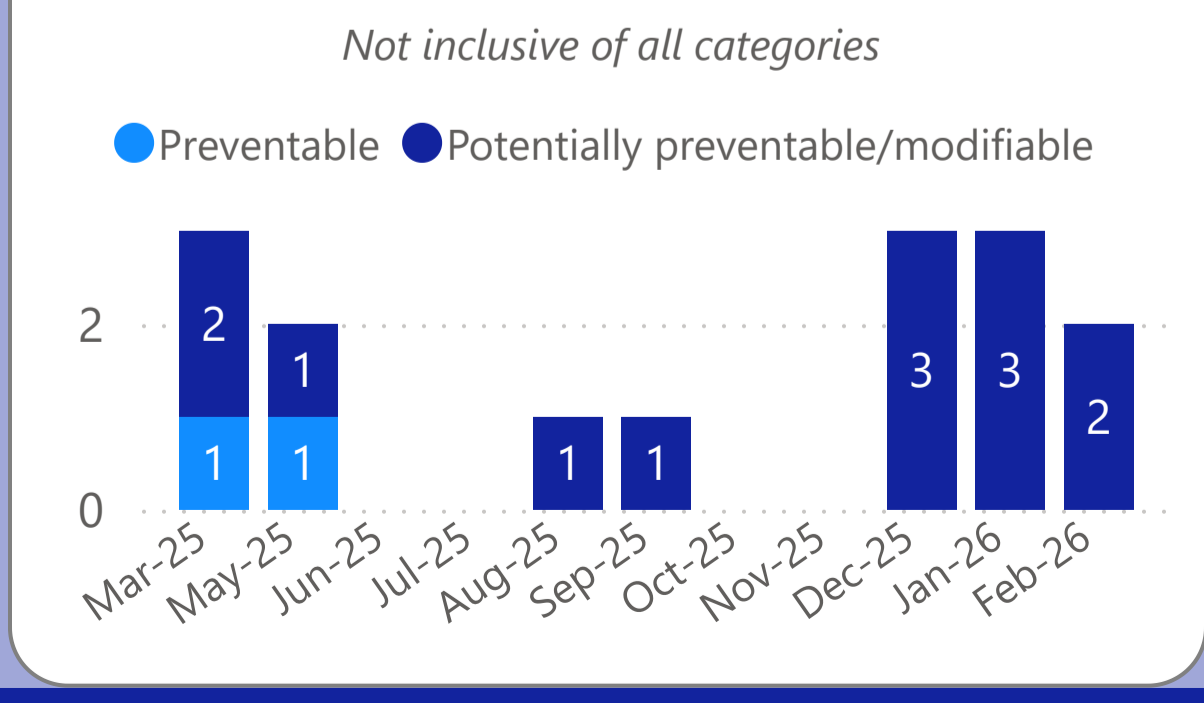
ED: % of very good/good ratings for 'Overall, how was your experience of our service'



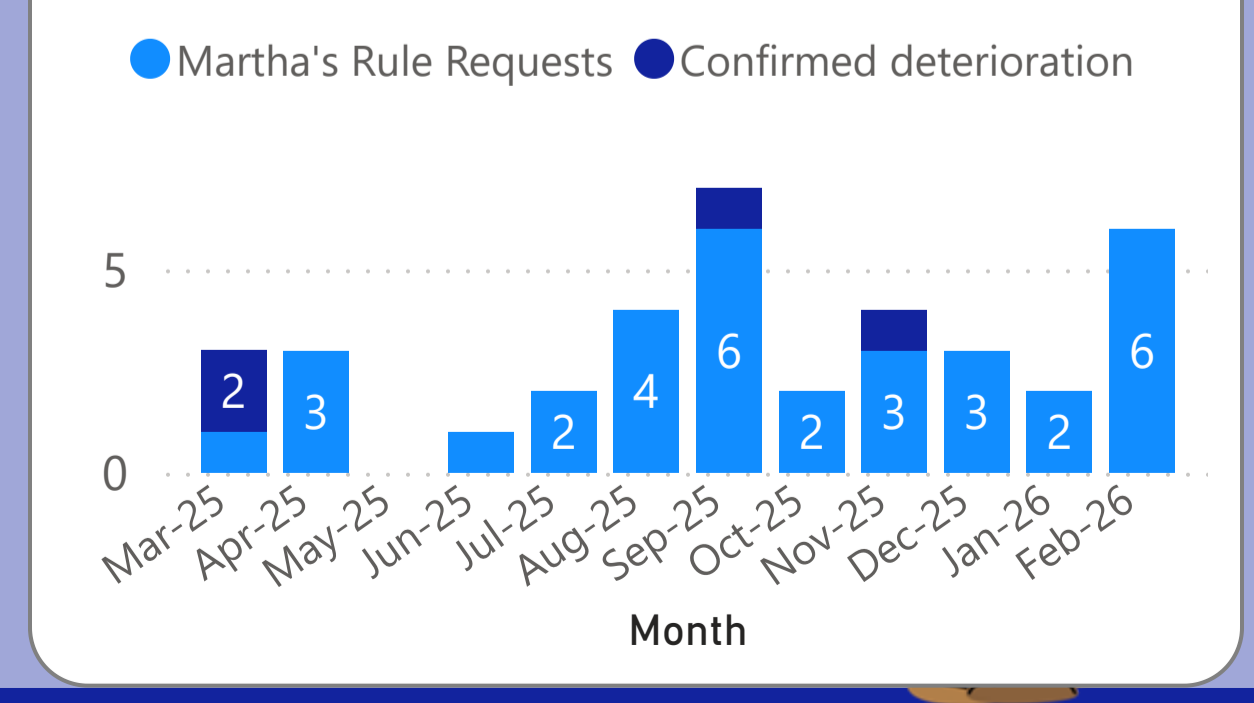
Number of patients deteriorating from HDU admitted to PICU



Predictable and preventable deteriorating patients



Martha's Rule





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: February saw 80.3% of patients treated withing 4 hours • DM01 performance has increased from 90% in January, to 95% in February • There has been a 4-month improvement in time to first attendance, with 68% of patients having a first appointment within 18 weeks • The February 18 week RTT position was 63.5% against a year-end target of 63.1%

Areas of Concern:

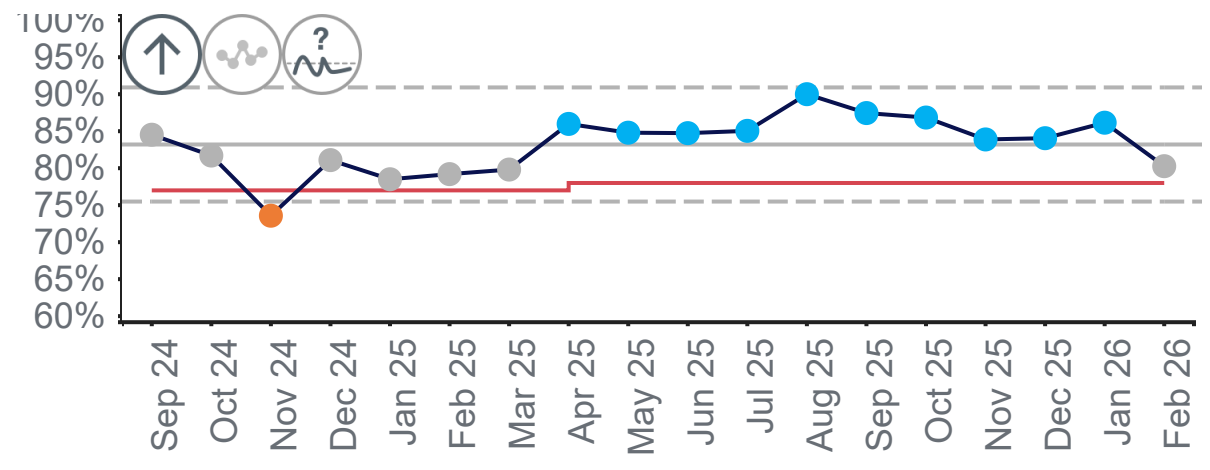
- The number of CAMHS 52-week breaches has increased from 30 to 36 • The % of neurodevelopmental assessment waiting list over 65 weeks remains below 20% • Slight decrease in capped theatre utilisation in month at 79% • Number of follow ups (2 years overdue) is now above 4,000, after decreasing to 3,000 in February 2025.

Forward Look (with actions)

- Community & Mental Health Division have a plan for all 52-week patients to be seen before the end of March • Continued focus on 18-week RTT performance to reduce waiting times for CYP • Patient portal development ongoing to support reduction in WNB rate.

ED: % treated within 4 Hours

Target: Statutory



Technical Analysis:

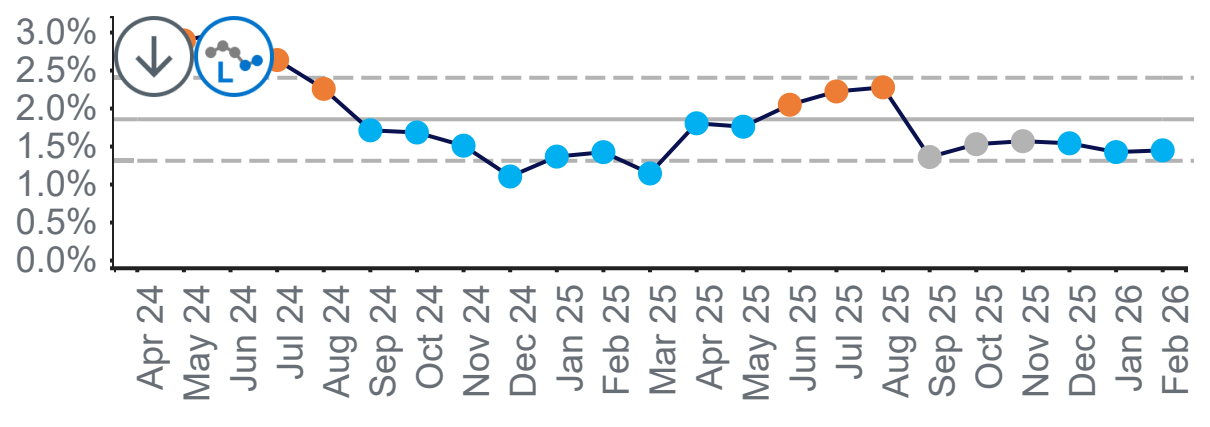
Achieved the national target in February-26 with the 15th consecutive month above target. Common cause variation observed with performance of 80.3% in February 2026, a decrease from Jan-26 (86.1%). Feb-26 represents performance +1.9% compared to Feb-25 (79.2%) whilst Feb-26 experienced +0.8% in Very Urgent/Red patient compared to Feb-25.

Actions:

- Enhanced ED escalation plan is in place, with additional specialty in-reach support • Briefings have been rolled out for on-call managers to support with ED pressures until the end of March • UEC sprint has tasked the Trust with achieving 95% in March, response provided • On Call Manager attending 17:15 huddle to support overnight plan

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

Target: Statutory



Technical Analysis:

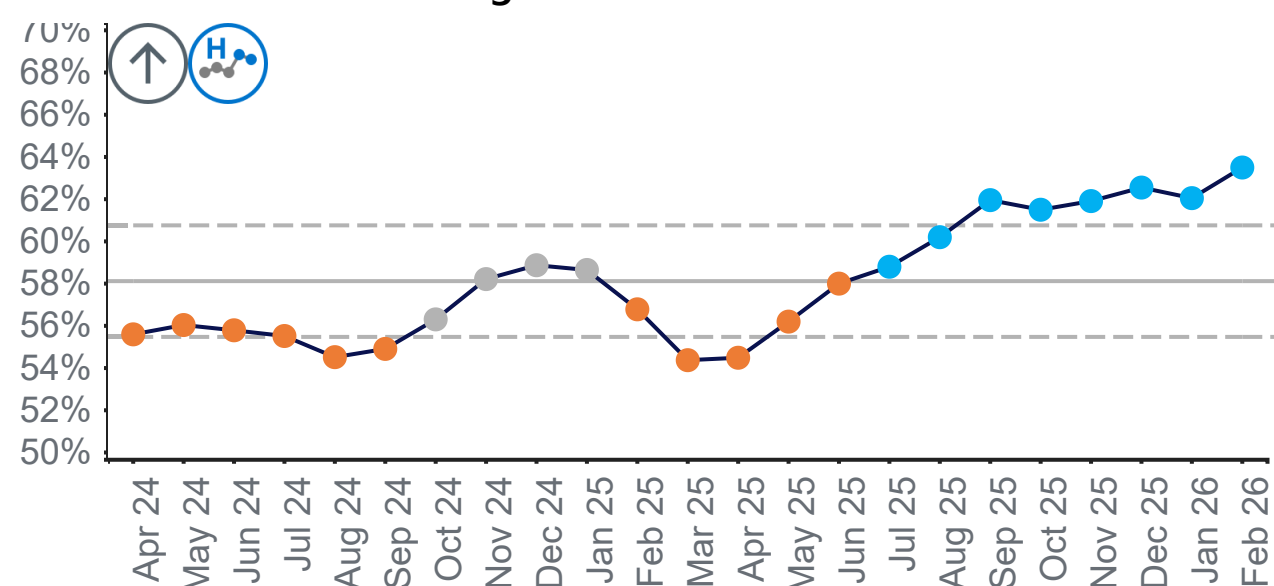
1.45% of our open IP & OP RTT waiting list is waiting >52 weeks against a national target of less than 1% waiting lists waiting >52 weeks by March 2026. This is a minor increase from January 2026 position of 1.43%. With the total volume now at 232 breaches. 71% of current waits >52 weeks within Dentistry service.

Actions:

- Paediatric dentistry is the Trust's most challenged area for 52 weeks and now equates to 1% of the total waiting list. 'Super Saturdays' are continuing throughout March, with high volume clinics and allocation of additional theatres where possible.

Revolutionise Care- Effective & Responsive

RTT waiting list within 18 weeks



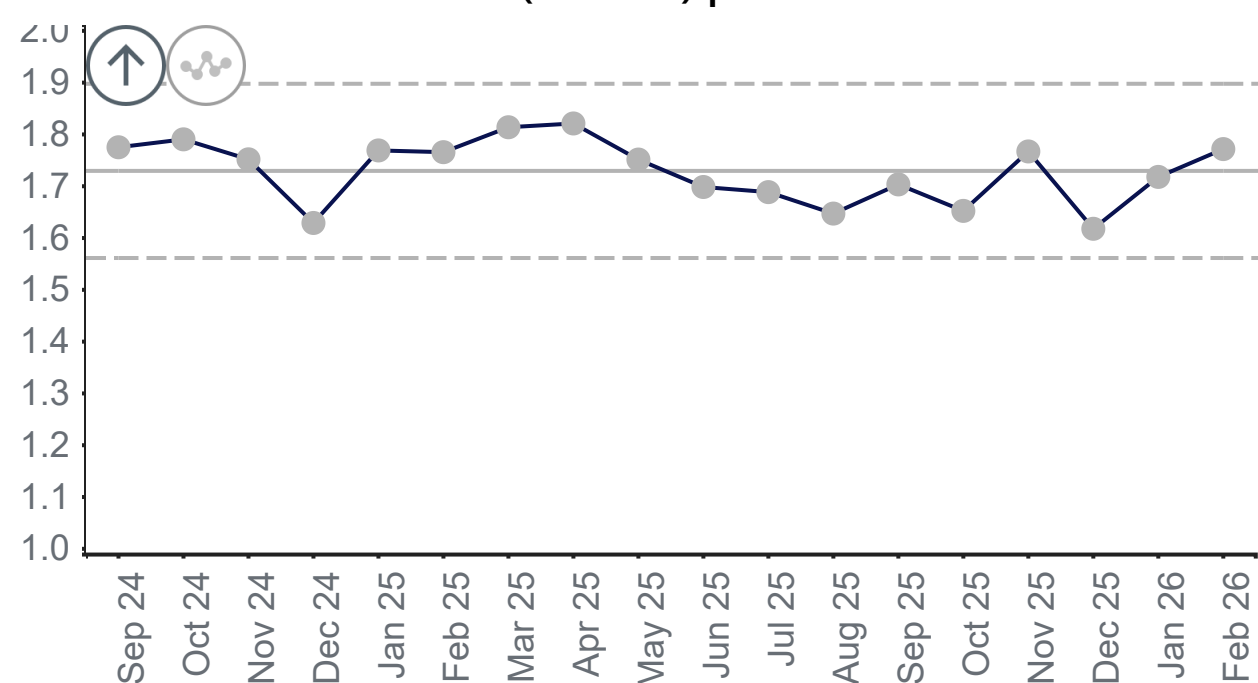
Technical Analysis:

Special cause variation with performance of 63.5% against a year end target of 63.1% by March 2026. This is an increase from January 2026 position of 62%. Dentistry, General Paediatrics and Plastic Surgery lowest performing of services with >100 waiters.

Actions:

The Trust was successful in Q4 outpatient bid and has gained funding for additional activity. Enhanced validation implemented. Referrals are logged on day one, and a focus on cashing up clinics for March. Optimised booking productivity scheme is ongoing.

Elective admissions (IP & DC) per clinical WTE



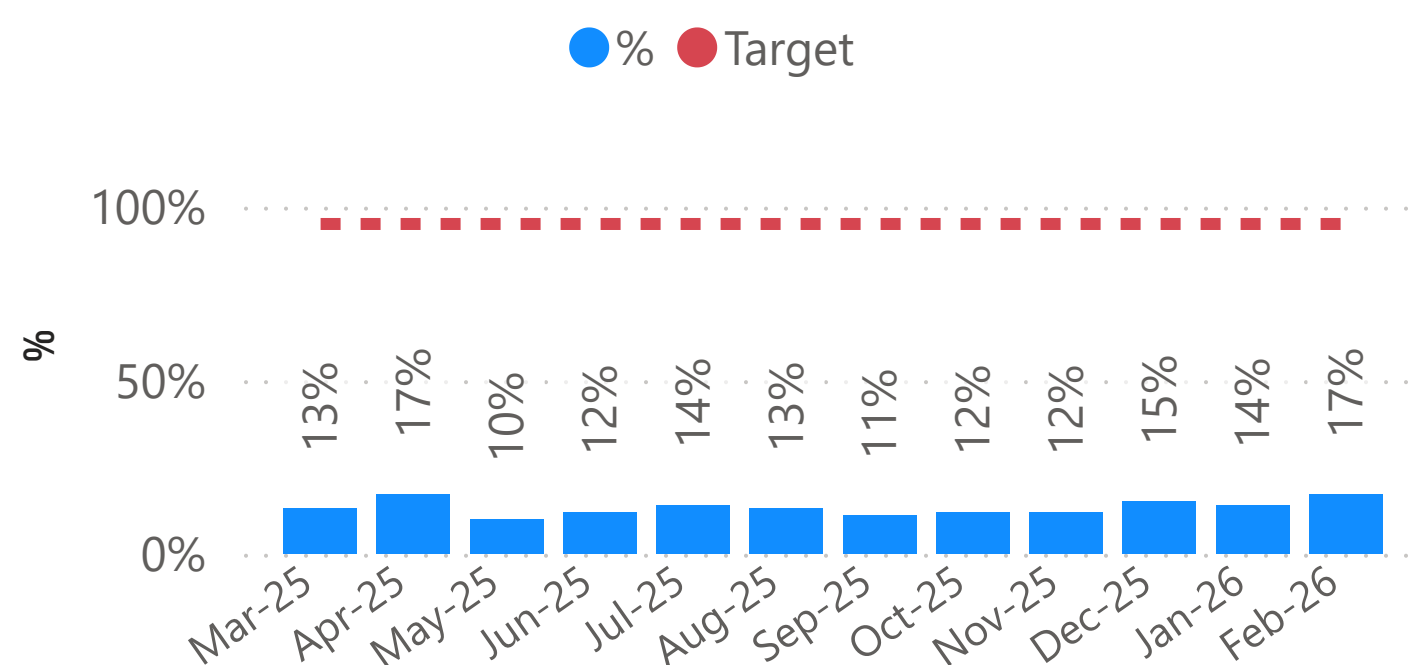
Technical Analysis:

Common cause variation has been observed with performance of 1.77 admissions per Clinical WTE (1600). Ratio mirrors February 2025 rate at 1.77.

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 began on 12th March, review is required.

Neurodevelopmental Assessment waiting list: % within 65 weeks



Technical Analysis:

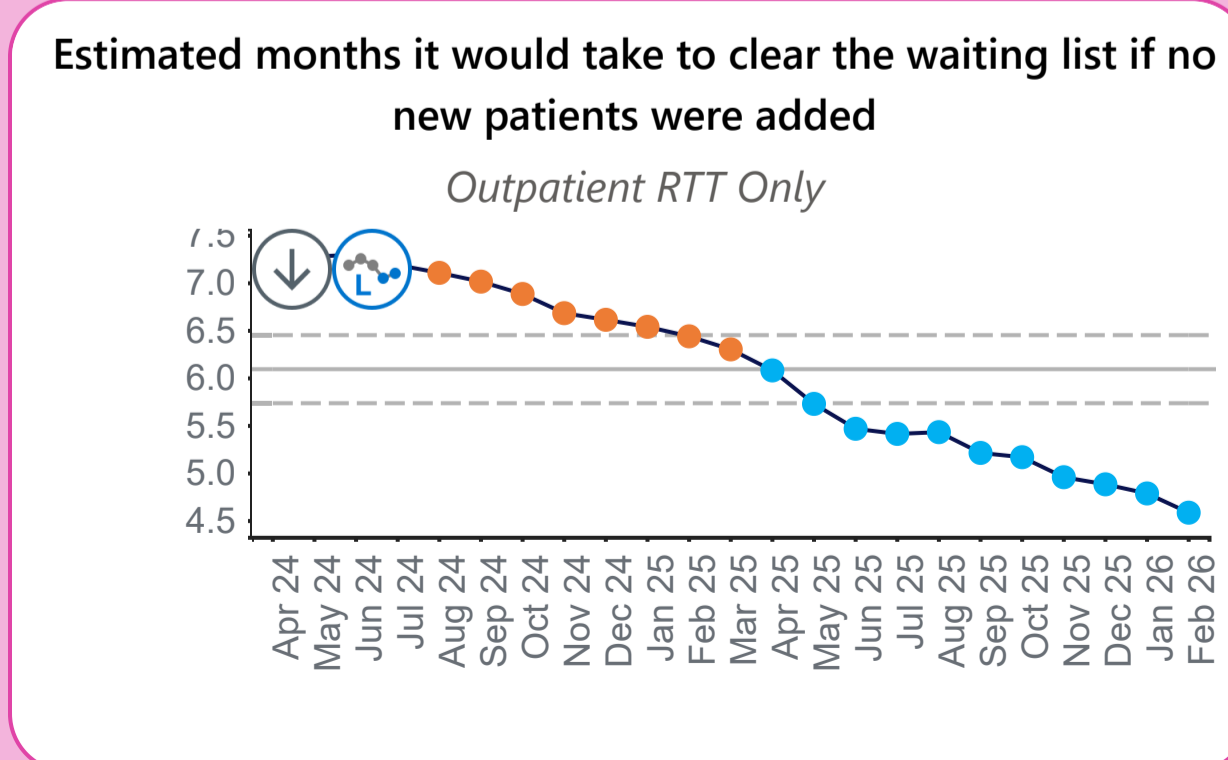
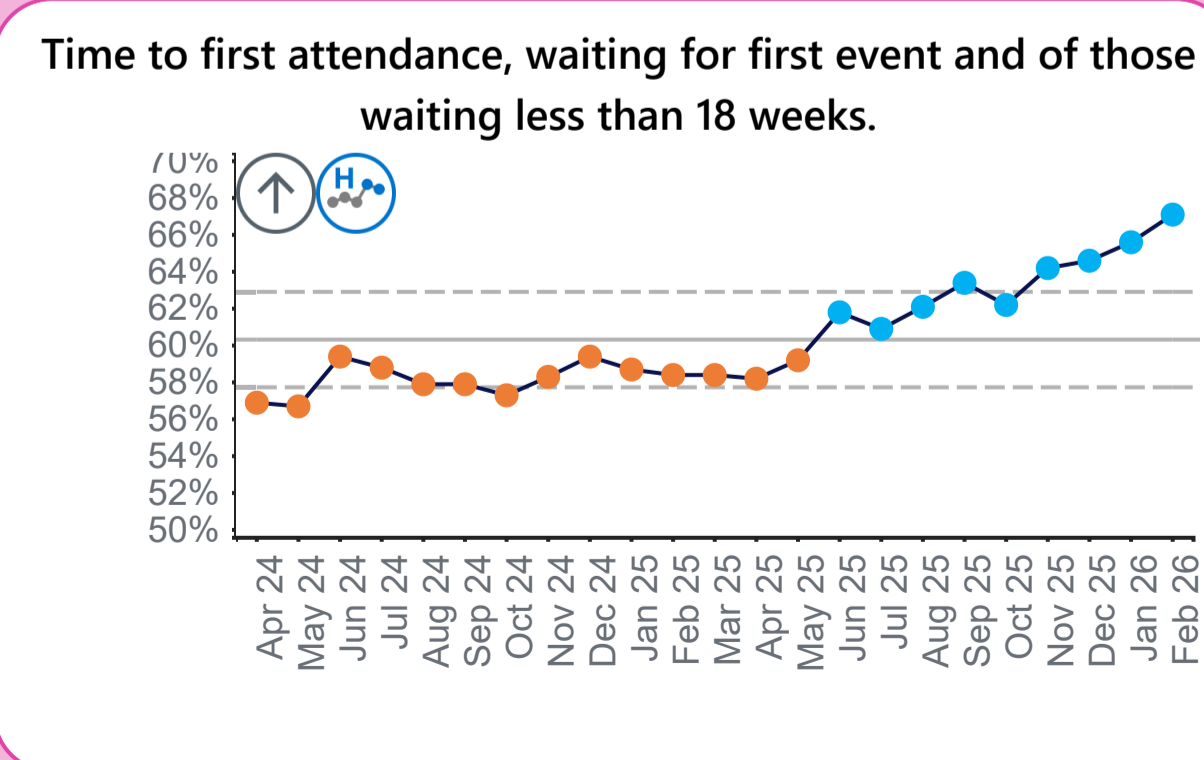
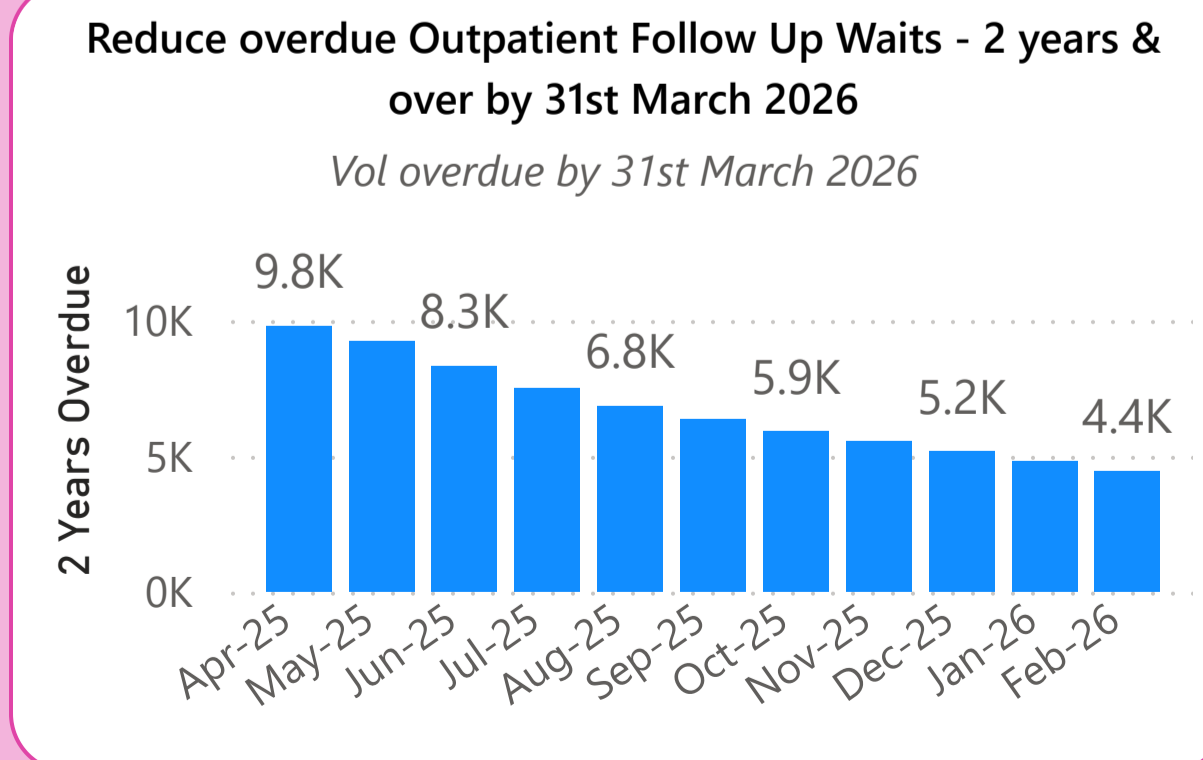
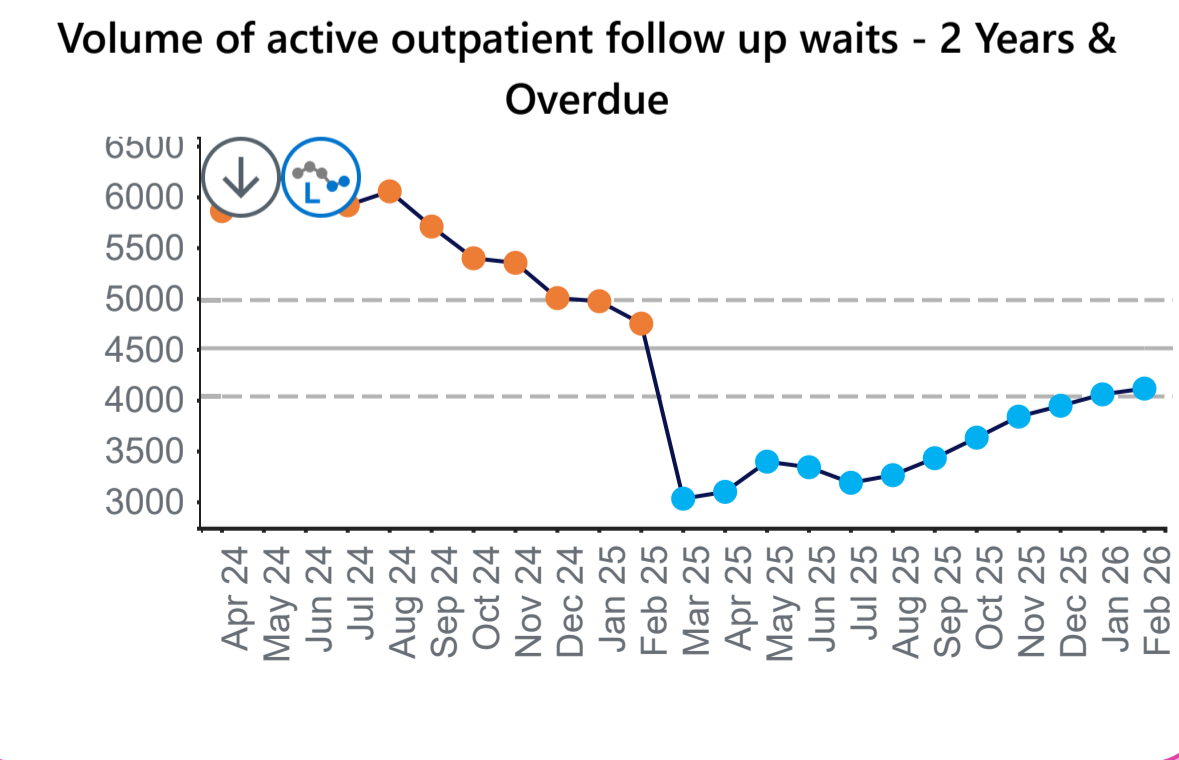
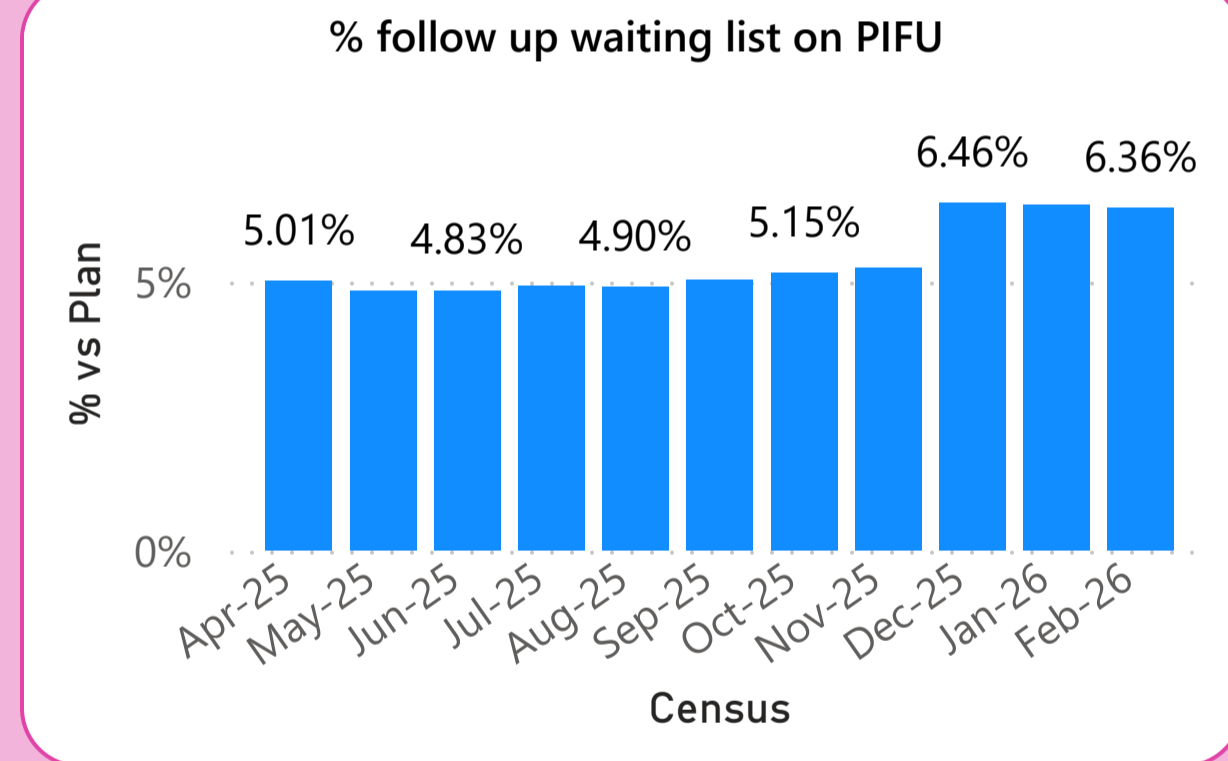
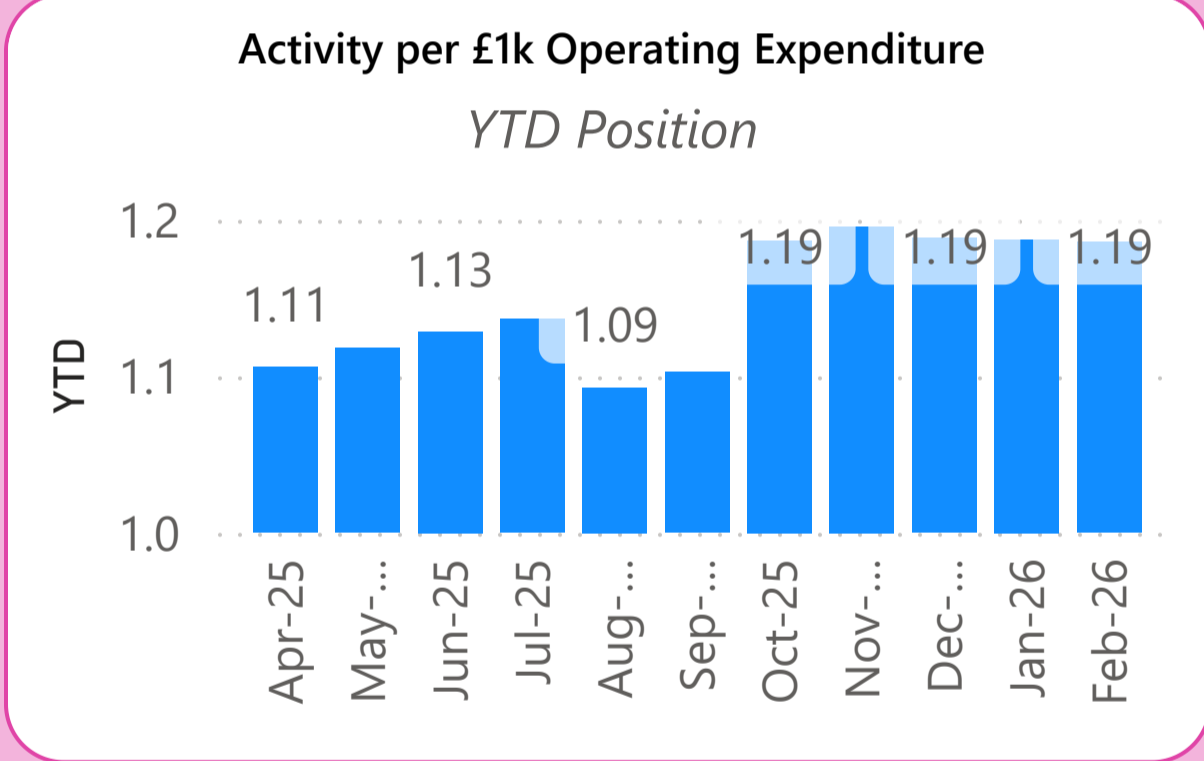
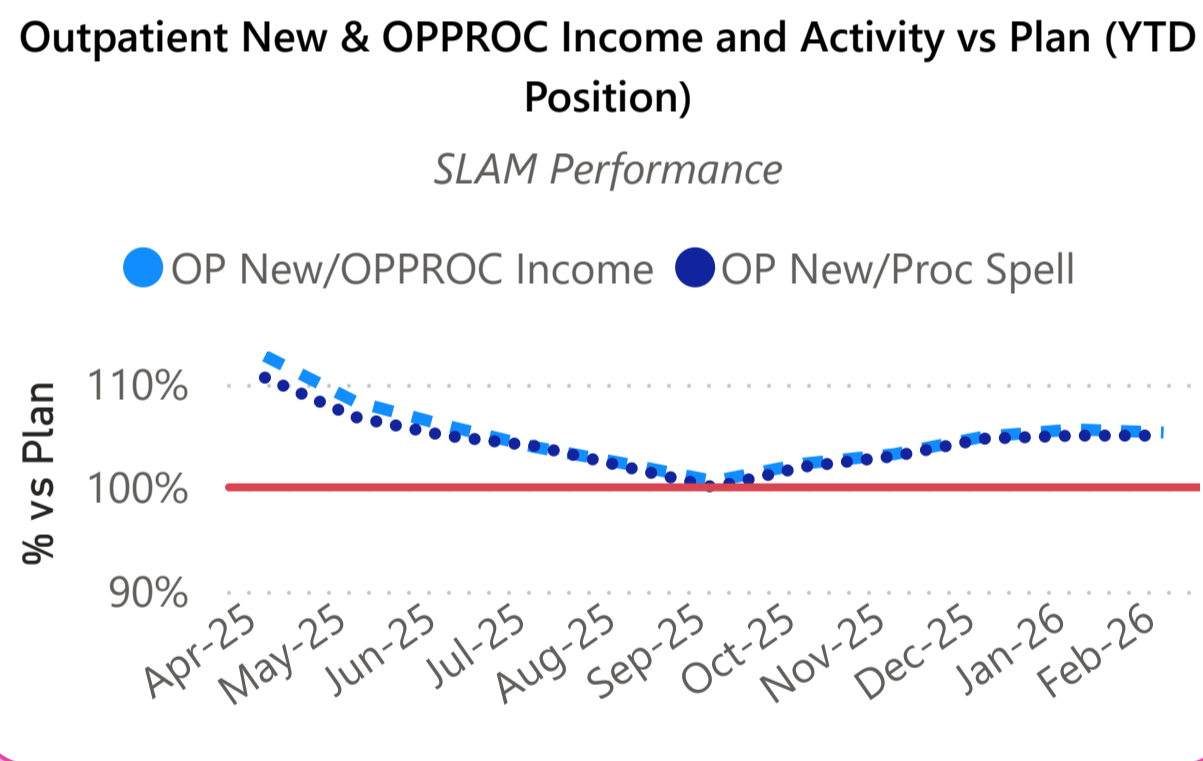
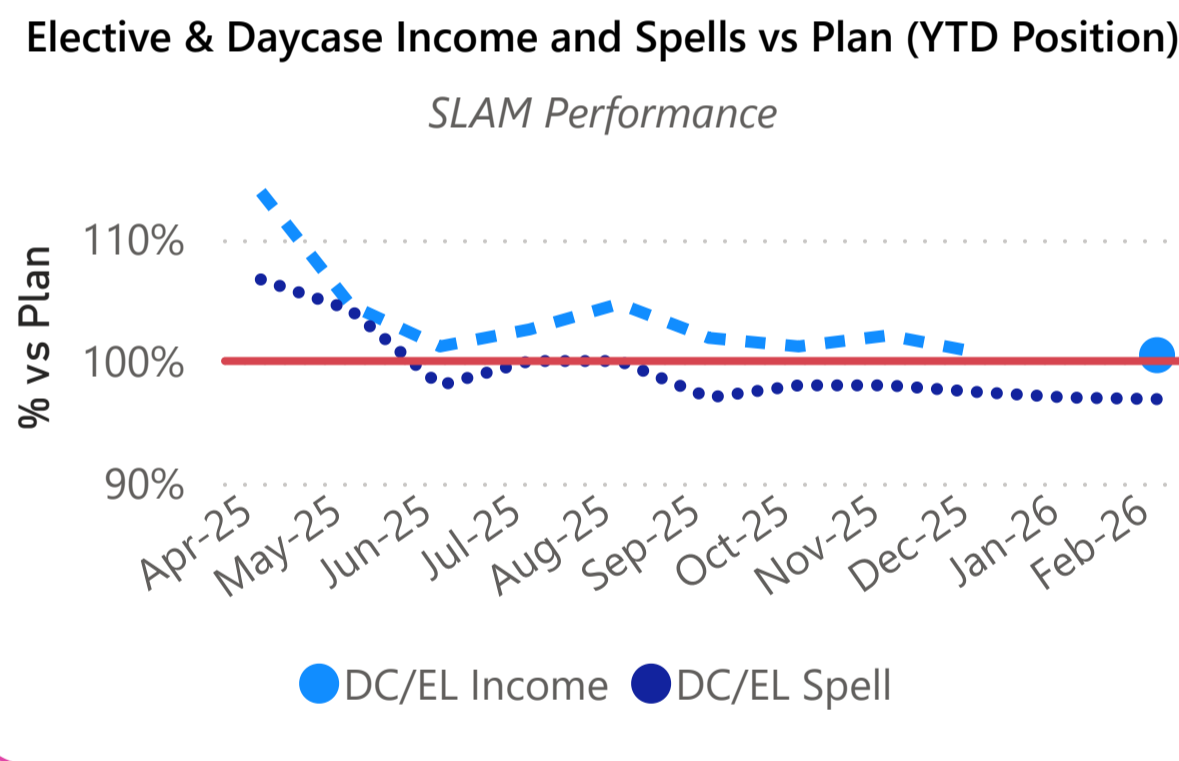
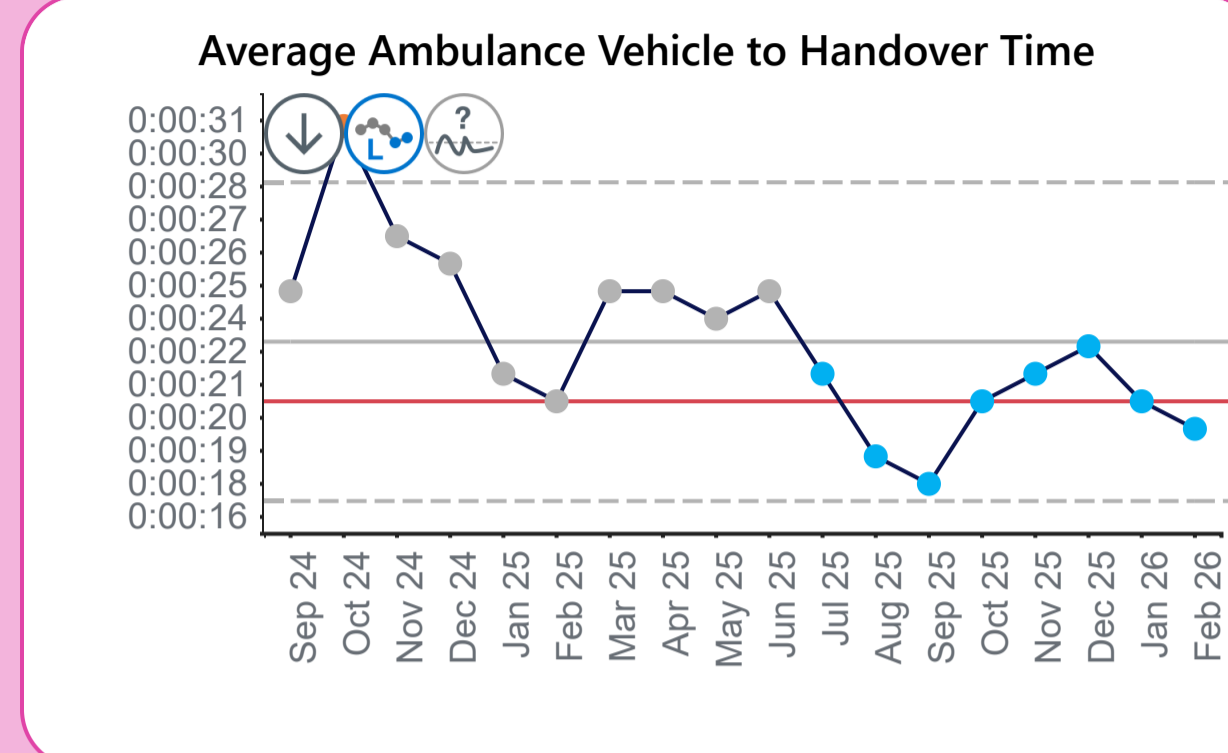
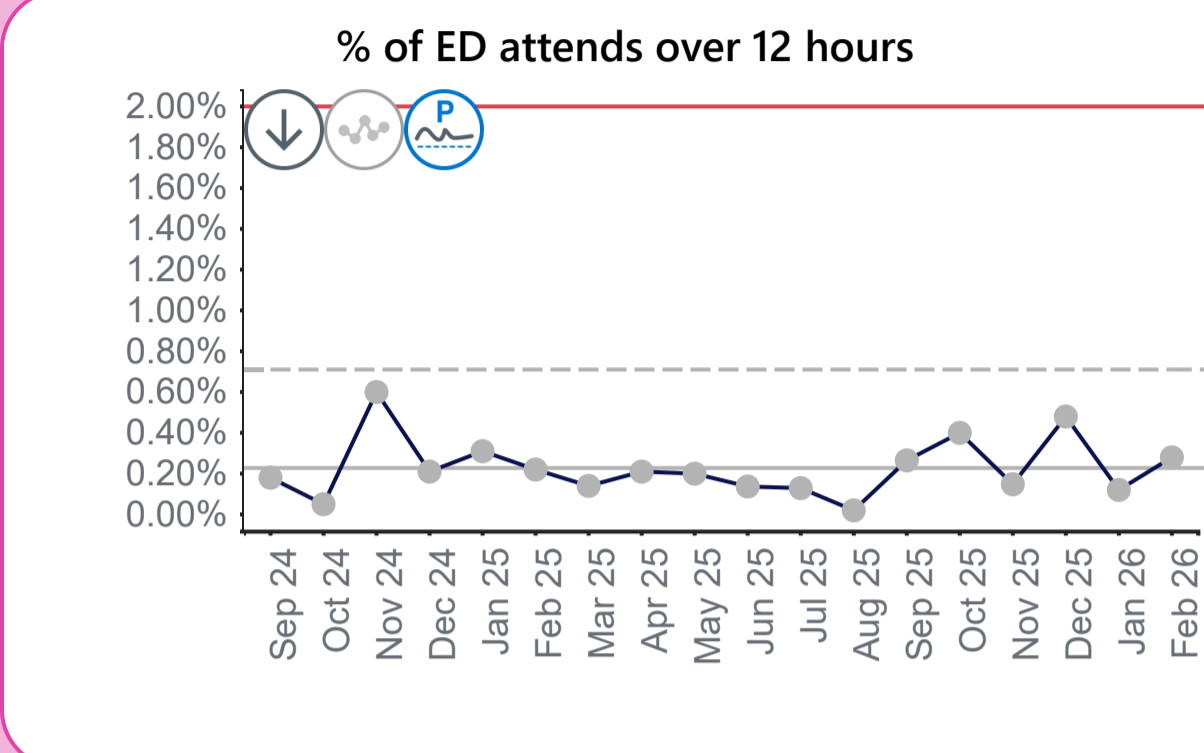
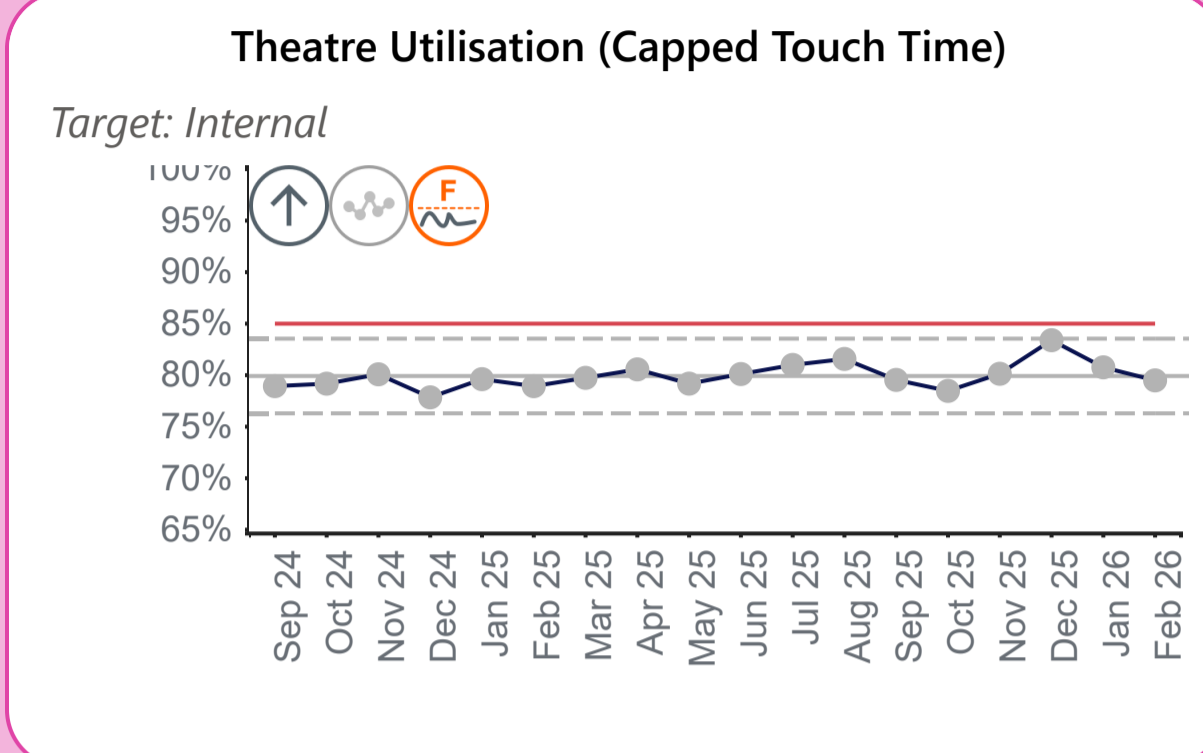
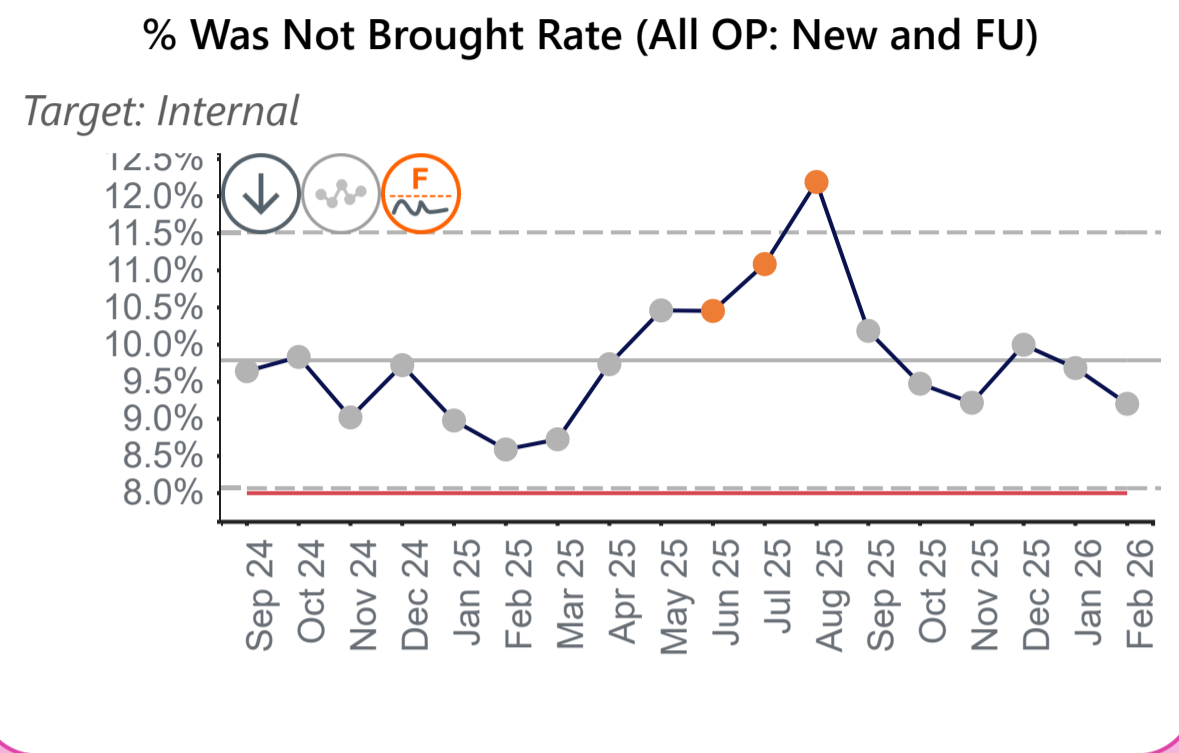
Performance at the end of February 2026 is 17% against a target of 95% which is a slight improvement on January's position.

Actions:

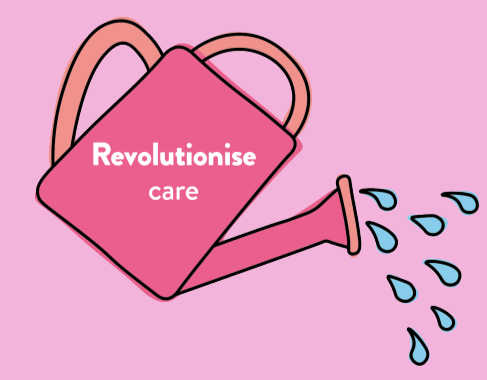
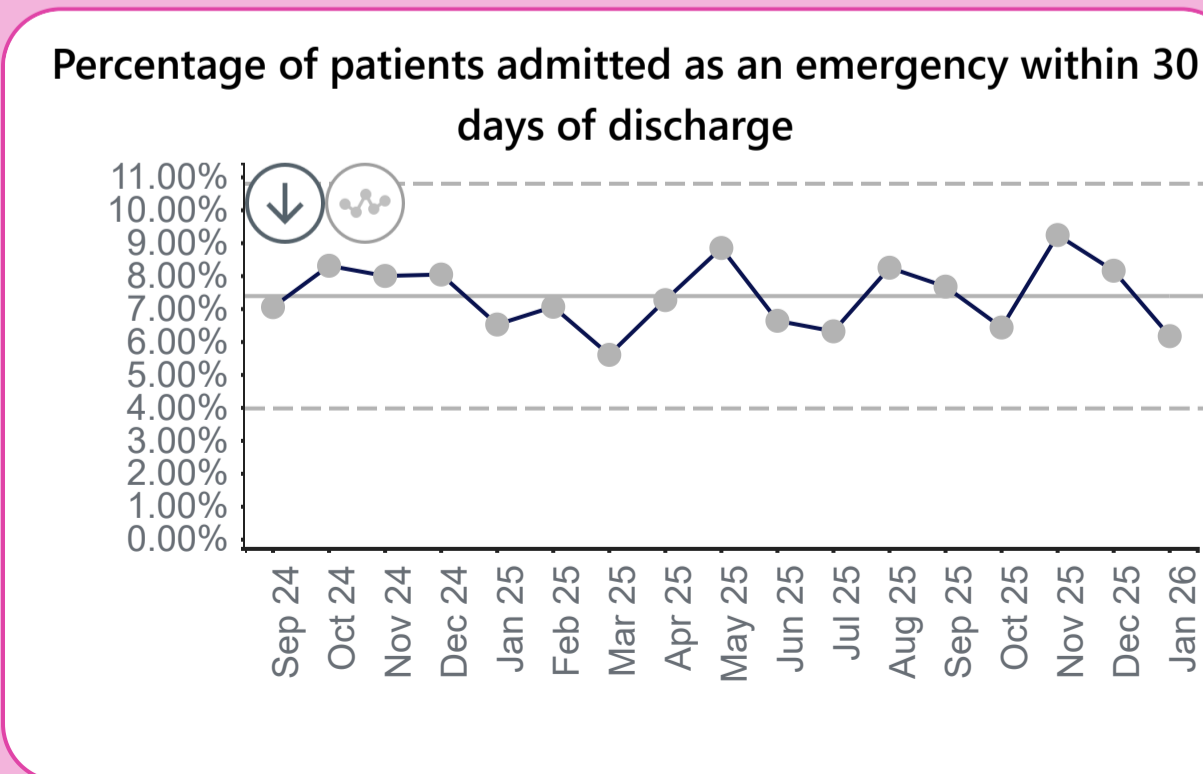
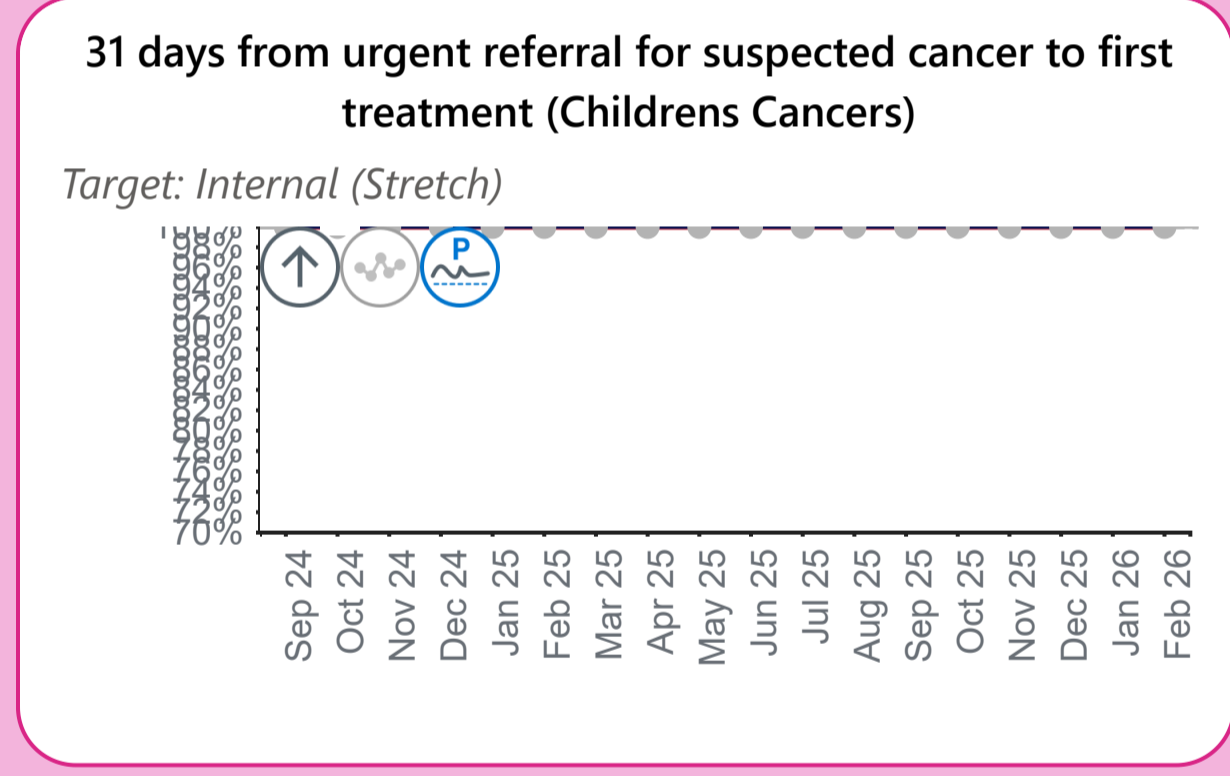
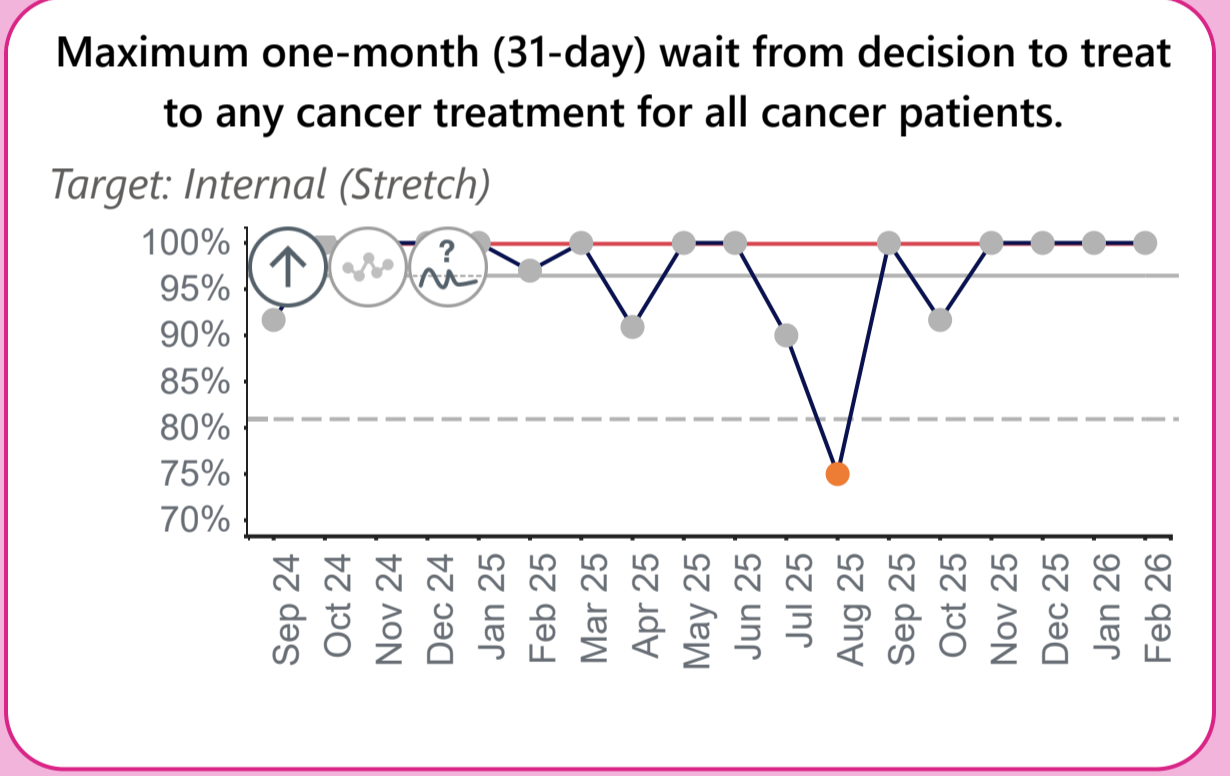
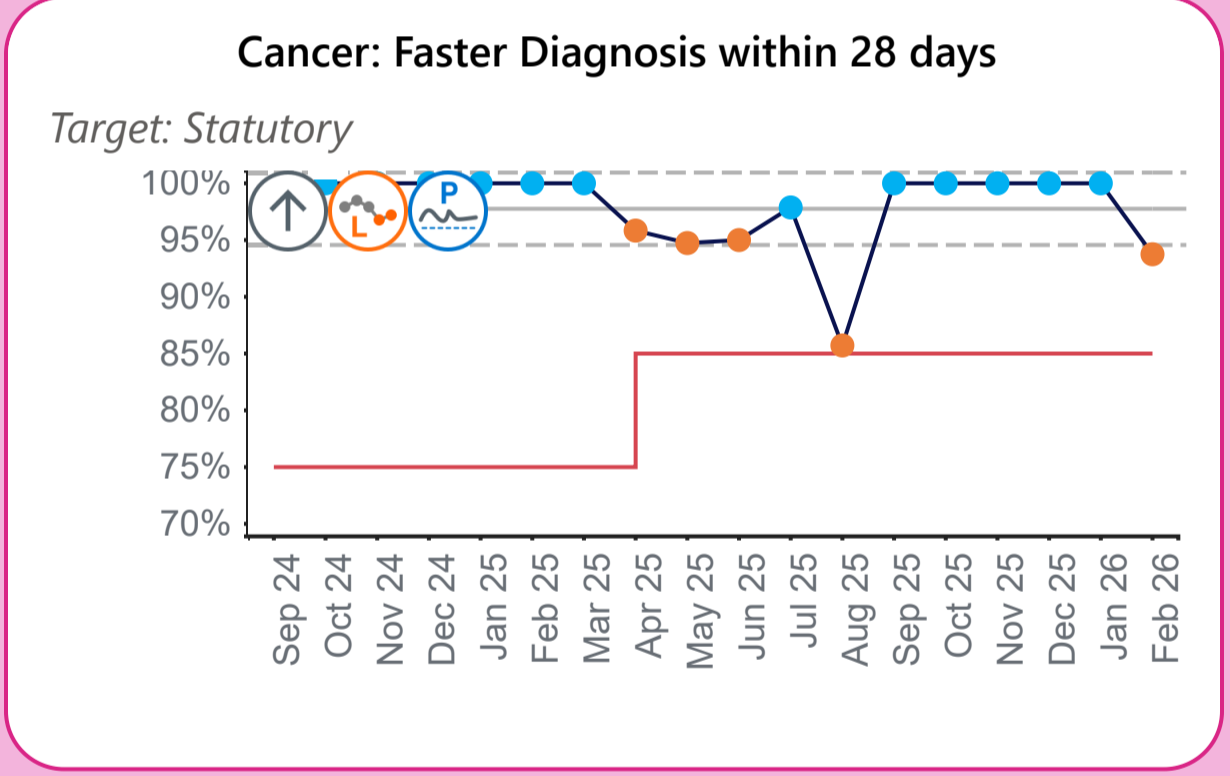
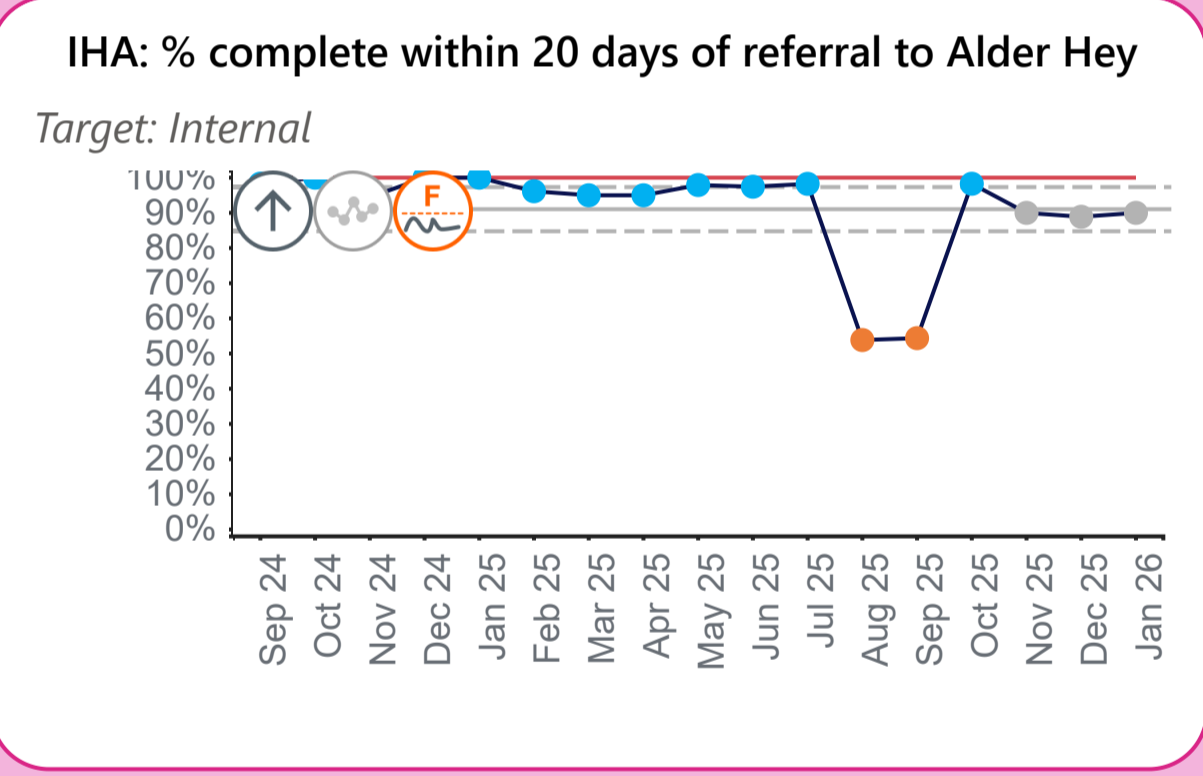
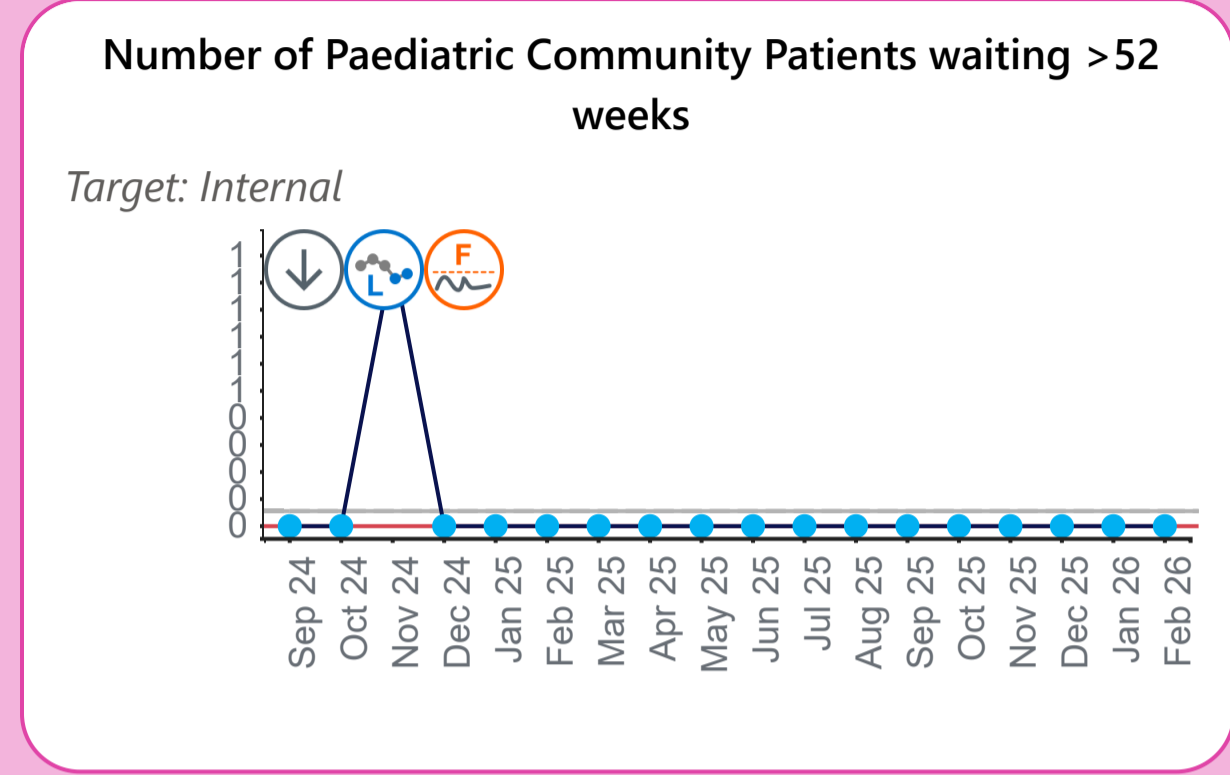
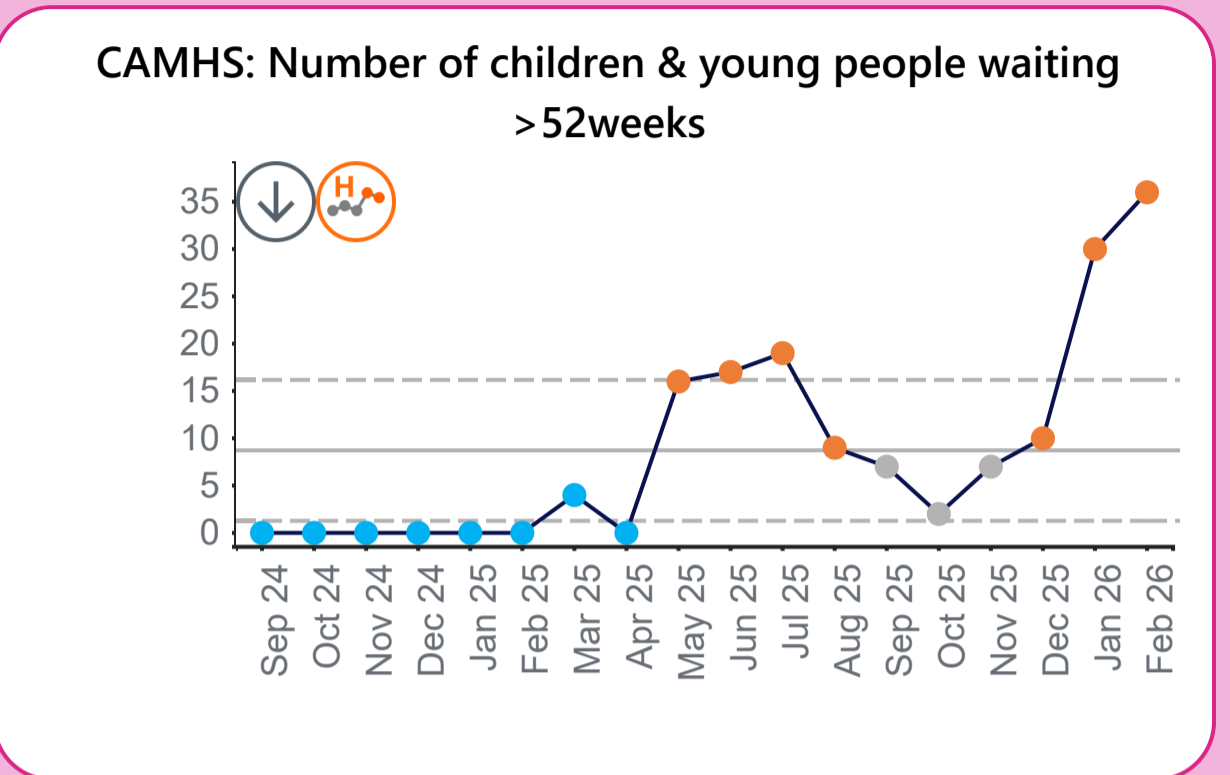
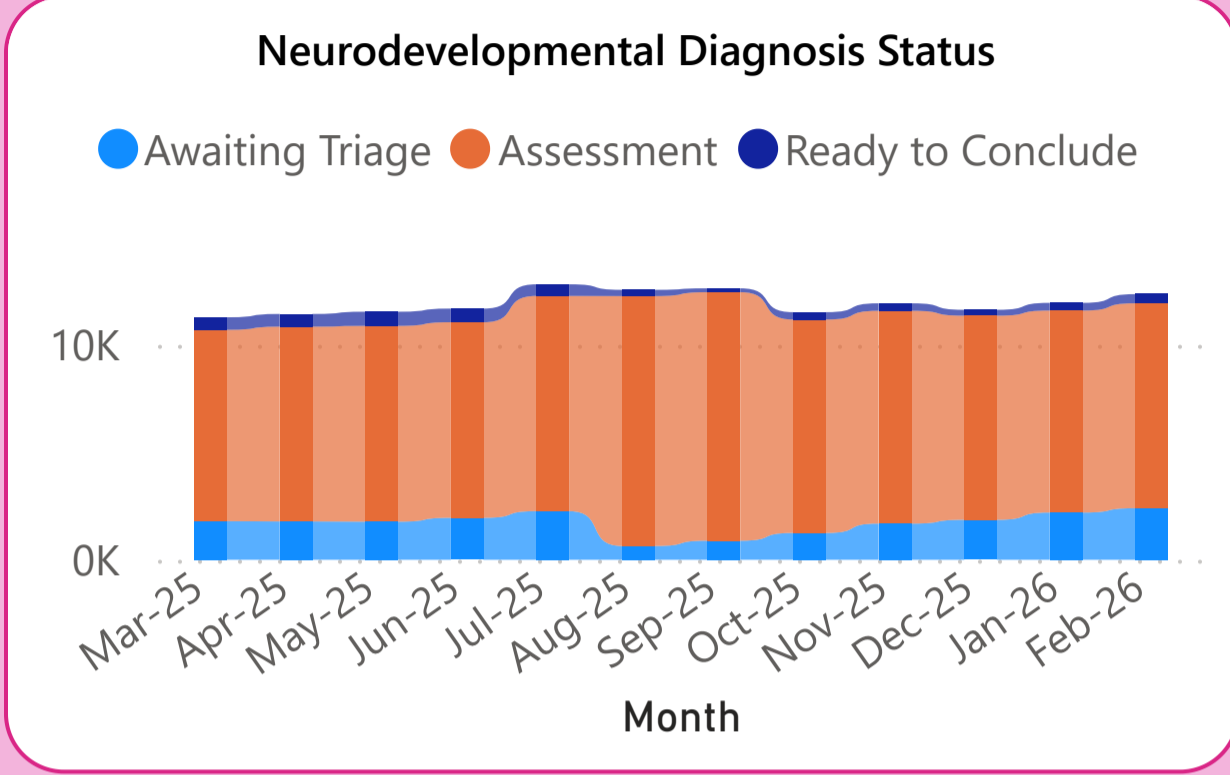
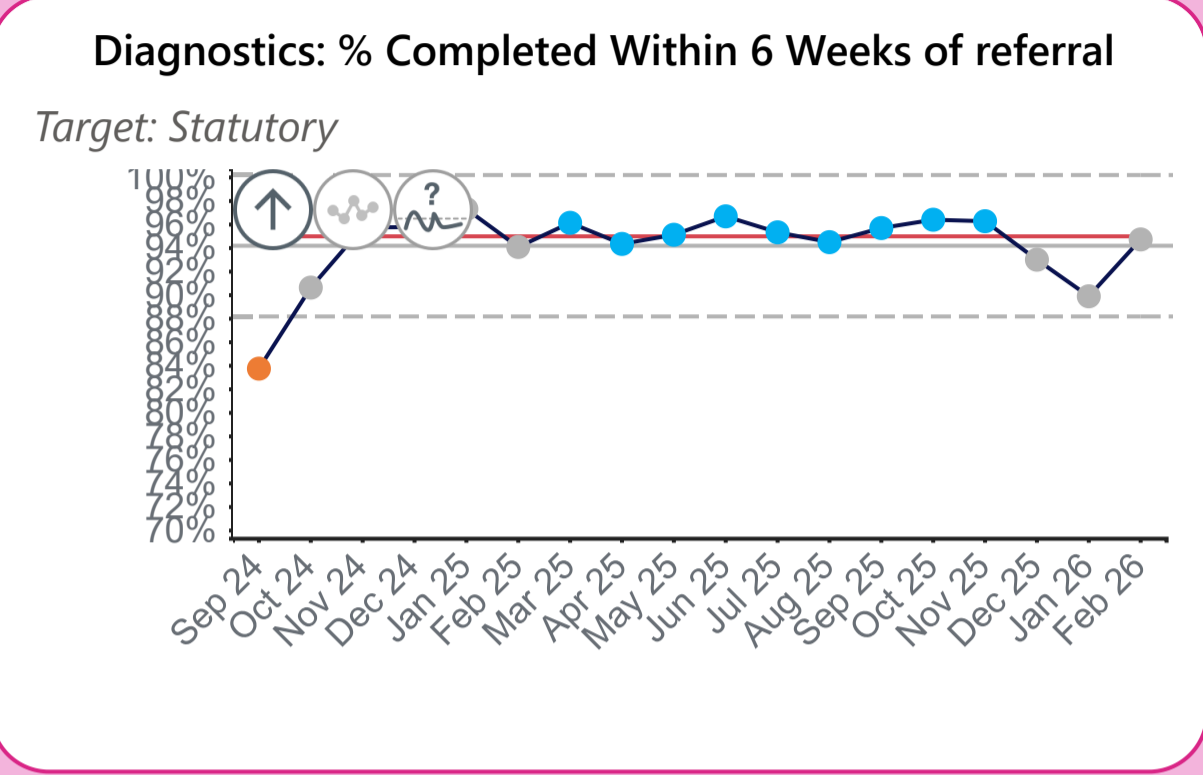
The new single neuro-developmental pathway went live Sept- 25. Evaluation is underway. Demand and Capacity work was completed January 2026; analysis is required to ensure resource is allocated correctly.



Revolutionise Care - Effective & Responsive - Watch Metrics



Revolutionise Care - Effective & Responsive - Watch Metrics



Support Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

- Mandatory training completion remains over 90%. Work is underway reviewing modules with lower compliance levels
- Long term sickness has reduced by >1% since the peak in December

Areas of Concern:

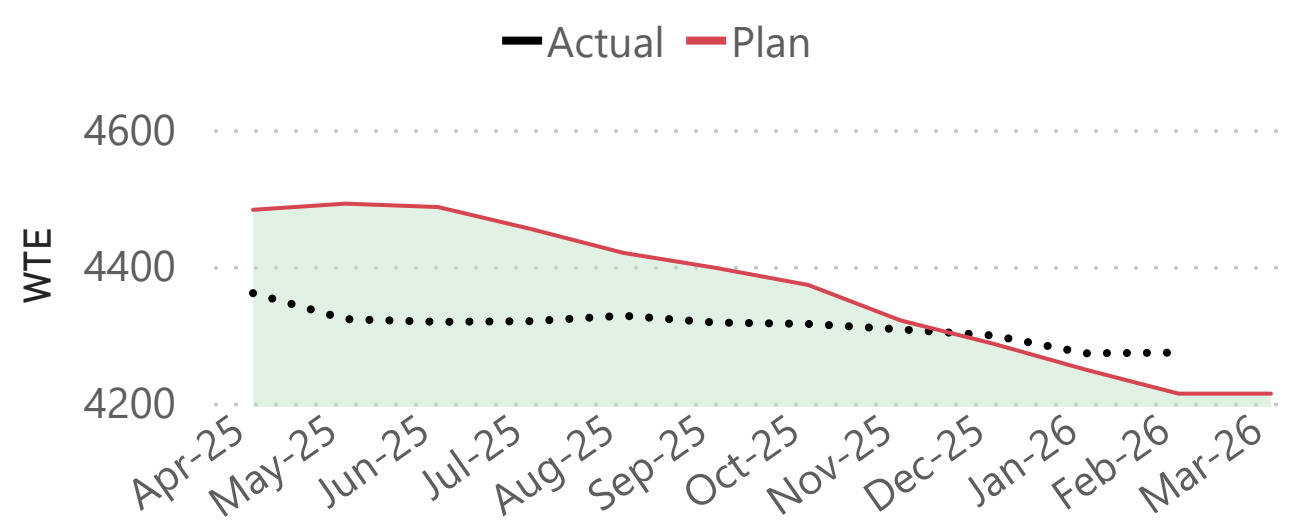
- Total workforce remains above plan. The voluntary redundancy scheme has now been launched, and plans have been submitted to achieve further reductions in 2026/27 • While long term sickness absence has reduced, short-term sickness has jumped up in month. As reported to People Committee, actions remain underway to support sickness absence reductions across the Trust.

Forward Look (with actions)

- Completion of B7+ PDRs has continued to steady increase, currently at 89%, with completion of all PDRs at 75%. L&D colleagues continue to support managers to achieve PDR completion. The new PDR App has been launched to support capturing and recording of PDR data.

Total Workforce - WTE

Target: Internal 24/25



Technical Analysis:

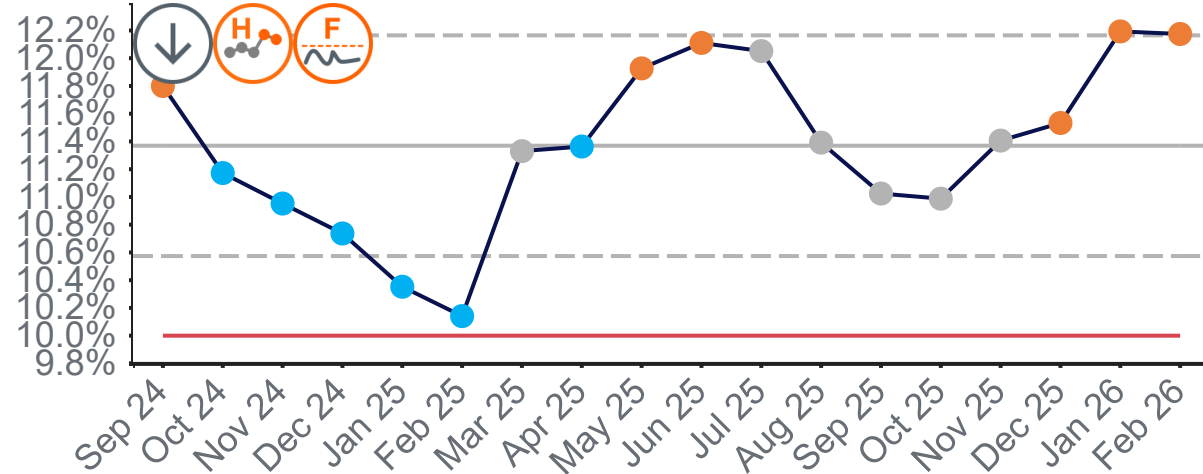
Total workforce for the end of February 2026 was 59.8 WTE above plan. M11 Total workforce was 4,273.09, against a plan of 4,213.31

Actions:

While the WTE position remains above plan, progress has been made through the recent MARS programme, non-clinical recruitment freeze, and ending of fixed term contracts. Overtime spend increased marginally in February; the increase in bank spend and WTE was more significant, with a notable increase in PICU spend.

Staff Turnover

Target: Internal



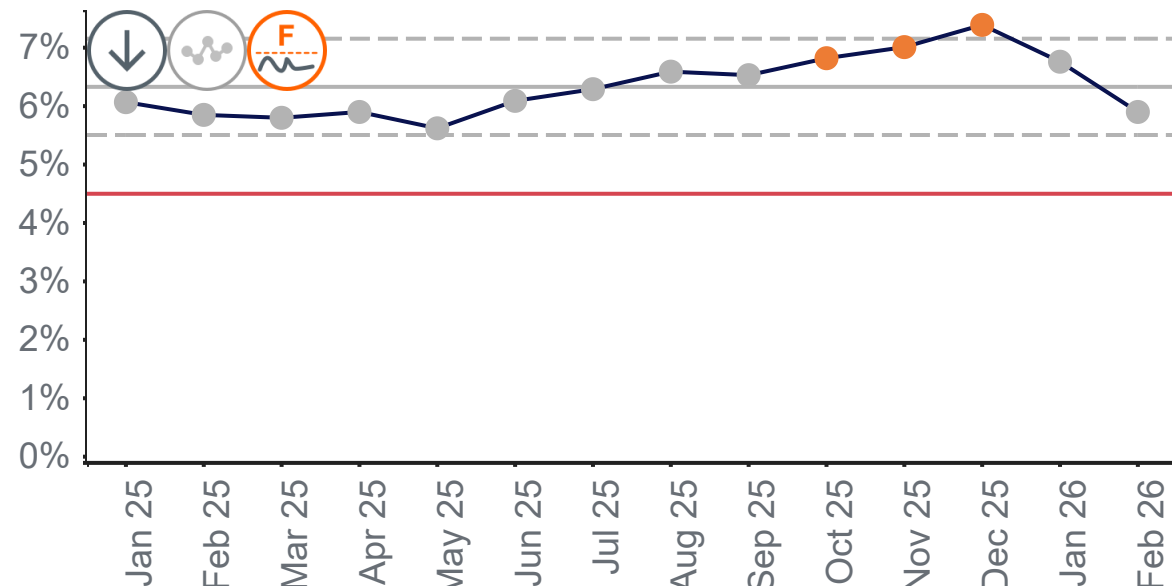
Technical Analysis:

Special cause variation of cause observed with performance of 12.2% in February 2026 against an internal target of 10%. Same performance as January 2026. Consistently failing metric.

Actions:

Turnover remains above target due to the end of fixed term contracts and colleagues leaving on MARS. This figure is anticipated to remain above target, with leavers on the voluntary redundancy scheme expected to exit in M12 and early 26/27. There are no changing trends amongst voluntary reasons for leaving.

Sickness Absence Overall



Technical Analysis:

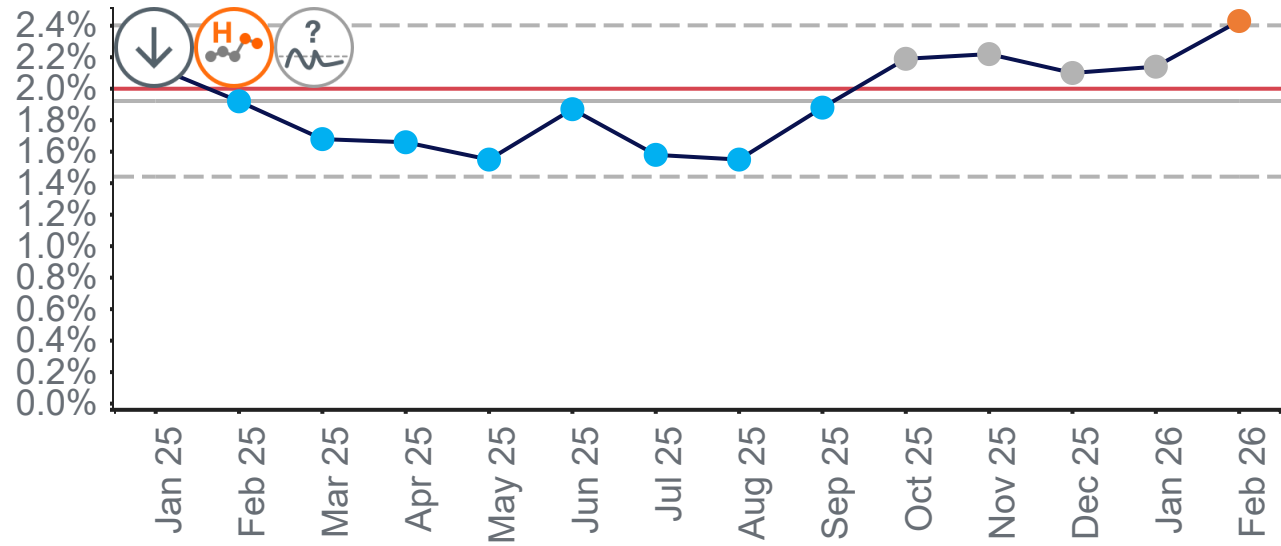
Special cause variation of concerning nature observed. Total sickness absence in February 2026 is 5.90% which is above the 5% target, a 0.86% decrease from January 2026 at 6.76%. February 2026 performance comprises STS at 2.43% and LTS at 3.47%. Monthly target being 4.5% in 2025/2026.

Actions:

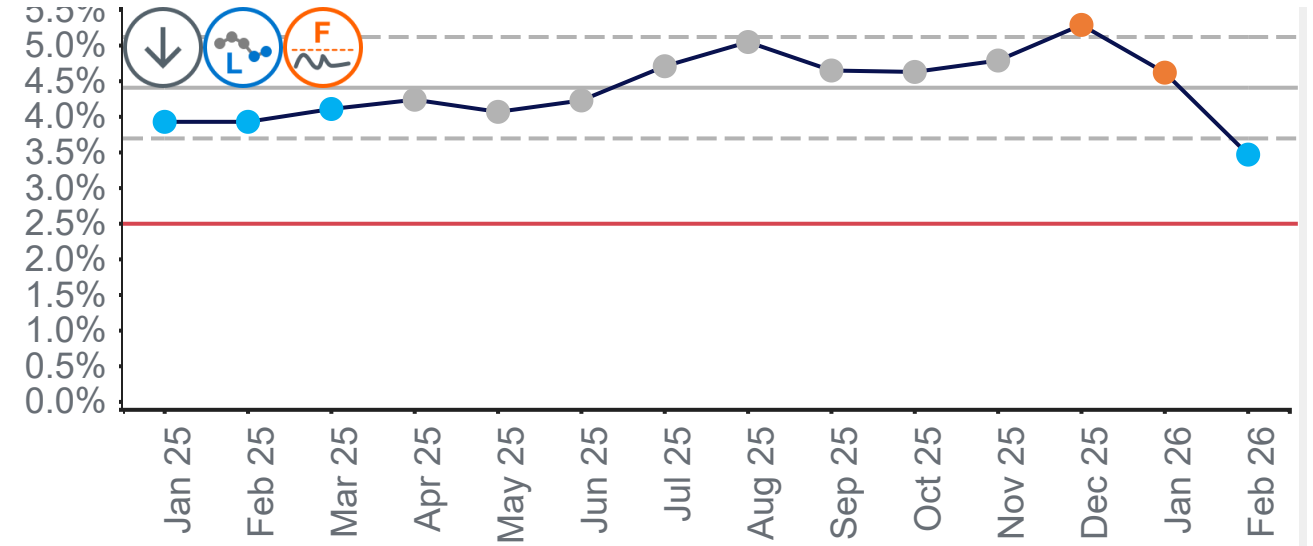
Following targeted support for LTS, there is a notable improvement in the position. Focus remains on prevention, working with SALS, OH & TU colleagues, with support for reasonable adjustments, management training, and targeted support for areas with higher absence to support both short- and long-term absence.

Supporting Our People - Watch Metrics

Short Term Sickness

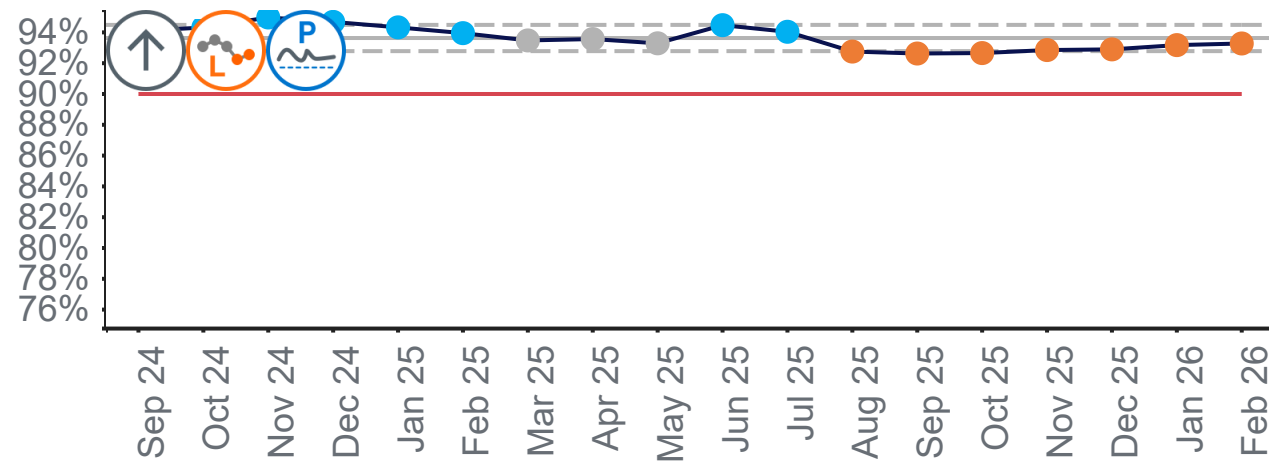


Long Term Sickness

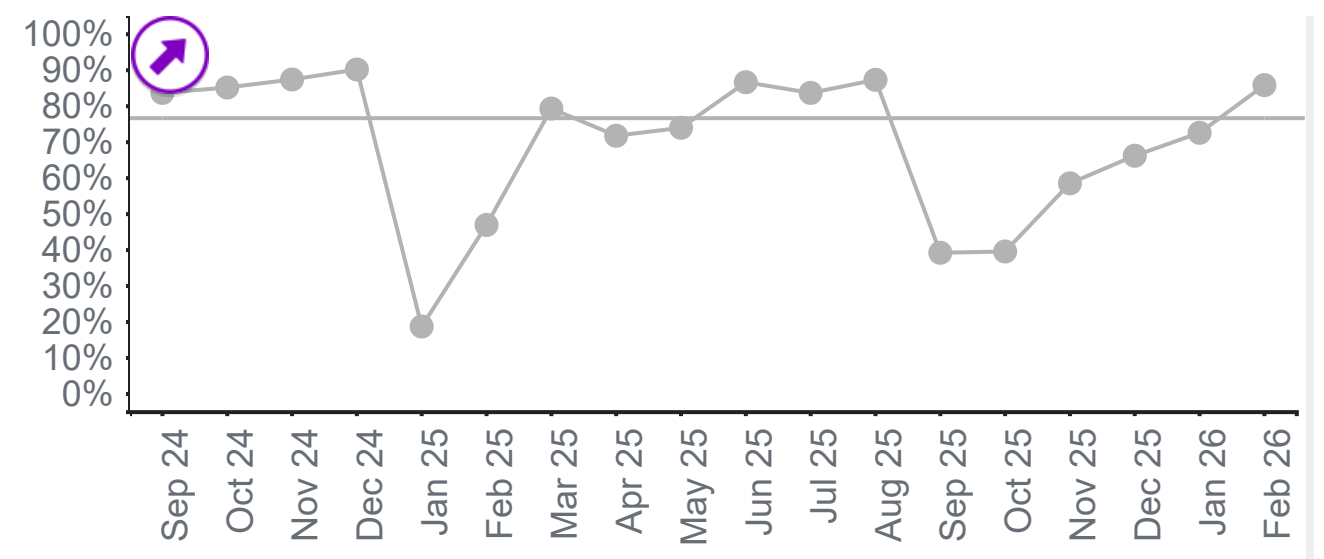


Mandatory Training

Target: Internal

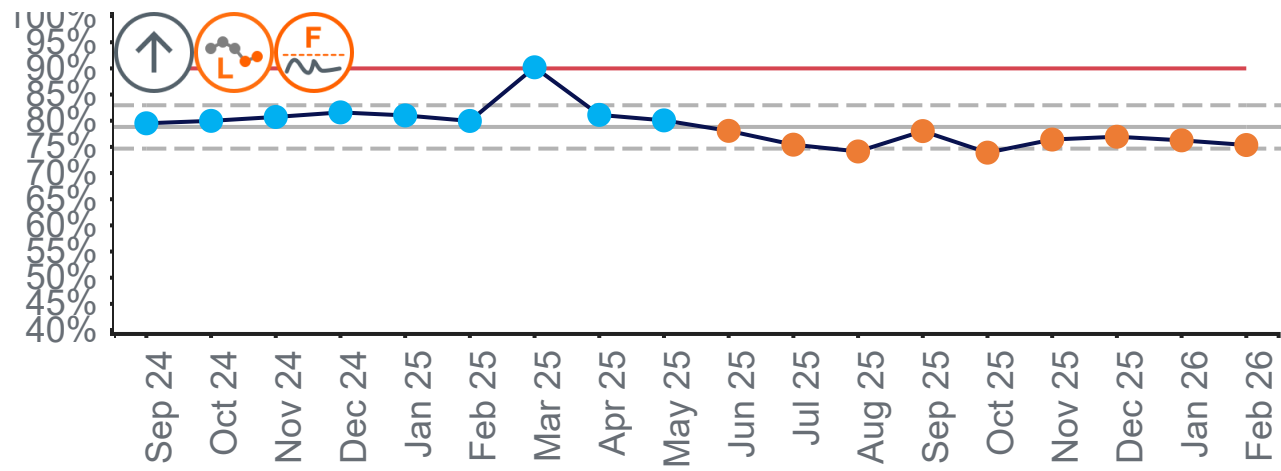


Medical Appraisal

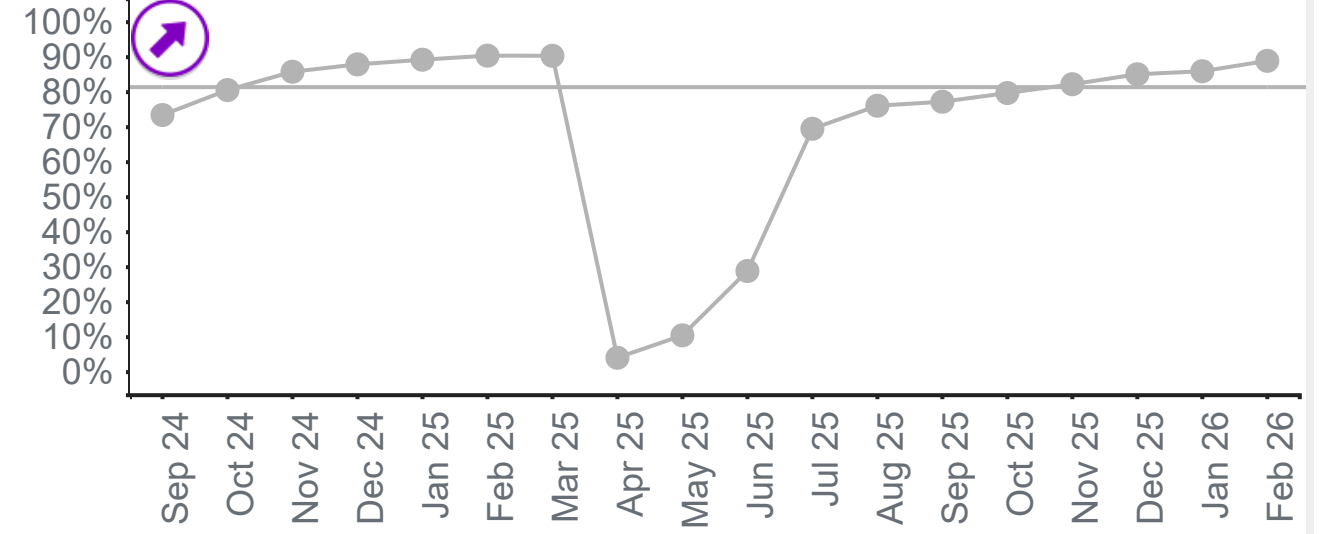


% PDRs Completed (Rolling 12 Months)

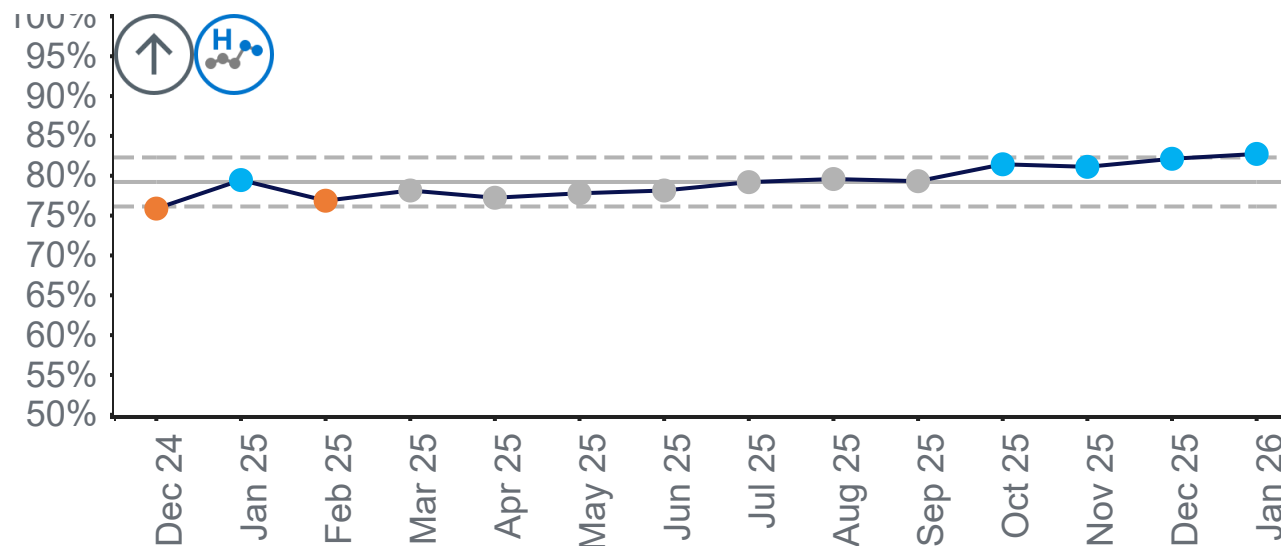
Target: Internal



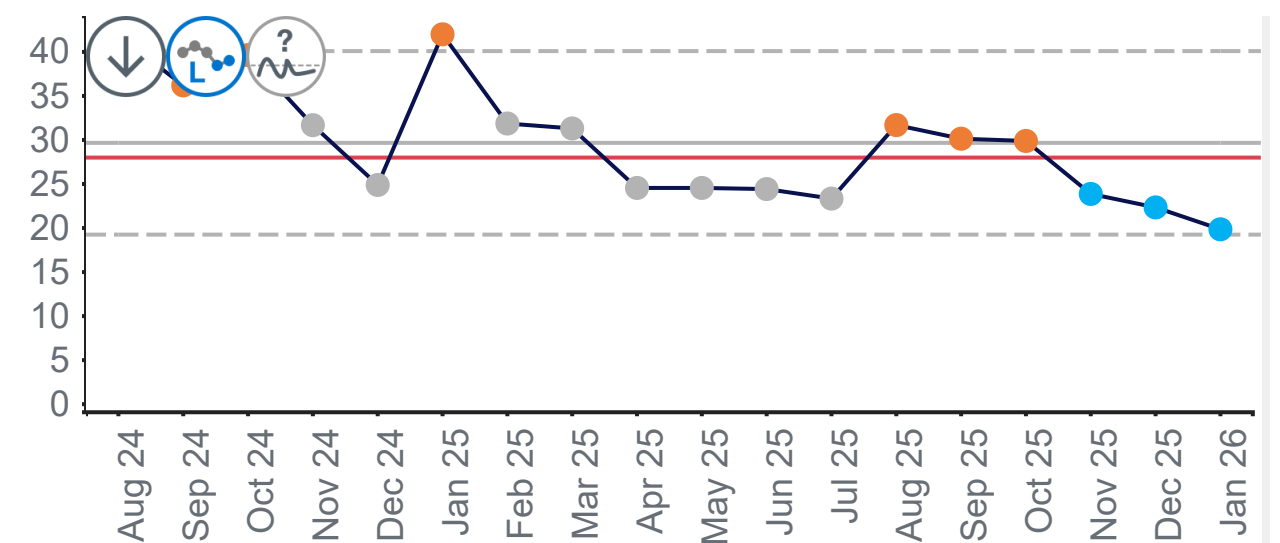
PDR B7+ Completed (Rolling 12 Months)



Workforce Stability



Average Time to Hire





Pioneering Breakthroughs

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

Highlights:

- Increased commercial research income and benefit from regional transformation funding for AVT have improved the financial position with a forecast surplus • Internal strategic funding call focused on health equity has closed with 8 applications received across a range of specialities – review panel meeting on 24th March • Research PPIE Officer recruited and starting in early April • Paediatric Open Innovation Zone presentation delivered at Children's Hospital Alliance Conference creating further networking opportunities • Staff now in post for the Charities Together funded project for developing the Was Not Brought tool for vulnerable populations

Areas of Concern:

- 3rd MRI income targets remain a concern but financial pressures have been mitigated by increased commercial research income • Strategic funding applications to NIHR Regional Delivery Network unsuccessful but positive feedback received including encouragement to work more closely with RMCH – a meeting is being set up with RMCH to discuss opportunities • Progress with development of Secure data Environment utilising POIZ capital funding is delayed however work is underway to scope the project with Telefonica (in partnership with the digital team)

Forward Look (with actions)

- Innovation 10-year celebration taking place on 19th and 20th March with attendance from the Children's Commissioner and the Metro Mayor • Plans underway to transfer RPA team to digital for more effective oversight and capacity building

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

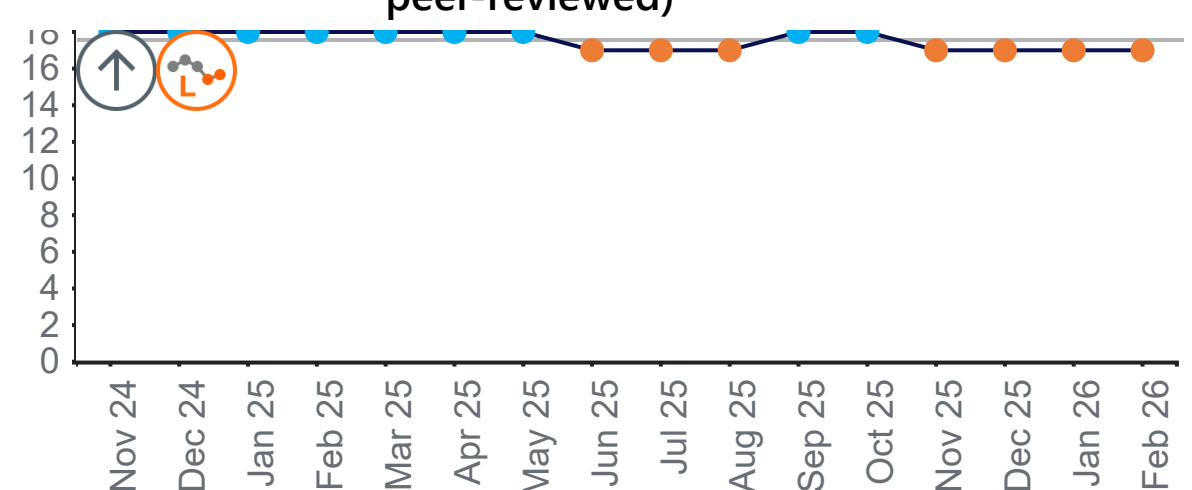
Technical Analysis:

Under Review

Actions:

Under Review

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

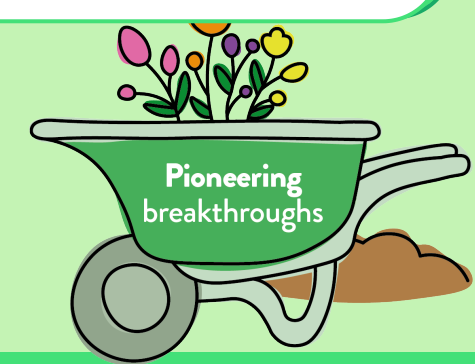


Technical Analysis:

Number of AH Chief Investigators leading NIHR portfolio studies

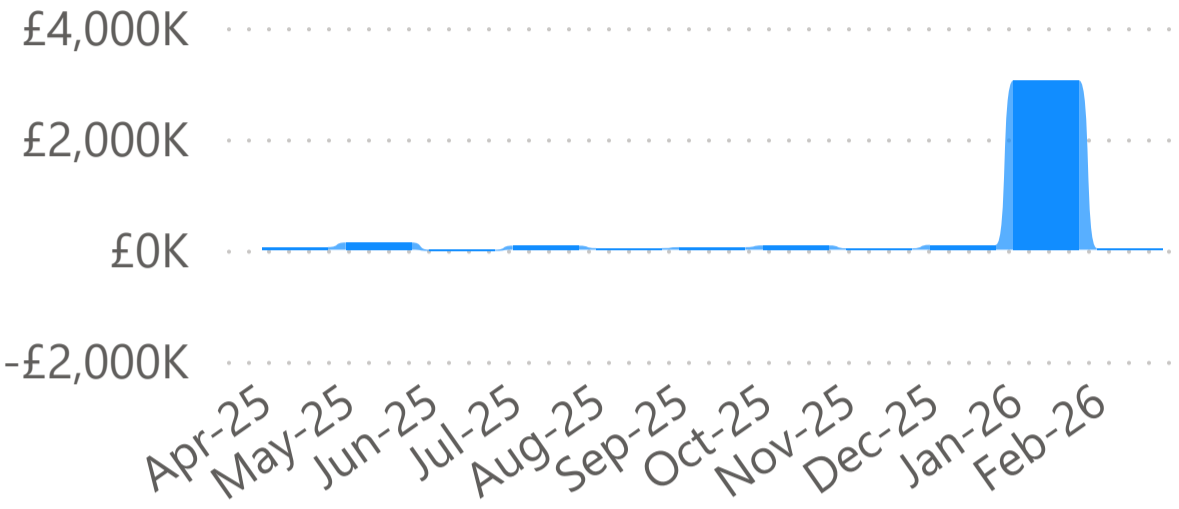
Actions:

This number remains stable. The internal strategic funding allocation will support further developments in this area.

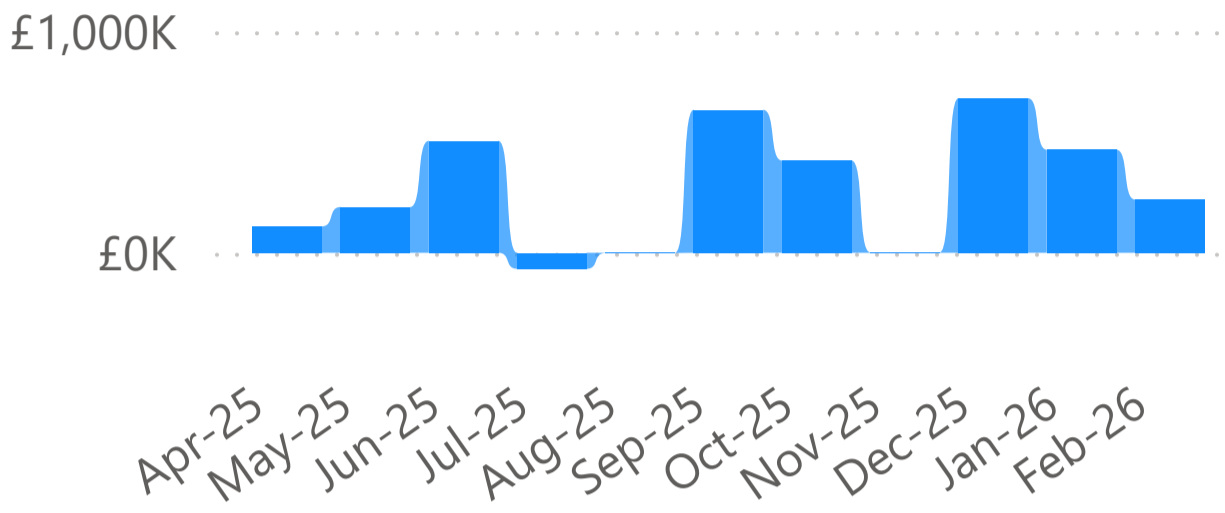


Pioneering Breakthroughs

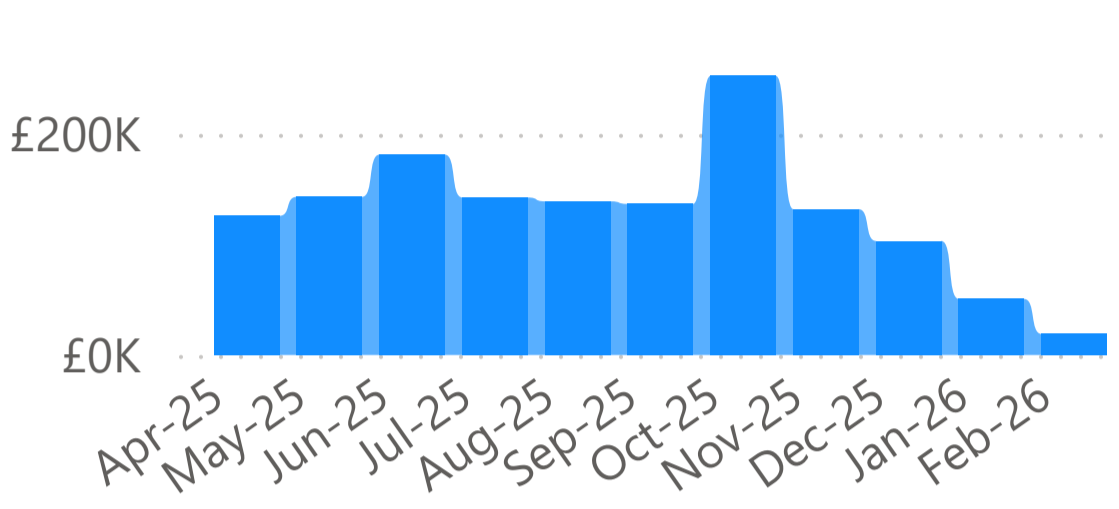
External innovation income received by month (commercial and non-commercial)



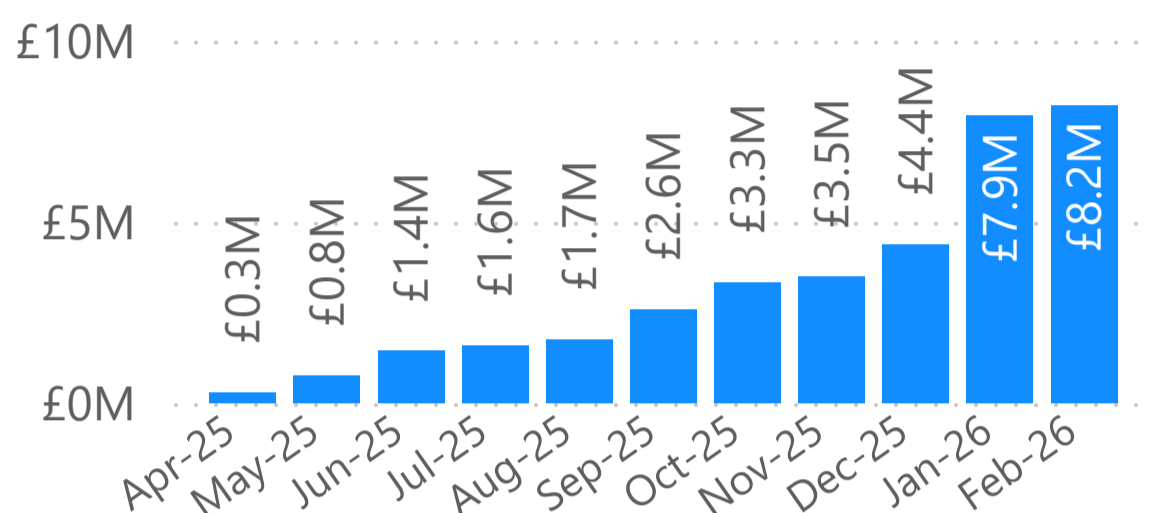
External research income received by month (commercial and non-commercial but excluding NIHR)



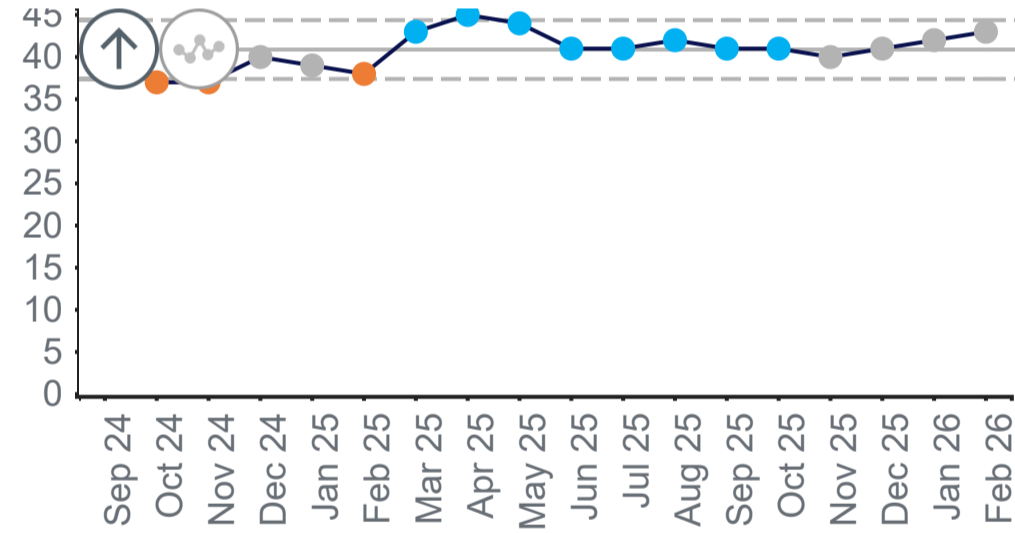
NIHR grant income by month (AH hosted NIHR awards only as these attract Research Capability Funding)



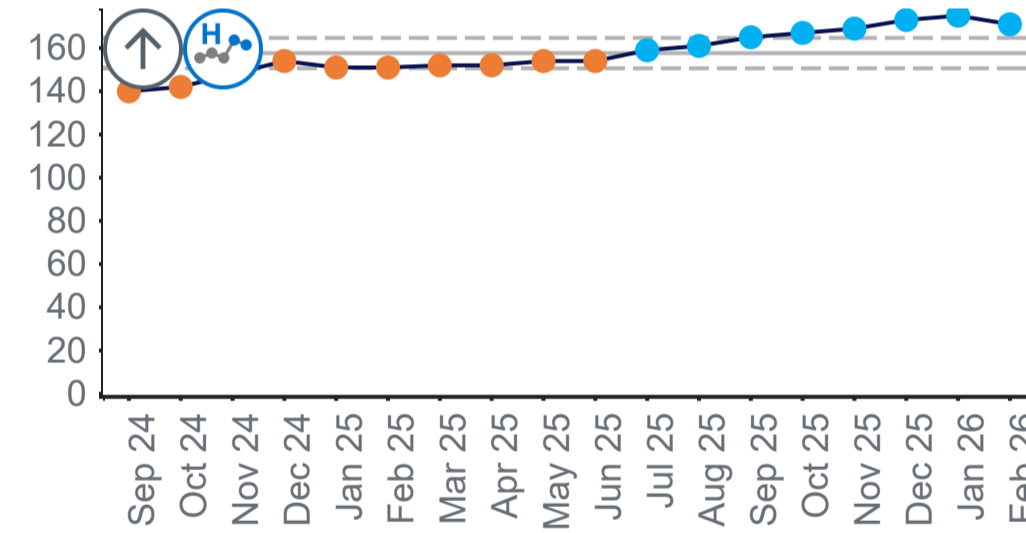
External income received by month across Research and Innovation (YTD Cumulative)



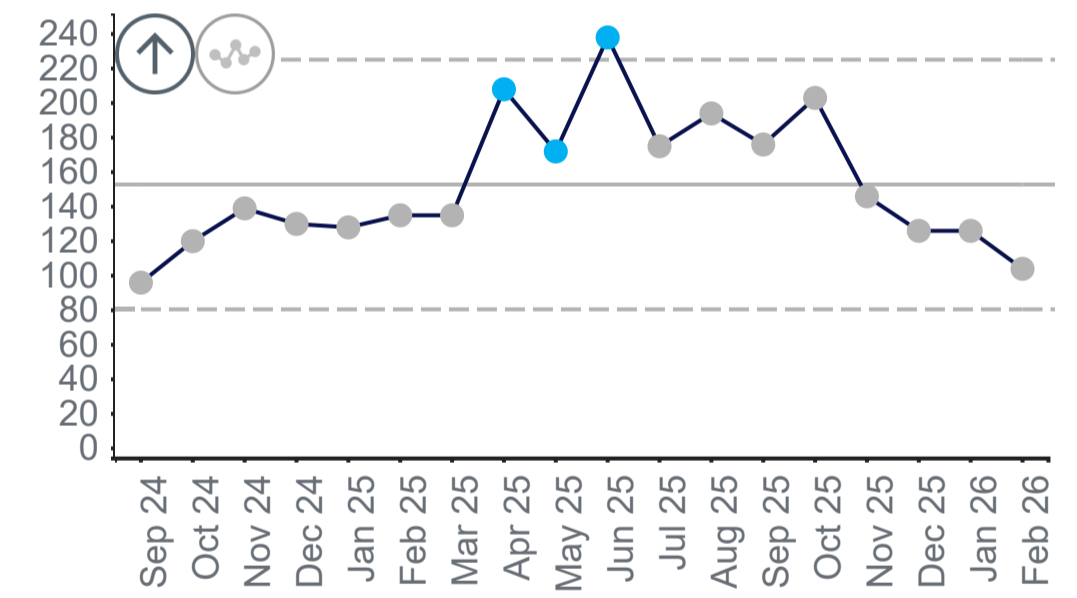
Number of open commercial studies (recruiting and in follow up)



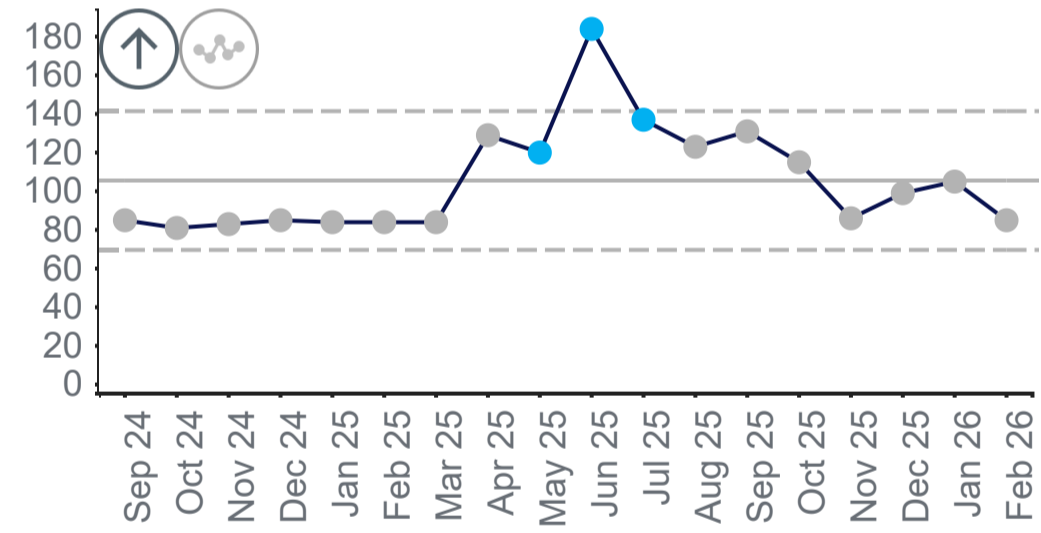
Number of open non-commercial studies (recruiting and in follow up)



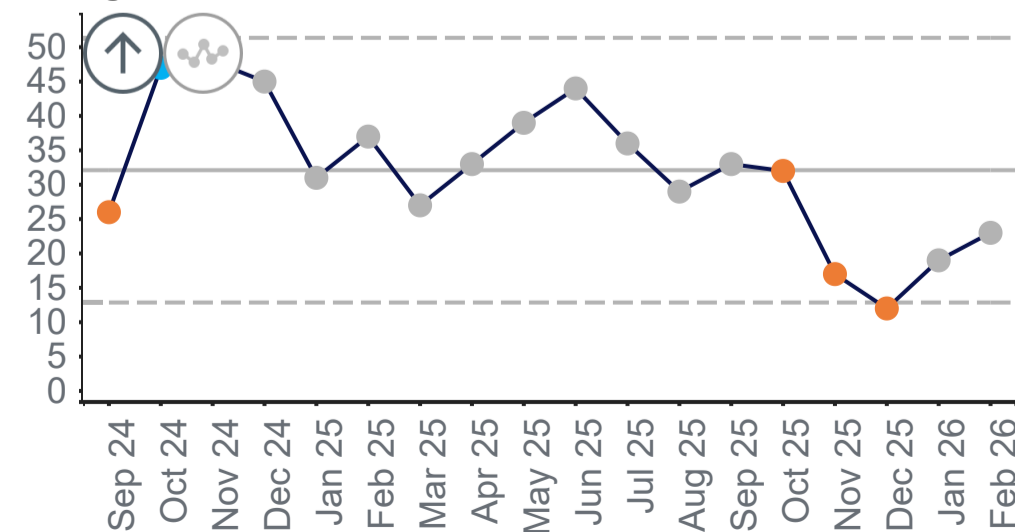
Number of participants recruited to all studies



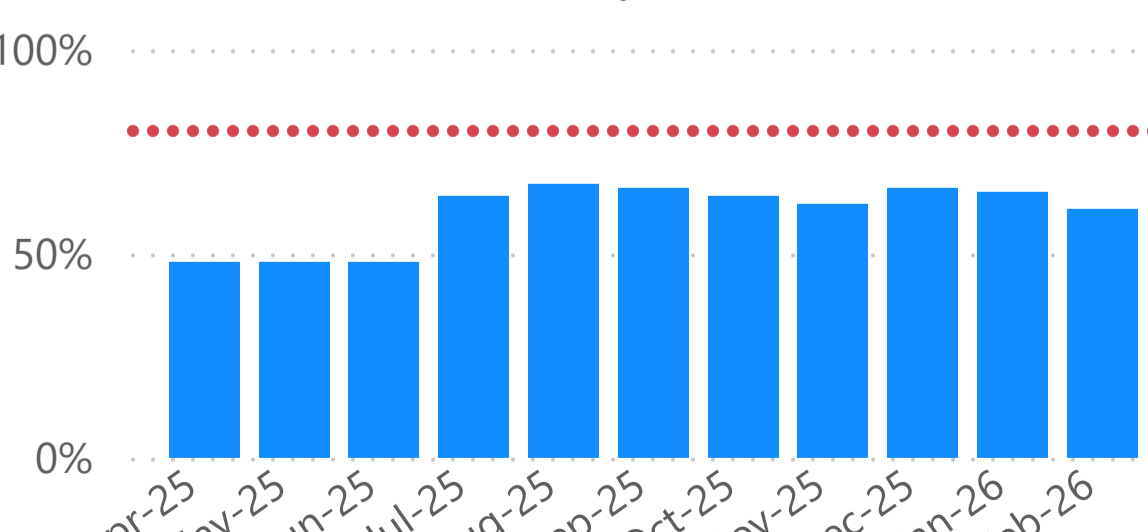
Number of participants recruited to all NIHR portfolio studies



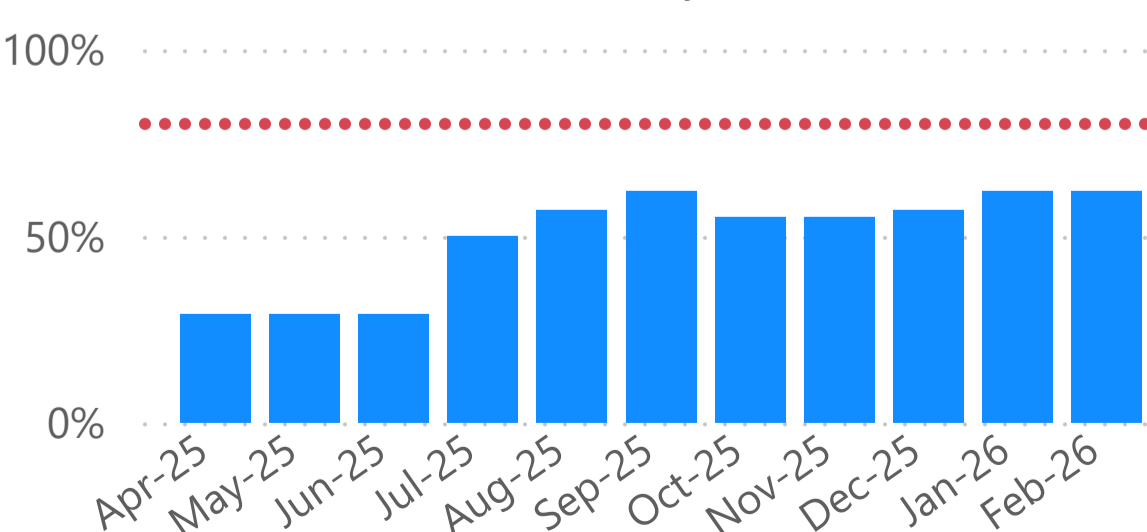
Number of participants recruited to interventional studies (including CTIMPs, devices, therapeutic interventions)



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



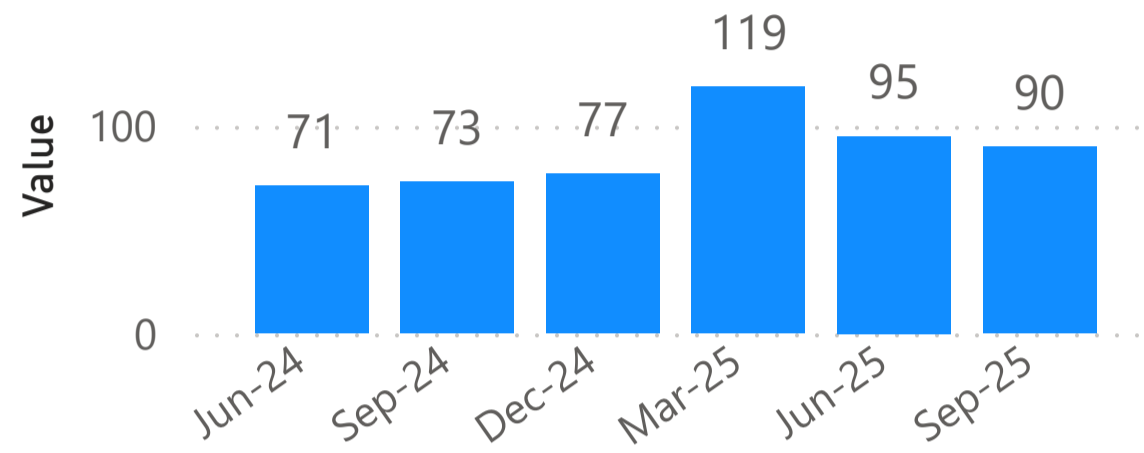
Recruitment to time and target (RTT) open AH sponsored studies only



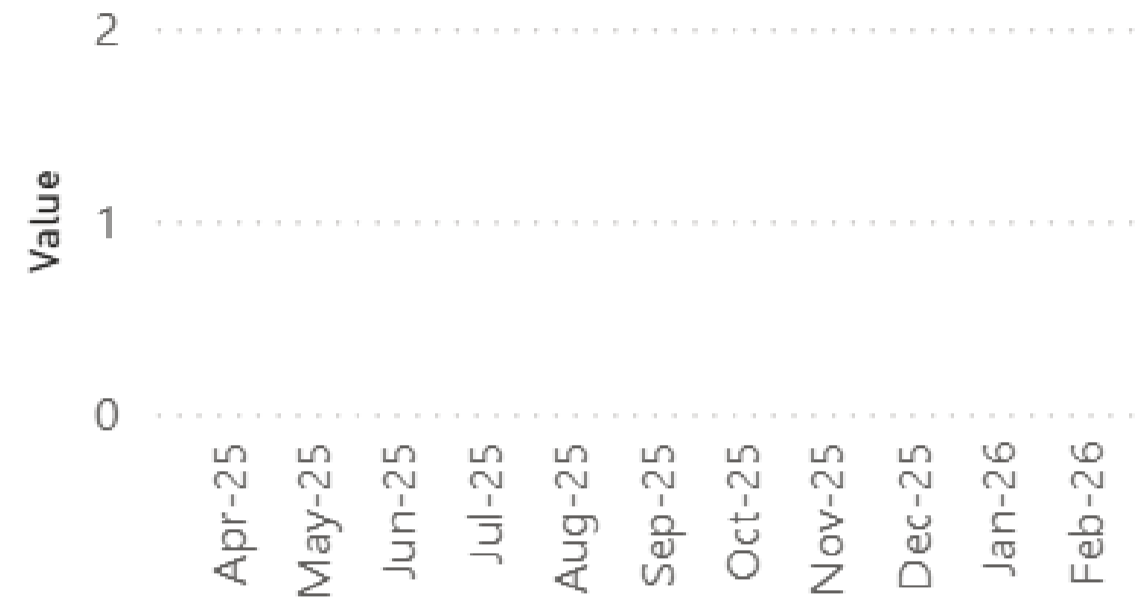
Pioneering Breakthroughs

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

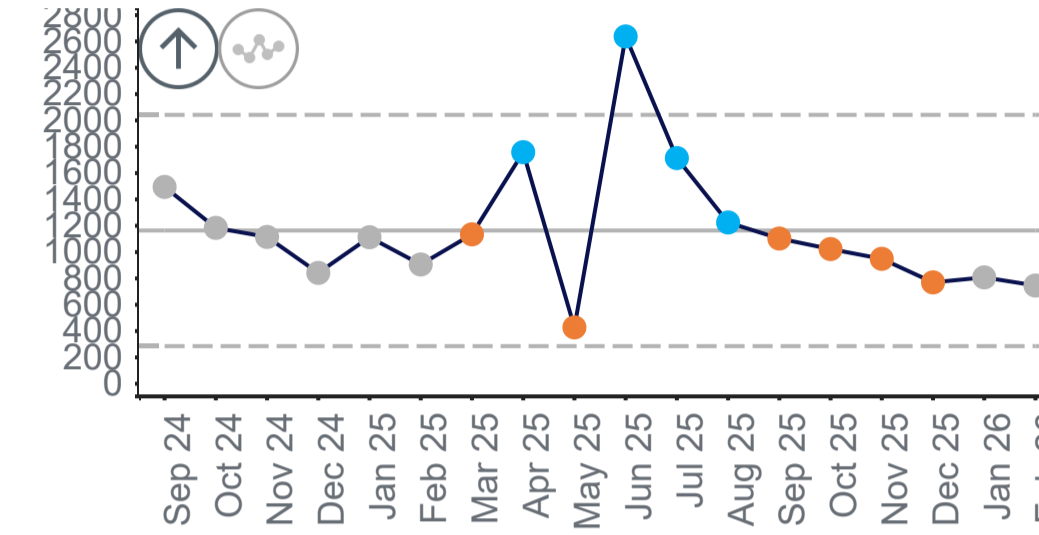
Quarterly



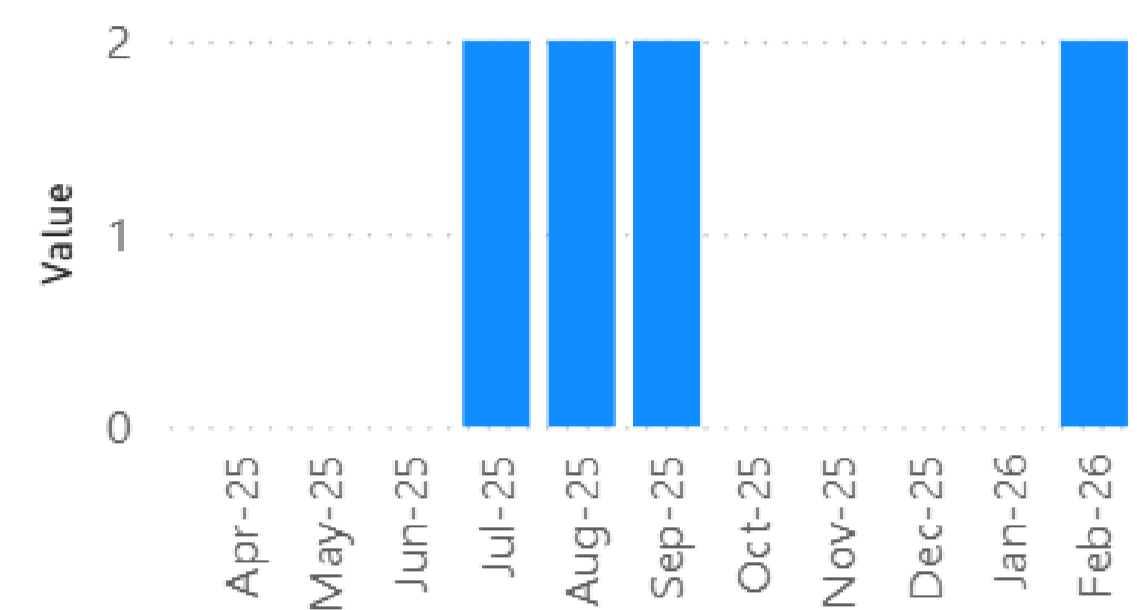
Number of businesses supported by POIZ



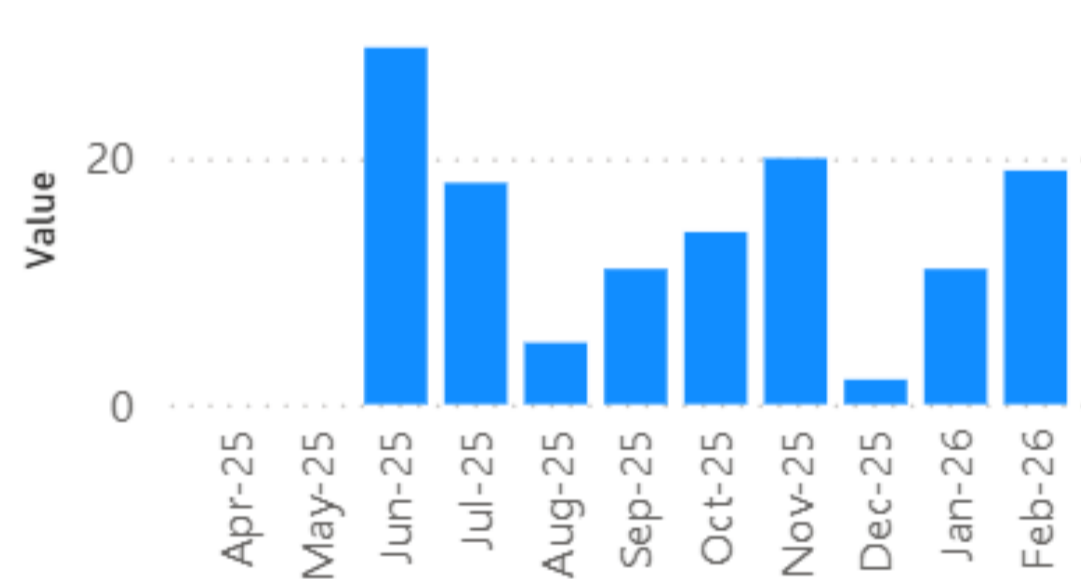
Manual hours released from automation/AI solutions - Monthly



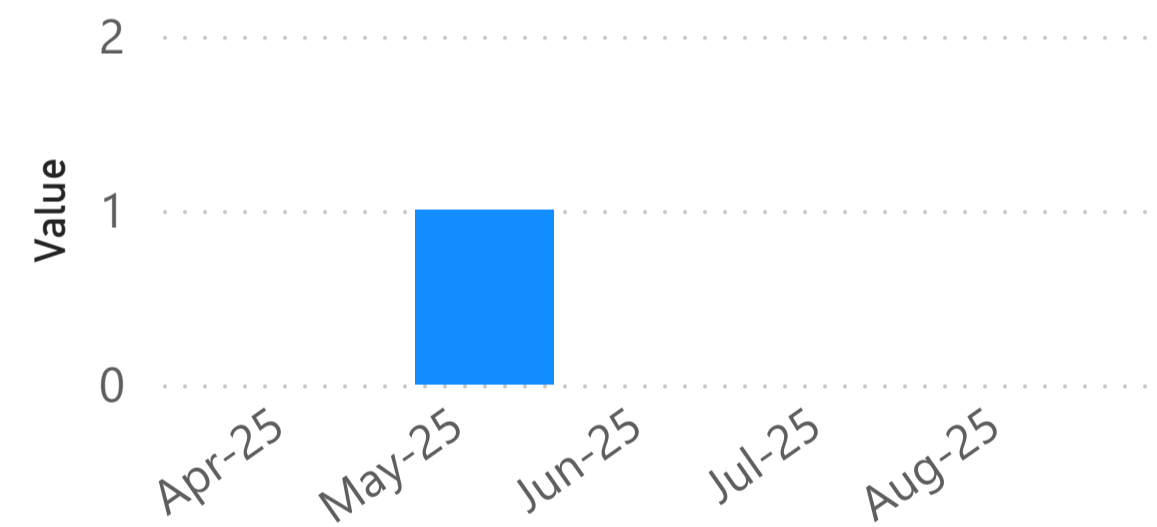
Number of staff trained in innovation methods



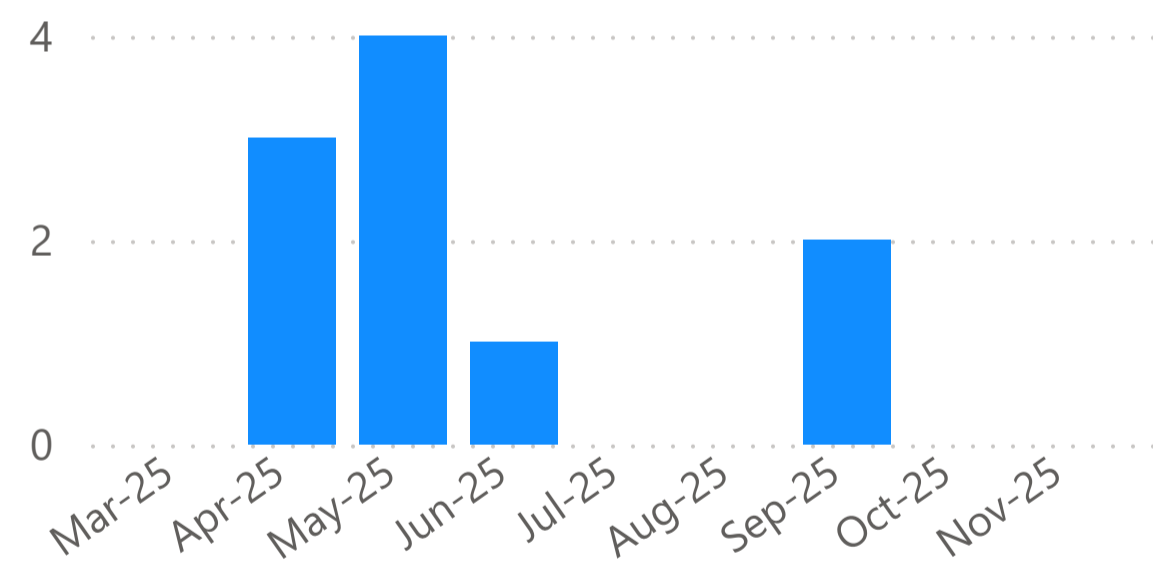
Number of staff trained in research methods



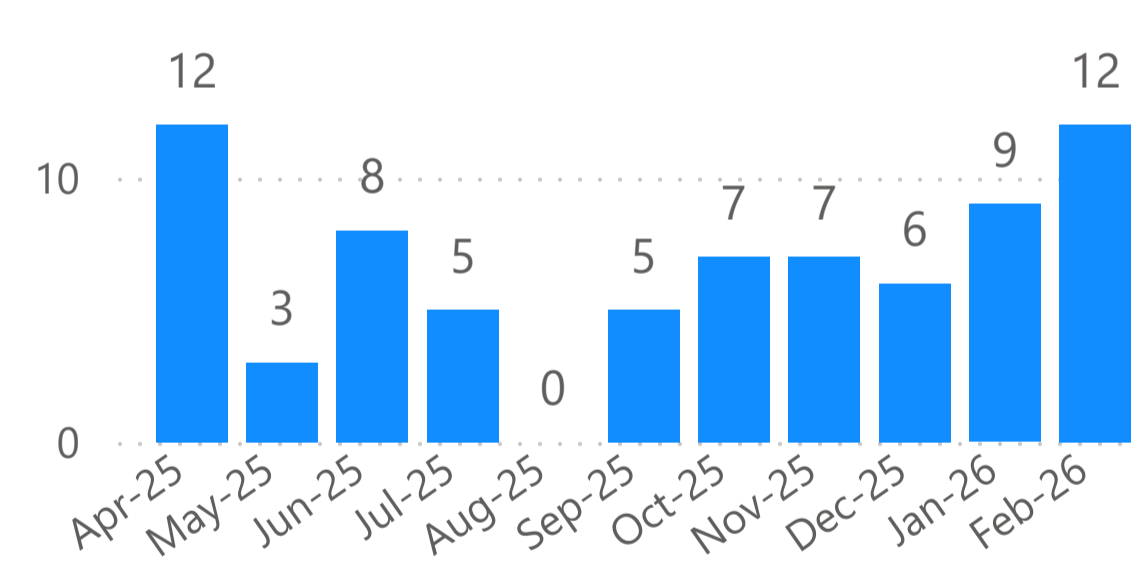
Number of AH-hosted jobs created through new external funding (POIZ metric)



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:

£0.9m surplus reported in month, £2.1m surplus YTD which is in line with plan. Following discussions with ICB post month end, the most likely forecast is now £7.2m given that ICB have resolved to pay PFI credit (in year only) (£2.4m), £0.8m of prior year income, £1m MARS funding, £1.2m spec comm over performance which largely derisks the year end position. £22.3m CIP has been transacted in year (£13m recurrently) - on plan YTD. Cash lower than plan due to high levels of non-cash CIP, and capital spend ahead of plan. Capital ahead of plan due to over profiling in line with prioritisation panel based on expected funding, and funding approved after plan set. £2m additional capital awarded due to elective performance to be used over 25/26 and 26/27 and £2.1m SDEC capital funding now confirmed.

Areas of Concern:

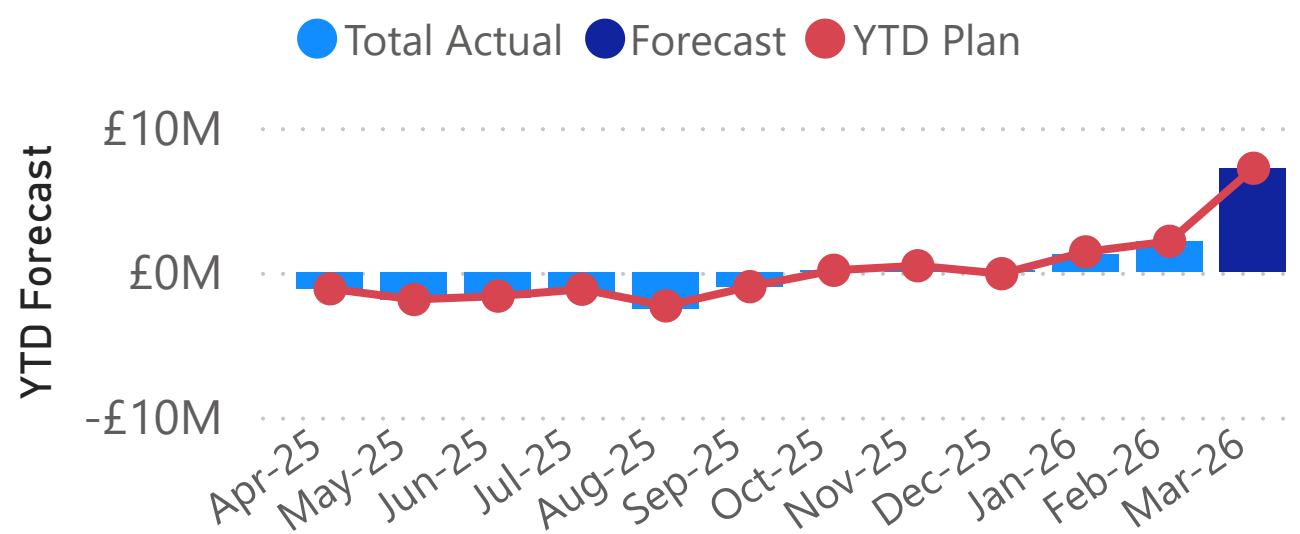
Delivery of recurrent CIP programme continues to present a risk. Cash is being closely monitored given non-cash CIPs. This is also leading to lower interest receivable.

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. Overall divisional forecasts have remained largely in line with M10 with some divisions deteriorating offset by improvements in other divisions. Divisions that have deteriorated are being asked to attend execs to explain movement. 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:

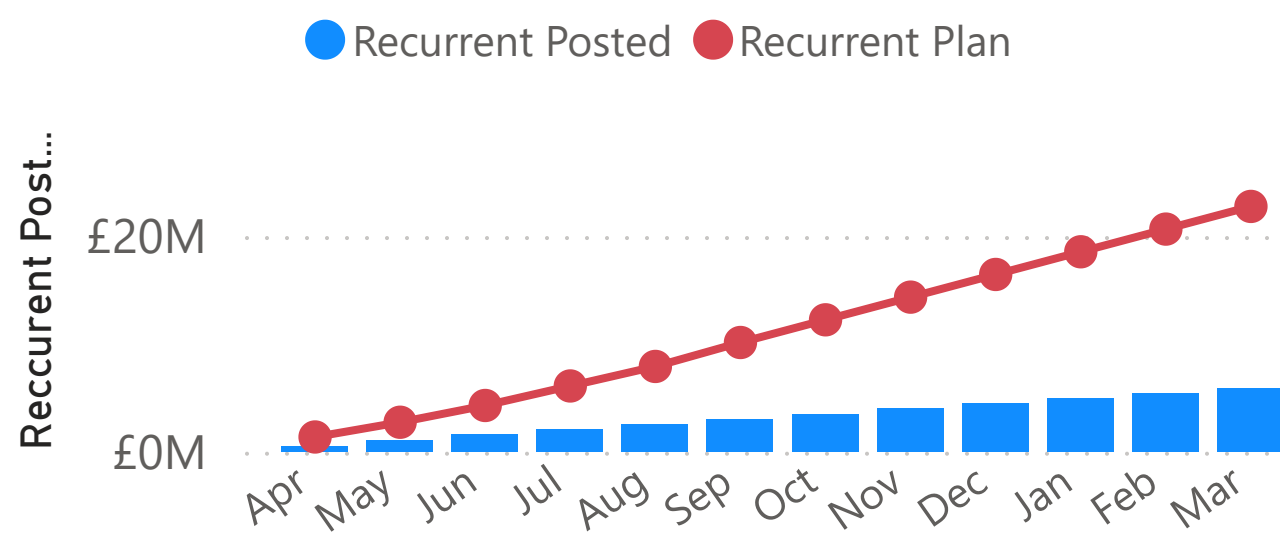
Current plan is £7.160m surplus which we aim to achieve.

Actions:

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

Recurrent Efficiency Plans Delivered (Forecast)

Target: Internal



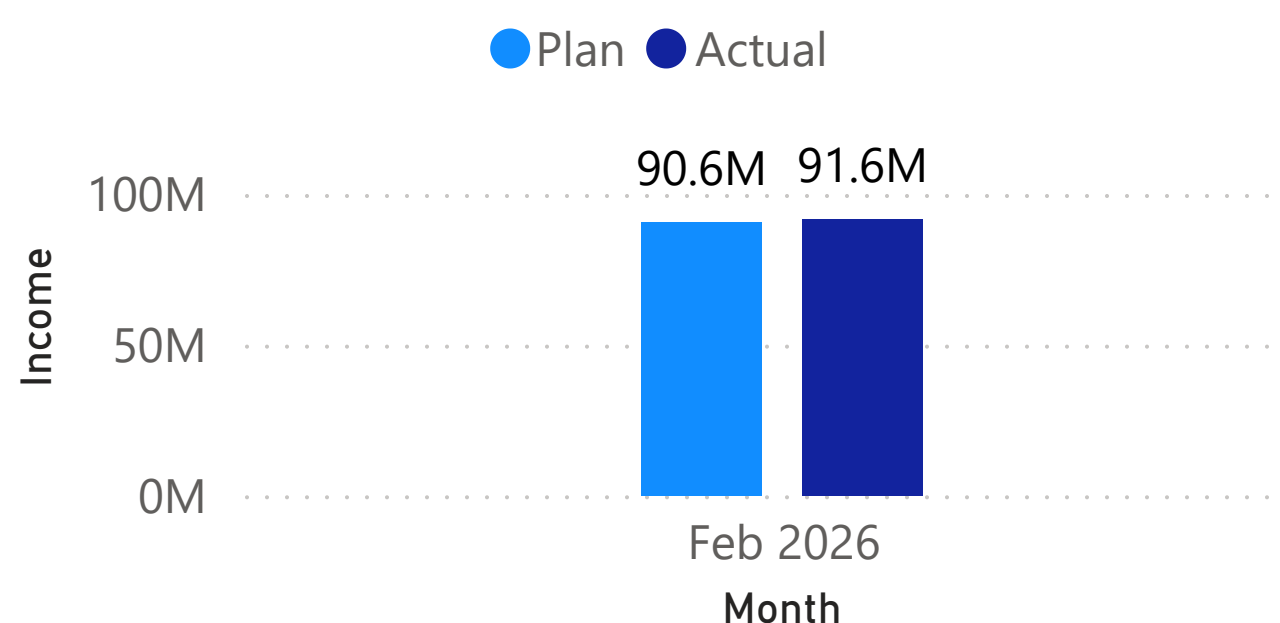
Technical Analysis:

Recurrent CIP identified is £13m which leaves a recurrent gap of £9.7m to be carried forward to 26/27.

Actions:

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

YTD ERF Income



Technical Analysis:

February performance estimated at 98%.

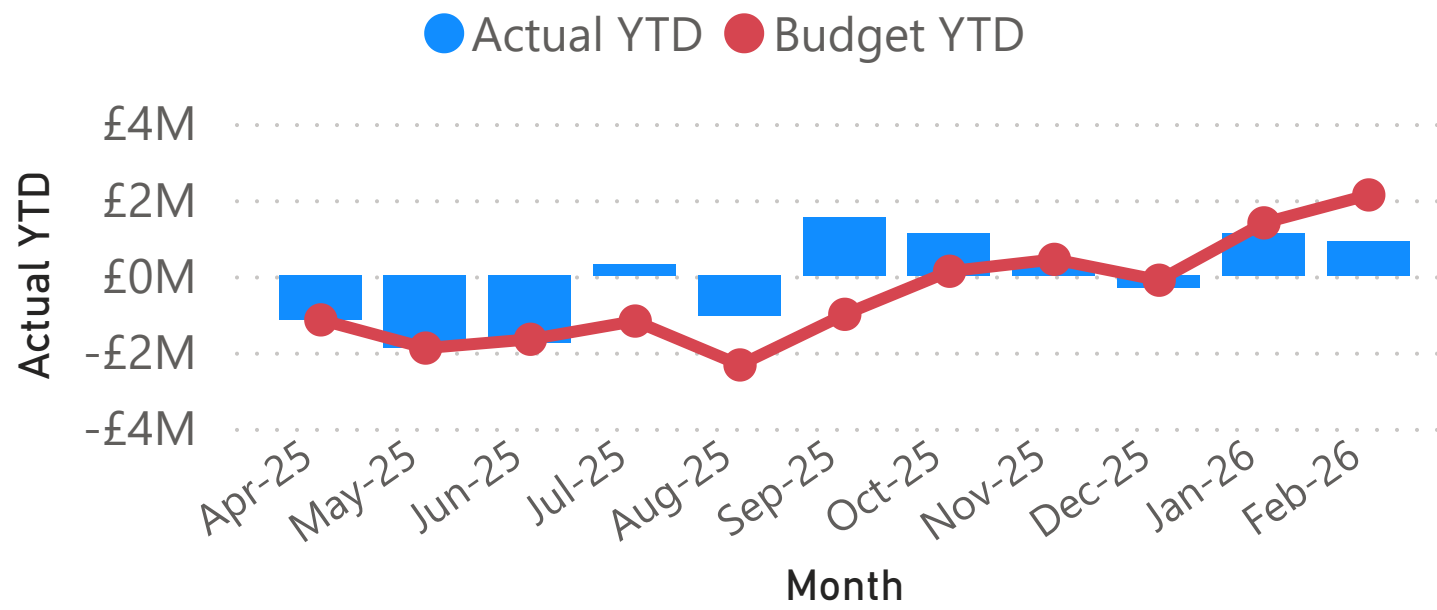
Actions:

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

Financial Sustainability: Well Led - Watch Metrics

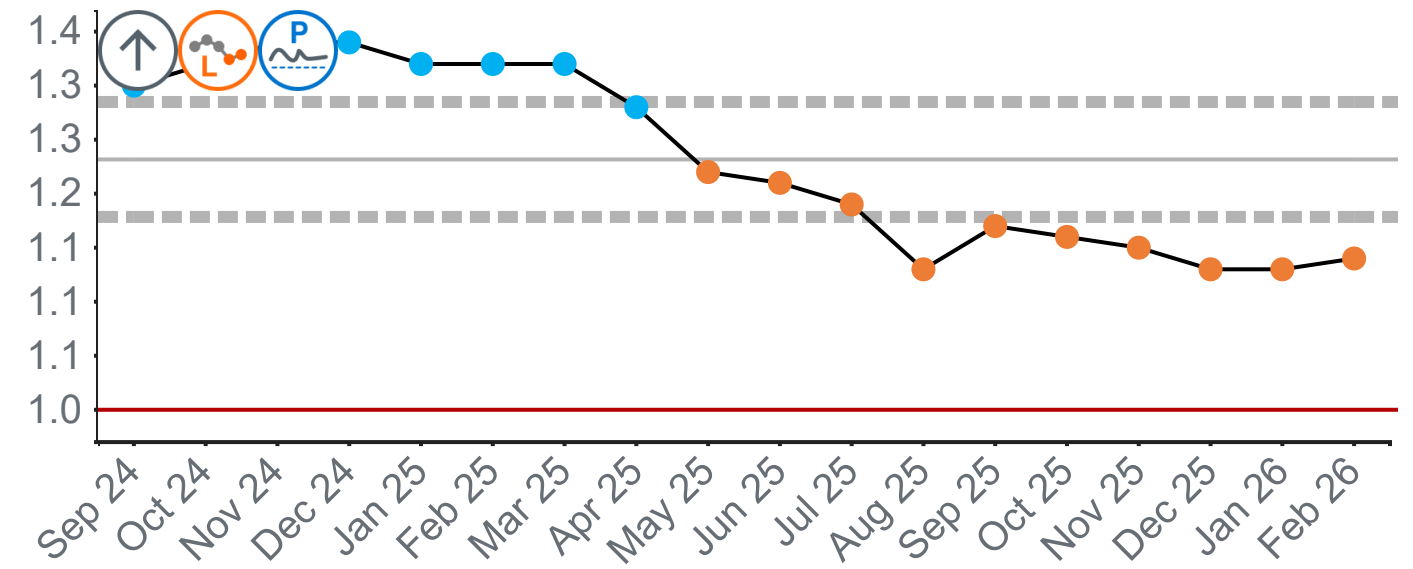
I&E distance from target (cumulative YTD)

Target: Internal

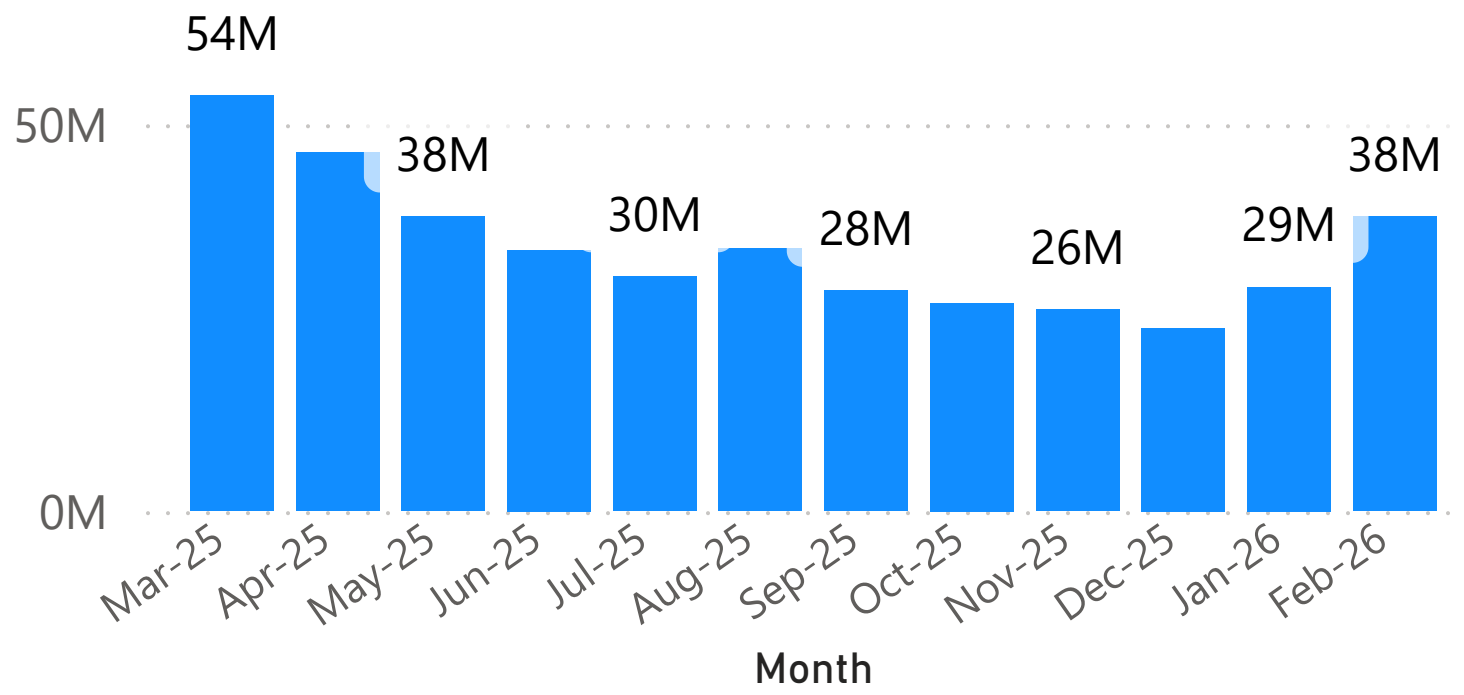


Liquidity

Target: Internal

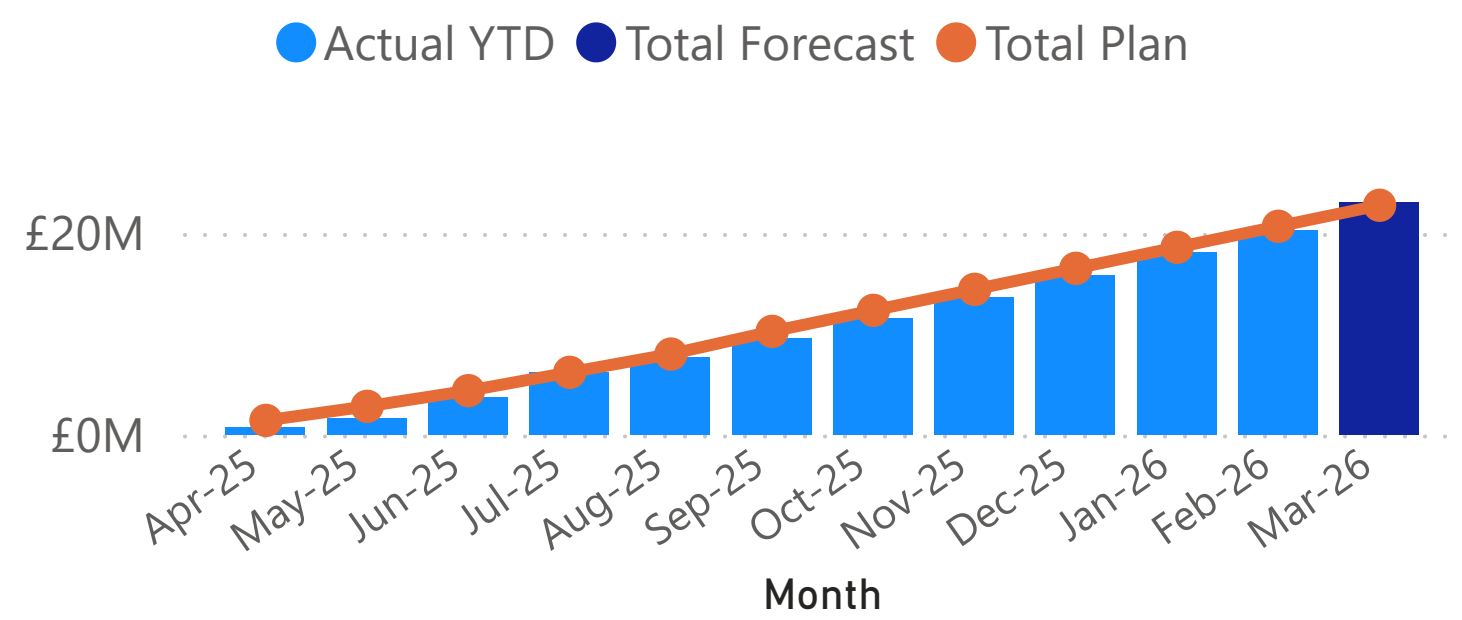


Cash In Bank



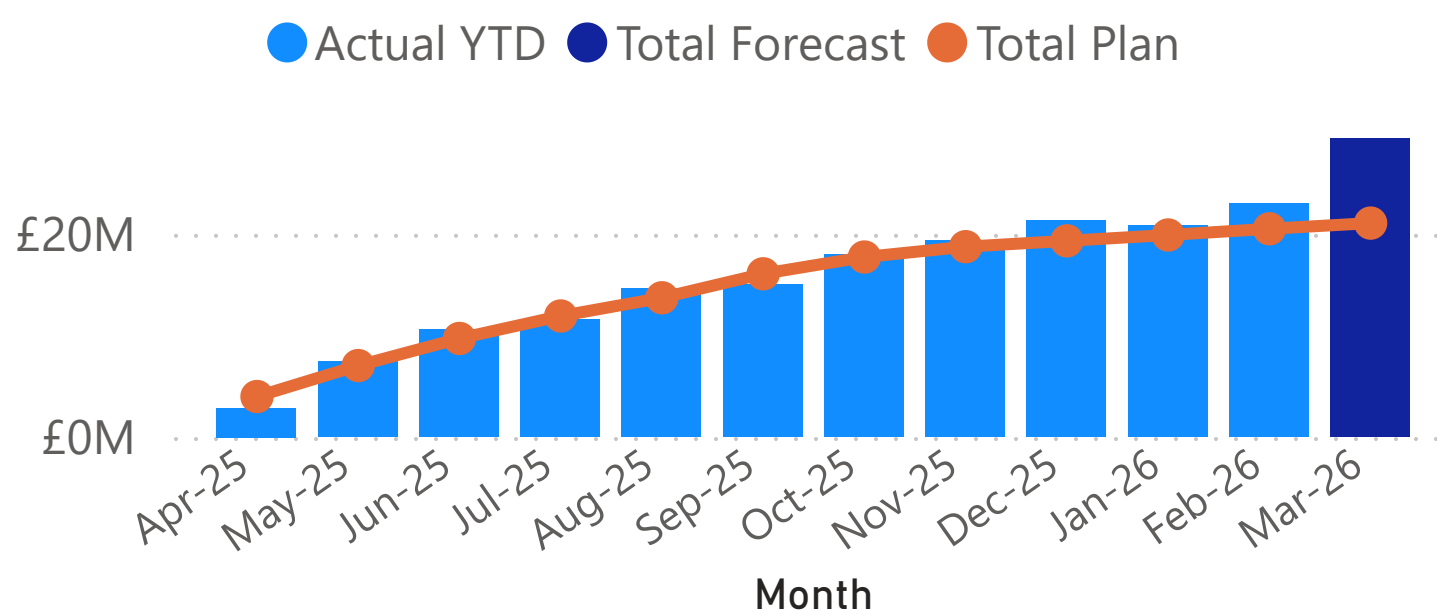
In Year CIP – forecast against plan

Target: Internal



Capital – YTD spend and forecast against plan

Target: Internal



Well Led - Risk Management

SRO: Erica Saunders, Chief Corporate Affairs Officer

Highlights:

- 100% of risks within review date • Education of staff on risk management processes, use of risk registers, risk description and scoring continues to be promoted and delivered by the Corporate Governance and Risk Team, supported by the divisional governance teams • Standardised risk oversight package approved for Trust-wide use in February 2026.

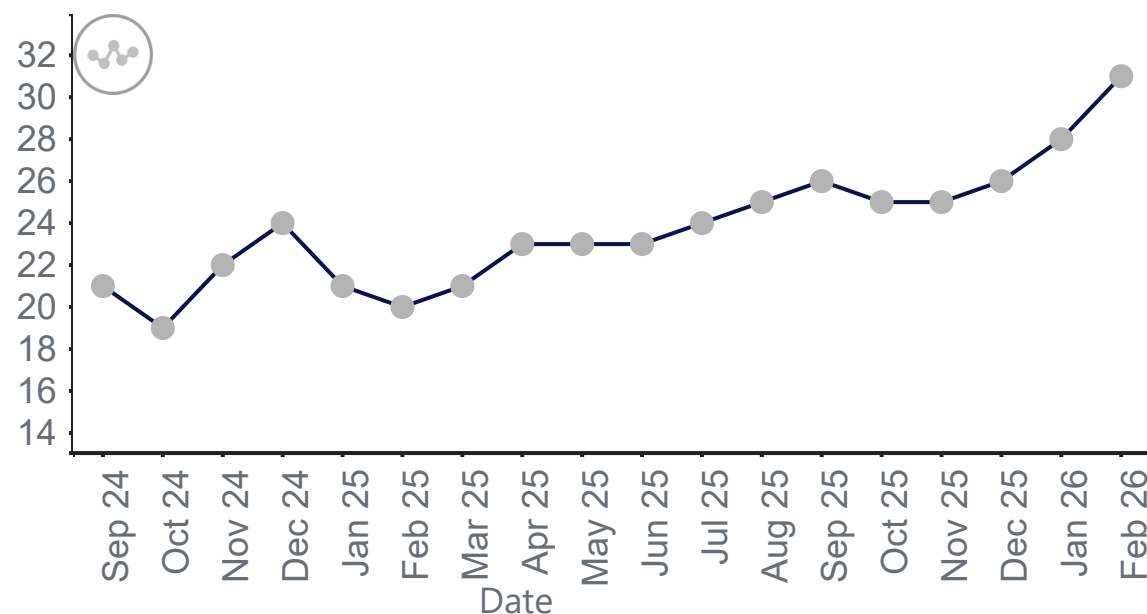
Areas of Concern:

- 12.9% of high risks with overdue actions (4/31). Monthly report continues to be presented at Corporate Services Collaborative to highlight and monitor overdue actions for Corporate Services and risks with overdue actions reported into Risk Management Forum / Audit and Risk Committee

Forward Look (with actions)

- Although an improved position is noted for risks with overdue actions, this remains an area of focus throughout corporate / divisional risk oversight meetings • Currently roll out of Risk Appetite remains on hold pending further review and approval of risk tolerances by Trust Board early 2026 to inform the Risk Appetite Principles document and subsequent training • Analysis of risk mitigations and whether they are within / outside of the Trust's control and analysis of risks with a clear action plan to reduce the risk score is now part of the corporate risk register report into ARC • Work is ongoing to develop a more intuitive Risk App to support effective risk management.

Number of High Risks (scored 15 and above)



Technical Analysis:

31 high risks on the register as of 28/02/2026. Reporting categories outlined below:

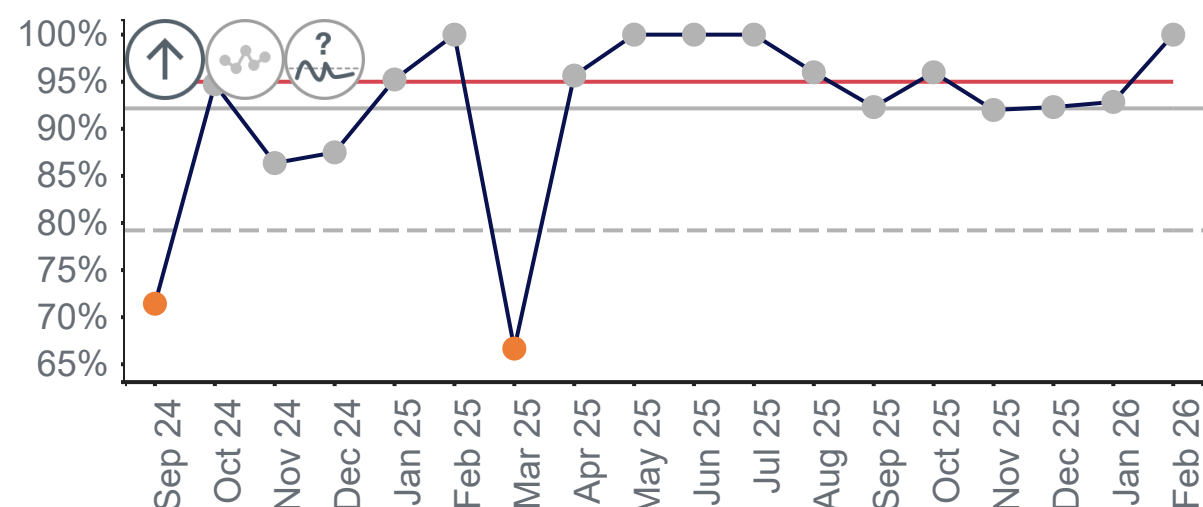
- Quality – Safety = 17 risks
- Workforce – Sustainability = 5 risks
- Compliance and Regulatory = 3 risks
- Commercial = 2 risks
- Financial – Investment = 2 risks
- Financial – Compliance = 1 risk

Actions:

High risks continue to be reviewed at Risk Management Forum via the corporate risk register report. Analysis of risk mitigations for high risks and whether they are within / outside of the Trust's control is now reported into ARC as part of the corporate risk register report.

% of High Risks within review date

Target: Internal



Technical Analysis:

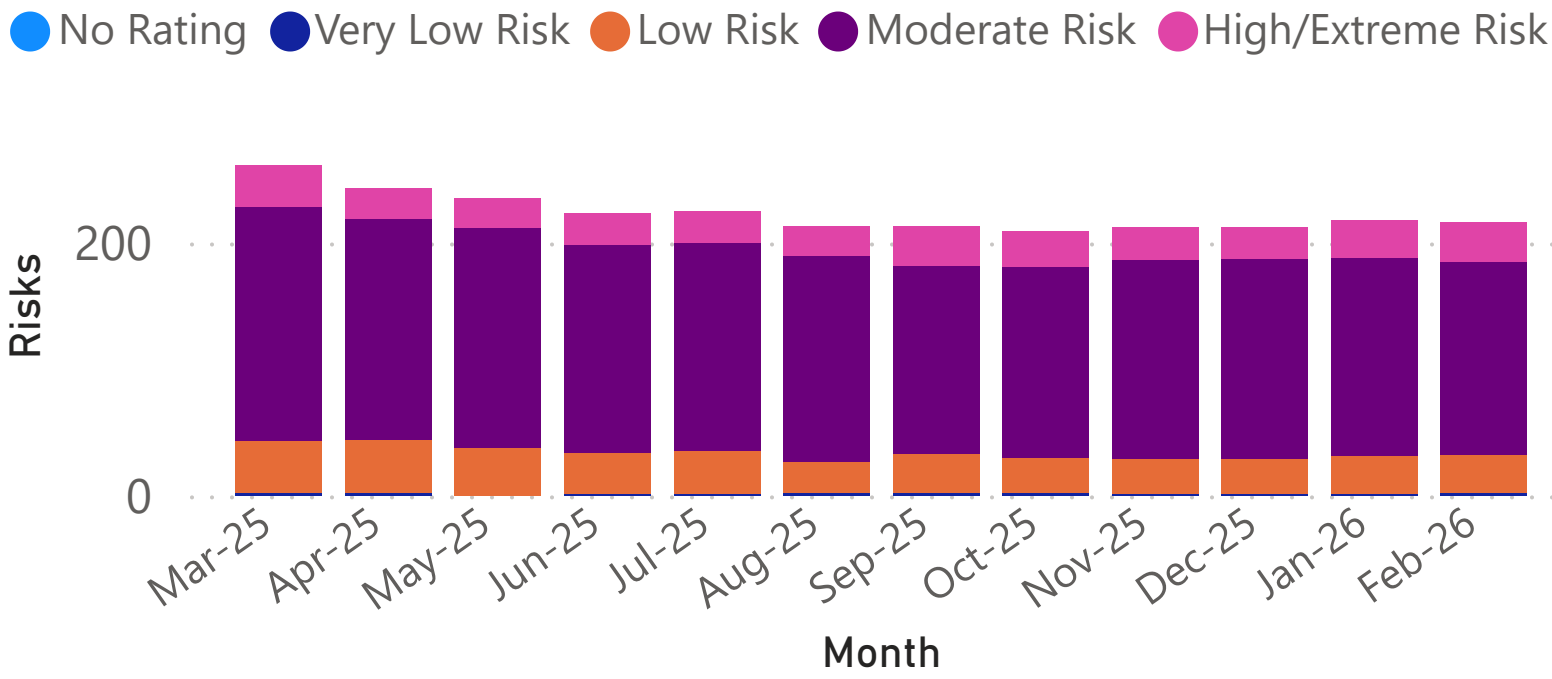
Improved performance with 100% of risks within review date for February 2026 with a performance of 93% for January.

Actions:

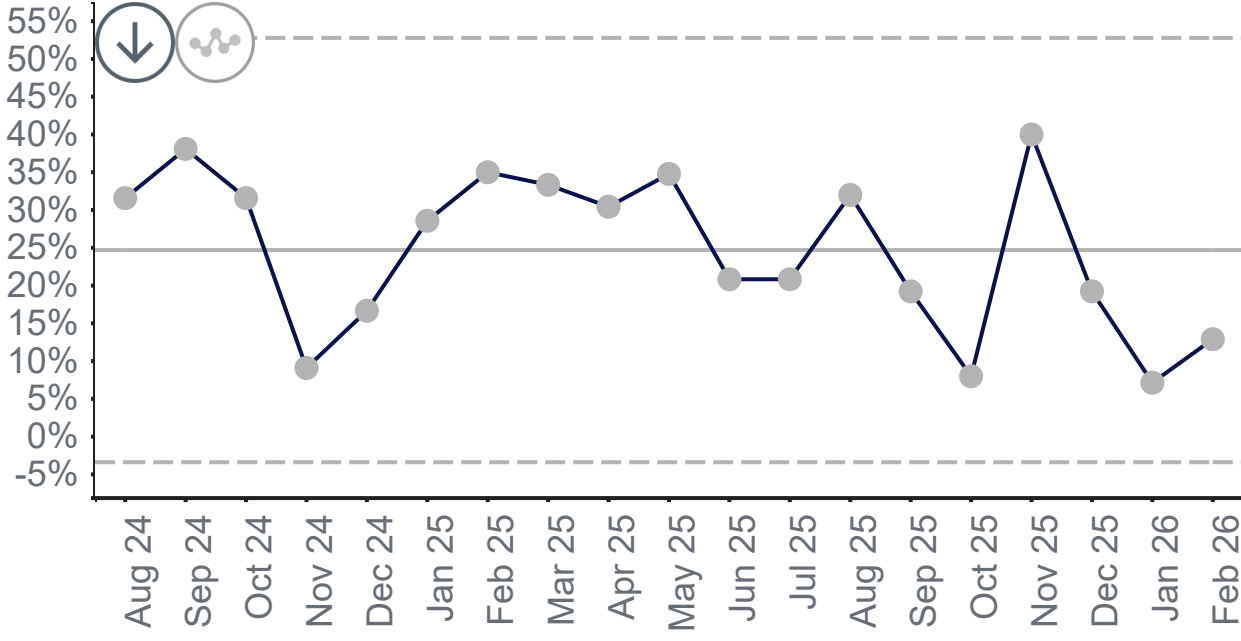
Risks with overdue actions to remain an area of focus at the risk oversight meetings with divisions / corporate functions.

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

- Mandatory training compliance remains above target (96%)
- Improvement in all FFT response rates
- Improvement in sickness absence rate (5%) predominantly within long term sickness
- Community Therapy Services continue to meet 18 week RTT (Community Dietetics – 100%; SALT – 99%, Physio – 99%, OT -100%)
- Improvement in number of children and young people receiving first appointment within 6 weeks of referral for Community Mental Health Services (88%)
- Continued improvement in 18-week RTT for Community Paediatrics (81%) and reduction in waiting list size
- No children or young people waiting over a year for follow up in Community Paediatrics
- WNB rate remains below target (12%)
- 100% of children & young people reported waiting >104 weeks for Community Mental Health Services – Completed. To be reported in April 2026.

Areas of Concern

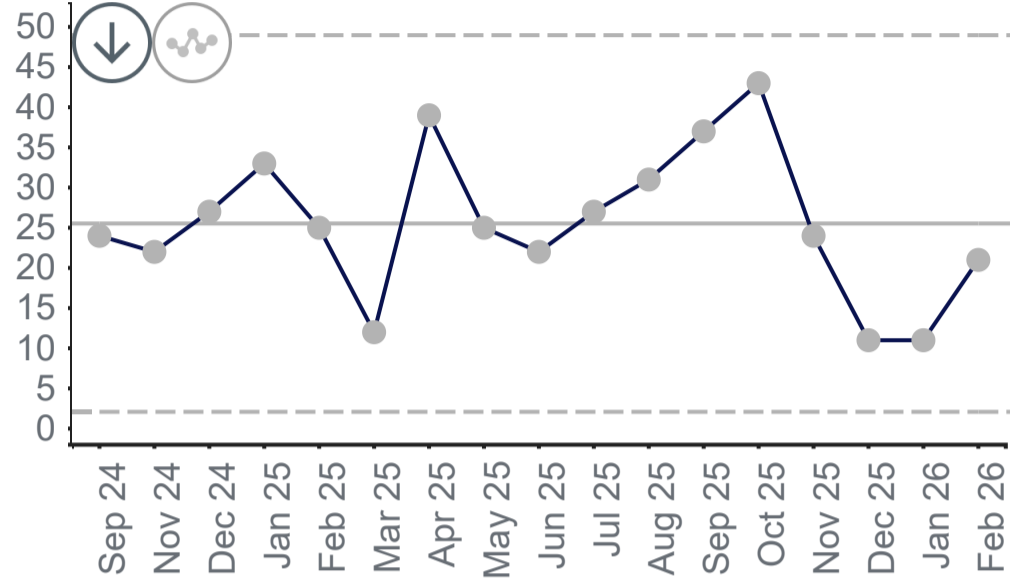
- Increase in patient safety incidents rated low and no harm
- Reduction in number of complaints responded within 25 days (50%) & PALS response rate remains above target (93%)
- Venus Centre closed due to unprecedented demand – impacting on referrals and capacity for Community Mental Health Services (Sefton). Escalated to ICB.
- Further deterioration in timeliness to triage for ND assessments (65%)
- Increase in number of children & young people waiting over 52 weeks for treatment to start in Community Mental Health Services (Liverpool) (36). This is due to delays with recruitment. An improvement plan is in place, with all due to have been seen by 31 March 2026.
- Further reduction in number of children and young people seen within 4 weeks in Eating Disorder Service (66%) due to increase demand, and delays with transcription impacting on timeliness of referrals received. Urgent compliance remains at 100%.
- Ongoing concerns regarding the number of clinical letters due to delays in transcription process – although improved in M11 (46%)
- Ongoing challenges with ADHD medication shortages which is impacting on waiting times for the treatment pathway

Forward Look (with actions)

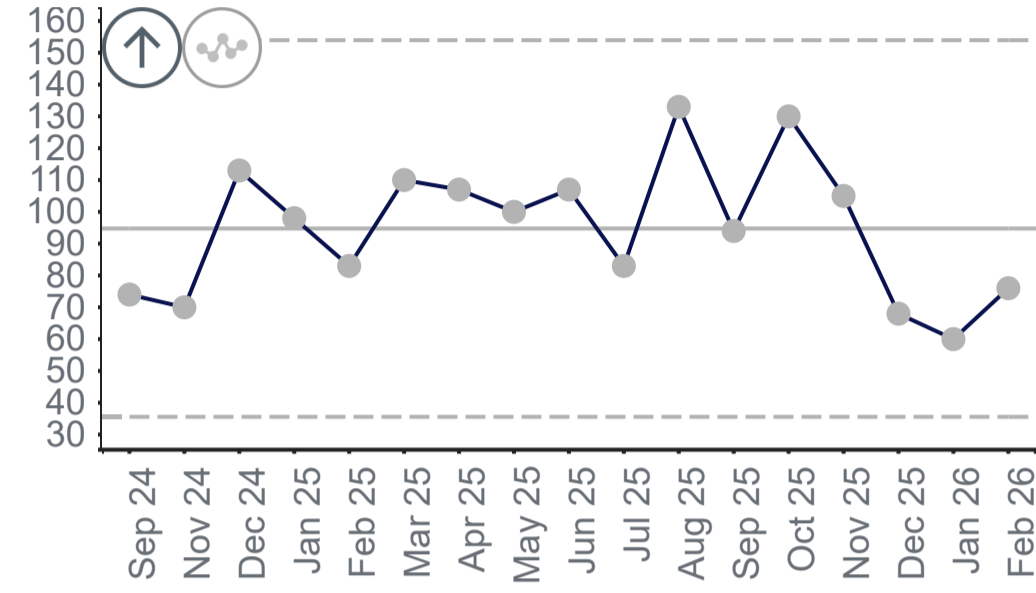
- ND transformation programme continues with a review of ADHD medication planned and improvement plan to be delivered.
- Liverpool Community Mental Health Services performance improvement plan in place using A3 brilliant basics methodology
 - Waiting times managed against improvement trajectory.
 - Improvement in waiting time for urgent and routine choice appointment
 - Increase in 52+ weeks due to maternity and vacancies – plans in place for all relevant CYP to be seen before end M12.
 - Recruitment ongoing, with additional posts requested to mitigate for gaps in service. 2 WTE started in post Feb 2026, with further start dates and recruitment ongoing.
 - WNB rate improvement in Feb 2026 although remains high. Improvement within new assessment appointment type, deep dive into group appointments ongoing. Reminder calls using WNB predictor ongoing and action plan under review.
- Mental Health data reporting – work ongoing
 - Task & finish group ongoing to improve routine outcome measures collection and reporting
 - Paper prepared to revise access and performance KPIs in line with NHSE proposal of standards for access and waiting times for Children and Young People Mental Health Services –approved through executive review and commissioners, work ongoing to update reporting metrics and dashboards.
 - MHSDS Phase 2 (Crisis Care) commenced, with Meditech developments completed in January 2026, go live date to be confirmed.
 - IT and Operational Team working with IAPTUS to review scope of IAPTUS to Meditech data migration
- Work ongoing to provide psychological support to children impacted by the Southport critical incident. PIFU discharge pathway agreed to enable follow up until CYP turn 18. Ongoing discussions with ICB regarding funding for this resource.

Divisional Performance Summary - Community & Mental Health

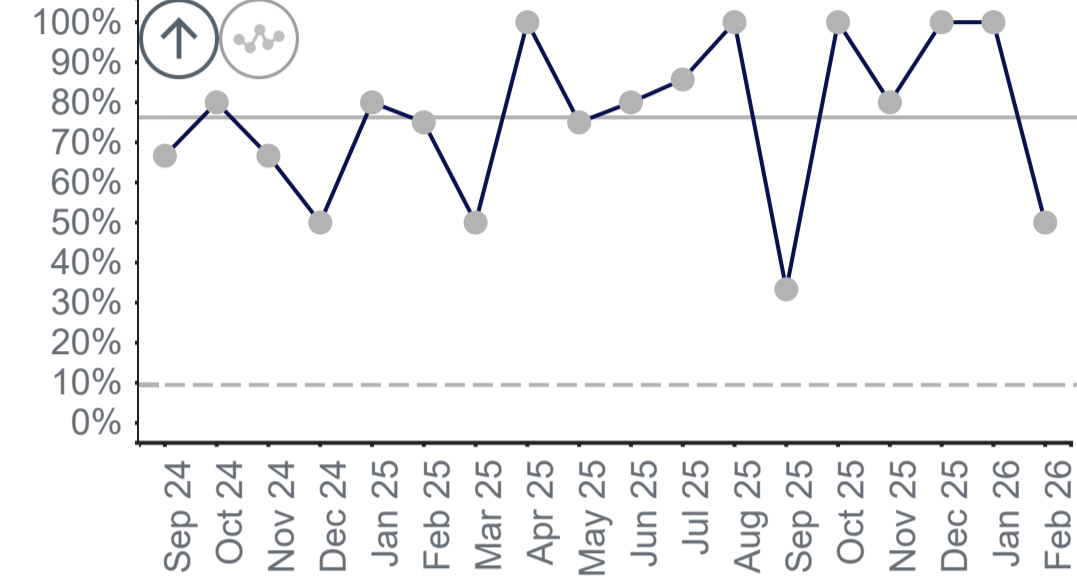
Patient Safety Incidents rated Low Harm & Above



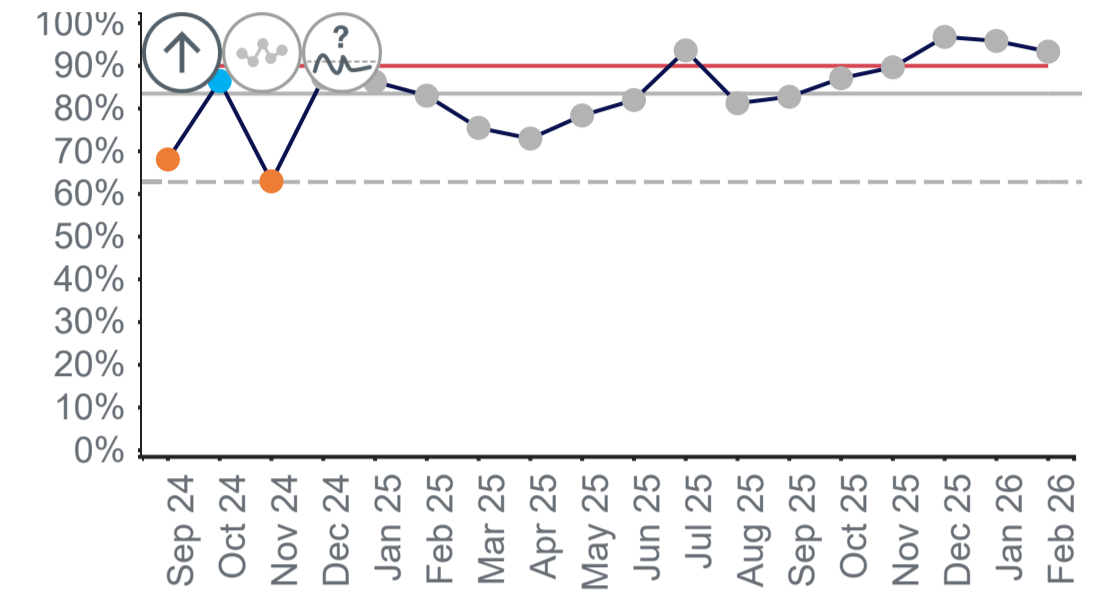
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

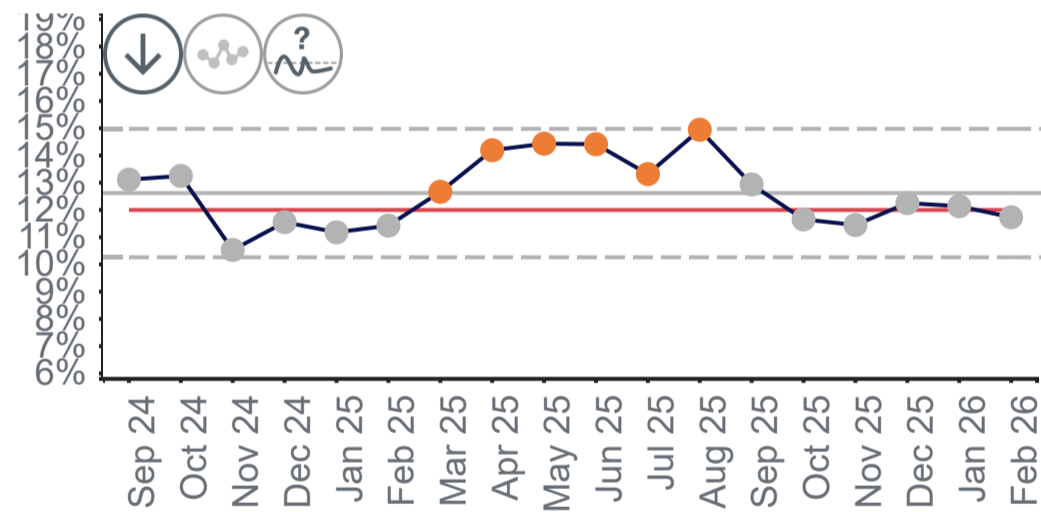


% PALS Resolved within 5 Days

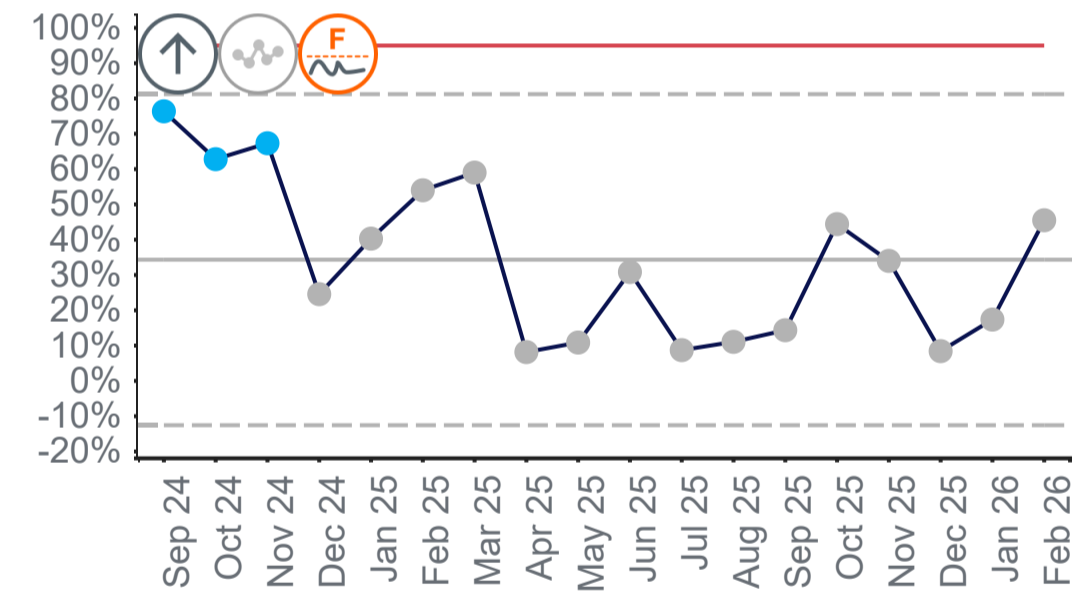


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

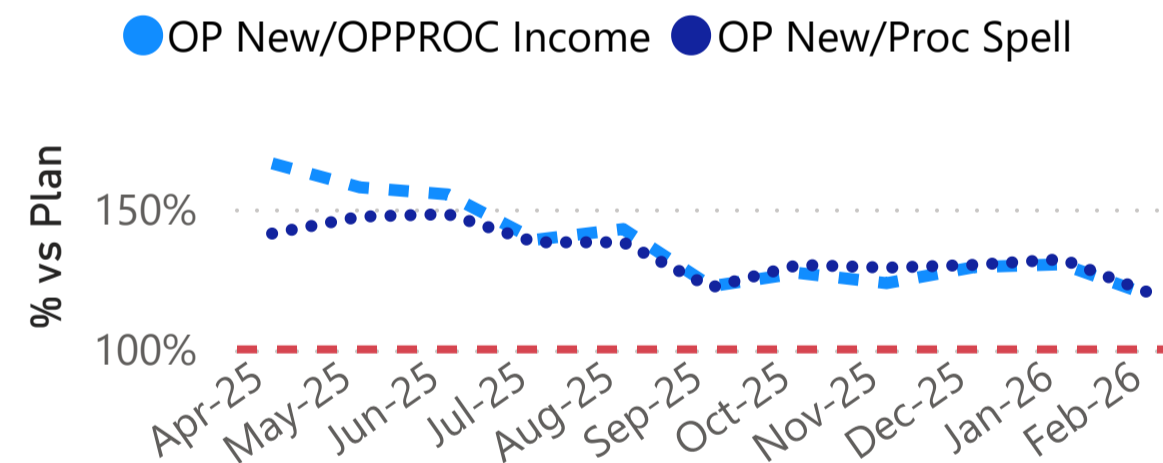


% of Clinical Letters completed within 10 Days

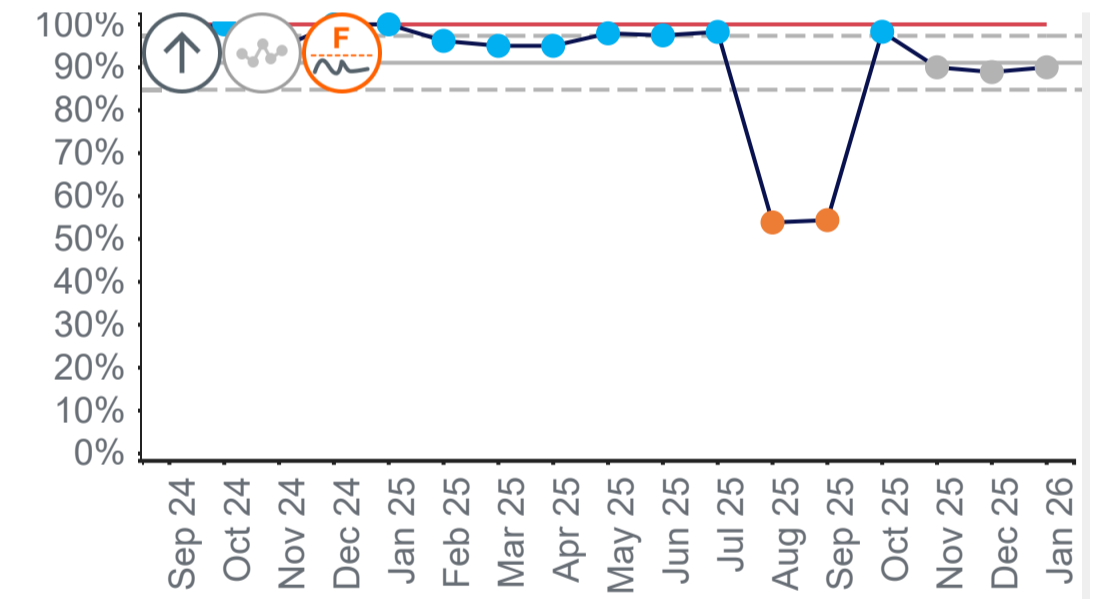


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

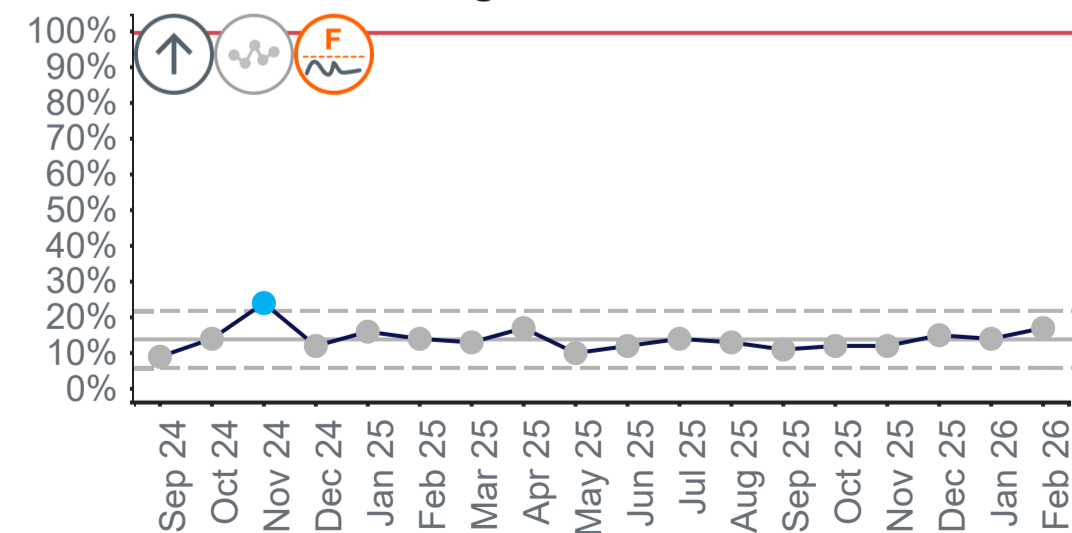
SLAM Performance



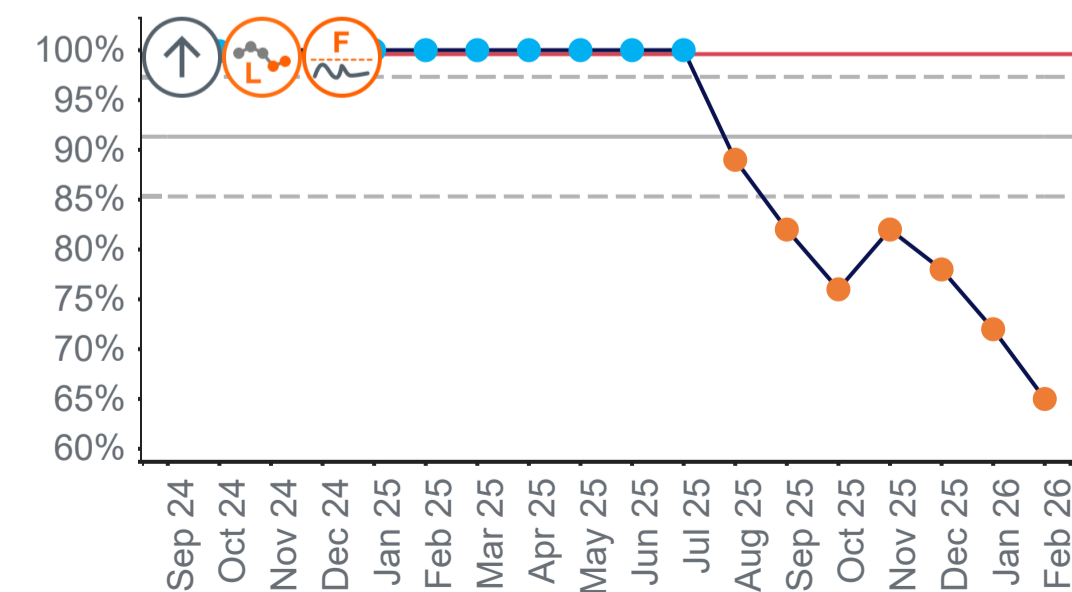
IHA: % complete within 20 days of referral to Alder Hey



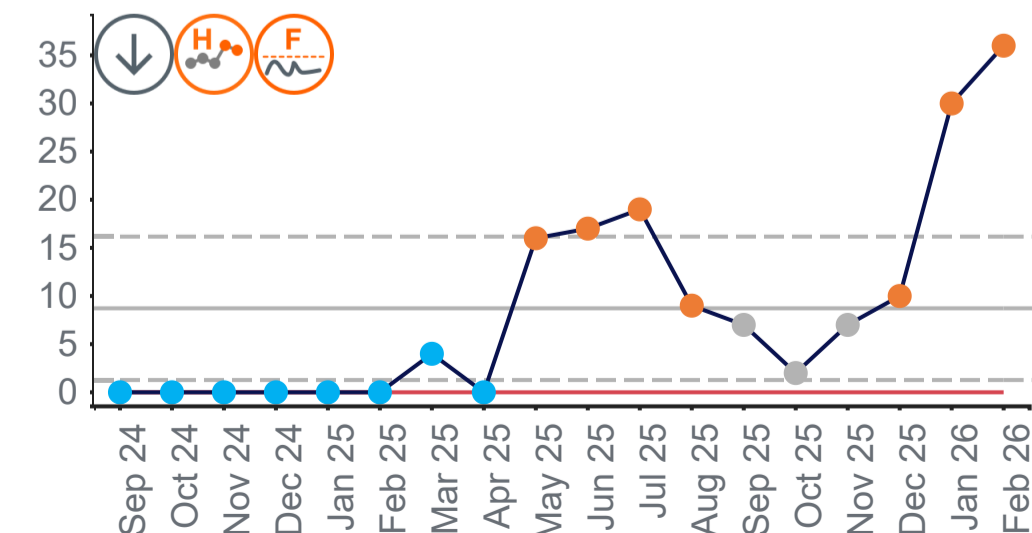
ND Assessment: % waiting <65 weeks for concluded diagnosis



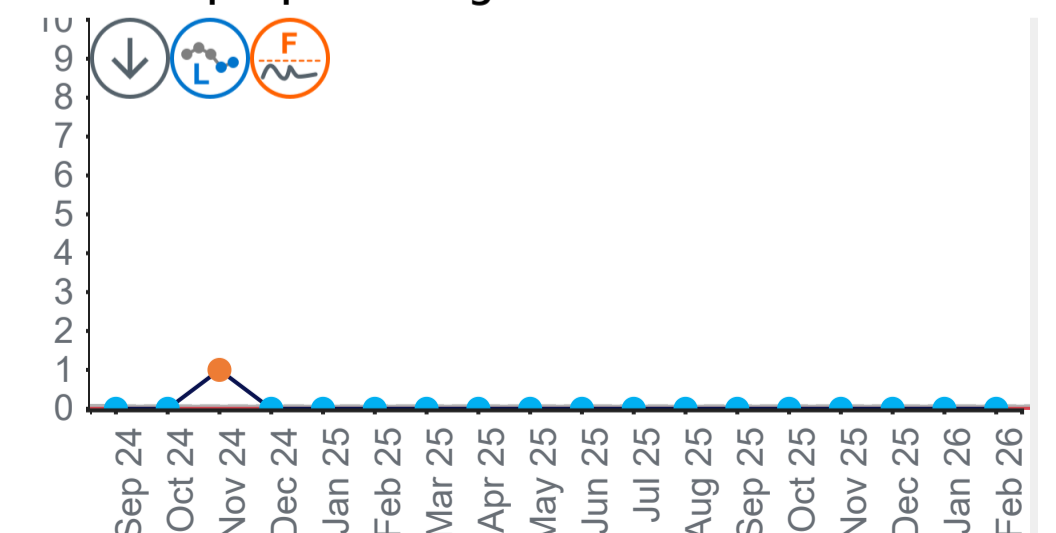
ND Assessment: % triage within 12 weeks



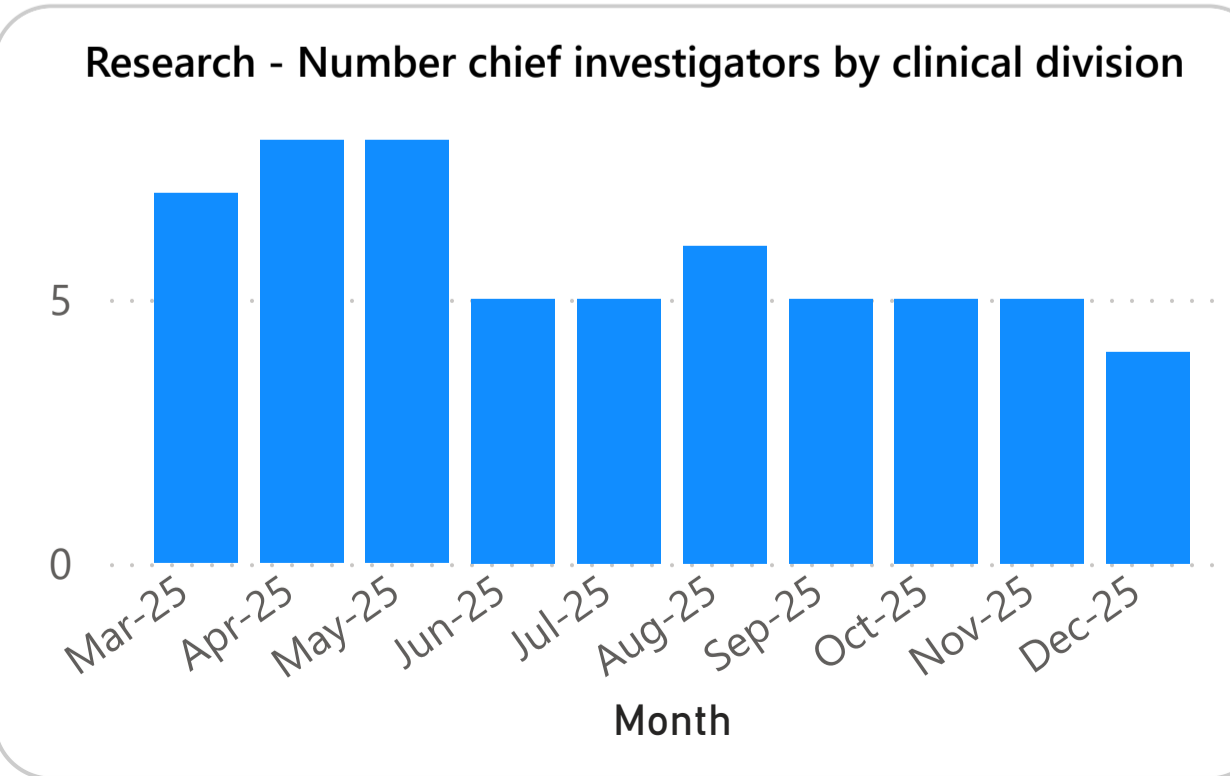
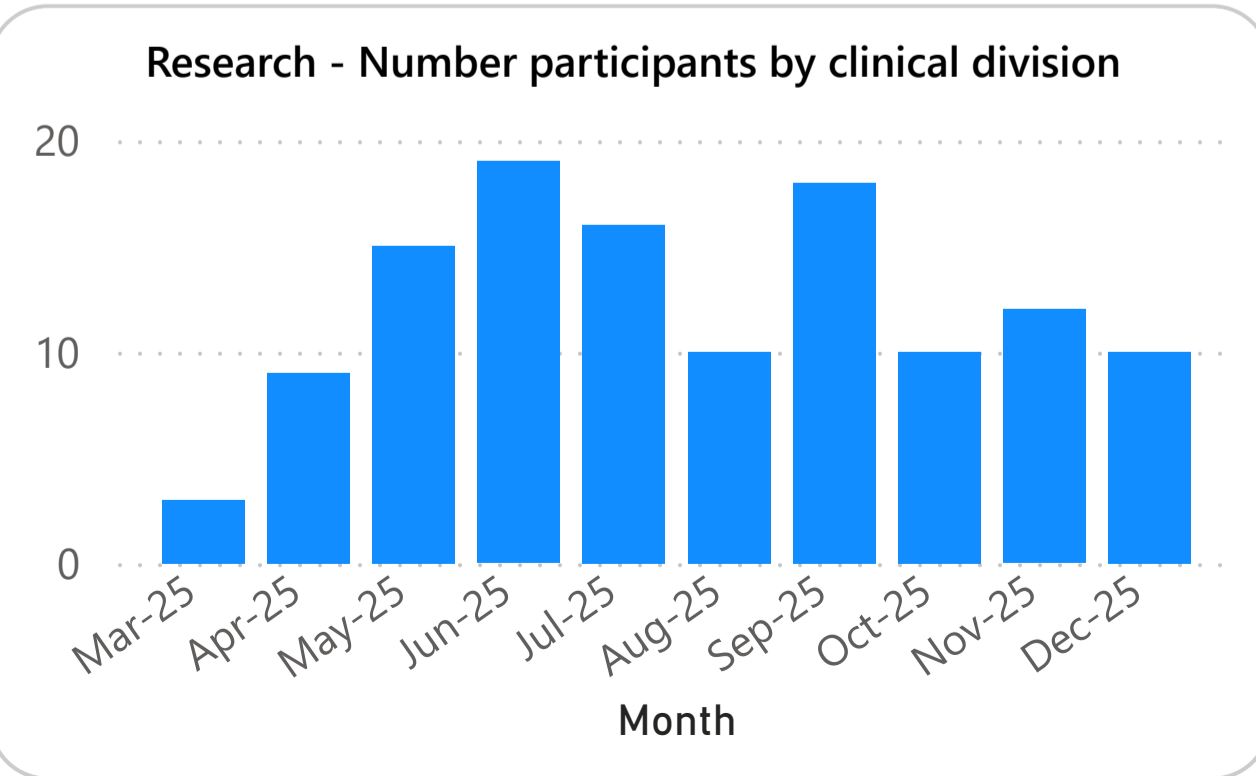
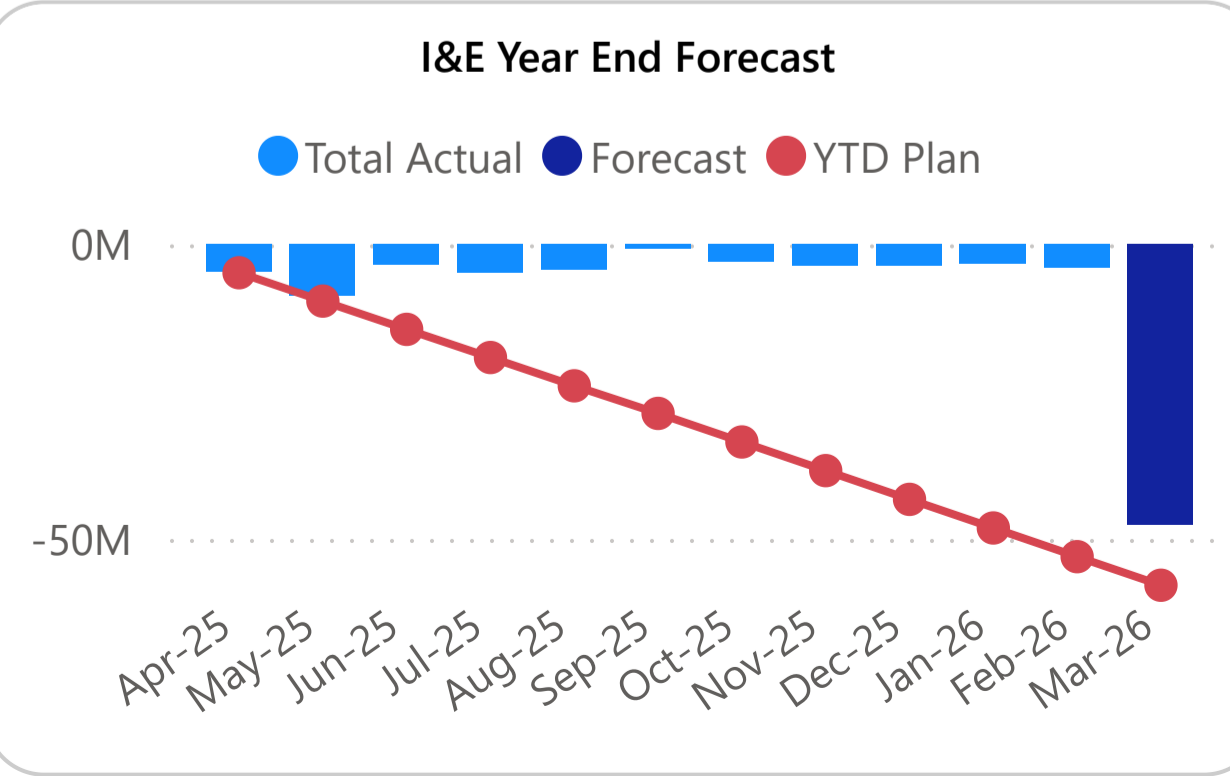
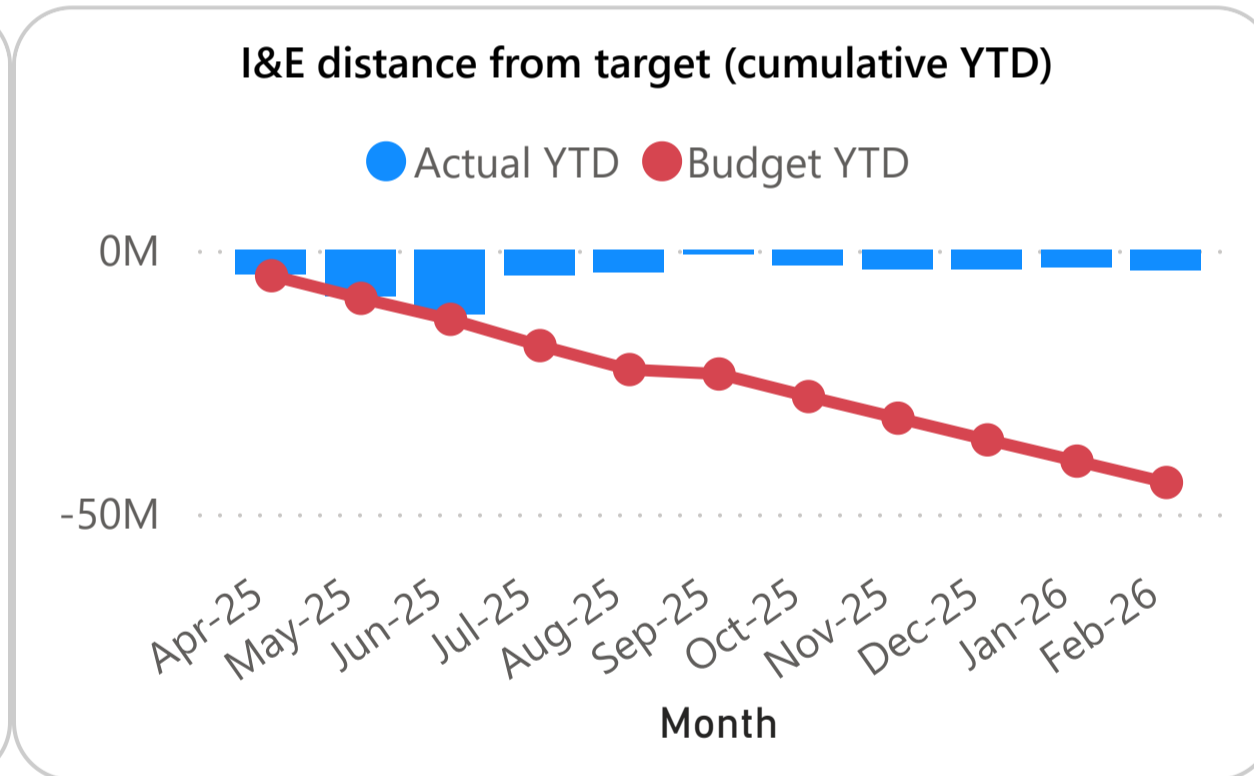
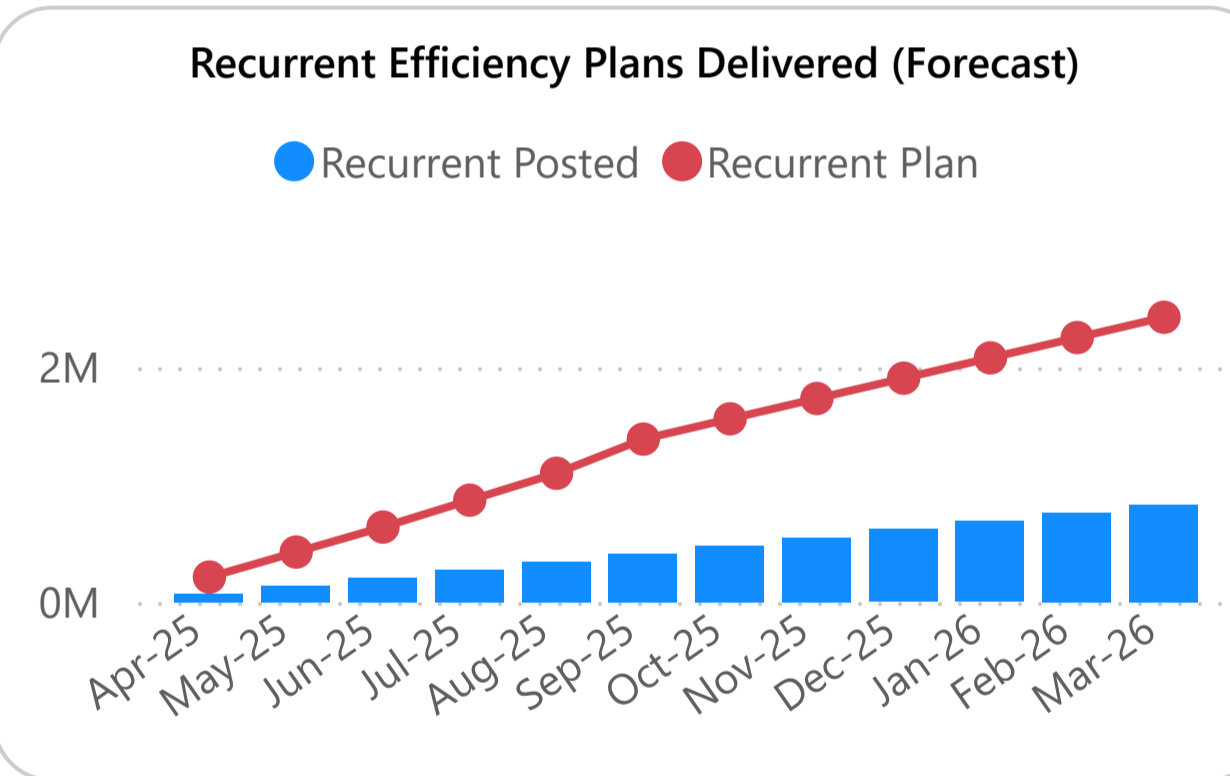
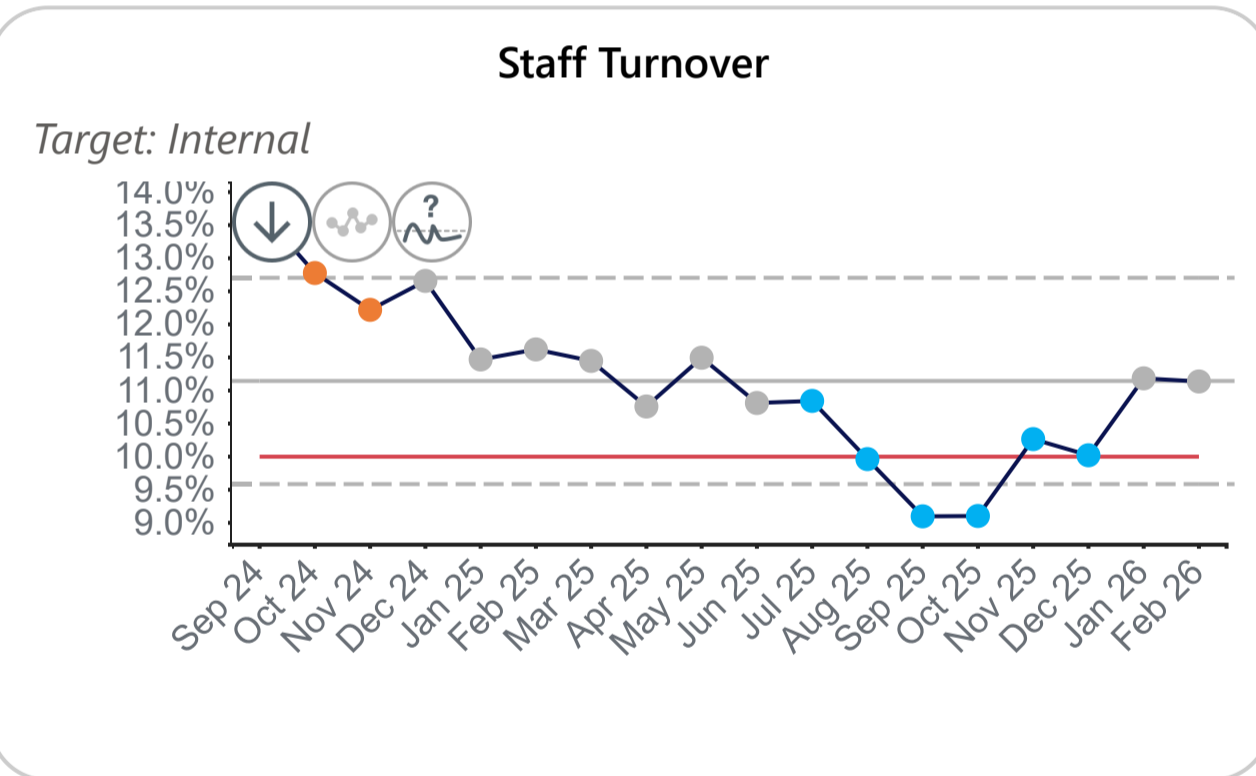
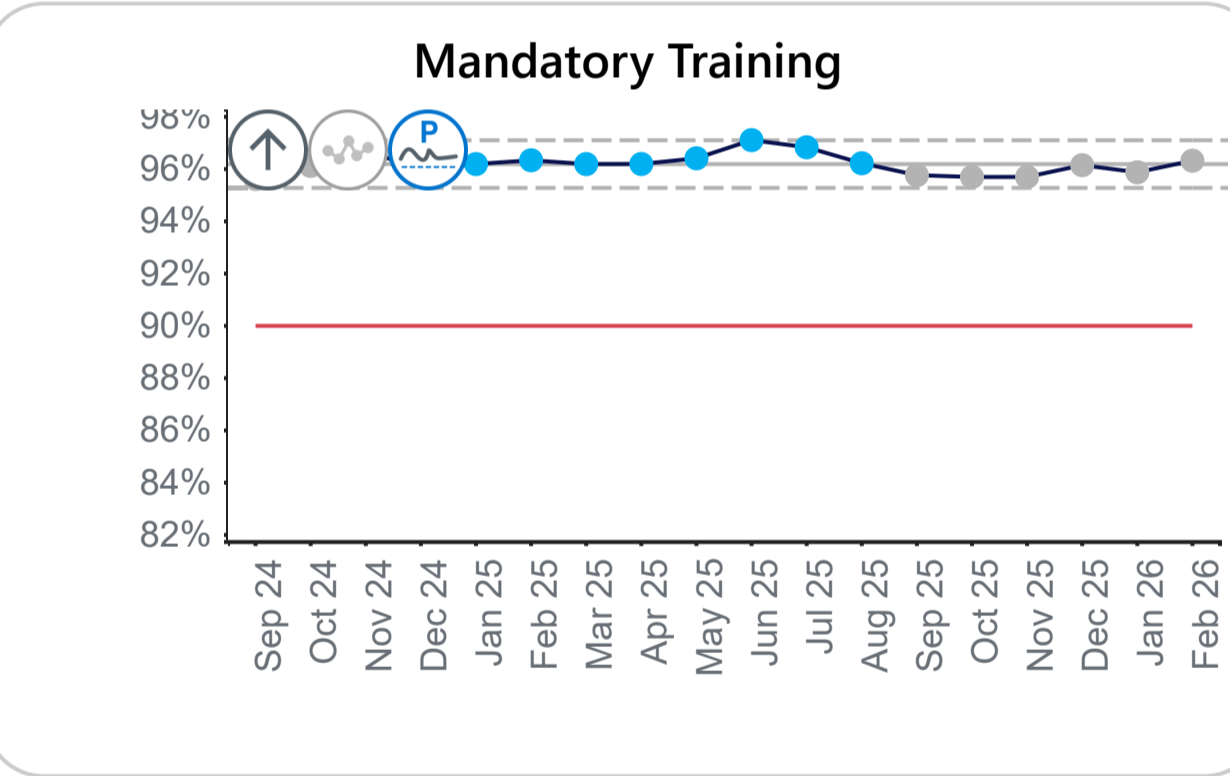
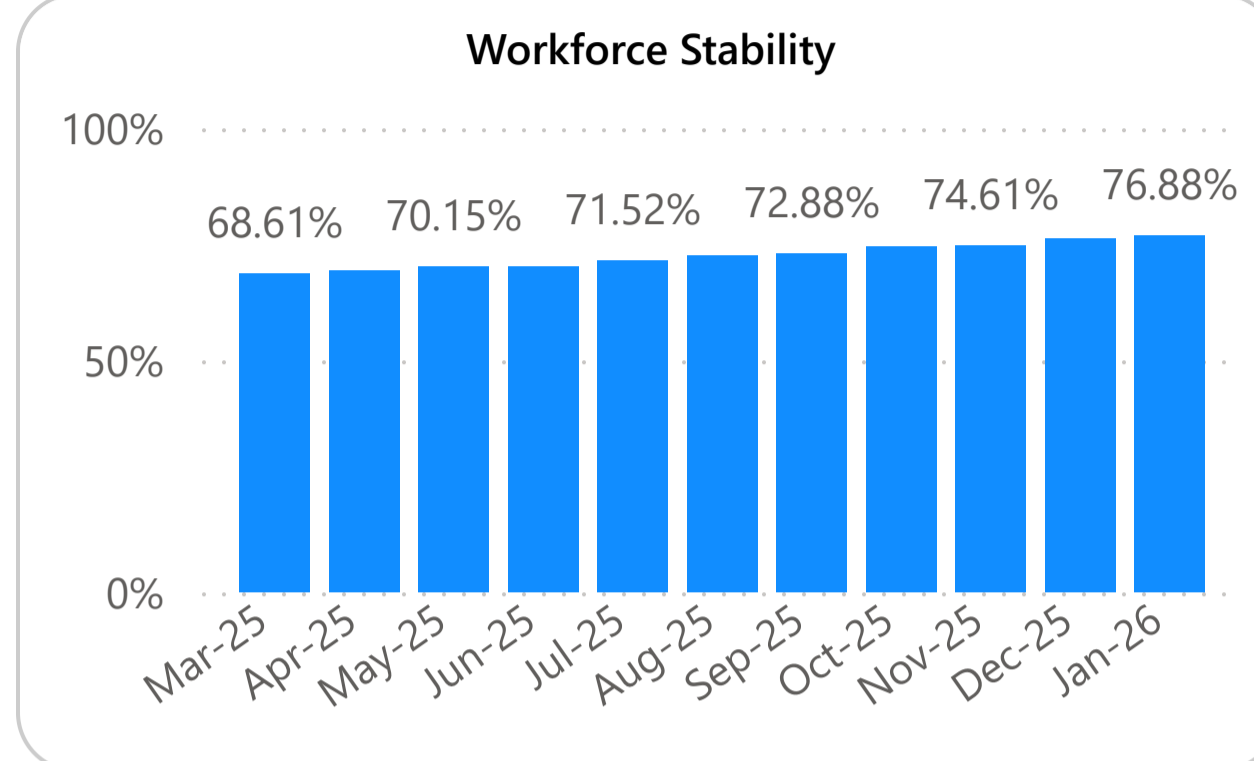
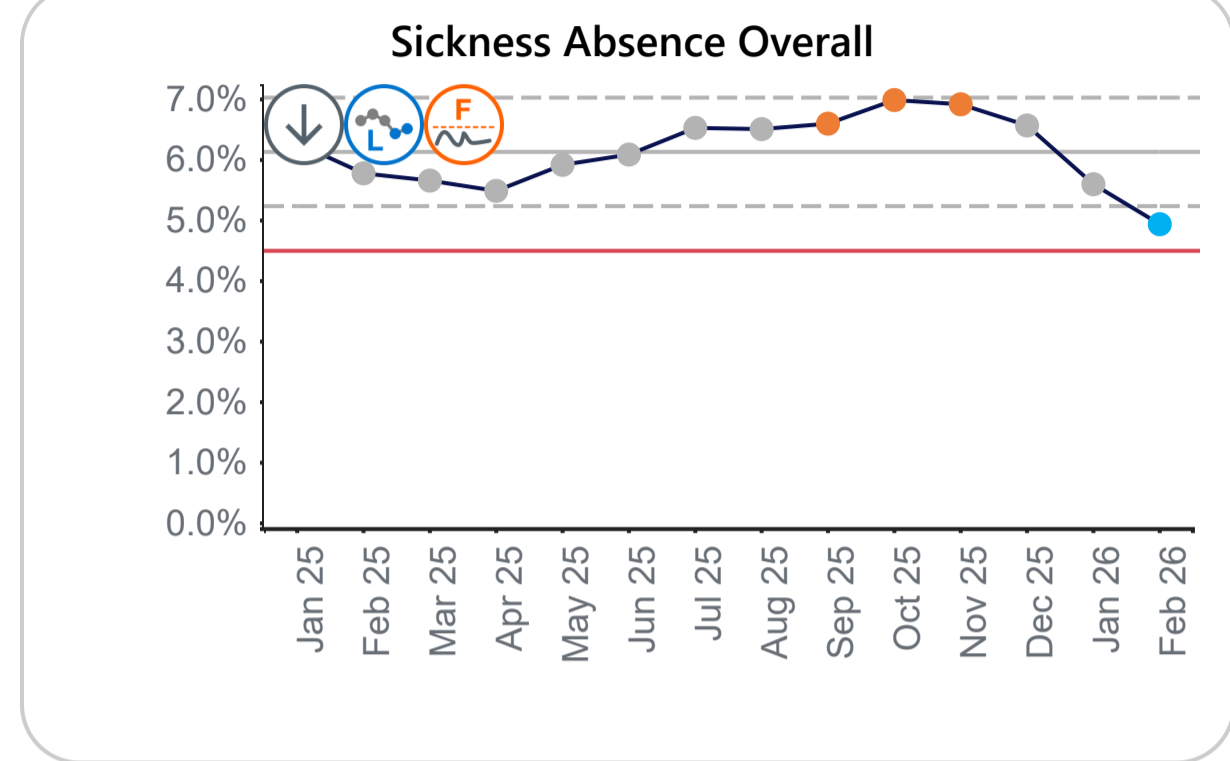
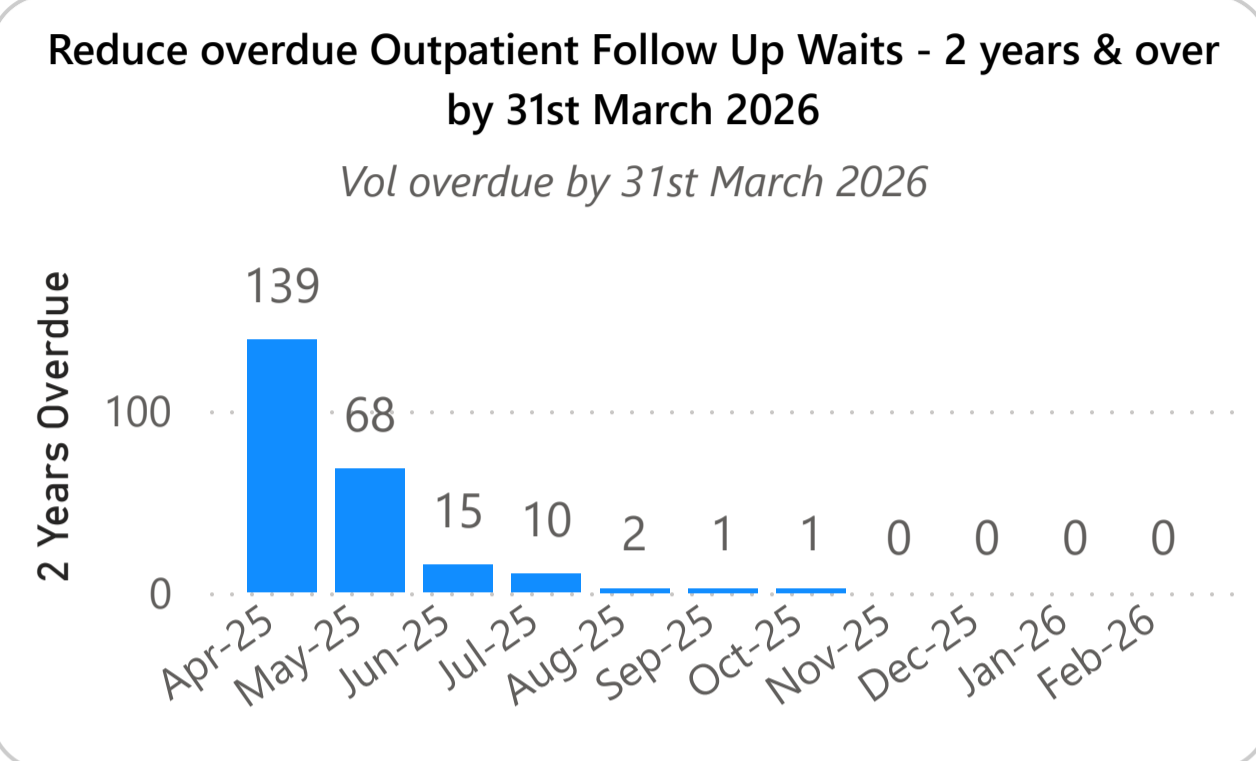
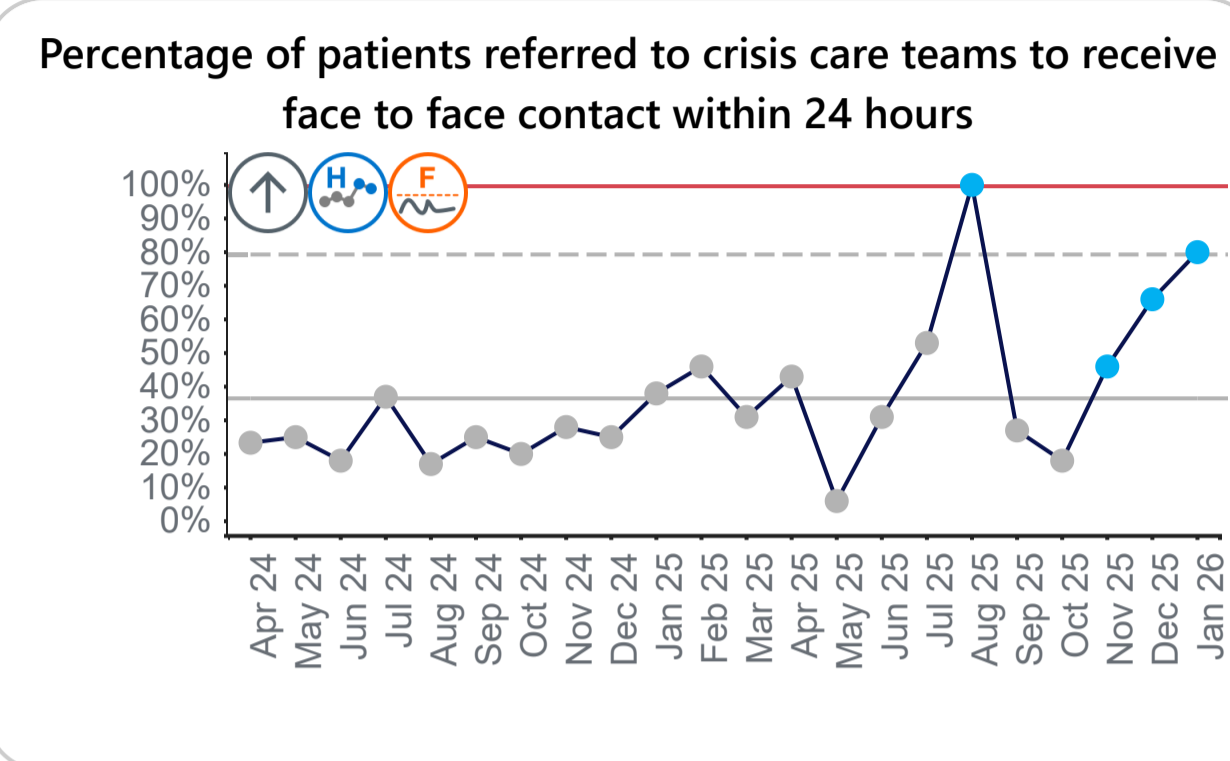
CAMHS: Number of children & young people waiting >52weeks



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



Divisional Performance Summary - Community & Mental Health



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

- Complaints responded to within 25 working days improved in February (n=100%) compared to January (n=60%). PALS responses within 5 days also maintained at 100%.
- Inpatient discharges per working day increased in February to 6 per day from 4 per day in January. This has had a positive impact on maintaining flow within the hospital.
- Daycase and Elective income maintained at 104% of plan, recognising increased complexity.
- OPD News and OPPROCs also maintained above plan in terms of both activity numbers (103%) and financial income (104%).
- We saw a decline in sickness absence in February compared to January which is a positive step if we can maintain this trajectory.
- DM01, the number of Diagnostics complete within 6 weeks, improved in February (n=95%) compared to January (n=90%).
- Follow ups overdue beyond two years reduced to 178 in February. April 2025 this was at 1107, demonstrating a significant improvement.

Areas of Concern

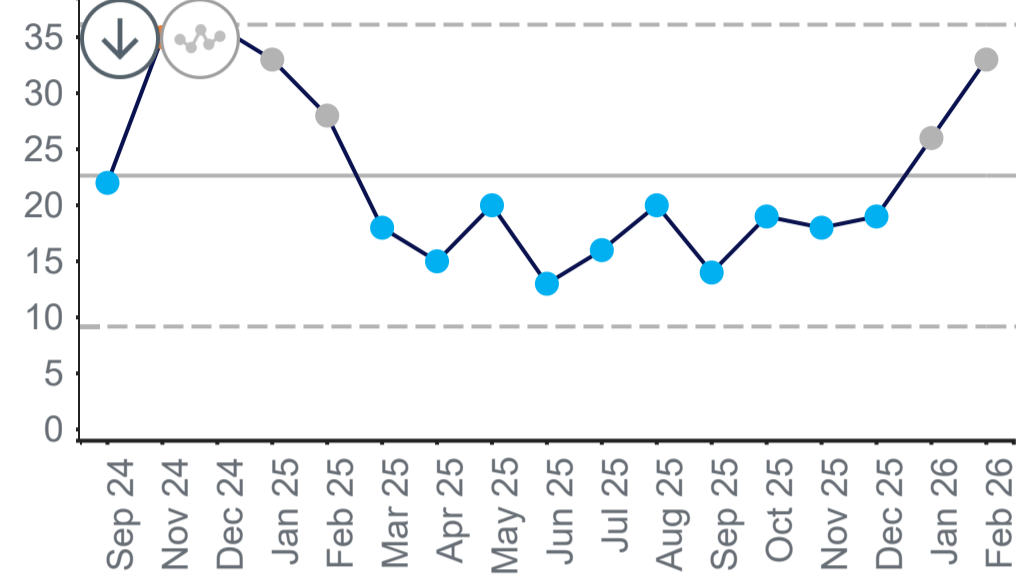
- ED Performance was challenged in February with 80.3% of attendees treated and discharged or transferred to a bed within 4 hours. This is the first month this financial year that we have been below our set plan of 83%. To note, this is still above the national target of 78% for this year.
- The Was Not Brought (WNB) Rate for OPD appointments has maintained at the same position in February of 8%. This is above the Trust target of 6%.
- There were three patients over 52 weeks in February 2026; working is ongoing to address these and return to the position to 0.

Forward Look (with actions)

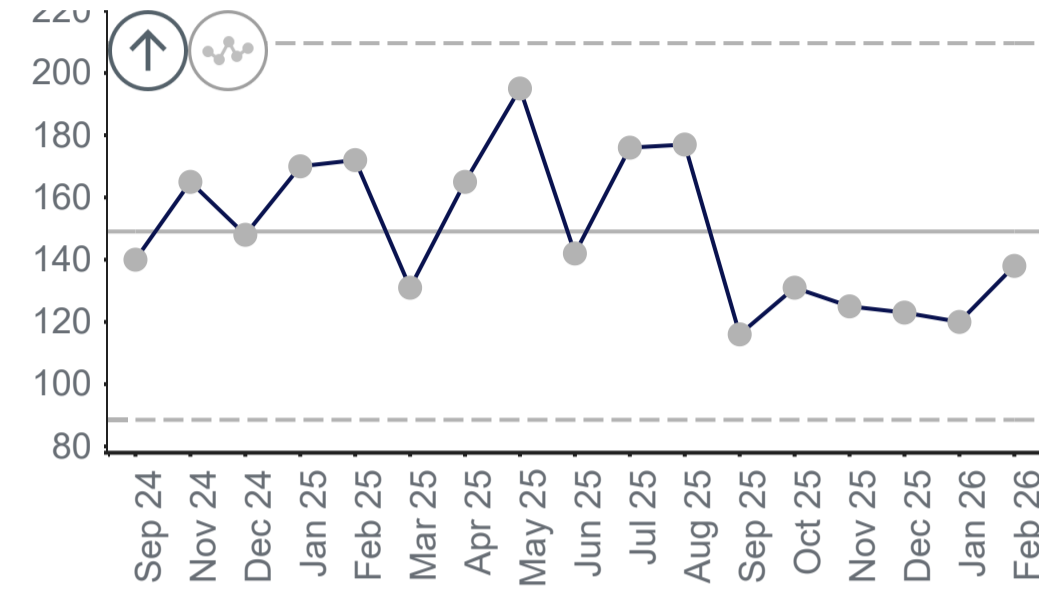
- The ED team are trialling new ways of working with new roles for ACPs and Patient Trackers to improve the 4 hour performance standard within March. Furthermore, work is ongoing to review the baseline medical workforce required to maintain performance.
- The teams are working at speciality level to address risks with WNB patients and reduce the lost capacity overall. The actions are speciality specific and include work with reminders, overbooking and the roll out of opt in services.
- The team continue to focus on patients over 52 weeks to return to previous position.
- There is enhanced focus on DMO1 in March to maintain the improvement further to the challenges we experienced in January. We are focusing on validation, accurate data entry and capacity management.
- We are focusing on the Q4 Sprint to improve the overall RTT position and deliver an improvement.

Divisional Performance Summary - Medicine

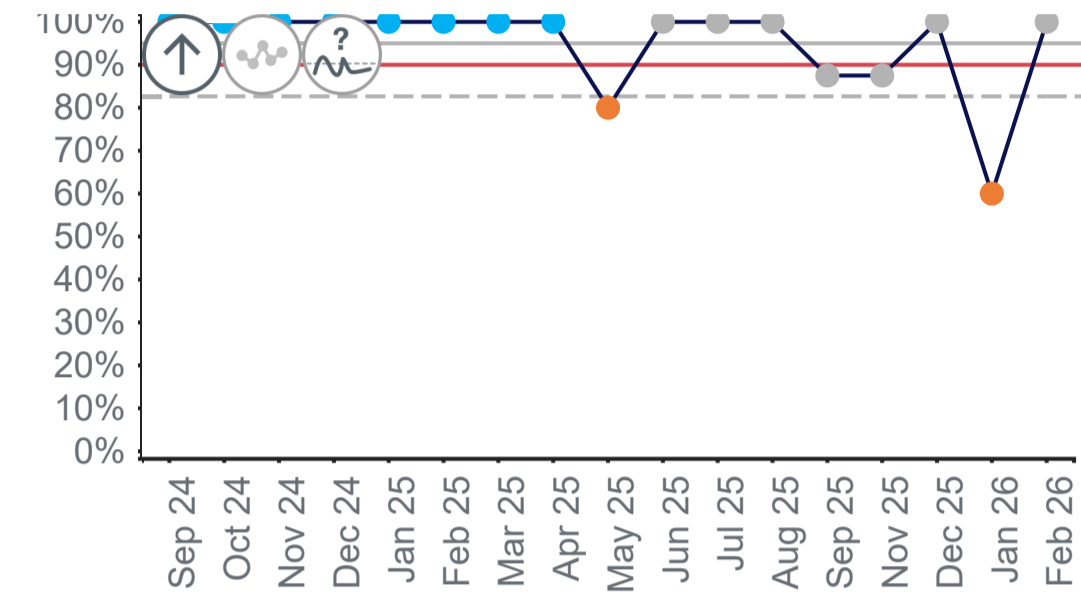
Patient Safety Incidents rated Low Harm & Above



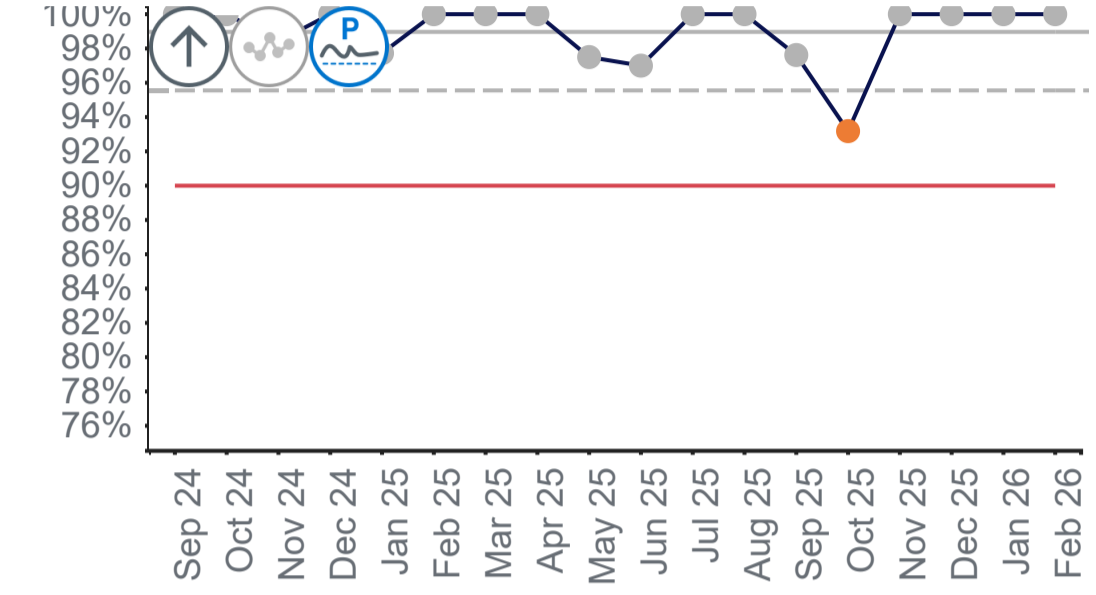
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

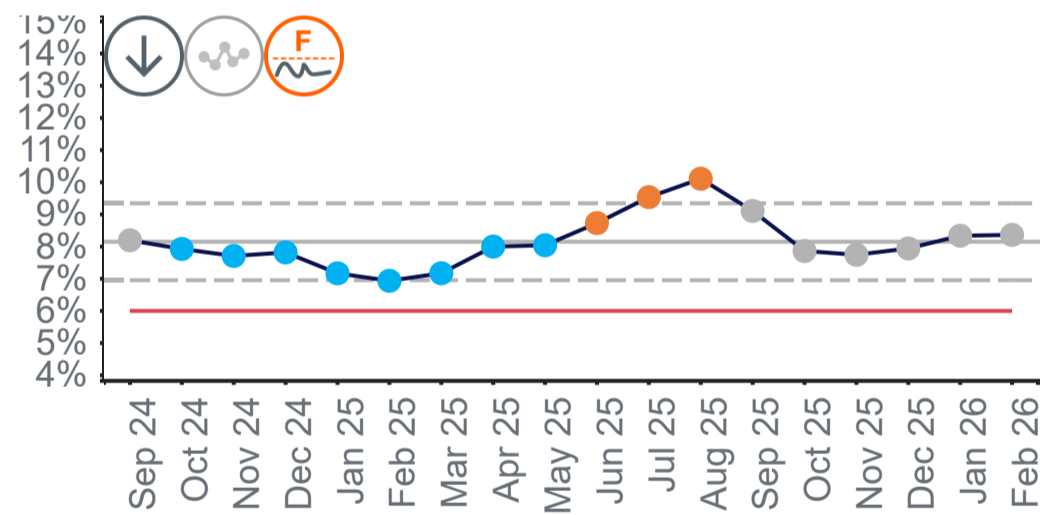


% PALS Resolved within 5 Days

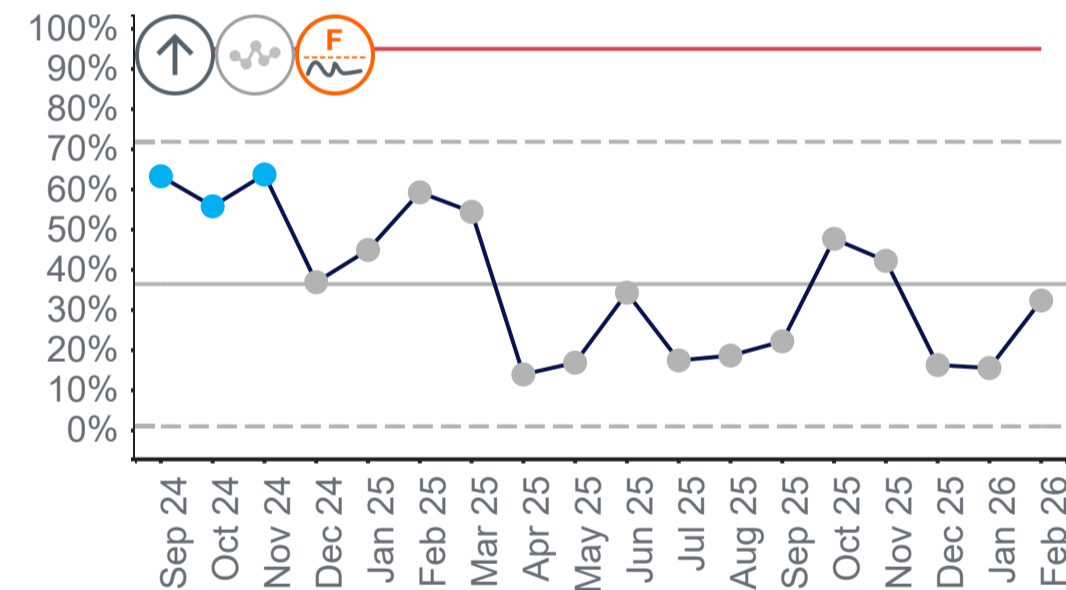


% Was Not Brought Rate (All OP: New and FU)

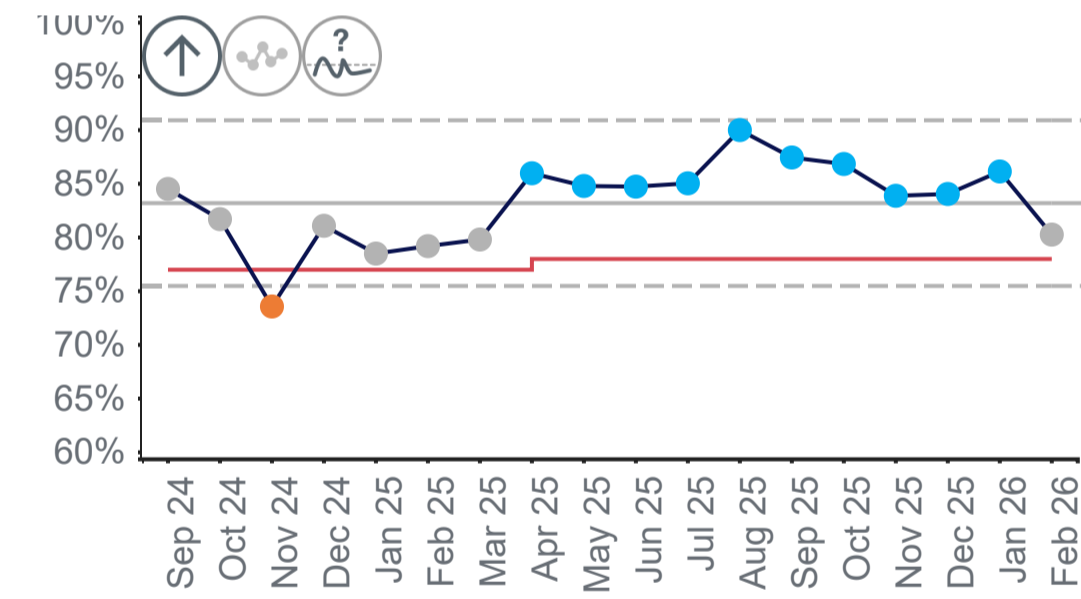
Target: Internal



% of Clinical Letters completed within 10 Days

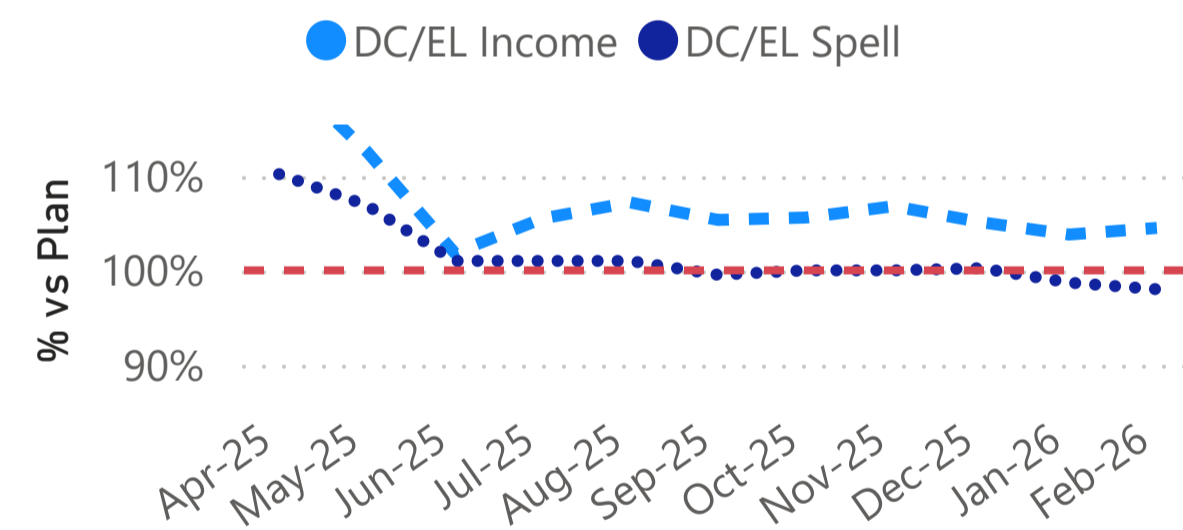


ED: % treated within 4 Hours



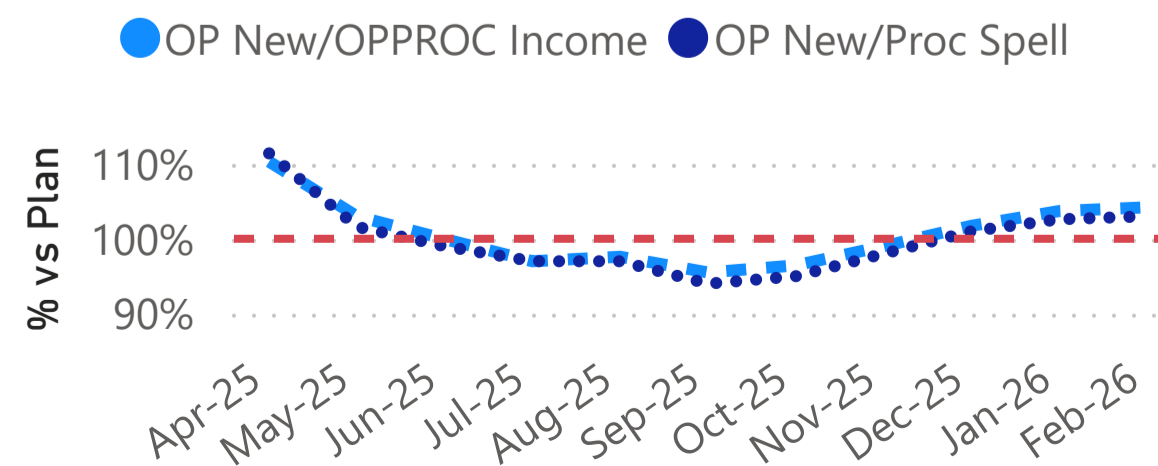
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

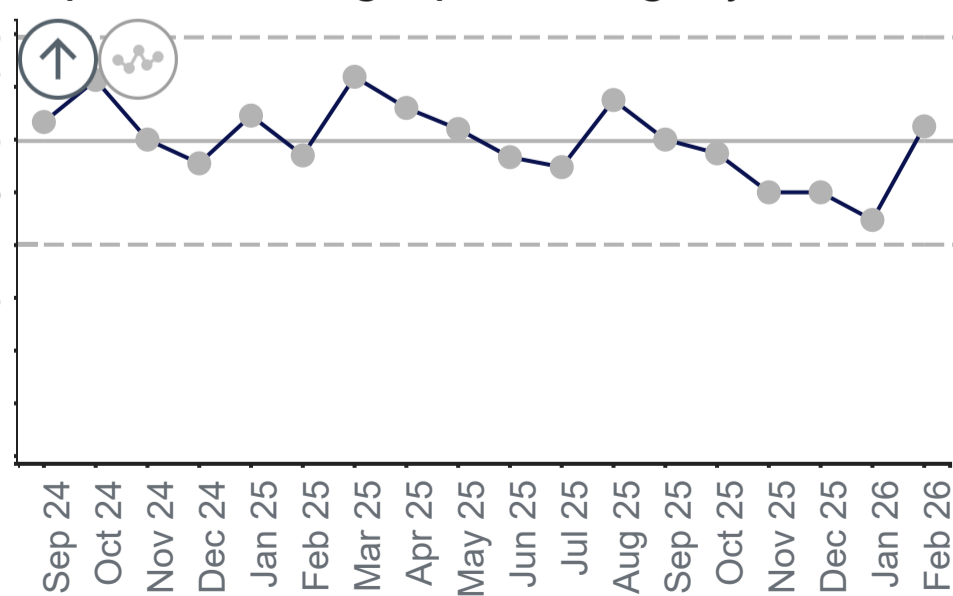


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

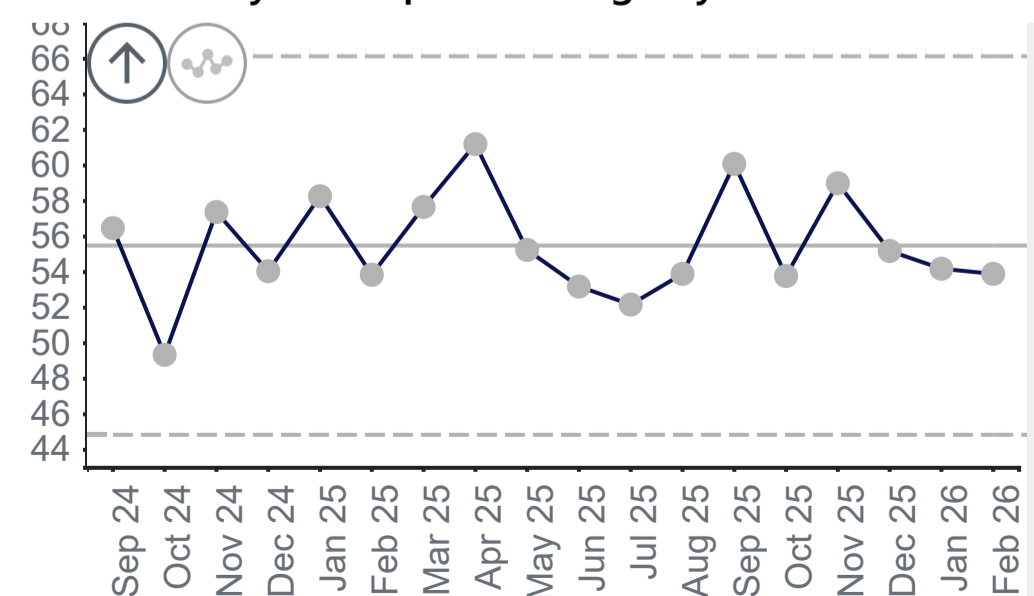
SLAM Performance



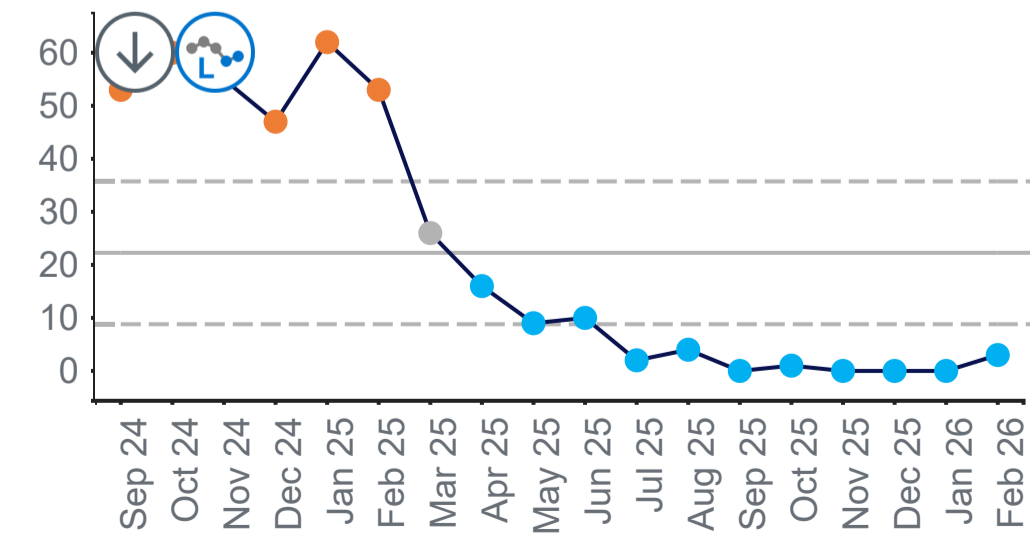
Inpatient Discharges per working day



Day Cases per working day

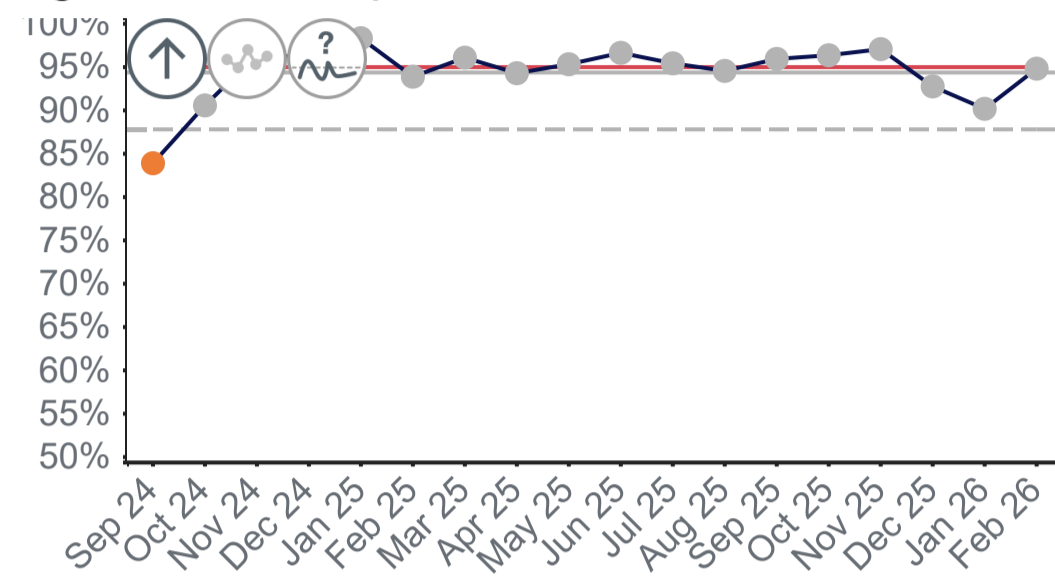


Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



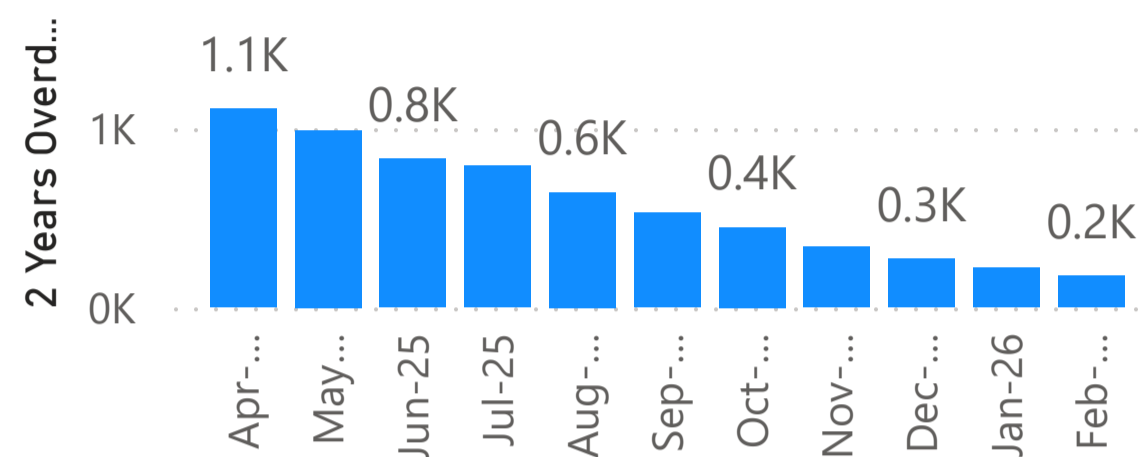
Divisional Performance Summary - Medicine

Diagnostics: % Completed Within 6 Weeks of referral

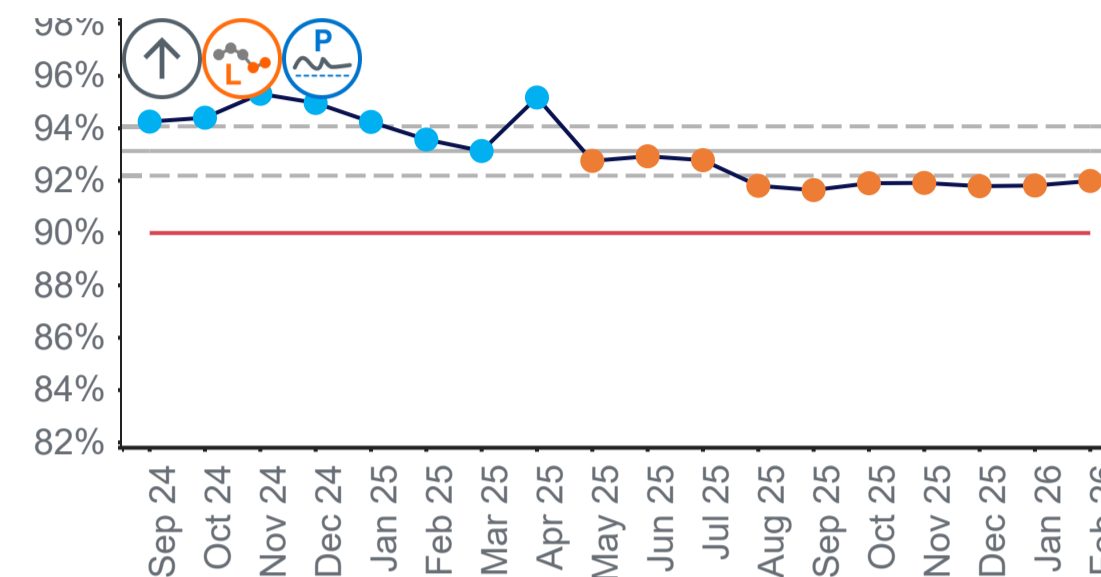


Reduce overdue Outpatient Follow Up Waits - 2 years & over by 31st March 2026

Vol overdue by 31st March 2026

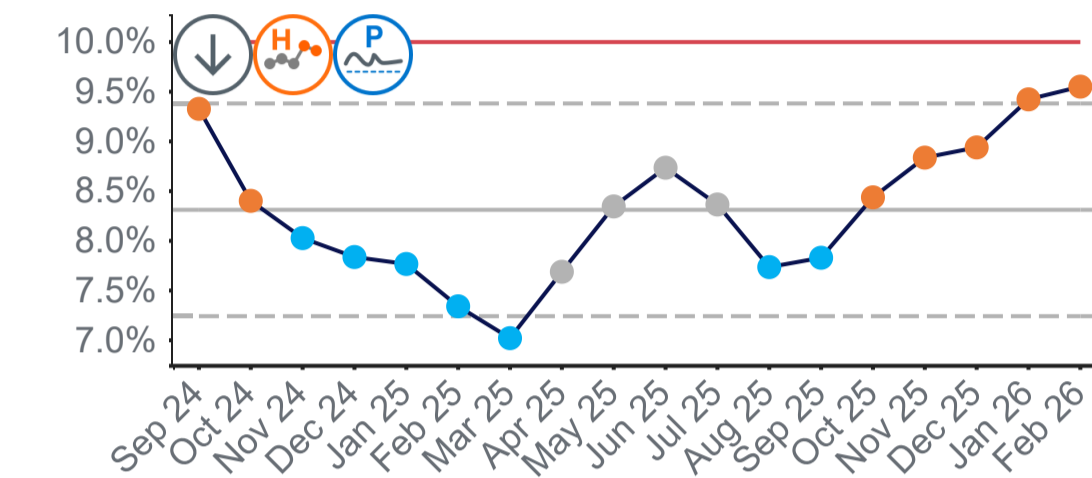


Mandatory Training

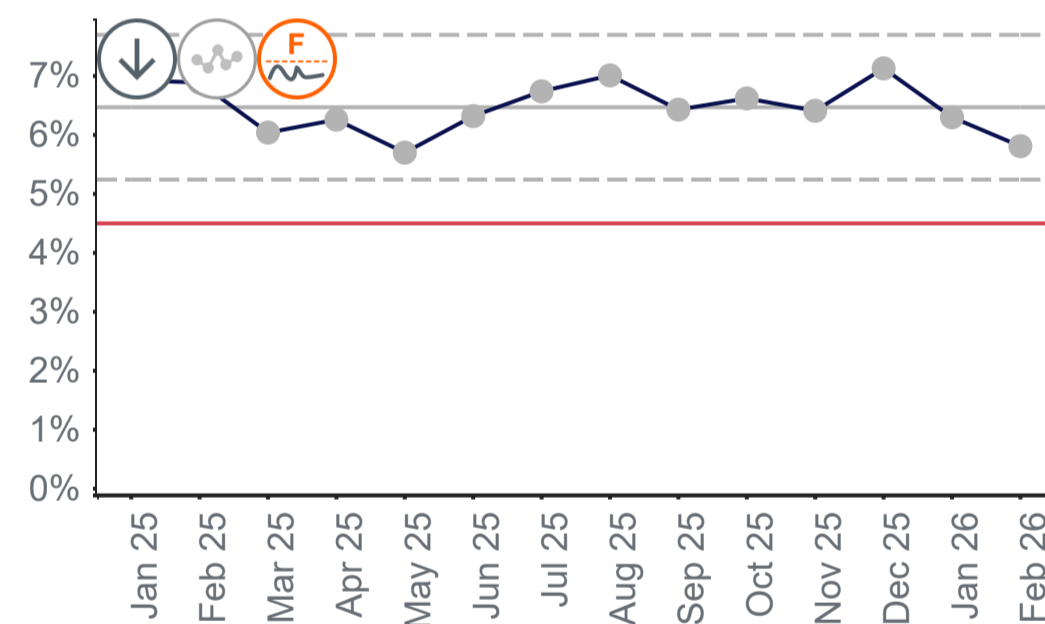


Staff Turnover

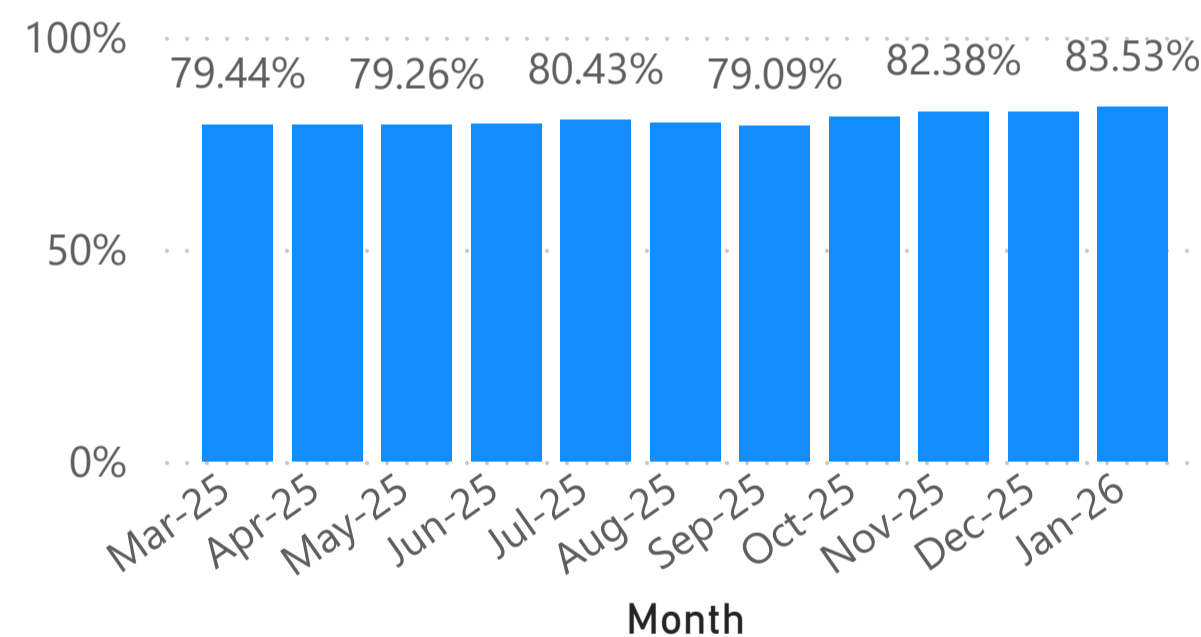
Target: Internal



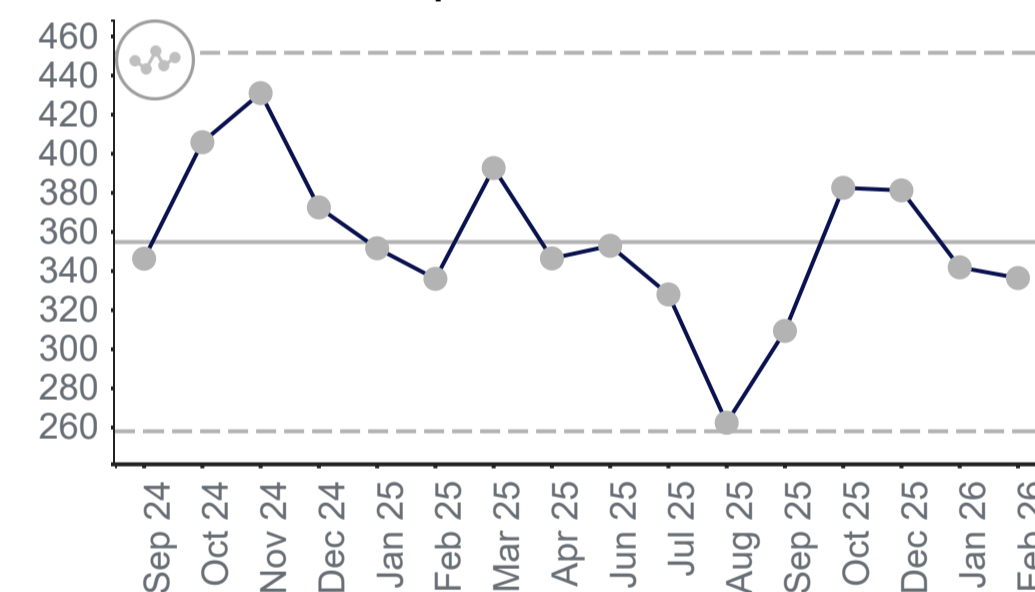
Sickness Absence Overall



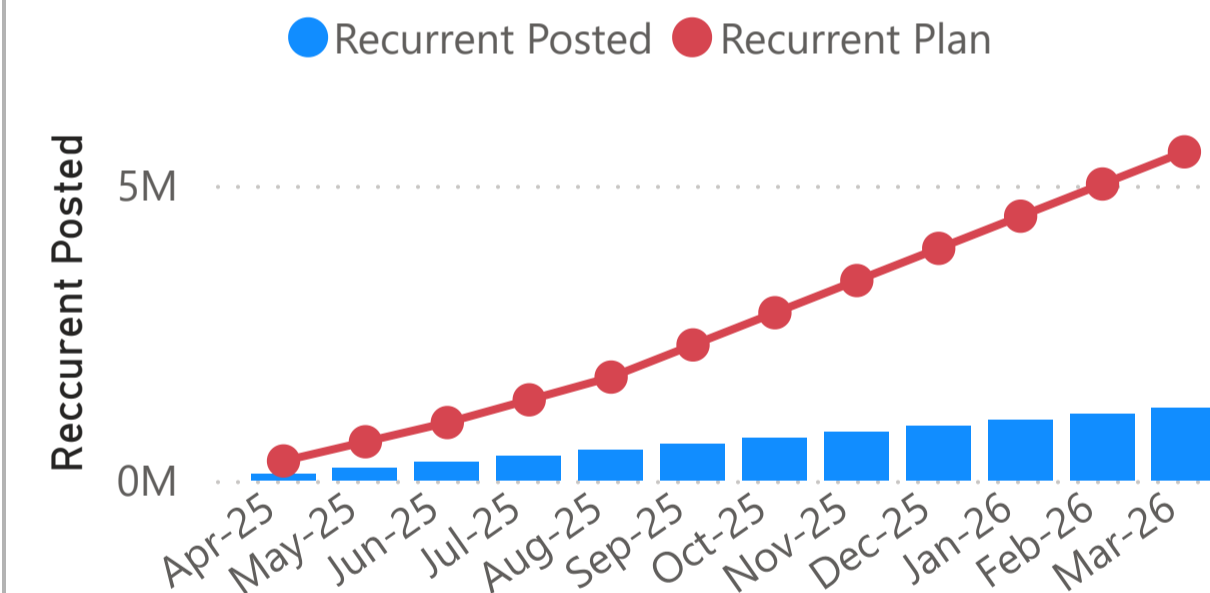
Workforce Stability



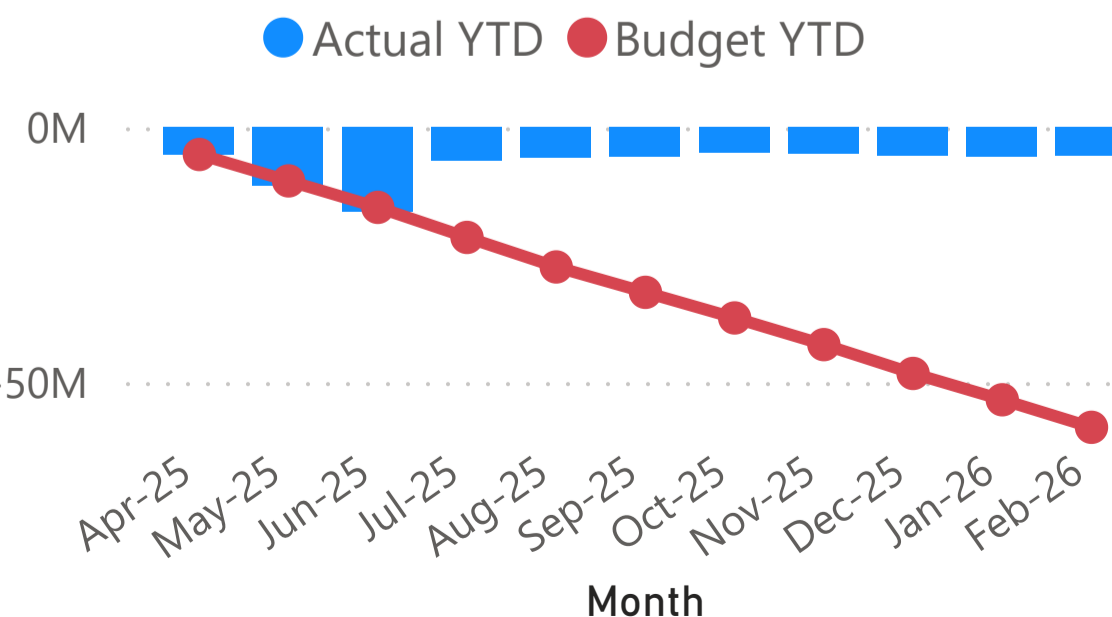
A&E Attendances per ED Consultant WTE



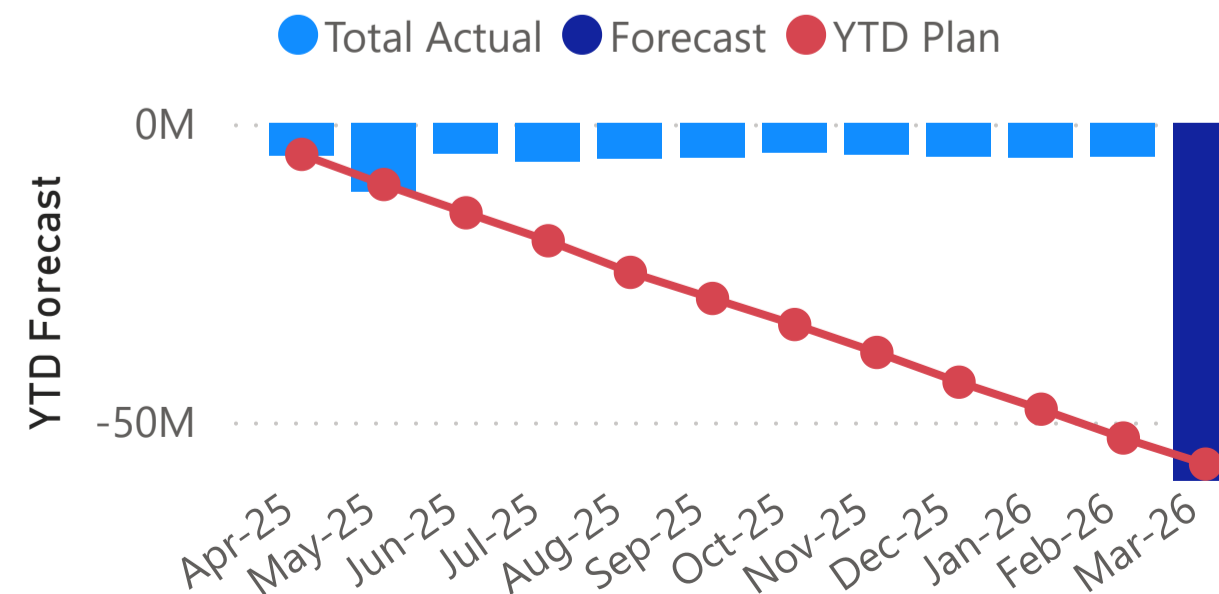
Recurrent Efficiency Plans Delivered (Forecast)



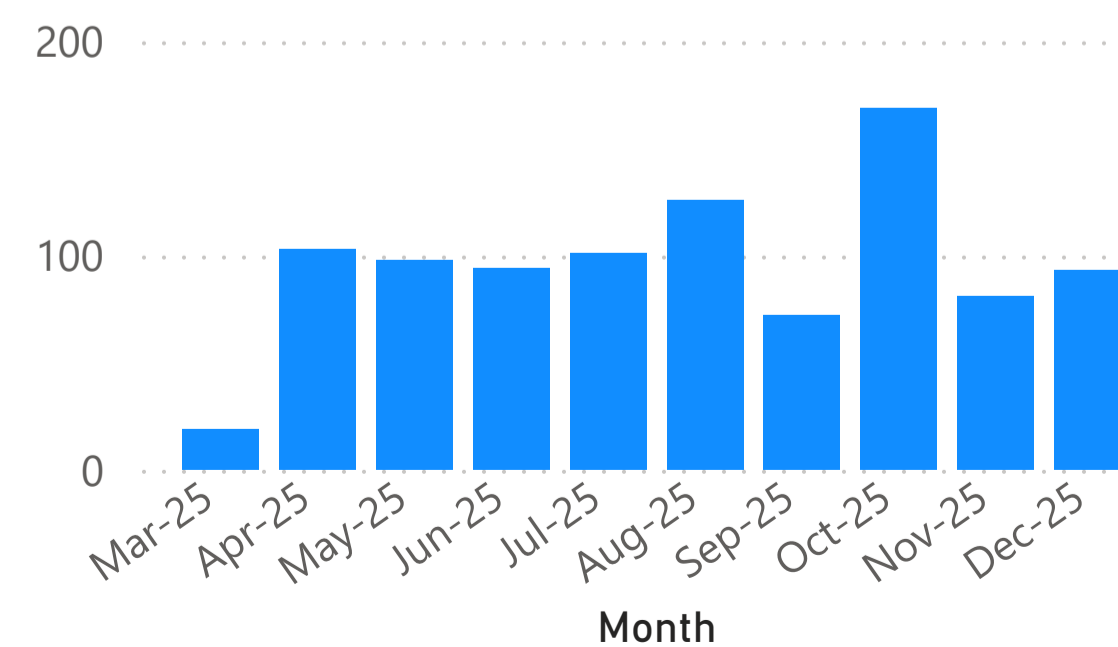
I&E distance from target (cumulative YTD)



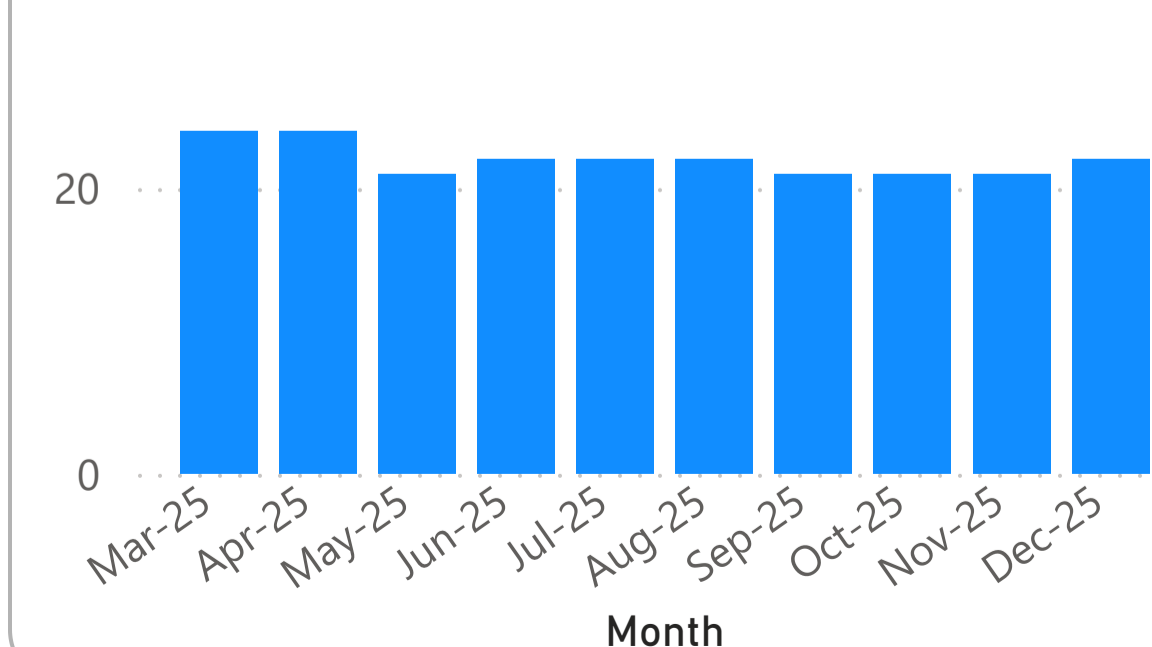
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

- Increase in reporting for patient safety incidents rated no harm showing a strong reporting culture.
- Outpatient NEW and PROC remained above plan (104% income) with a continued step up in activity in March as a result of the national sprint incentive.
- Continued increase in day cases per working day (55) for the 3rd consecutive months as a result of targeted improvement work to convert inpatient pathways and targeted productivity schemes.
- RTT patients waiting over 52 weeks decreased and is in line with trajectory at 240 patients.
- PALS compliance remains above Trust target despite an increase in volume.
- DM01 achieved trust target at 95%.
- Although below Trust target, WNB rate decreased for the 3rd consecutive month.

Areas of Concern

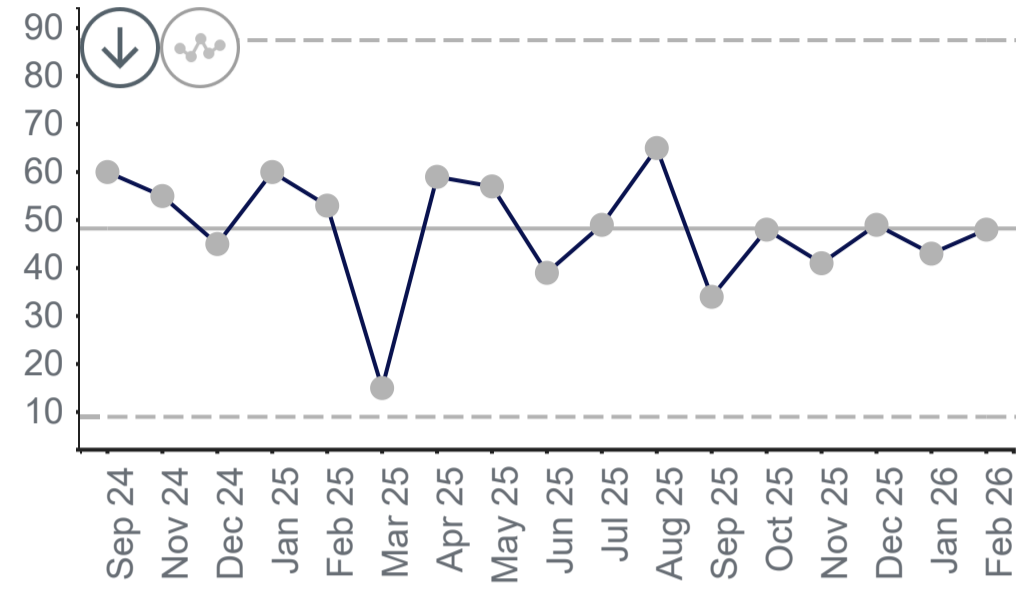
- Sickness absence has reduced in month but remains above trust target at 7%.
- Overdue follow ups remain high, however has reduced by 50% as a division since the start of year taking the total patients from 8600 to 4300. Key areas of concern remain within Paediatric Surgery, Plastic Surgery & Audiology.
- Compliance with formal complaints response reduced to 50% in month. 2 cases out of 4 breached due to complexity, the further 2 had extensions granted & require removal from the data.

Forward Look (with actions)

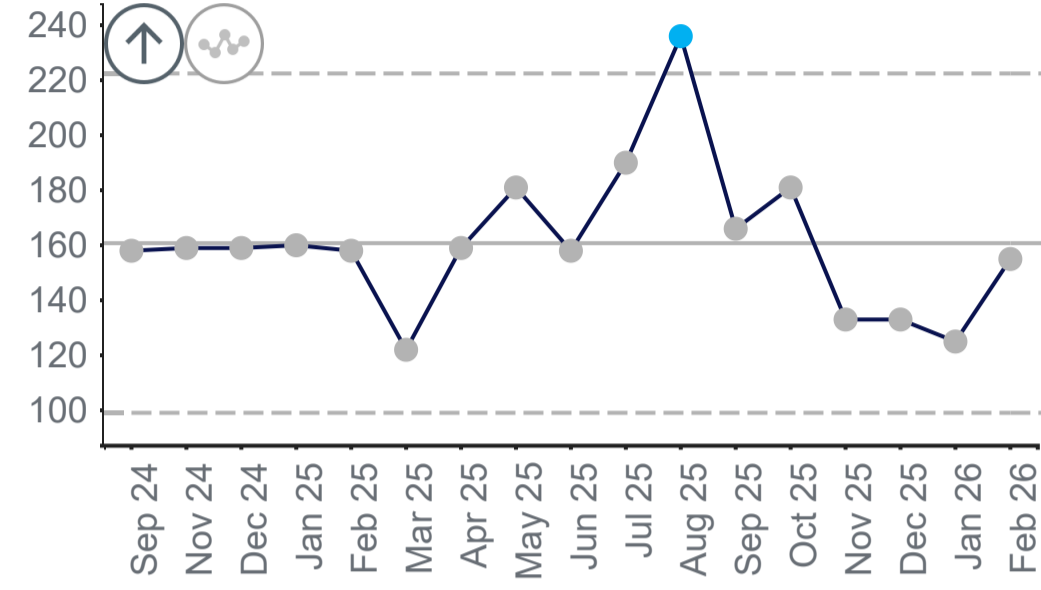
- Top 3 risk areas for 2-year overdue follow ups have action plans with agreed timescales for clearance. All have clinical leadership and will report into the Divisional Integrated Governance meeting.
- Day case improvement work to continue with a strong work plan going into 2026/27. To include focused improvement on reducing cancelled operations within 72 hours, maximising and expanding physical day case capacity and implementing a full theatre management system to support maximum efficiencies across the department.
- Work continues at speciality level to target WNB via continued rollout of opt out alongside targeting lost capacity via safe overbooking.
- Divisional governance lead meeting with data team to review process around formal complaints data to ensure accurate capture. Divisional weekly complaints review meeting continues and will focus on review of any themes from complex complaints.
- Continue to work closely with HR team to focus on sickness management.

Divisional Performance Summary - Surgery

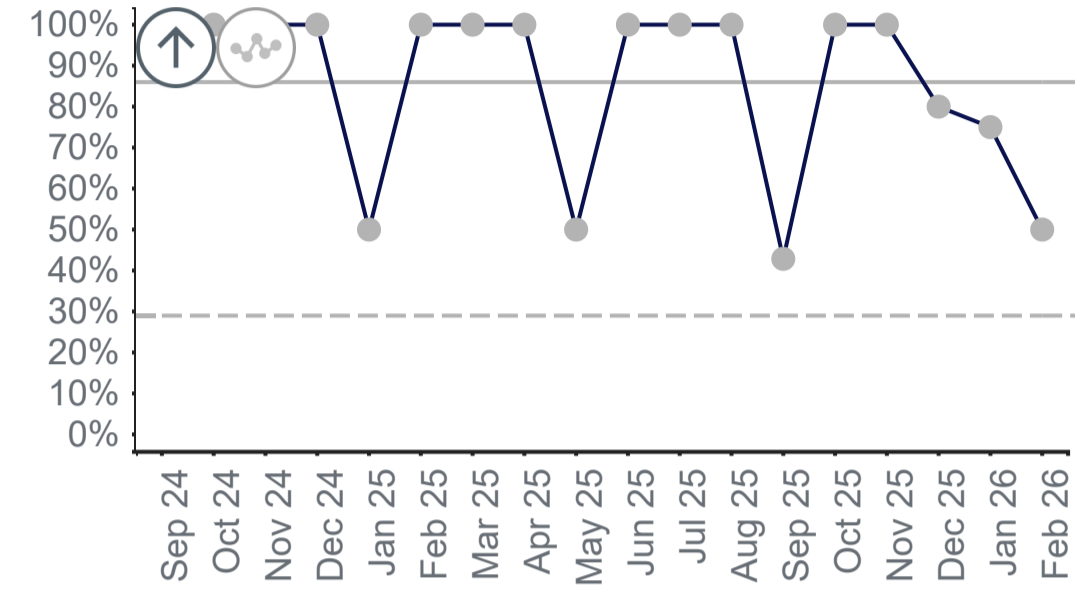
Patient Safety Incidents rated Low Harm & Above



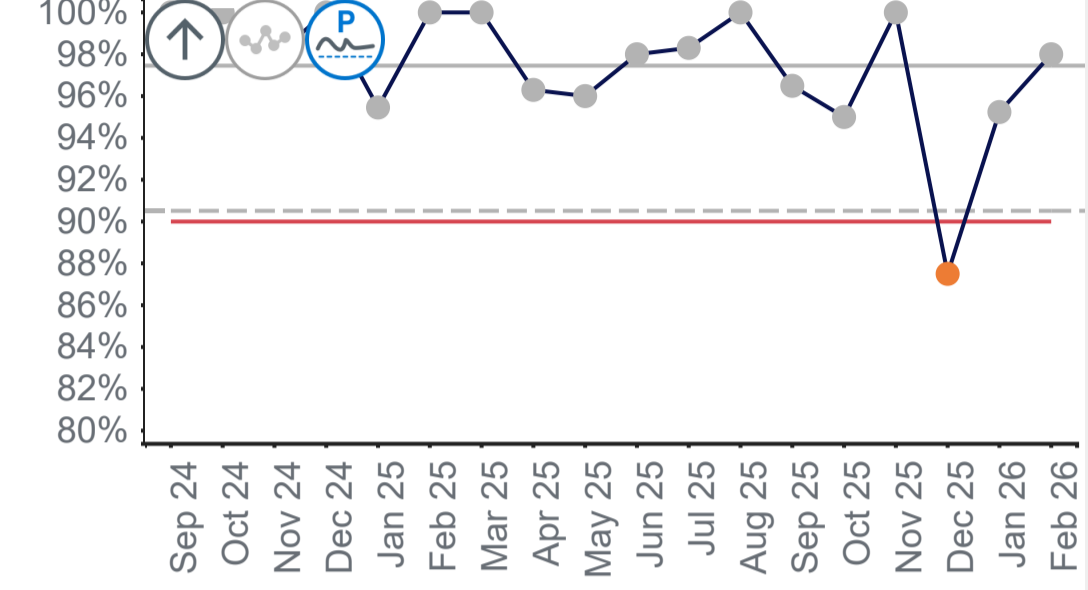
Patient Safety Incidents rated No Harm



% Complaints Responded to within 25 working days

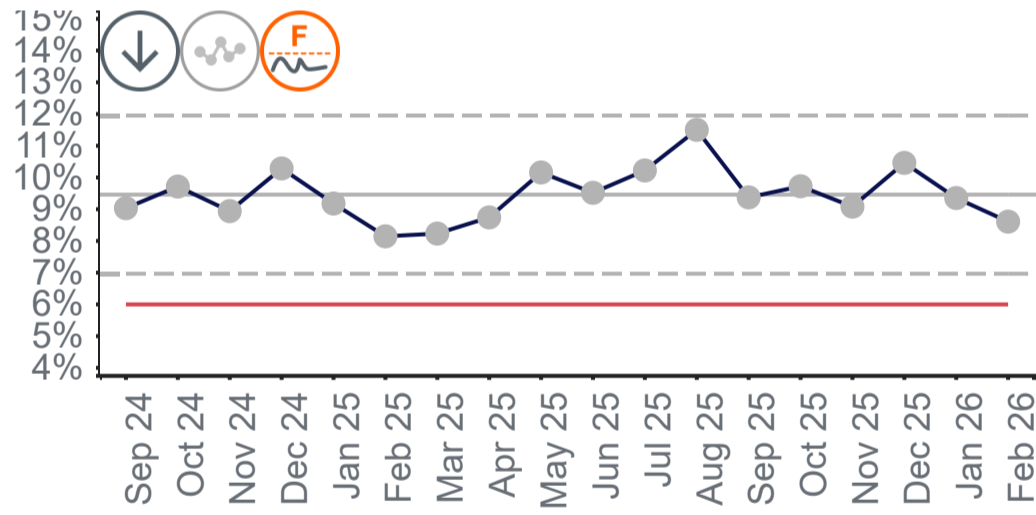


% PALS Resolved within 5 Days

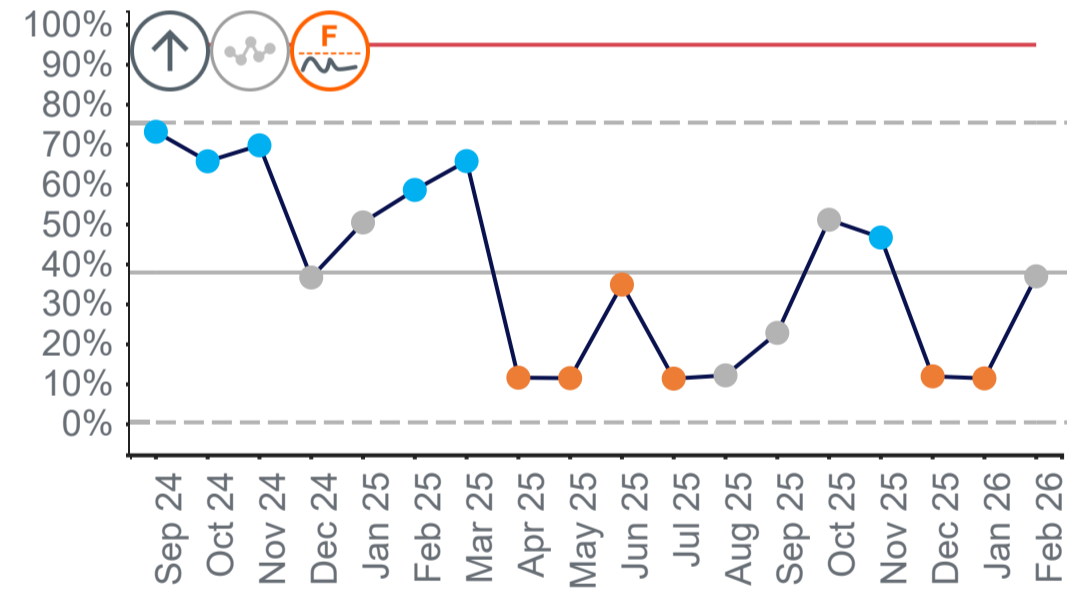


% Was Not Brought Rate (All OP: New and FU)

Target: Internal

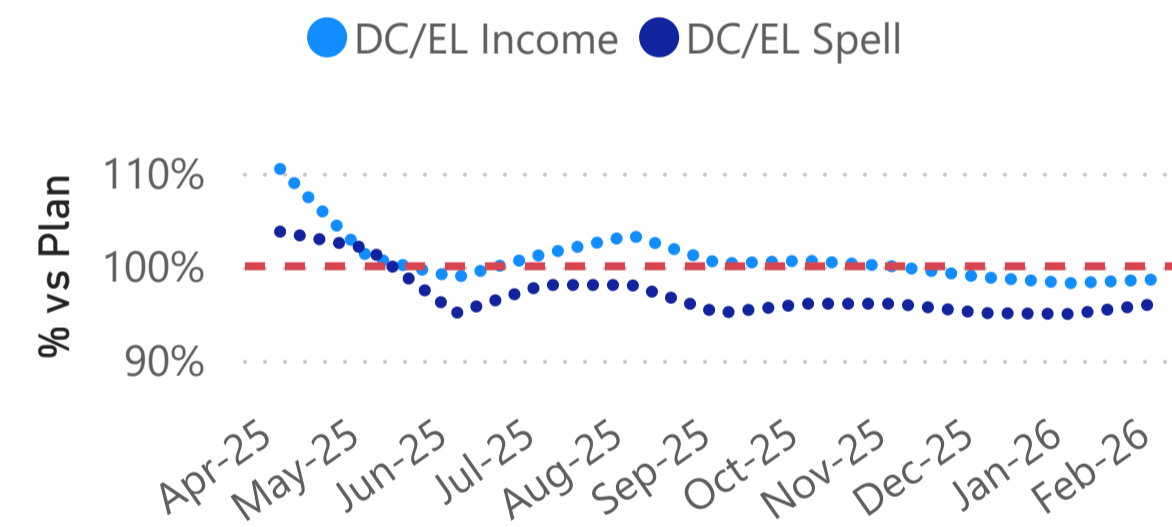


% of Clinical Letters completed within 10 Days



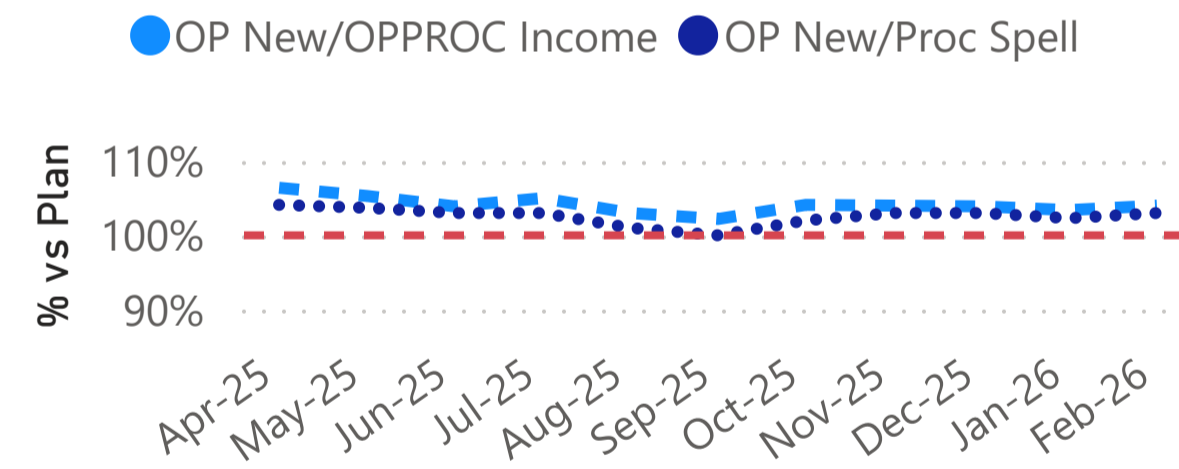
Elective & Daycase Income and Spells vs Plan (YTD Position)

SLAM Performance

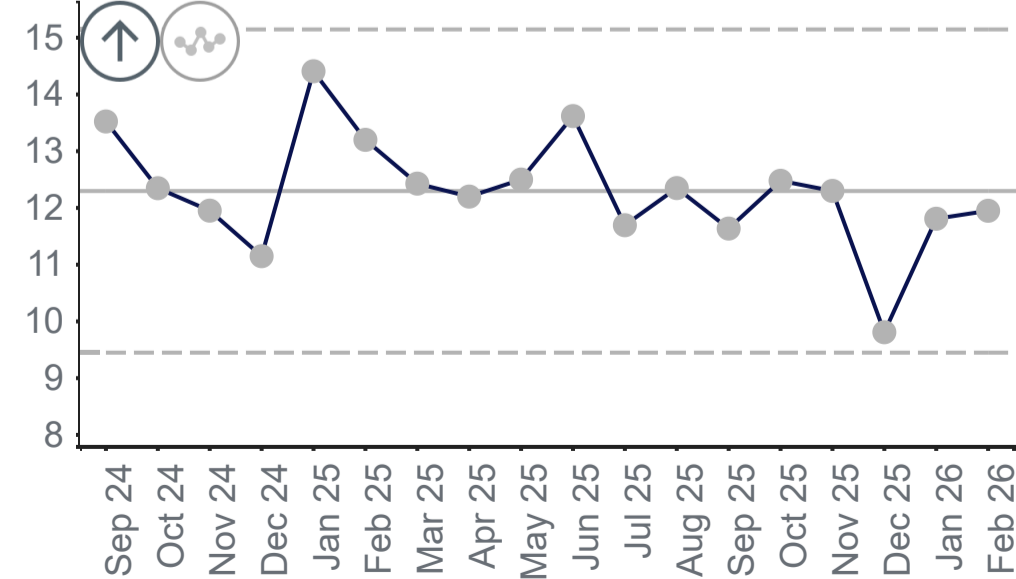


Outpatient New & OPPROC Income and Activity vs Plan (YTD Position)

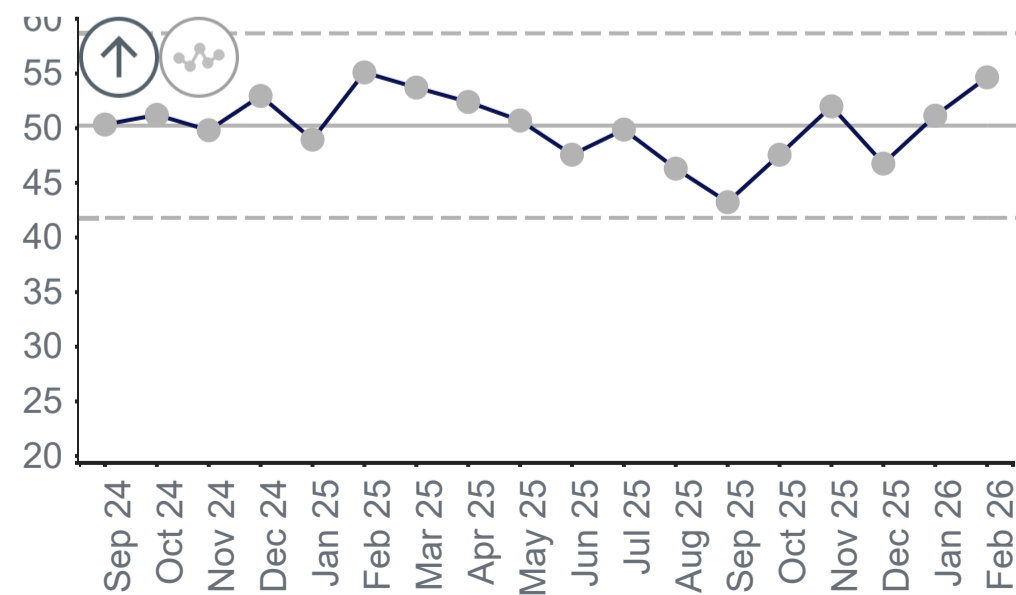
SLAM Performance



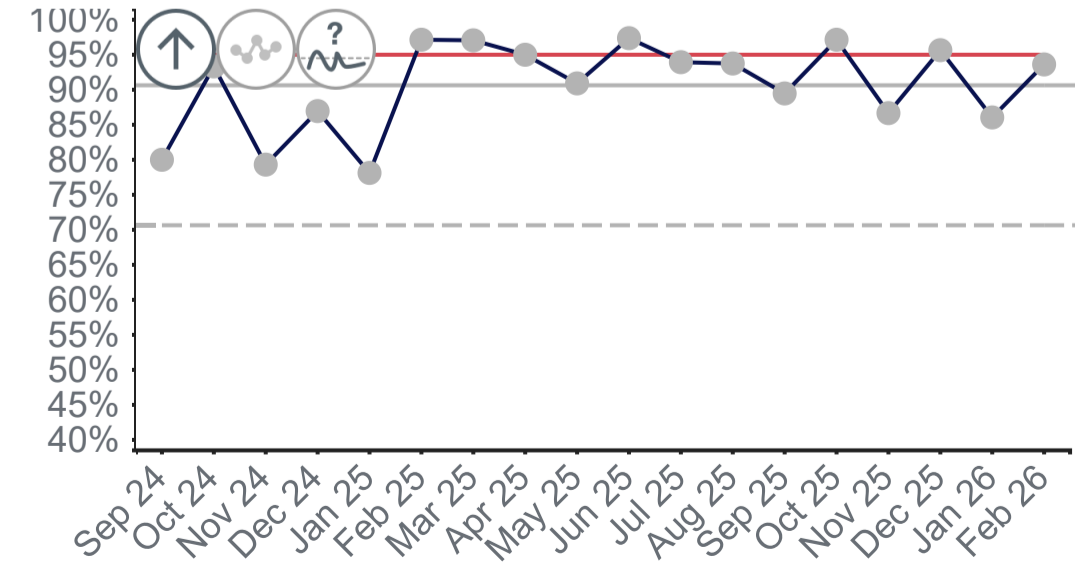
Inpatient Discharges per working day



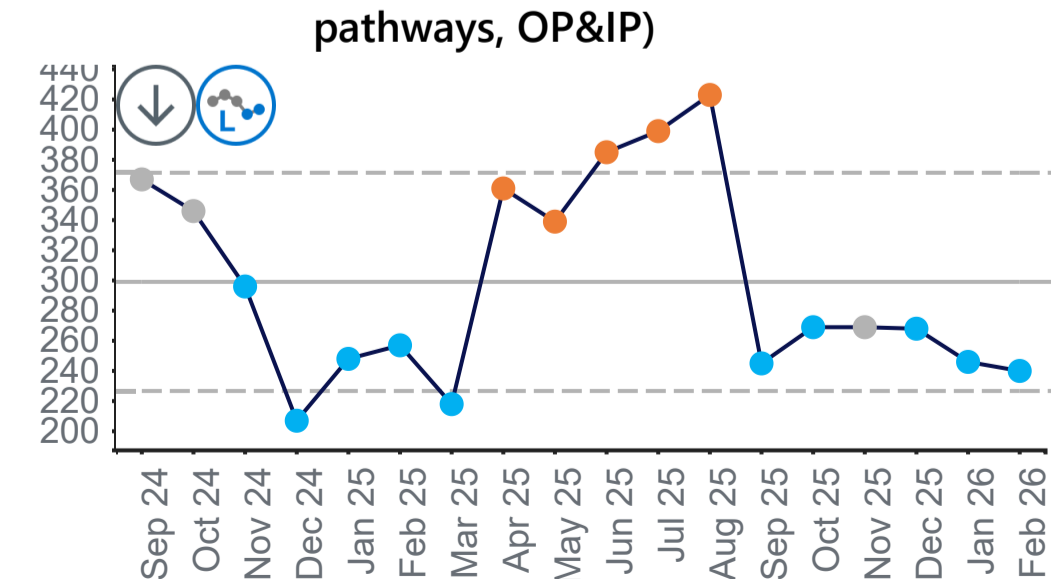
Day Cases per working day



Diagnostics: % Completed Within 6 Weeks of referral



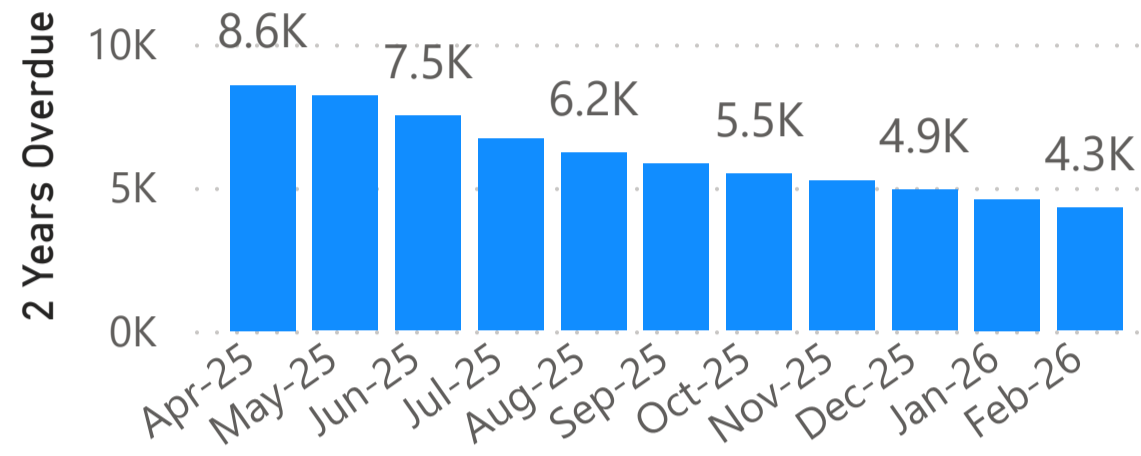
Number of RTT Patients waiting >52 weeks (Incomplete pathways, OP&IP)



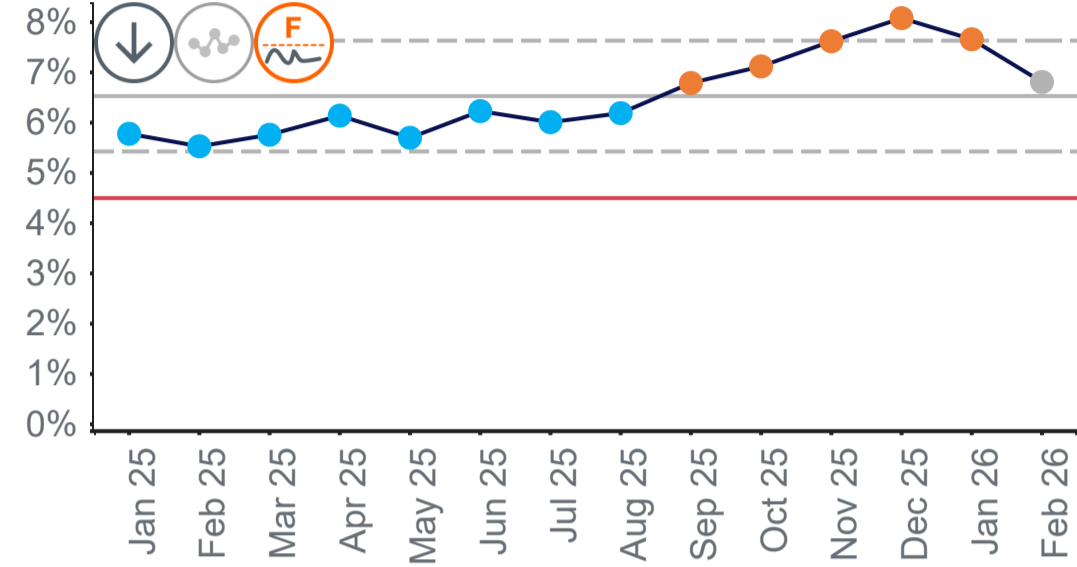
Divisional Performance Summary - Surgery

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

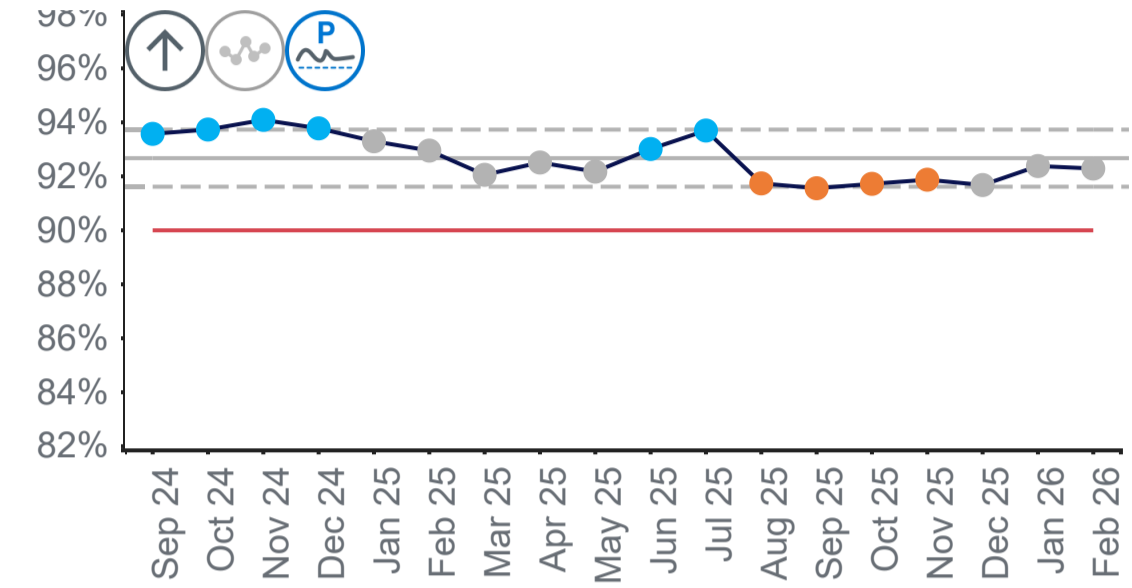
Vol overdue by 31st March 2026



Sickness Absence Overall

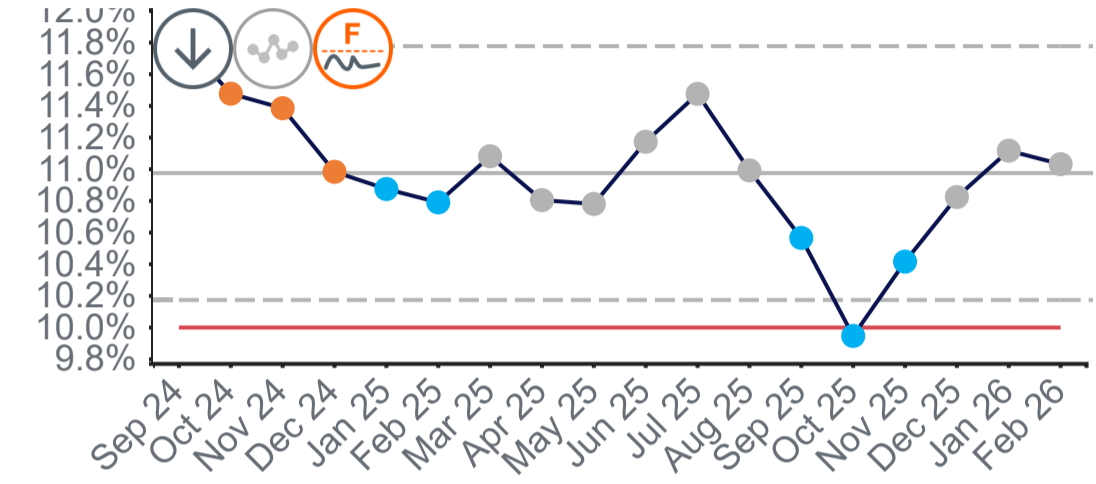


Mandatory Training

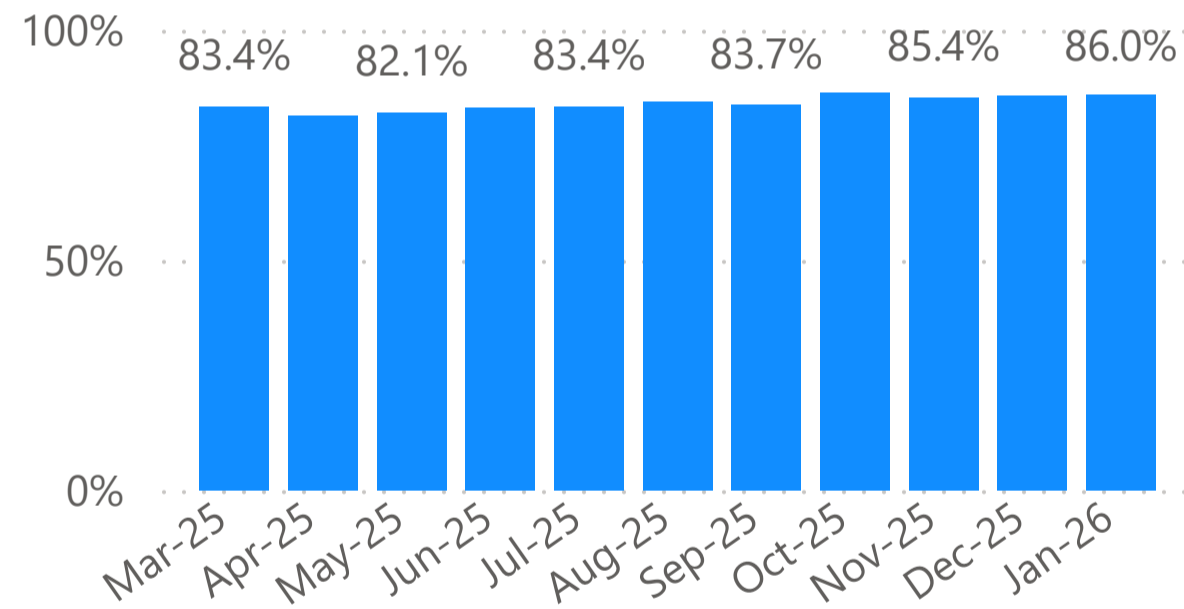


Staff Turnover

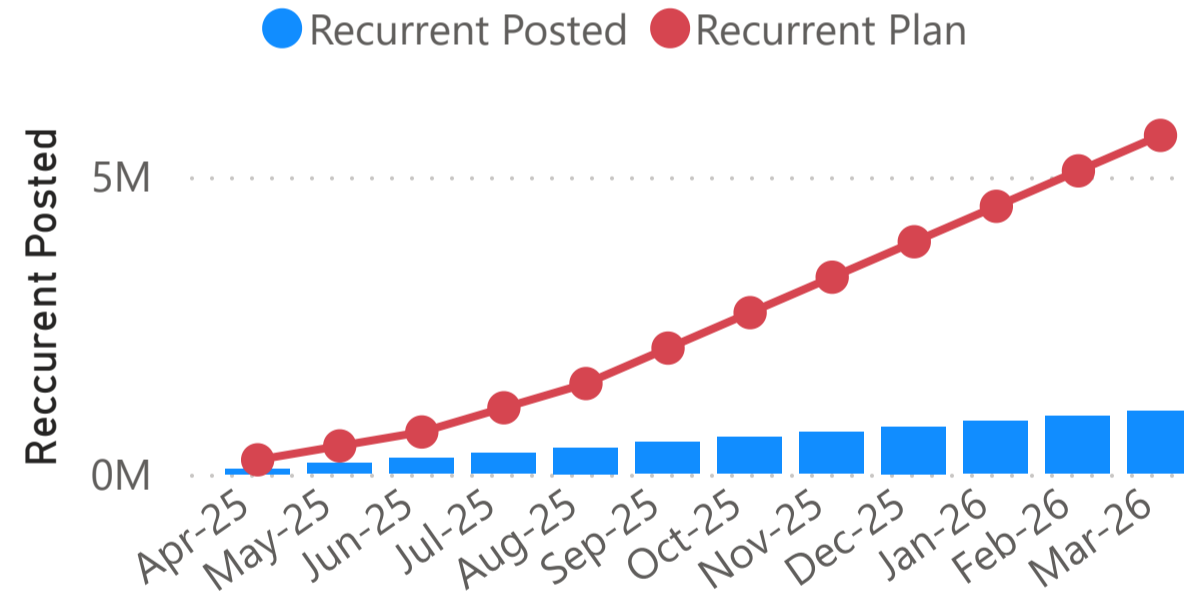
Target: Internal



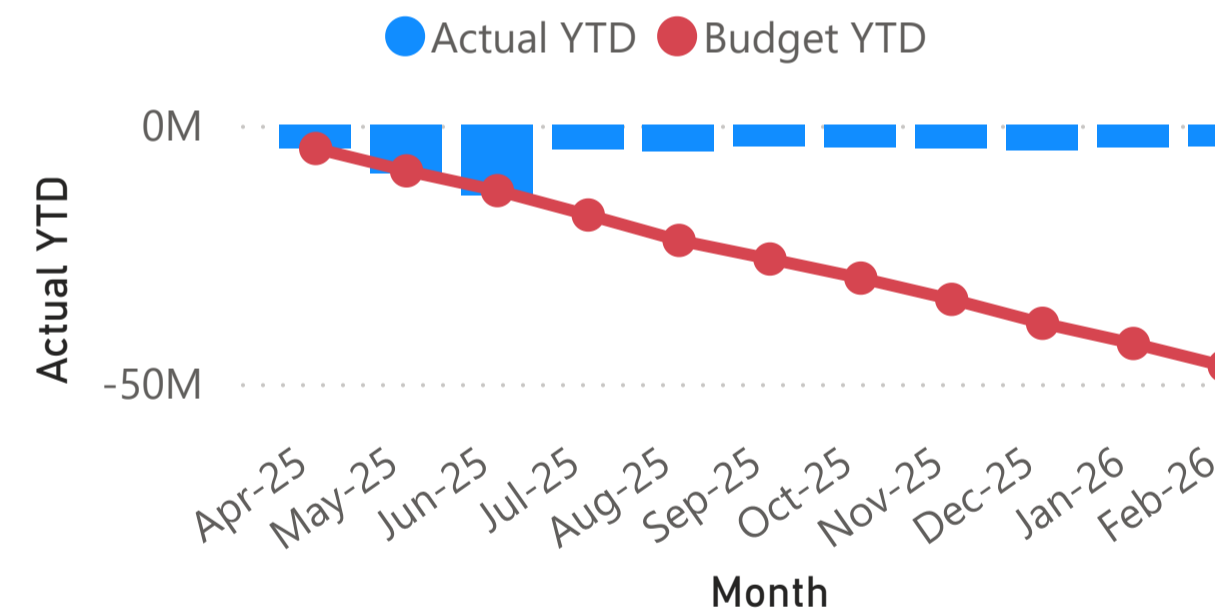
Workforce Stability



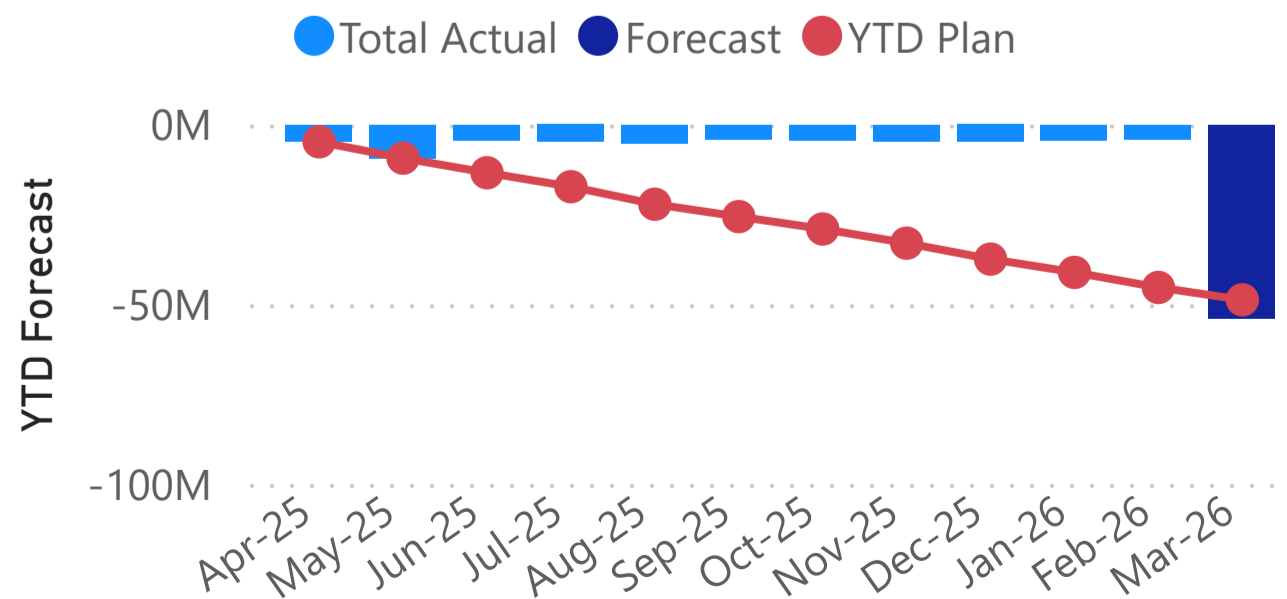
Recurrent Efficiency Plans Delivered (Forecast)



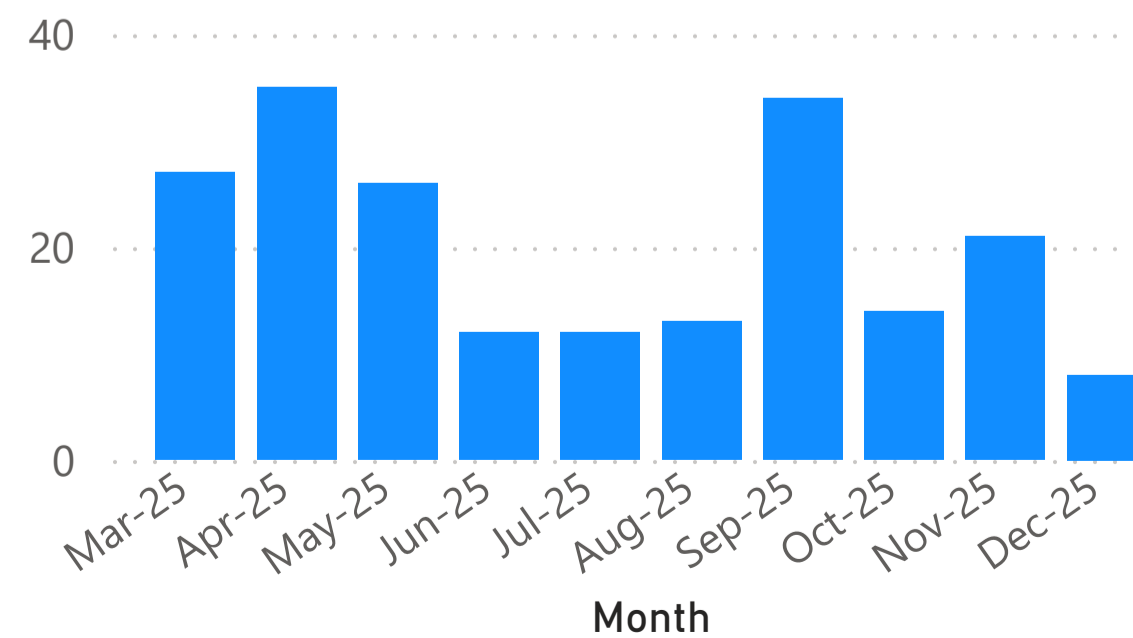
I&E distance from target (cumulative YTD)



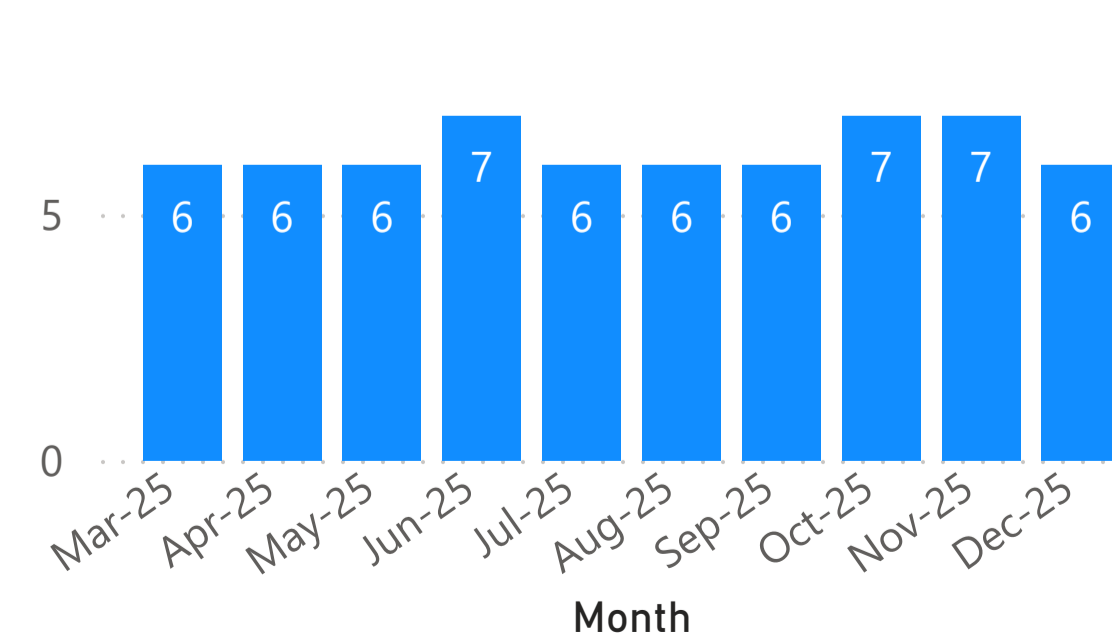
I&E Year End Forecast



Research - Number participants by clinical division



Research - Number chief investigators by clinical division



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

- Sickness has reduced again and long term cases are being managed effectively
- All other metrics are on track

Areas of Concern

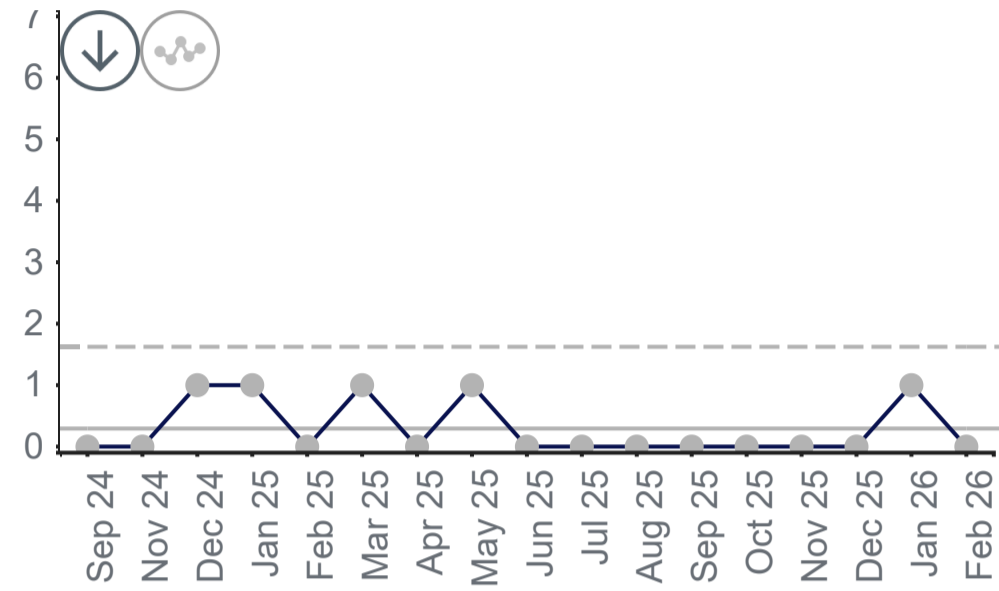
- See Pioneering Breakthroughs section

Forward Look (with actions)

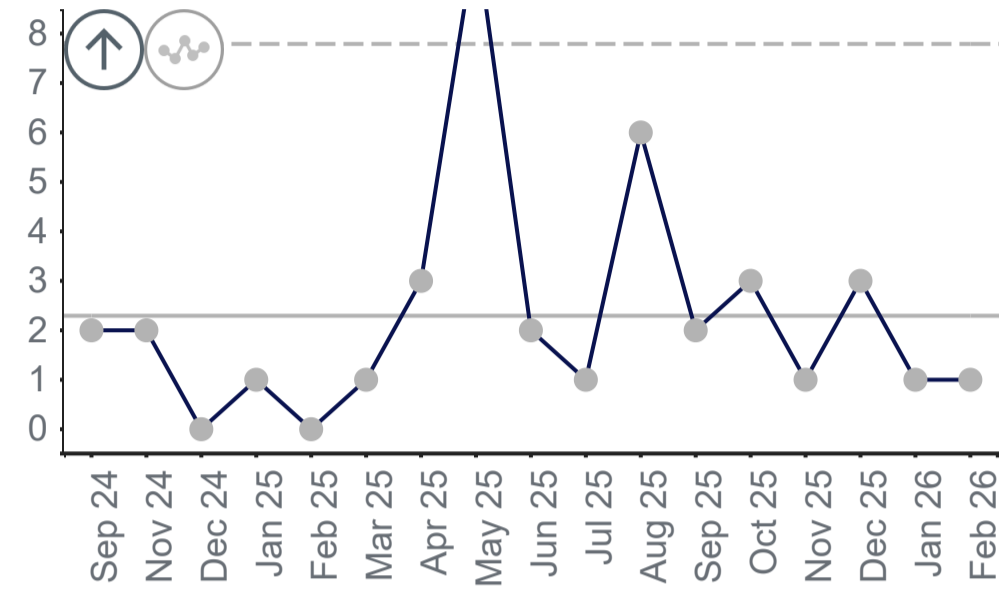
- See Pioneering Breakthroughs section

Divisional Performance Summary - Clinical Research

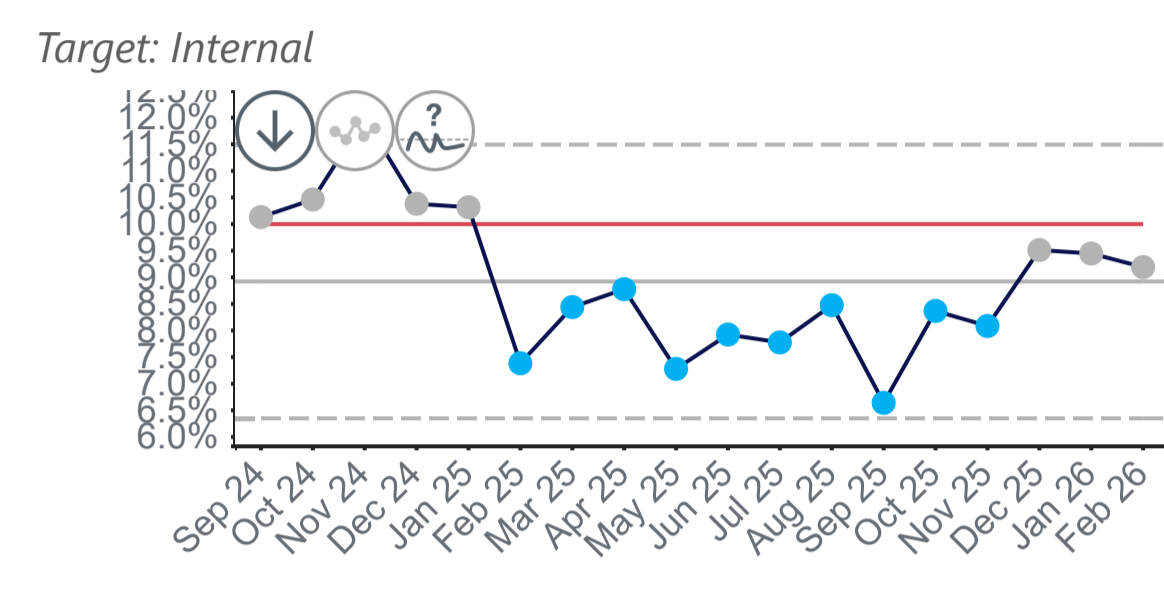
Patient Safety Incidents rated Low Harm & Above



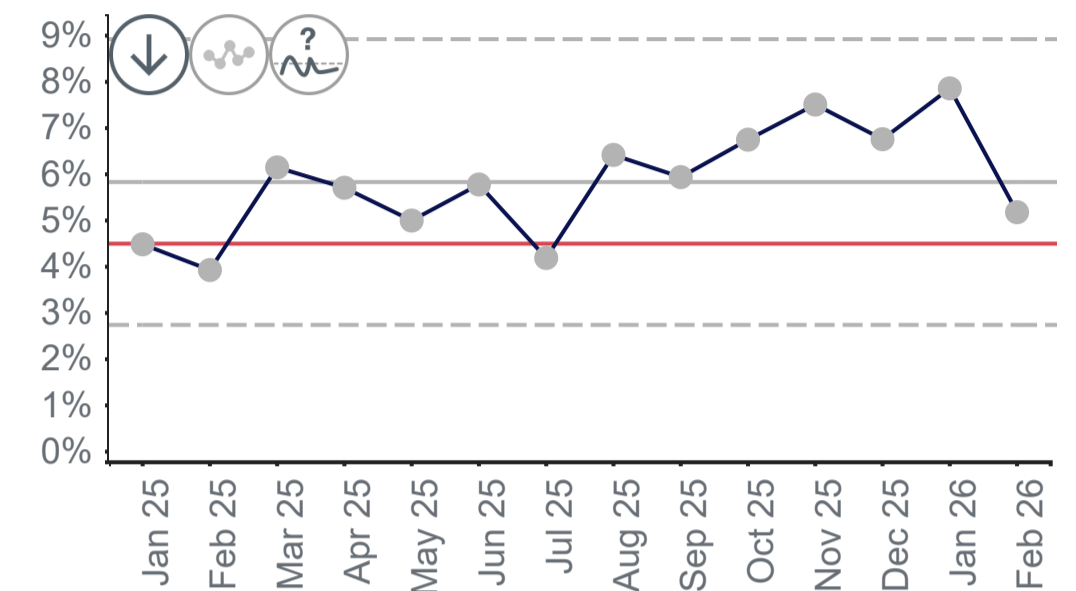
Patient Safety Incidents rated No Harm



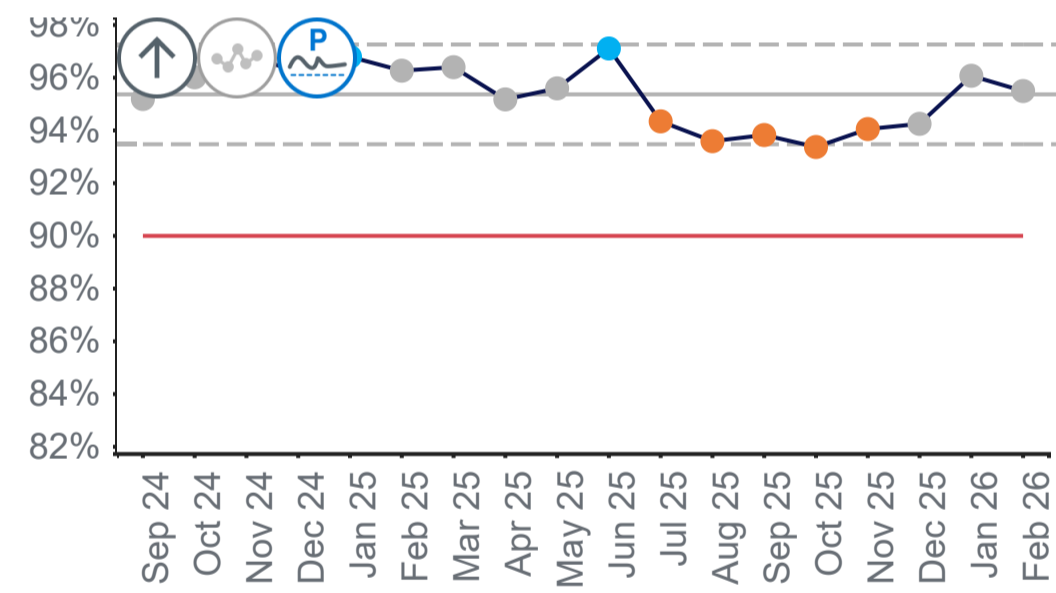
Staff Turnover



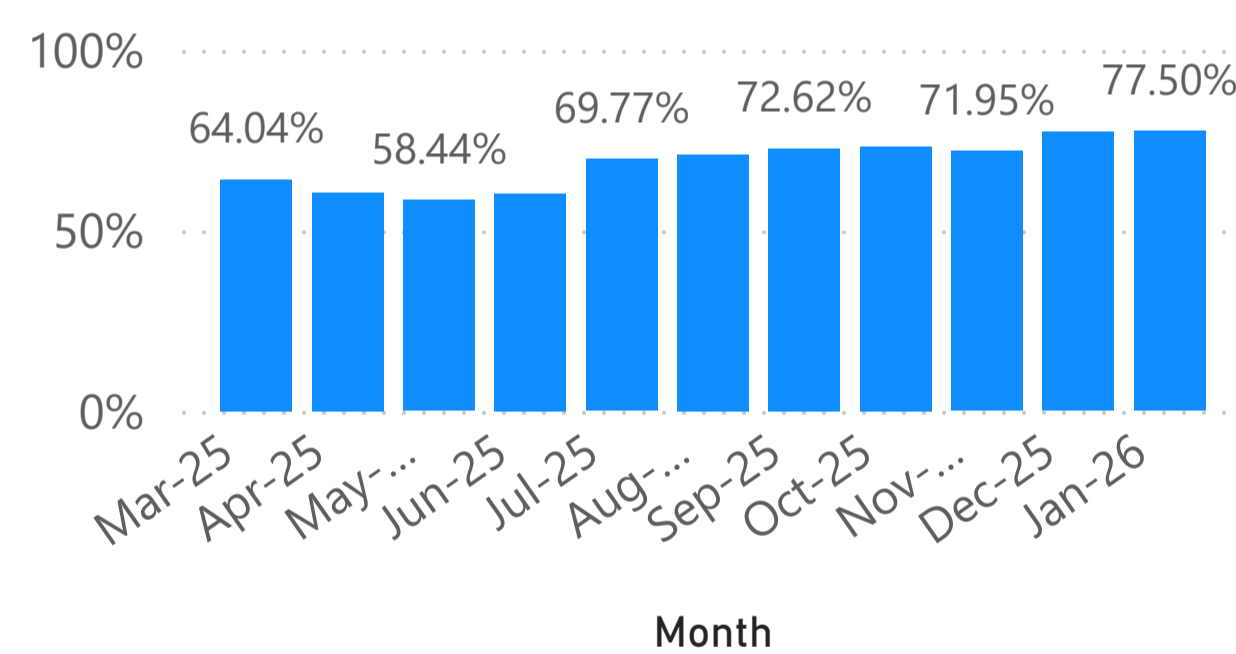
Sickness Absence Overall



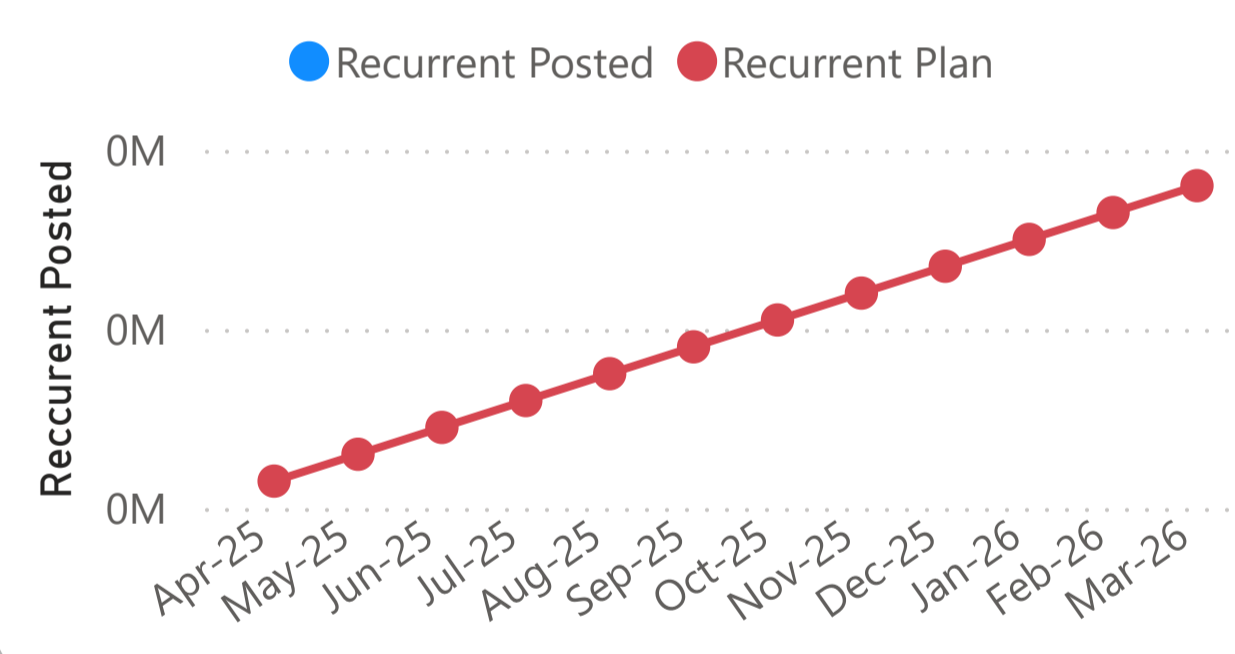
Mandatory Training



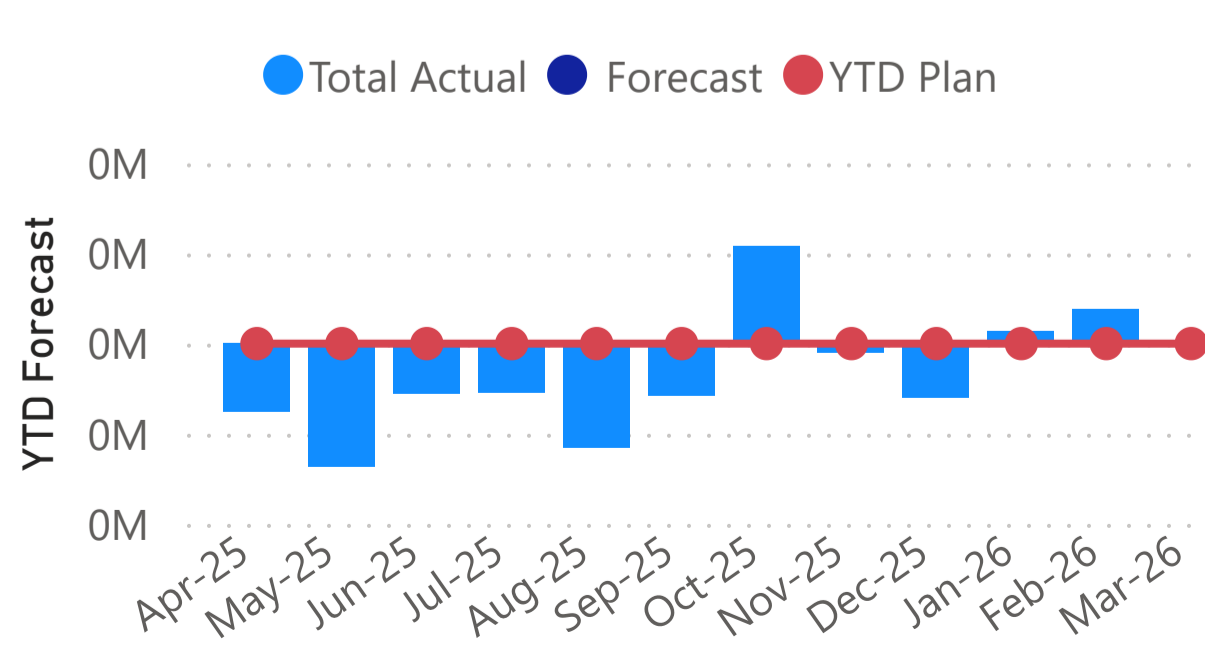
Workforce Stability



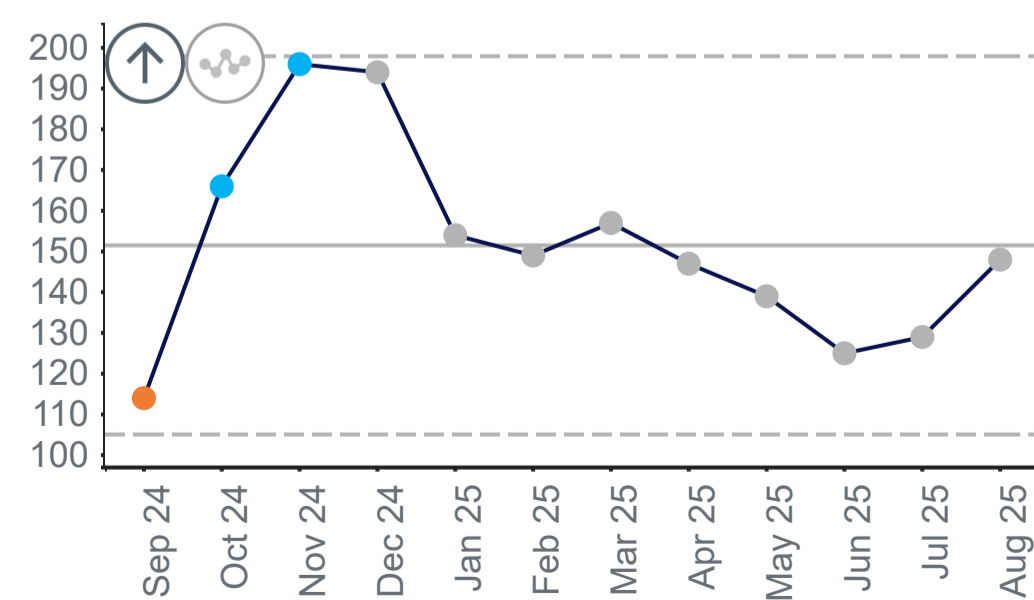
Recurrent Efficiency Plans Delivered (Forecast)



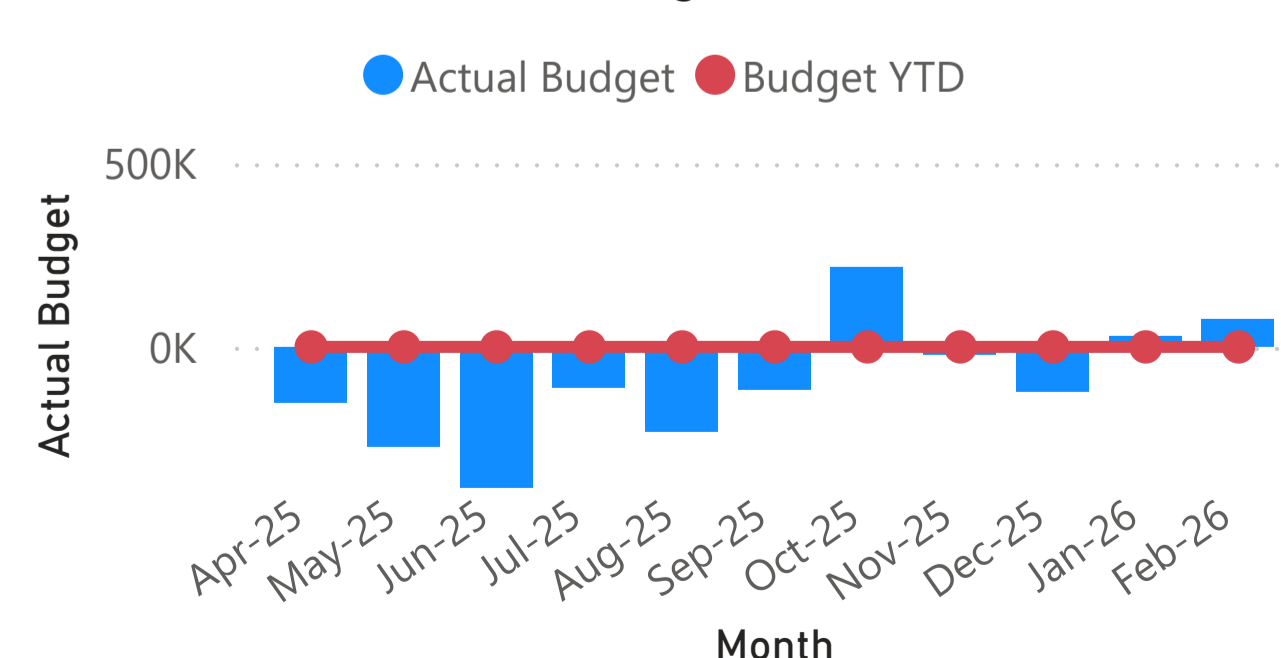
I&E Year End Forecast



Number of Patients Recruited into Research Studies



I&E distance from target (cumulative YTD)



Divisional Performance Summary - Corporate

SRO: Erica Saunders, Chief Corporate Affairs Officer

Highlights

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

- PDR compliance for B7+ remains above Trust target at 97%
- Mandatory Training compliance remains above Trust target at 93%
- 100% of risks in date
- Overall compliance targets for corporate documents have been met since April 2025, with further improvements noted since September. There are currently 16 documents overdue; plans are in place to review this documentation in the coming period.
- The Corporate Collaborative identified CIP plans and/or delivered a total of £5.8m, £4.5m recurrently.
- Short term sickness saw a decrease from 2.4% to 1.47%

Areas of Concern

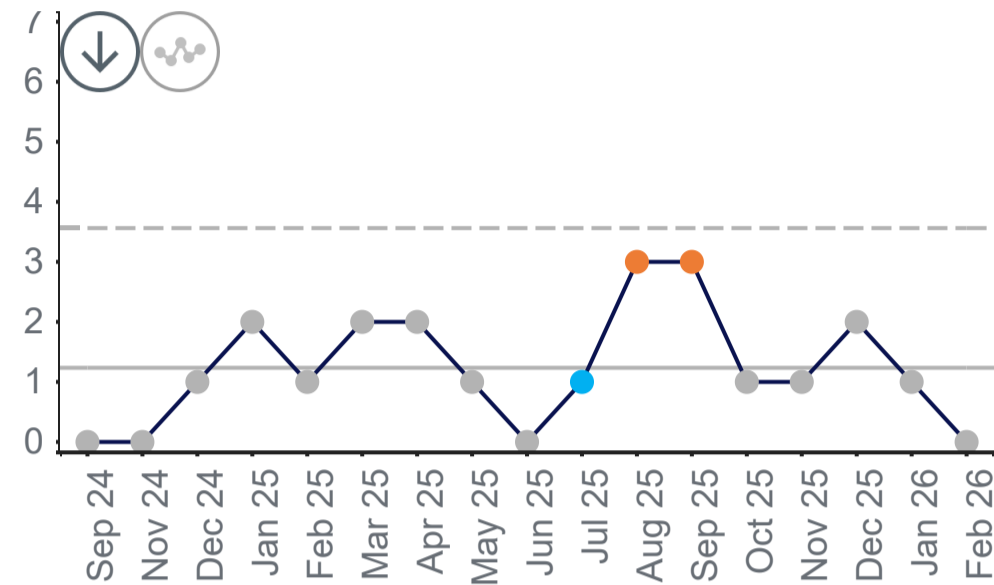
- Despite a decrease from January 2026, overall sickness absence remains above target at 5.87% for the month of February 2026.
- Long term sickness absence is sitting at 4.31% and is outside of Trust target of 2.5%.
- PDRs for all staff within corporate services is sitting at 86% against a 90% target.

Forward Look (with actions)

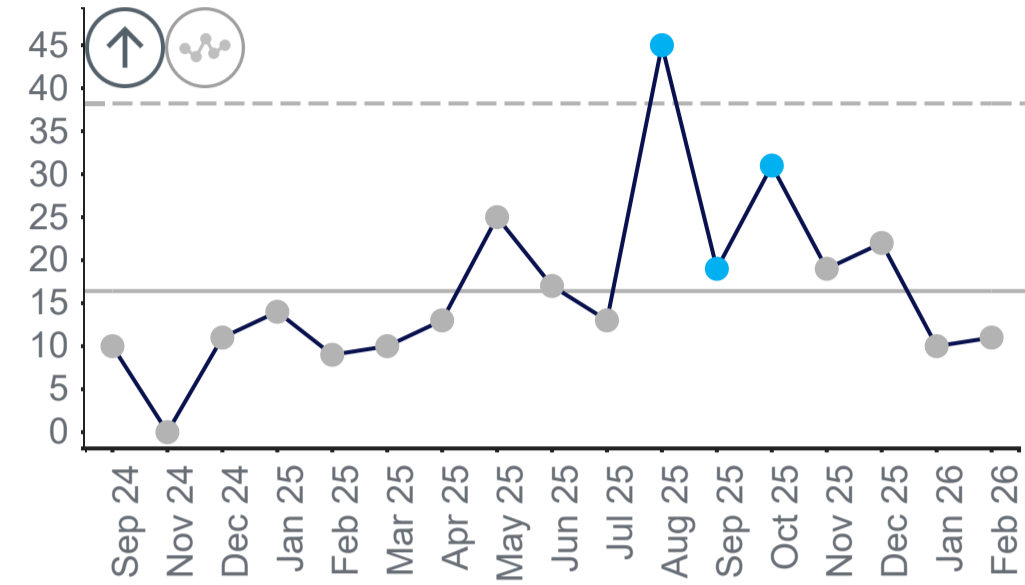
- Focus on financial position, system finance and opportunities.

Divisional Performance Summary - Corporate

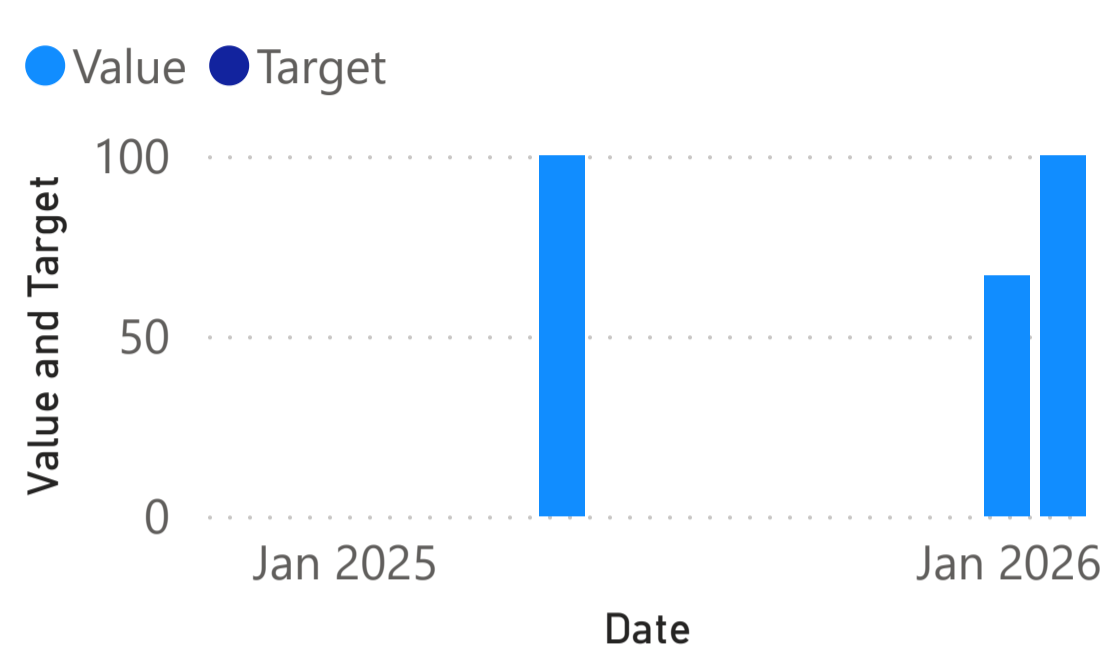
Patient Safety Incidents rated Low Harm & Above



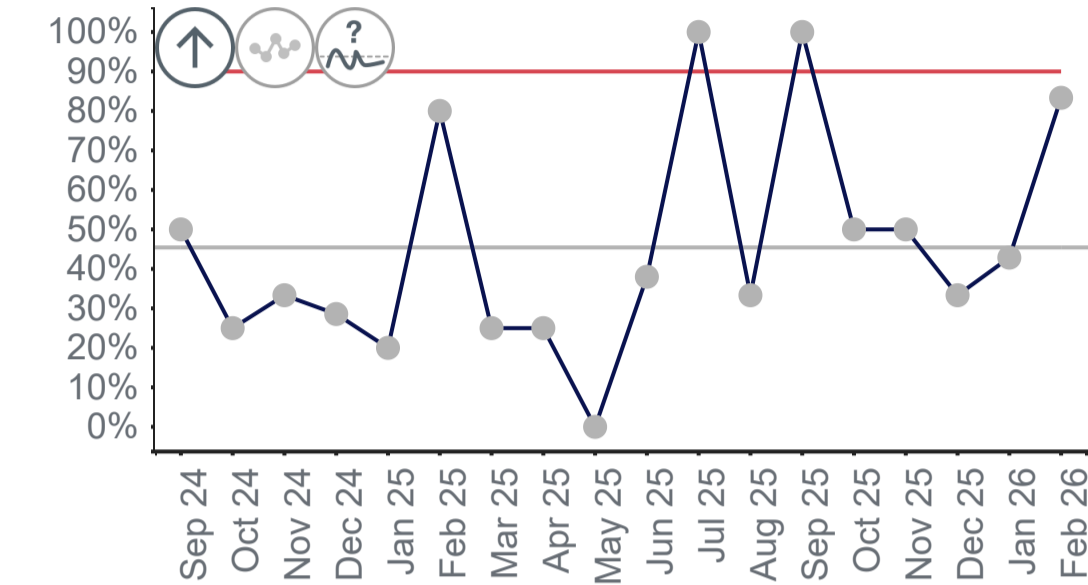
Patient Safety Incidents rated No Harm



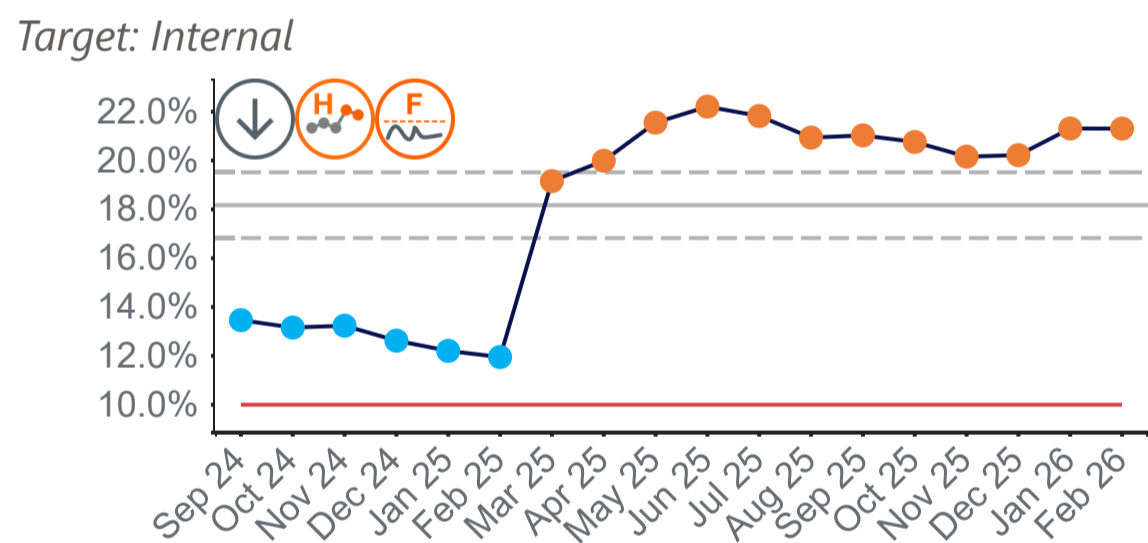
% Complaints Responded to within 25 working days



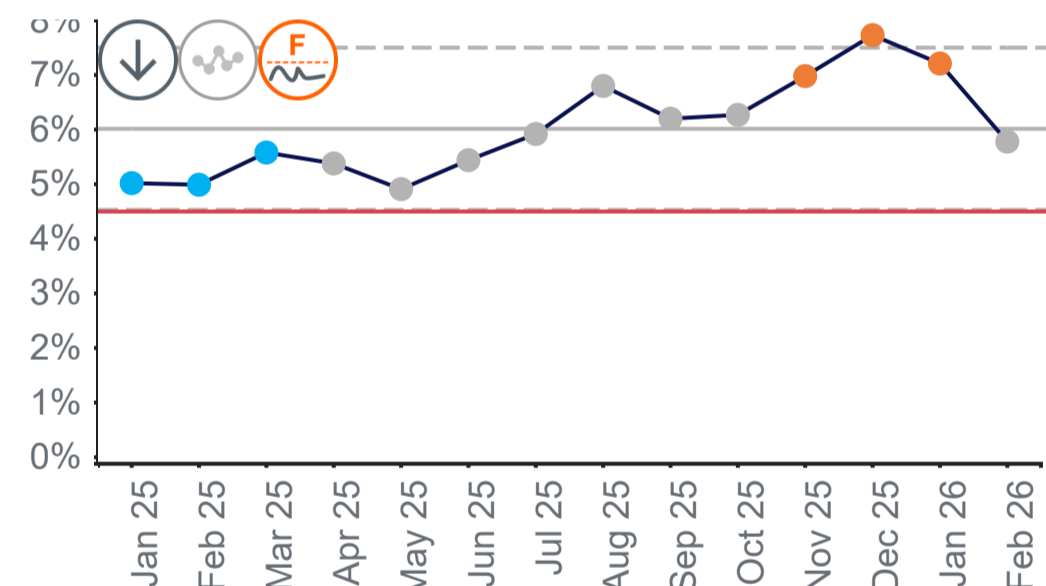
% PALS Resolved within 5 Days



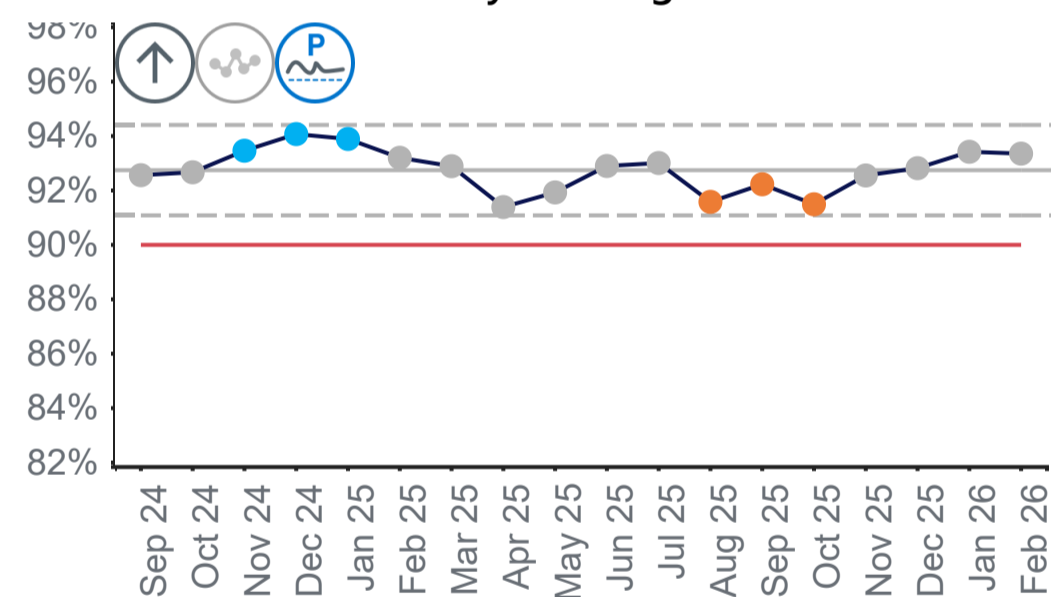
Staff Turnover



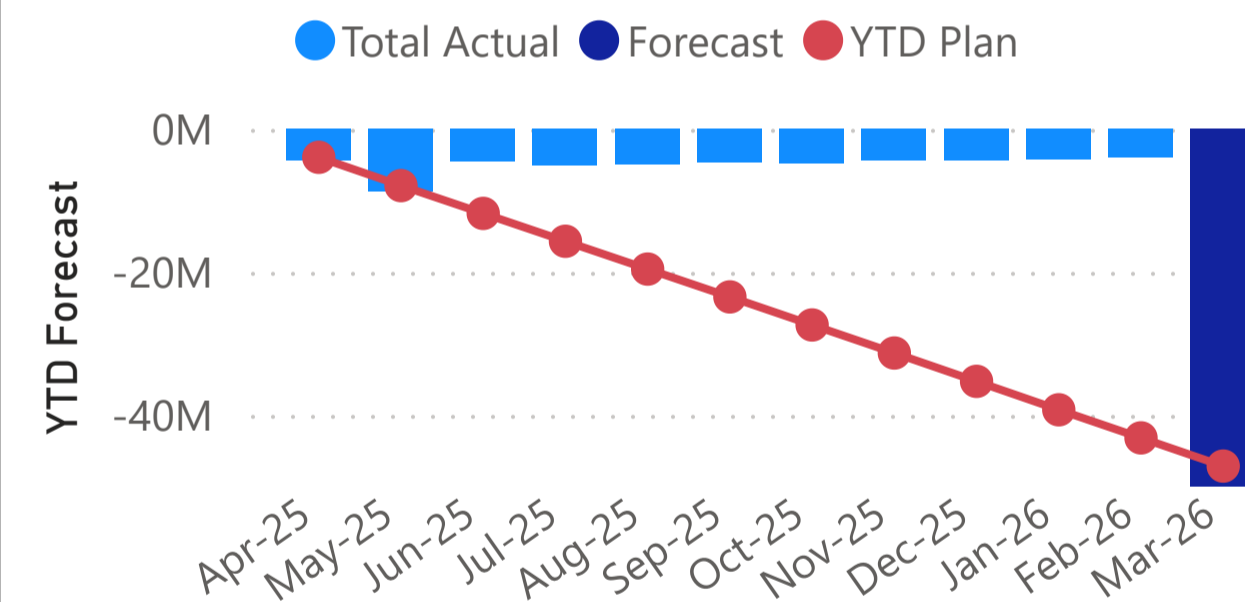
Sickness Absence Overall



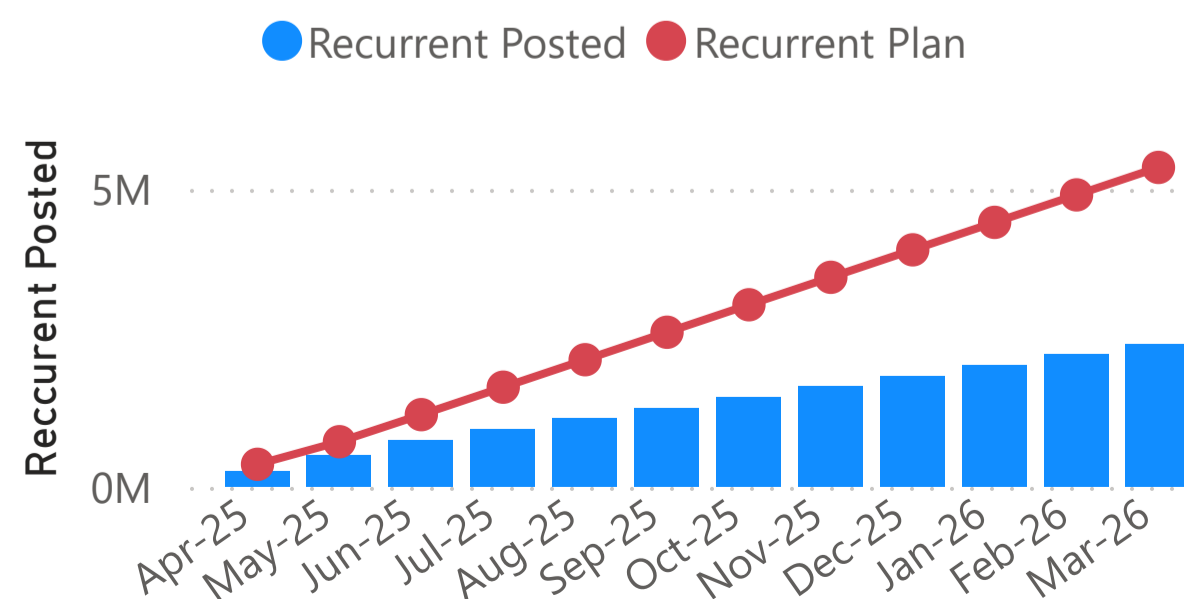
Mandatory Training



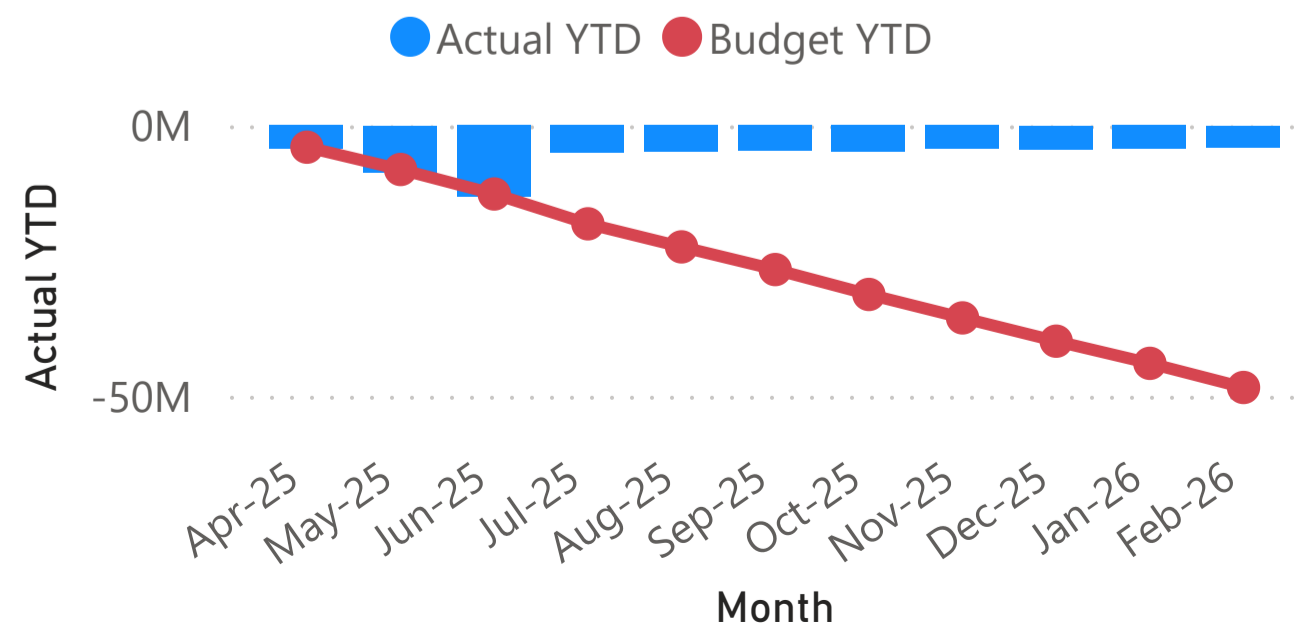
I&E Year End Forecast









Recurrent Efficiency Plans Delivered (Forecast)



I&E distance from target (cumulative YTD)



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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





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

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

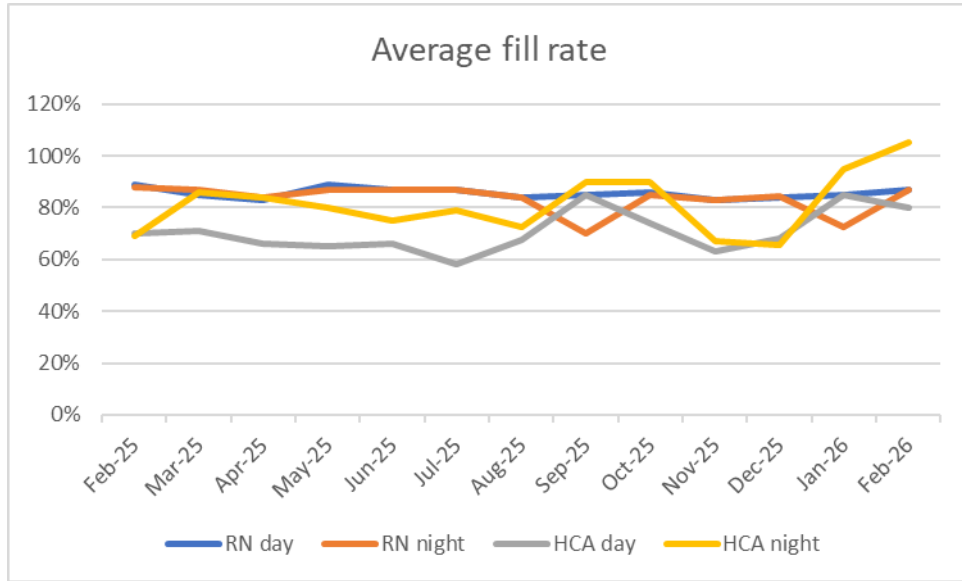
Safe Staffing & Patient Quality Indicator Report February 2026 Staffing, CHPPD and Benchmark

	Day		Night		Patients	CHPPD	National benchmark	Availability		Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT			Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff				Total count of Patients at Midnight	CHPPD Rate	Dec-25	RN - FTE	HCA - FTE	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	
Burns Unit	84%		100%		94	17.40	18.94	479.17	28	-0.8		0		0.00	0.00%	0.00	0.00%	3.8	0.79%	0	0.00%	2	2	0	0	10	100%	0	1
HDU	77%	61%	76%	56%	278	24.50	26.76	1,934.27	52.64	-5.70		3.23		0.00	0.00%	0.00	0.00%	152.61	7.89%	0	0.00%	11	15	1	2	0	0%	1	1
ICU	90%	89%	90%	61%	465	35.80	36.58	4,451.70	84	-2.43		1.00		0.00	0.00%	0.00	0.00%	333.38	7.49%	0	0.00%	7	12	0	0	3	100%	0	1
Ward 1cC	91%	85%	89%	85%	546	12.00	13.45	1,667.47	140.75	-1.94		0.08		0.00	0.00%	0.00	0.00%	105.68	6.34%	20.72	14.72%	3	8	5	10	7	100.00%	2	0
Ward 1cN	95%	7%	104%		231	15.20	16.43	1,105.07	22.4	-4.26		1.63		0.02	2.33%	0.00	0.00%	84.12	7.61%	0	0.00%	5	7	0	2	1	100%	0	0
Ward 3A	92%	73%	94%	141%	709	10.00	11.23	1,477.24	360.23	-5.13		2.46		0.00	0.00%			206.24	13.96%	59.18	16.43%	6	6	8	8	21	81.00%	1	0
Ward 3B	93%	162%	94%		348	13.80	13.06	1,097.73	160.23	3.71		2.09		0.00	0.00%	0.00	0.00%	54.66	4.98%	7.92	4.94%	1	6	0	0	7	100%	0	0
Ward 3C	71%	91%	71%	96%	630	9.20	10.25	1,624.36	426.85	0.79		3.65		0.00	0.00%	0.00	0.00%	147.90	9.11%	56.76	13.30%	11	16	0	0	7	100.00%	0	1
Ward 4A	80%	88%	76%	258%	684	11.10	12.13	1,839.51	144.85	-0.34		2.99		0.00	0.00%	0.00	0.00%	124.01	6.74%	23.01	15.89%	11	14	0	0	38	97%	1	0
Ward 4B	90%	84%	72%	82%	566	12.90	17.73	1,046.48	1219.91	-7.35		1.76		0.00	0.00%	0.00	0.00%	111.17	10.62%	173.3	14.21%	5	11	0	0	8	100%	1	0
Ward 4C	89%	59%	90%	58%	551	10.10	10.29	1,571.21	178.42	-5.01		4.84		0.00	0.00%	0.00	0.00%	109.37	6.96%	8.28	4.64%	8	19	0	0	20	95.24%	1	0

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Fill rates are produced by setting out the planned number of hours required for Registered Nurses (RN) across days and nights and the same for Health Care Assistants (HCA) for a full month period and is captured daily. The electronic roster produces the percentage fill for the month and accurately reflects the hours worked against the planned number. The percentage fill rates include any hours worked by bank staff. The benchmark for CHPPD for the above tables is based on December 2025 data, which is the latest information available from the model hospital so may not be directly comparable in regard to activity and acuity. Staffing fill rates across the Trust for the month of February are above 80% for both Registered and Unregistered Nurses indicating that planned nursing and HCA hours are largely being met, however CHPPD is sitting slightly below the national Model Hospital benchmark. This variation is representative of all wards except 3B and can be somewhat explained by vacancies, high sickness absence and differences in patient acuity and activity compared with the December 2025 national dataset. Local rostering efficiencies can also mean that safe care is delivered with fewer hours per patient Overall the slightly lower CHPPD does not currently indicate a decline in care quality and should be interpreted in the context of sustained fill rates and stable patient outcomes.

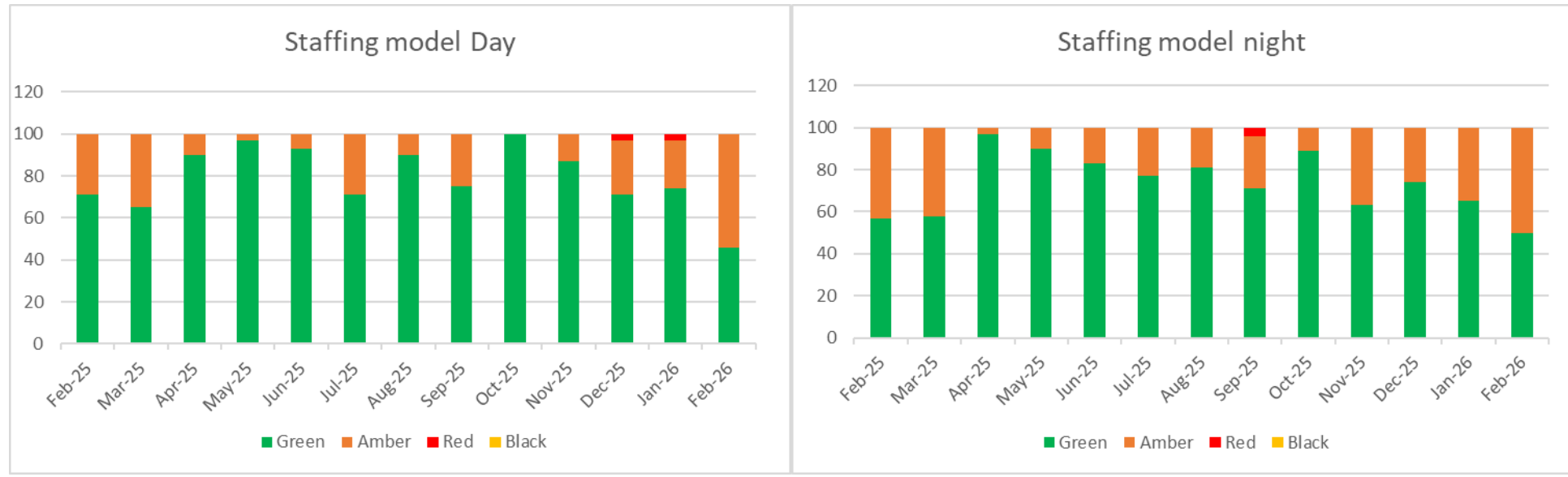
Nursing and care staff average fill rate February 2026		Nursing and care staff average fill rate February 2026	
Day average fill rate		Night average fill rate	
Registered (%)	Care Staff (%)	Registered (%)	Care Staff (%)
87% 	80% 	87% 	105% 

All fill rates have slightly increased, with HCA on nights being the biggest shift due to mainly increase in 1-1 patients.



Summary of Staffing models Mach 2025- February 2026 Registered Nurses

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



Across both day and night staffing models, there has been a clear increase in amber rated shifts reflecting a rise in periods where staffing resilience is reduced but still manageable. To note there has been no red rated shifts recorded for both days and nights during the reporting period. This indicates that while pressure on staffing has been challenged, it has not escalated to severe or unsafe levels, and the service has avoided operating at the highest level of staffing risk.

Registered Nurse and Unregistered Bank Spend February 2026

The Divisions has demonstrated strong governance and sustained progress in reducing temporary staffing costs, improving workforce efficiency and strengthening assurance processes. Temporary staffing is monitored closely with previous oversight from Workforce Efficiencies group attended and represented by senior staff from various disciplines including nursing. This group developed trust and divisional dashboards to support the monitoring of bank and agency use across all areas and has oversight from executives. Weekly monitoring of bank and agency occurs in each division as well as daily oversight from Safe Staffing Chair and Senior Clinical Site Practitioner out of hours. As an additional measure the Director of Nursing and Associate Chief Nurses attended the daily safe staffing meeting allowing greater scrutiny over the present processes when booking NHSP shifts. To note, there was assurance from this meeting that correct processes were being followed consistently and there was evidence of grip and control over temporary spend with Head of Nursing (Band 8B) approving all NHSP in hours and out of hours Senior Site Clinical Practitioner. Over the past 12 months bank and agency usage has significantly reduced. Registered Nurse Bank usage did increase of 38.8% in February 2026 compared to January 2026. This increase is primarily attributed to sustained high levels of sickness across all wards and departments alongside increased bed capacity, higher patient acuity and a surge in emergency attendees. In line with the SOP for Closing and Rapid Reopening of beds, Nurse Bank utilisation is an essential part of the process to ensure safe staffing when beds are reopened, and temporary workforce is required. The areas with notable high bank spend are within critical care HDU & ICU as well as 3A and 4A where there are staffing gaps and specific nursing skills are required. There has been a deep dive reviewing the request for bank with the requirement for specific skills commonly listed as a reason. The senior nurses will continue to work together to address this, and Heads of Nursing continue to have oversight and scrutiny in ensuring the request for bank has gone through the correct process. To note there is no agency within the wards and specialist nursing teams. To note over the last 12 months there has been a consistent decrease in agency spend in theatres with the last two months showing nil agency. This is positive and reflects a significant improvement in grip and oversight of temporary spend,

Within the month of January, we have maintained a robust and sustained focus on reducing overtime across all divisions. Each division has conducted a deep dive to identify specific areas and individuals where overtime usage has been used. This has enabled a more targeted and focused approach to reducing overtime and operational efficiency. There is a robust process now in place for any overtime requests related to Nursing and Allied Health Professionals to go through the strengthened approval process requiring Chief Nurse sign-off.

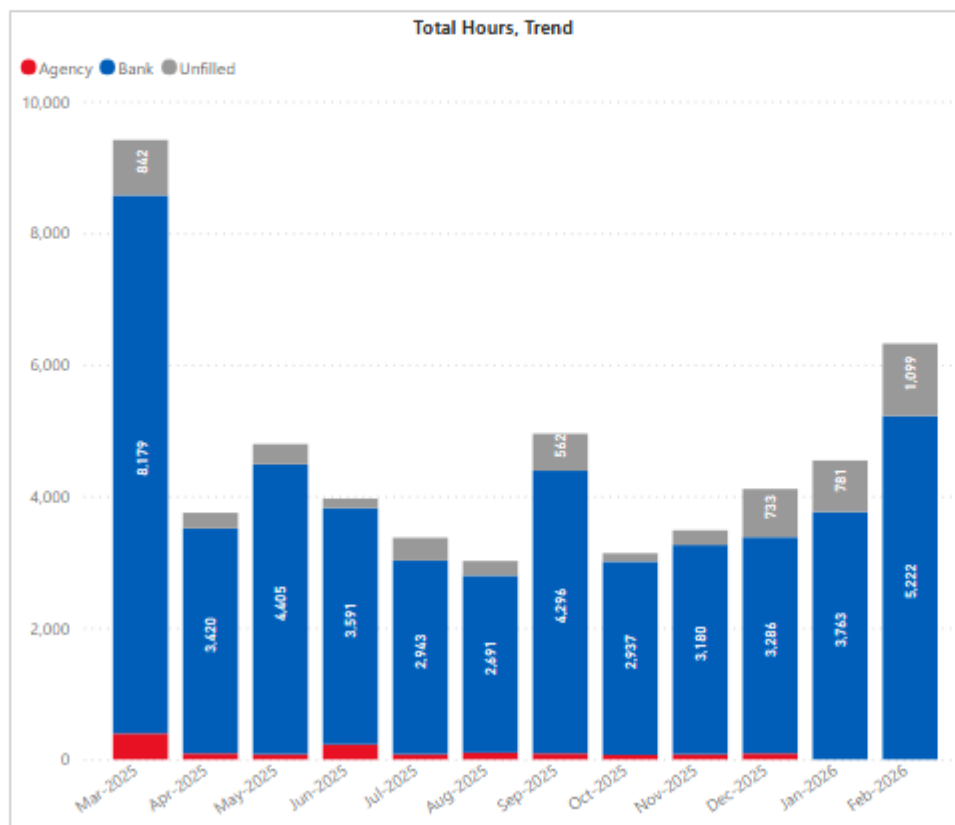
Unregistered Nurse Bank increased by 13.9% from January 2026 but continuing to remain low in comparison with the same period last year. This reduction is particularly positive given on-going substantive workforce gaps and higher than usual sickness levels across the Trust. Ward 3C, which had long standing substantive HCA vacancies, has strengthened its establishment with 3 new starters in June and a further 6 redeployed staff who commenced in September. In addition, 12 NHSP trainees have recently completed their competencies and have all been appointed to permanent HCA roles within the Trust, further reducing historic gaps. Substantive recruitment continues at pace, with prioritisation of high demand wards to maintain staffing resilience. These collective actions demonstrate strong grip, effective controls and sustained improvement in workforce efficiency, contributing to reduced reliance on temporary staffing.

Staff Group

Hours Performance

YOY Comparison for Feb-2026

WTE	38.9! 64.6
% Total Fill	82.6%! 92.3%
% Bank Fill	82.6%! 88.2%
% Agency Fill	(Blank)✓ 4.1%
% Unfilled	17.4%! 7.7%



Demand: in Feb-2026 totalled 6,321 hours (608 shifts), a change of 39.1% on Jan-2026

Bank: in Feb-2026 totalled 5,222 hours (507 shifts), a change of 38.8% on Jan-2026

Unfilled: in Feb-2026 totalled 1,099 hours (101 shifts), a change of 40.7% on Jan-2026

Agency: in Feb-2026 totalled hours (shifts), a change of -100.0% on Jan-2026

Unregistered Nurse Bank Spend February 2026

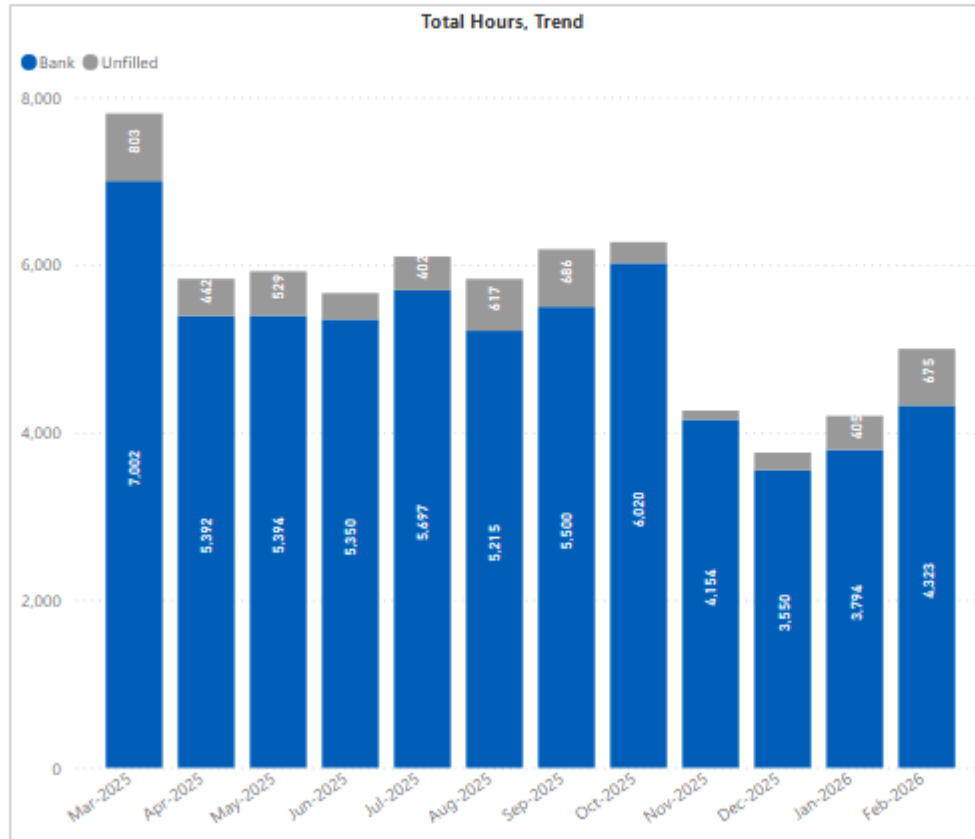


Staff Group

Hours Performance

YOY Comparison for Feb-2026

WTE
30.8! 50.9
% Total Fill
86.5%! 87.0%
% Bank Fill
86.5%! 87.0%
% Agency Fill
(Blank)
% Unfilled
13.5%! 13.0%



Demand: in Feb-2026 totalled 4,998 hours (478 shifts), a change of 19.0% on Jan-2026

Bank: in Feb-2026 totalled 4,323 hours (415 shifts), a change of 13.9% on Jan-2026

Unfilled: in Feb-2026 totalled 675 hours (63 shifts), a change of 66.9% on Jan-2026

Agency: in Feb-2026 totalled hours (shifts), a change of -100.0% on Jan-2026

KPI E-Roster 2nd February-1st March 2026

RosterPerform 11 Overview														
KPI Description	The minimum no of days notice teams need to be given for shifts to be worked	% of changes made in roster since full approval	The number of contracted hours people owe or are owed (Negative = owed, positive = owes)	The % of shifts filled by temporary staffing	The total number of hours filled by temporary staff	The number of shifts created ontop of the establishment	The % of shifts in the roster that have not been filled	% of staff in post on Annual Leave	% of staff in post on Study Leave	% of staff in post on other leave	% of staff in post on sick leave	% of staff in post on parenting leave (Mat/Pat)	Total % of staff in post booked off as an unavailability	
KPI Metric	42 Days	<25%	Unit Level KPI (Column D)	<10%	NA	0	<15%	Between 11% & 17%	<2%	<5%	<5%	<7%	<30%	
Org.Units/Metrics	Roster Approval (Full) Lead Time Days (2nd February - 1st March 2026)	% Changed Since Approval	Net Hours (1 pro rated day per person)	Net Hours	Bank / Agency Use %	Bank / Agency Usage Hours	Additional Duties	Unfilled Roster %	Annual Leave %	Study Day %	Other Leave %	Sickness %	Parenting %	Total Unavailability %
Accident & Emergency - APNP (912201)	43	23.60%	80.00	-52.92	0.00%	0	0	36.99%	11.35%	9.12%	0.44%	5.65%	0.00%	27.00%
Accident & Emergency - Nursing (912201)	45	19.50%	720.00	58.69	2.21%	207.25	0	20.32%	12.66%	2.35%	1.30%	6.27%	9.43%	32.74%
Burns Unit (915208)	44	24.26%	140.00	106.57	19.05%	360.5	0	16.08%	19.14%	1.42%	0.36%	1.33%	18.54%	40.79%
Critical Care Ward (913208)	41	29.82%	1200.00	1726.43	7.74%	1458.5	0	16.30%	12.70%	2.68%	1.52%	8.07%	4.95%	29.92%
High Dependency Unit (HDU) (913210)	44	24.35%	640.00	264.58	9.31%	669	1	24.65%	13.35%	3.83%	2.06%	8.20%	10.01%	37.55%
Medical Daycase Unit (911314)	41	13.00%	50.00	26.35	0.00%	0	4	13.77%	15.69%	0.90%	0.00%	5.37%	0.00%	21.95%
Outpatients (916503)	47	21.11%	420.00	-207.45	3.76%	152.25	0	25.79%	11.52%	0.70%	1.08%	20.56%	2.38%	38.33%
Sunflower House (912310)	27	32.43%	190.00	140.48	11.89%	461.5	30	10.52%	15.56%	8.53%	0.57%	2.52%	1.43%	36.33%
Surgical Daycase Unit (915418)	44	34.99%	85.00	-31.97	6.78%	190.5	1	25.28%	17.07%	0.02%	3.00%	7.94%	3.97%	31.99%
Theatres - Cardiac & Cardiology (915405)	44	30.59%	130.00	-4.5	0.00%	0	0	6.63%	14.49%	2.26%	0.79%	3.51%	0.00%	21.05%
Theatres - Emergency (915420)	44	24.09%	230.00	29.33	6.10%	132.75	0	0.56%	19.21%	0.74%	1.23%	5.56%	0.00%	26.73%
Theatres - IP Anaesthetics (915423)	44	26.06%	82.00	41.17	3.60%	117.5	1	9.01%	19.87%	0.74%	4.31%	6.11%	0.00%	31.04%
Theatres - IP Porters (915435)	44	42.86%	101.00	38.25	5.71%	70	0	25.26%	11.44%	0.00%	0.00%	31.81%	0.00%	43.25%
Theatres - IP Recovery (915422)	26	29.17%	103.00	-8.45	6.75%	106.75	0	5.99%	17.26%	3.07%	9.19%	2.93%	0.00%	32.45%
Theatres - IP Scrub (915424)	44	26.70%	128.00	2.25	4.54%	78.75	0	13.69%	15.43%	2.00%	0.18%	9.30%	16.07%	46.98%
Theatres - Ortho & Neuro Scrub (915436)	44	24.82%	37.80	3.12	1.64%	40	0	11.42%	14.31%	2.04%	1.70%	9.78%	0.00%	27.84%
Theatres - SDC Anaesthetics (915429)	44	50.82%	58.40	7.25	17.41%	190	0	13.12%	11.05%	2.92%	3.33%	11.61%	2.92%	31.84%
Theatres - SDC Recovery (915430)	44	44.02%	177.30	-4.02	8.73%	137	0	9.16%	10.42%	2.07%	1.79%	11.60%	0.00%	25.89%
Theatres - SDC Scrub (915421)	44	28.17%	532.00	-8.61	3.60%	75.5	0	17.67%	12.42%	2.45%	6.29%	14.79%	4.92%	40.87%
Ward 1C Cardiac (913307)	44	30.40%	361.00	251.7	7.45%	513.5	5	11.35%	13.41%	1.21%	3.93%	7.70%	6.29%	34.02%
Ward 1C Neonatal (913310)	48	43.44%	556.00	2266.27	0.00%	0	0	19.20%	11.08%	4.25%	0.15%	7.38%	7.02%	33.10%
Ward 3A (915309)	40	38.89%	371.00	97.27	17.12%	1243	49	15.54%	12.74%	1.56%	4.24%	15.70%	5.08%	39.31%
Ward 3B - Oncology (911208)	44	28.66%	555.00	254.35	9.80%	500.5	2	12.57%	16.33%	3.90%	4.05%	6.35%	2.24%	32.86%
Ward 3C (911313)	46	32.28%	607.00	152.94	5.84%	425.5	16	29.54%	15.50%	1.35%	4.30%	10.61%	5.60%	37.82%
Ward 4A (914210)	40	32.46%	634.00	65.9	14.35%	1097	44	20.45%	15.77%	1.96%	1.17%	7.10%	9.45%	36.56%
Ward 4B (914211)	47	28.18%	533.00	283.95	4.79%	392.33	4	19.90%	14.00%	0.92%	1.43%	13.31%	4.88%	34.54%
Ward 4C (912207)	47	16.96%	280.00	150.65	4.21%	239	0	18.39%	14.85%	2.11%	4.89%	8.23%	3.20%	33.78%

Trust Summary

Data compared to previous month and measured against agreed KPI's

- Roster approval lead time (43 -43 days) meets the KPI >42-day
- Bank usage increased: rate (5.6%- 6.8%) KPI < 10%
- Additional duties decreased slightly (161 -157) KPI 0 Additional Duties Above Establishment
- Study leave increased (2.0% - 2.4%), now above the KPI >2%
- Sickness reduced slightly (9.6% → 9.2%), but remains well above the KPI <5%
- Total unavailability increased (31.1% → 33.6%), moving further above the KPI <30%



BOARD OF DIRECTORS

Thursday, 2nd April 2026

Paper Title:	Reconfiguration of ward 4C
Report of:	Nathan Askew, Chief Nursing, AHP and Experience Officer Adam Bateman, Deputy Chief Executive and Chief Operating Officer
Paper Prepared by:	Catherine Wardell – Associate Chief Nurse, Division of Medicine Nikita Pickard – Associate Chief Operating Officer, Division of Medicine Urmi Das – Clinical Director, Division of Medicine Natalie Rixon – Management Consultant

Purpose of Paper:	Decision <input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Information <input type="checkbox"/> Regulation <input type="checkbox"/>
Action/Decision Required:	To note <input type="checkbox"/> To approve <input checked="" type="checkbox"/>
Summary / supporting information	Please see introduction and appendices
Strategic Context	Outstanding care and experience <input checked="" type="checkbox"/> Collaborate for children & young people <input type="checkbox"/> Revolutionise care <input type="checkbox"/> Support our people <input type="checkbox"/> Pioneering breakthroughs <input type="checkbox"/> Strong Foundations <input checked="" type="checkbox"/>
This paper links to the following:	
Resource Implications:	A cost reduction of circa £1.49m recurrently

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)	<input type="checkbox"/>	Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input checked="" type="checkbox"/>	Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	Not Assured Evidence indicates poor effectiveness of controls

Introduction

This paper presents the board with a proposal to approve a change in the current configuration of the acute bed base. The proposal makes a recommendation to the board in light of significant and sustained changes in occupancy of inpatient beds.

The Trust has supported several changes to the clinical model for urgent and emergency care such as the introduction of Urgent Care appointments, Paediatric Assessment Unit (PAU) and Rapid Access Clinics, all of which have contributed to a step change reduction in inpatient ward occupancy.

With further delays envisaged to the opening of the new urgent care facility this reduction in occupancy presents an opportunity to review the current bed base and utilise inpatient capacity to embed the future model of urgent care prior to the new facility opening.

Since the development of the original PAU and SDEC business case there have been two significant changes from NHS England:

1. The 4-hour ED standard expectation for paediatrics has been set at 95% from April 2027
2. NHS England have recently published guidance in relation to extended emergency medicine ambulatory care model (EEMAC)

Whilst the Trust performs well nationally against the current 4-hour ED standard there will be a significant step change required to reach the new target, the development of EEMAC will support the Trust to achieve this standard and will increase the number of patients who could be cared for in a short stay facility.

Whilst the Trust remains committed to the development of Same Day Emergency Care (SDEC) for paediatrics, to date there have been limited new pathways

identified. It should be noted that a range of SDEC type pathways already exist throughout the organisation as detailed in the main body of the paper.

This paper therefore proposes the board to consider the reduction in inpatient beds and repurpose that clinical space to embed the future model of PAU and EEMAC with the proposed future staffing model already approved as part of the business case, alongside a reduced SDEC area of 4 spaces to test the benefits of the multi-speciality care pathways (e.g. abdominal pain).

Long term, following the opening of the new urgent care facility, the Trust will need to consider a range of options for the ongoing use of the inpatient space. The Executive team will consider these options and will make further recommendations to the Trust Board in due course.

Executive Summary

Children's services are entering a period of significant transformation, driven by changing patterns of demand, advances in paediatric models of care, and an increasing need to optimise the way acute inpatient capacity is used. As the organisation continues to embed the principles of How We Will Work in the Future, it is essential that our bed base, workforce, and pathways are aligned to deliver safe, sustainable and modern paediatric care.

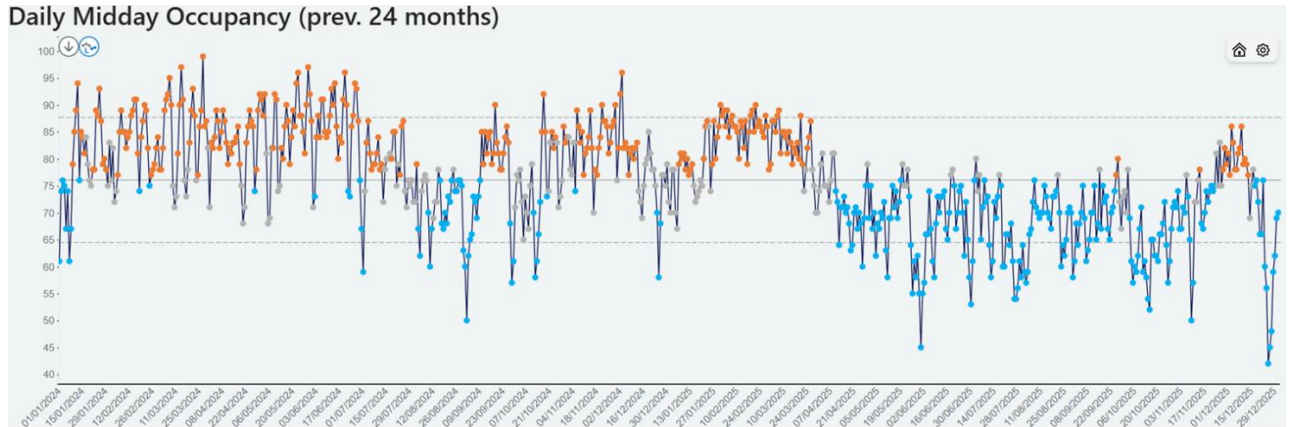
This paper sets out a strategic proposal to realign general paediatric bed capacity onto an alternative ward or wards, enabled by the enhanced Paediatric Assessment Unit (PAU) model, improved same-day emergency care (SDEC) pathways, and a more efficient, future-focused way of working to provide urgent and emergency care. This is not a proposal to remove general paediatrics from the acute trust, nor to reduce the availability of general paediatric inpatient services. Instead, it is a redesign of how and where those beds are located in order to strengthen the safety, quality and resilience of the service.

The modern PAU model, supported by the Emergency Day Unit (EDU)/ Extended Emergency Medicine Ambulatory Care (EEMAC) and SDEC, creates a significant opportunity to reshape how children move through the acute hospital. As more children are assessed, treated and discharged within the first few hours of arrival, traditional bed configurations no longer reflect the actual demand profile. This shift allows the organisation to optimise bed utilisation, reduce unwarranted variation, and ensure that the inpatient footprint is proportionate to clinical need.

This paper describes an opportunity to modernise paediatric pathways, improve flow, and embed operational optimisation across the division. It aligns directly with How We Will Work in the Future by:

- delivering care in the most appropriate setting through strengthened front-door assessment models.

The SPC chart below highlight the daily variability and sustained trend that lower occupancy has been achieved over an 8/9-month period of 2025. It also demonstrates a significant step change in demand which has been achieved through the improved models of urgent and emergency care.

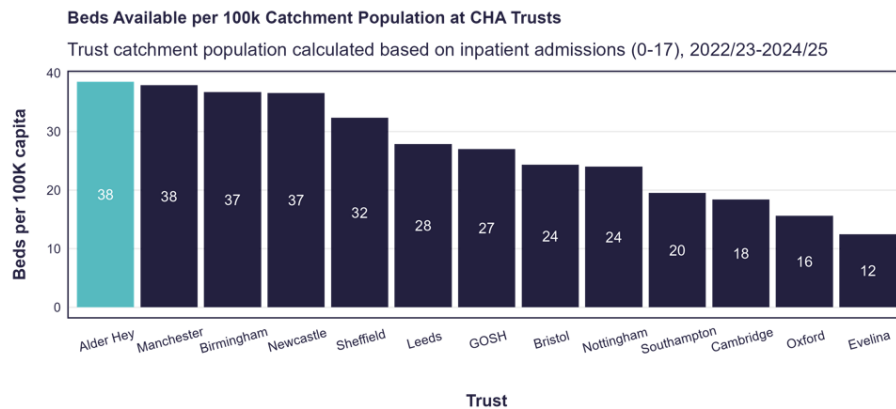


In addition, the Children’s Hospital Alliance have benchmarked bed availability across general and acute with Alder Hey having the highest number of acute beds per 1000 catchment population (0-17 years)

3.1 Bed Availability - General and Acute



- Alder Hey had a total of 202 general and acute beds, the equivalent of 38 per 1,000 catchment population (0-17 years old).
 - Note: Catchment population is based on all patients aged 0-17 years old.

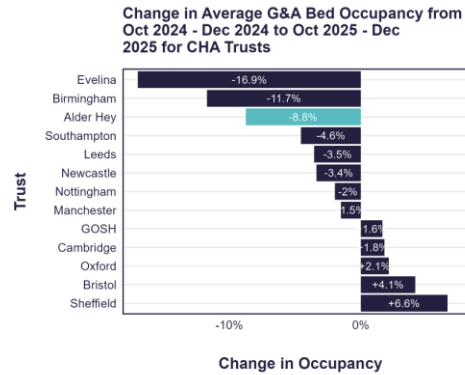
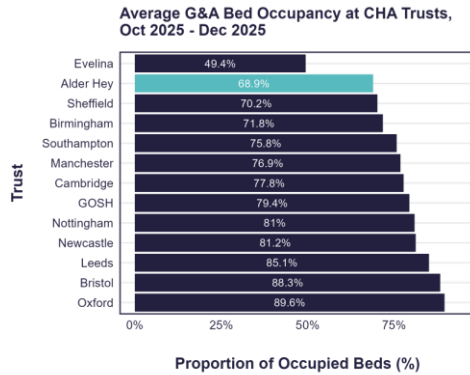


The CHA also indicates lower occupancy levels with an 8.8% reduction trust wide.

3.2 Bed Occupancy - General and Acute, quarter



- Alder Hey's average G&A bed occupancy in the last quarter was 68.9%.
- Compared to the same quarter in the previous year, G&A bed occupancy has changed at Alder Hey by -8.8%.
 - *Note: these figures use publicly available data that may not accurately capture the full number of available paediatric beds at your trust.*



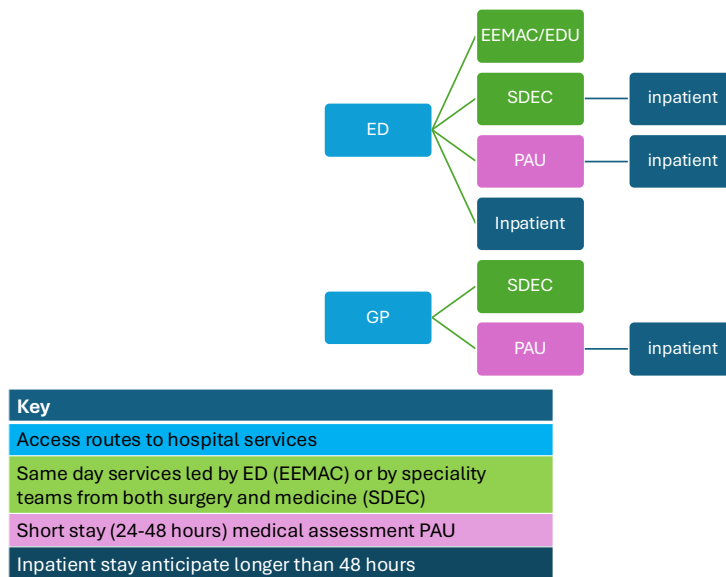
Several options have been reviewed that confirm that occupancy drops from April – September, and there has been a change to the seasonal level of demand usually experienced through the winter. The purpose of this paper is to provide a revised delivery model and to repurpose ward 4C during this period whilst the building works are completed in the new urgent care facility.

Preferred Option

To reconfigure ward 4C to provide:

- 16 spaces dedicated to PAU during the day and 12 at night,
- Four spaces 24 hours a day for EEMAC/EDU
- Four spaces to test the benefits of SDEC open 7am to 7pm

The diagram below provides a simple graphic of the proposed patient pathways through the main referral routes to hospital care.



Increase in Paediatric Assessment Unit (PAU) Capacity

The analysis of the current PAU, operating from 10 bed spaces shows on average 13.5 patients are cared for through the service each day, with a peak of 19 patients. Overnight the activity drops to an average occupancy of 5. The proposal assumes that the current general paediatric patients with a length of stay up to two days would be managed through the PAU service, increasing demand by 5.8 bed spaces over the 24-hour period. This would assume approximate capacity for 22 patients during the day and 12 patients overnight, maintaining an 85% occupancy. The PAU team will utilise a combination of trolleys and chairs to accommodate patients through the daytime hours and ensure adequate overnight facilities are available for all children that require them.

Extended Emergency Medical Ambulatory Care (EEMAC)

NHS England have recently published guidance in relation to extended emergency medicine ambulatory care model (EEMAC) (appendix 1). The guidance suggested developing a dedicated area for patients who are identified as requiring care, investigation or treatments, meaning the patient is likely to be in the ED for over 4 hours and, following this period of care, would then be discharged. Only patients with a specific need that falls within the scope of emergency medicine practice should be admitted to an EEMAC area for ongoing care. For children and young people, the equivalent to EEMAC facilities are often paediatric assessment units (PAUs) or short stay units (EDU).

The anticipated total length of stay for patients directed to the EEMAC is a maximum of 12 hours and supports patients remaining under the care of the

emergency team, four bed spaces have been identified to test the new model and the associated benefits to enhancing patient flow from the emergency department.

This model aims to deliver focused and patient-centred care that improves patients' experiences without unnecessary admissions.

Same Day Emergency Care (SDEC)

Through the exploratory phase of the SDEC working group, it has been identified that a proportion of same day emergency care (SDEC) already takes place in various locations. The plan is not to relocate existing pathway but to identify further opportunities. The table in appendix 2 below provides a 12-month (January 25 – December 25) summary of the patients admitted for one, two or three days. This data will be utilised to prioritise pathways for testing.

The model to be tested will also focus upon integrated medical and surgical SDEC pathways, where physicians and surgeons work together to manage a patients care and develop joint pathways to best meet the needs of children where an overnight stay in hospital can be safely avoided. Pathways such as abdominal pain, stoma management are examples where joint management would be advantageous.

Inpatient General Paediatrics

The analysis undertaken indicates that if the patients with a pathway of 48 hours or less are managed through PAU, the inpatient general paediatric inpatient bed occupancy ranges from 13 beds to 32 beds (at a 92% occupancy level)

Number of beds required for 92% occupancy each month based on total bed days and LOS > 2 days

	2025											2026
Month	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Beds required @ 92% occupancy	22.6	17	15	13	13	15	17	15	29	32	21	20

The core general paediatric bed base will reduce to 16 (from 22 current) will be assigned ten beds on ward 3C and six beds on ward 4B. The surge capacity will be provided from ward 4C in the first winter and then re-assessed once the benefits have been realised. There are a number of movements and changes across the hospital that will then support the future surge model. A budget to accommodate 52 surge beds throughout the year has been factored into the new delivery model.

The table below highlights the overall reduction in capacity against budget which equates to 18 when accounting for all inpatient and assessment spaces that are available.

Ward	Budget (pre EDU Closure)	Winter 24/25	Current core capacity exc temp closures	Future core capacity	Budget v Future Var
BURNS	5	5	5	5	0
CARDIAC	23	23	23	23	0
NEO	9	9	9	9	0
W3A	32	32	32	32	0
W3B	13	13	13	13	0
W3C	32	31	31	31	1
W4A	32	32	32	32	0
W4B	21	24	21	23	2
W4C	32	22	22	0	-32
Total G&A	199	191	188	170	-29
EDU	4	4	4	4	4
PAU	8	6	8	16	4
SDEC	0	0	0	4	4
Total assessment	12	10	12	24	12
Grand total	211	201	200	194	-17

It is important to note that there are currently 8 medical beds and 8 surgical beds temporarily closed that are not included in the table above.

Capacity and Demand Modelling

The table below provide a monthly comparison of the new capacity available, against the Feb 25 – Jan 26 actual demand.

Capacity proposal	February	March	April	May	June	July	August	September	October	November	December	January
Core medical beds (3b, 3c and 4b) at 92% occupancy	62	62	62	62	62	62	62	62	62	62	62	62
Assessment Capacity 24/7	12	12	12	12	12	12	12	12	12	12	12	12
Assessment capacity 7am 7 pm	4	4	4	4	4	4	4	4	4	4	4	4
SDEC 7am - 7pm	4	4	4	4	4	4	4	4	4	4	4	4
TOTAL CAPACITY	82	82	82	82	82	82	82	82	82	82	82	82
Assessment demand (No of patients)	15	14	12	11	10	11	9	12	14	16	17	14
new assessment demand	5	5	5	5	5	6	4	6	6	6	8	6
Inpatient demand > 48 hour stay	81	76	67	62	63	61	64	64	57	66	64	65
TOTAL DEMAND	101	96	84	78	78	78	77	83	77	88	88	85
Total surge requirement (51 beds throughout the year)	-19	-14	-2	4	4	4	5	-1	5	-6	-6	-3

The table highlights the seasonal variation and the need for a trust wide response to surge through February and March when peak levels of demand occur.

Workforce Implications

The new ways of working will result in a reduction in headcount for the current ward-based staff. There are currently sufficient vacancies within nursing and healthcare support worker roles across other areas of the Trust, ensuring the Trust retains these staff and minimises the risk of redundancy. The details are available in Appendix 3.

Financial analysis

The financial analysis has been carefully reviewed to ensure the approvals within the PAU/EDU/SDEC business case (July 25) have been accurately applied to the option below and also reflect the revised plan as follows:

- 4 PAU to 7am - 7pm
- 12 PAU 24/7
- 4 EEMAC 24/7
- 4 SDEC to 7am -7pm

The option outlines the current available budget alongside the proposed cost for the proposed delivery model.

Preferred Option

16 PAU Beds (12 Beds at night)
4 EEMAC Beds (4 Beds at night)
4 SDEC Beds

Costs	WTE	£	Budget	WTE	£
PAU	43.26	£2,795,440	Recurrent Budget 32 Beds (Pay & Non Pay)	71.45	£3,858,362
SDEC	11.02	£498,439	General Paeds Budget transfer	4.00	£261,555
Winter Surge Beds x 8	8.64	£420,010	EDU Budget transfer	19.64	£853,874
Domestics		£205,696	PAU Winter Funding	-	£892,000
Recurrent Non Pay		£147,200	E&F Reduction		£216,432
One off non pay NR		£26,250			
Build Revenue Costs		£500,000			
Total Costs	62.91	£4,593,036	Total Budget Available	95.09	£6,082,223

Saving 32.18 £1,489,187

Based on the analysis undertaken, this option delivers a full year saving of circa £1.49 million. It is also understood that financial incentives may be available aligned to the delivery of ED performance which would be enhanced through delivery of EEMAC but the details of any such incentives are still to be confirmed.

Actions required to achieve the proposed changes

There are several areas that would need to be worked through in order to maximise the benefits of the temporary location of ward 4C, these include:

- A full review of the activity that could be provided through PAU/ EDU as some pathways are reliant on co-location (NWAS, ED related pathways)
- There are a small number of staff who would be at risk from the change of use, these include the ward manager, chef and ward clerk. The ward clerk

- position will form part of trust wide review and the ward manager and chef would likely be redeployed with HR support to achieve this
- The SDEC booking system remains under development within Meditech and therefore an alternative arrangement is required (e.g. outlook Calander for test phase)
 - There is a requirement to provide organisational development input to help establish the new team with a focus on PAU, EEMAC and SDEC ways of working
 - The SDEC pathways require development and testing; by creating a dedicated space, this work can proceed at a greater pace undertaking PDSA cycles to measure the benefits achieved. To support the testing of SDEC pathways, there are two existing treatment rooms on Ward 4C that meet the necessary air handling standards for treatments to take place safely.

Optimising Patient Flow

In all options, a contingency fund 'winter surge' has been planned for to ensure adequate funds are available to respond quickly to periods of high inpatient demand. To help minimise the requirements for surge, the introduction of patient flow best practice principles should be considered.

Patient flow best practice principles

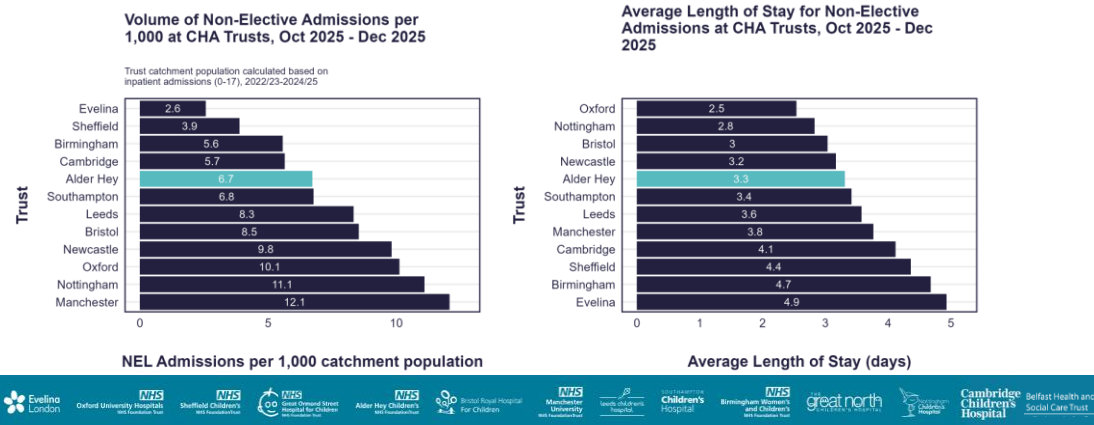
Working with a reduced bed base, particularly in the winter months will require consistent application of patient flow best practice principles. Realtime visibility of bed delays and predicted discharges are needed alongside modernisation of bed management systems to allow swift action and escalations to be embedded. The options included in appendix 4 describe opportunities to reduce length of stay through minimising delays in patient pathway, none of the reductions have been applied to the workings with the paper, they are to be considered as a future opportunity to reduce the need to surge capacity and to secure the bed savings.

The CHA have benchmarked length of stay for non-elective activity which indicates good performance but opportunity to meet with colleagues from Oxford, Nottingham, Bristol and Newcastle to compare delivery models and opportunities to reduce length of stay.

2.3 Non-Elective Activity



- In the last quarter, there were 3,532 non-elective admissions at Alder Hey, the equivalent of 6.7 per 1k catchment population.
- At Alder Hey, the average length of stay for non-elective admissions was 3.3 days.
 - Note: As GOSH casemix is difficult to compare to other trusts in this context, and the majority of their admissions are for complex electives, we have excluded them from charts depicting non-elective admissions.



Surge plan

The reduction of inpatient capacity is reliant upon an effective surge plan, the existing protocols specific to staffing and patient cohorts during surge are available in appendix 5

There are several areas available within the trust that could be used flexibly to respond to periods of high demand. It is anticipated that ward 4C will become vacant in September/October 2026 when the new facility will become available but could be utilised in the first winter, to safely transition through to business as usual. The partial use of ward 4C through the first winter would prevent the system becoming overwhelmed and reduces the risks associated with the ward closure through the first winter period.

The funding for the surge period is based upon staffing for 52 bed spaces with a 1:4 nurse to patient ratio. The funding can be utilised in response to surge and can be applied in a flexible way as the demand is not linear, i.e. 5 bed spaces may be required in November 10 in January, 5 in February etc.

Virtual Ward

The availability of the virtual ward is also an essential requirement to managing with a smaller bed base. Current virtual bed capacity is a of maximum 25 beds, but the team were able to flex in December 2025 to care for up to 40 patients discharged from PAU and 4C. Further detail is available in appendix 6

Capital requirements

There are no immediate requirements for modifications to ward 4C to allow the change in use to take place. The Head of Campus Services and Compliance has confirmed that the two treatment rooms on ward 4C meet the minimum requirements for a treatment room facility and the requirements for SDEC pathways.

Works required to ward 3B

There is a significant opportunity to deliver an enhancement in care to oncology patients by completing capital works on ward 3B. The works will increase the ward bed base from 13 to 15 and reduce the number of oncology outliers. It is assumed that these improvement works will be supported within the choices paper being developed.

The Board are asked to support the proposal to change the configuration of ward 4C inpatient beds to an integrated assessment area that aims to deliver:

- The total savings attributed to the change in use, including the provision to manage surge, is circa £1.49 million
- The majority of the service improvements from the agreed business case (PAU/EDU/SDEC July 25) can be implemented from May/June 2026 and provides the necessary time, staffing and facility to test the SDEC and EEMAC pathways. The proposal would be to run regular tests of change and provide a formal update of progress at 3 months and 6 months and in advance of the service relocation to the new unit. At this stage an informed decision can be made on the future model and the benefits delivered.
- Operational planning
 - If supported, the divisional leads would be able to mobilise the changes through May and June aligning staff to appropriate roles
 - Delivery of the business case approved in July 2025
 - Leading the way for children's services and SDEC
 - Development of EEMAC
 - Utilising a continuous improvement methodology to deliver effective change
 - Delivery of the 95% ED four-hour standard
- Capacity management
 - Maximising the use of the existing estate to deliver innovation and best practice principles
 - Providing effective surge response plans

- The division also support the prioritisation of best practice principles aligned to flow to maximise efficiencies through the hospital optimisation plan
- Patient care pathways
 - Safely reducing the time children spend in hospital
 - PDSA new ways of working
 - Improved patient experience with reduced delays to discharge and admission avoidance where possible
- Digital technologies
 - Utilising technologies to enhance patient flow and trust wide visibility
- Staff wellbeing
 - Working with our OD leads to support our teams to deliver excellence
 - There are enough posts for all clinical staff impacted by the proposed changed to be redeployed to, the change will need to be managed considerately and staff involved supported.
- Finance
 - Delivers circa £1.5m in savings
 - Creates opportunity to receive incentives aligned to new NHS England guidance
 - Removed the need for any further capital funding
 - A winter surge fund has been allocated as a contingency in year 1
- Estate
 - There are no capital works required on ward 4C
 - Creates an opportunity to commence the major life cycle replacement programme/ decant ward
 - Ward 3B enhancements will form part of the choices paper under development

Summary

Through effective changes to the model of urgent and emergency care there has been a sustained reduction in the demand for inpatient beds. This paper requests to change the current bed base to enable further developments in urgent care provision, delivery of nationally recognised models of care and the embedding of future ways of working relating to the new urgent care facility. It is anticipated this will further align our model with the principles of how we will work in the future, the delivery of Vision 2030 and improve the experience of children, young people and families.

Recommendation

The Trust Board are asked to:

- Support the reconfiguration of ward 4C to deliver the pathways approved in the PAU/SDEC case, plus the development of EMMAC in advance of the new facility facilities becoming available.

Appendix 1 – EEMAC and the model emergency department

<https://www.england.nhs.uk/long-read/the-model-emergency-department-high-performing-urgent-and-emergency-care-pathways/x>

Appendix 2 – SDEC

Speciality patients with a length of stay between 1 and 3 days (excluding ED and General Paediatrics)

Length of Stay (Days)	(All)
-----------------------	-------

Row Labels	Sum of Length of Stay (Days)
CAD	3
DIAB	1
ENDO	19
ENT	7
FRAC	3
GAST	102
GEN	4
HAEM	77
NEPH	107
NEUP	25
NEUS	4
ONC	192
ORTH	11
OSUR	7
PAES	22
PLAS	12
RESP	14
RHEU	14
UROP	4
Grand Total	628

Appendix 3 - workforce

The table below shows the current and proposed WTE, resulting in a surplus of 42.67WTE. At the present time, there are 47.89 vacancies across the trust which include Band 5 and Band 6. Band 6 have been included as internal recruitment in ongoing which will increase the B5 vacancies. The highest vacancies are in ICU



Requirement	WTE	Available	WTE	Difference
Band 8a	7.14	Band 8a	4.00	3.14
Band 7 TL	1.00	Band 7 TL	1.00	-
Band 7 PEF	2.00	Band 7 PEF	-	2.00
Band 6	8.27	Band 6	10.35	- 2.08
Band 5	15.53	Band 5	58.51	- 42.98
Band 3	11.02	Band 3	18.23	- 7.21
Admin Band 3	2.56	Admin Band 3		2.56
		B2 Other Staff	2.00	- 2.00
Medic YM7209	4.01			4.01
Total WTE Requirement	51.52	Total WTE Available	94.09	- 42.57

Appendix 4 – Optimising Flow



optimising%20flow.docx

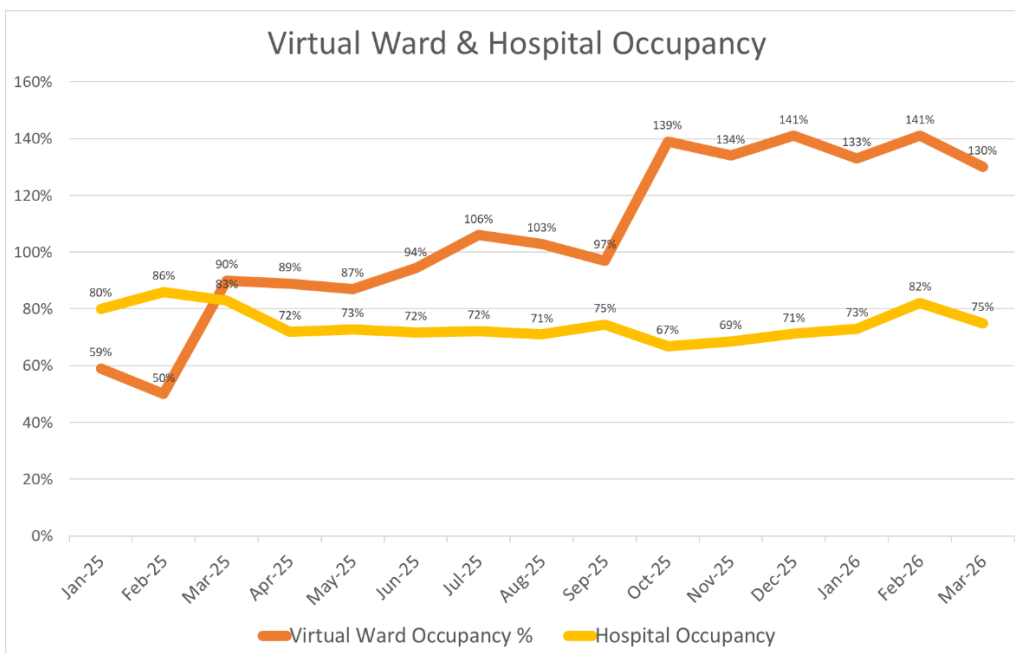
Appendix 5 – Surge protocol



Escalation Update v2.pptx

Appendix 6 – Virtual Ward

[Share](#)



BOARD OF DIRECTORS

Thursday, 2nd April 2026

Paper Title:	Children & Young People's Gender Service National Provider Network - Annual Report 2025/26
Report of:	Lisa Cooper, Director of Community & Mental Health Services
Paper Prepared by:	Emily Gardner, Programme Director Gender Service National Provider Network

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

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

Risk number	Risk description	Score	
#0382	There is a risk that the aim of the National Provider Network to deliver a consistent approach (which is cited in the Cass Review Final Report as "no matter where in the country the child/young person is seen, they will receive the same high standards of evidence-based care and better information upon which to base their decisions, avoiding a so-called 'postcode lottery'"), is unrealistic for providers and the CYPGS National Provider Network.	12	
#0384	There is no nationally agreed strategic approach to the long term commissioning of endocrinology, which creates a wide range of risk related to capacity and capability for all live and future CYPGS providers. It is expected that endocrinology is expected to form part of core service delivery for CYPGS, but it is known within services that this is not realistic within the next 1-2 years. This also increases the risk of inconsistent provision across providers or destabilise treatment pathways for patients.	12	
#0385	There is a risk of negative media scrutiny for Alder Hey in relation to gender services	9	
#0383	There is a risk that the CYP Gender Service National Provider Network host arrangements will be destabilised	6	
Level of assurance (as defined against the risk in InPhase)	<input type="checkbox"/> Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input checked="" type="checkbox"/> Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/> Not Assured Evidence indicates poor effectiveness of controls



1. Report Purpose

The purpose of this report is to present to Trust Board for information the Children and Young People's Gender Service National Provider Network Annual Report (2025/26).

2. Executive Summary

The Children and Young People's Gender Service National Provider Network was officially launched in March 2025, following several months of operating in a shadow capacity since October 2024. This transition marks a significant milestone in establishing the Network and formalising its activities.

Alder Hey currently serves as the host organisation for the Network, and will continue in this role in accordance with the contractual arrangements for the Children and Young People's Gender Service (North West). This ensures stability and consistency in the leadership and coordination of Network activities.

Annual reviews are scheduled across the Network, designed to confirm that all member organisations remain satisfied with the hosting arrangements. The Memorandum of Understanding stipulates that all members should be prepared to assume hosting responsibilities if required, promoting shared accountability and flexibility within the Network.

This annual report provides a summary of progress made, challenges encountered, and reflections from the reporting period. It also acknowledges the positive contributions and engagement demonstrated by all member organisations within the Network.

The annual report is available in Appendix 1.

3. Recommendations & proposed next steps

Trust Board is asked to note the Children and Young People's Gender Service National Provider Network's Annual Report (2025/26) and continuation of Alder Hey as the host organisation.

Appendix 1



NPN Annual Report
25 26 FINAL.pdf

Children and Young People's Gender Service National Provider Network

Annual Report 2025/26

V1.0

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Foreword by Dr Camilla Kingdon

Chair of the Children and Young People's Gender Service National Provider Network

As I complete my first year as Chair of the Children and Young People's Gender Service (CYPGS) National Provider Network (NPN), it gives me huge pleasure to present the inaugural NPN annual report. I took up the Chair's position at the establishment of the NPN in February 2025 and, as a paediatrician, have learnt a huge amount. I have gained crucial and privileged insight into the expertise of my many colleagues who are working steadfastly to develop high quality Children and Young People's Gender Services across England.



There has been extraordinary determination, progress, and momentum across the National Provider Network to build upon the foundations set by the final report of the Cass Review following its release in April 2024 and the subsequent NHS England Implementation plan. As Chair of the NPN, I have seen the dedication and commitment of the clinical, operational, and administrative teams to ensure a robust, safe service for children and young people experiencing gender dysphoria or gender incongruence and their families. The holistic child-centered approach advocated by the Cass Review is evident across the network of providers and in this report, we want to share the collective progress of the services and an overview of our plans for the coming year.

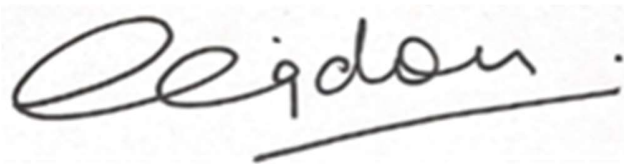
This dedication continues, despite the NHS finding itself at perhaps its most turbulent time, with many of our clinical services continuing to operate under significant pressure and ever-growing demand. I am well aware that there are many children and young people waiting for support from our services, and we are testing different approaches to ensure we can support those either on the national waiting list, or going through the referral process, as soon as possible. We are also working on proposals to make sure local services and GPs have access to the information they need. We know that there remains a lot of concern about the future of NHS gender care for children, young people and adults, and the National Provider Network is committed to ensuring that our services are evidence-based, safe and supportive and are delivered consistently across the country. Of course, there is still a long way to go, and the announcement of the PATHWAYS research study will give us important evidence to support care offered by the CYPGS providers.

I am delighted that each of the four current live services, including all the partner organisations which make up each service, are members of the NPN along with

endocrinology representation and representatives from the mobilising services. Our hope within the core NPN team is that we continue to support our members as we move into 2026/27, providing a central space for shared learning and continuous development. I have every hope that our established services will continue to flourish, and our mobilising services will be supported to go live and improve access closer to home for many young people and families.

Finally, the care of children and young people who use our CYP Gender Services is of paramount importance. Being able to provide consistent high quality safe care to the children and young people who need our services, regardless of where they live, is the ultimate aim of the National Provider Network and the golden thread that runs through all our work. I hope that this report attests to this ambition.

With my best wishes

A handwritten signature in black ink, appearing to read 'Camilla Kingdon', with a horizontal line underneath it.

Dr Camilla Kingdon
March 2026

1. Executive Summary

The 2025/26 reporting year marks a defining stage in establishing the CYPGS NPN. Since its formal launch in February 2025, the NPN has developed into a coordinated national structure uniting CYPGS providers, mobilising organisations and endocrine partners to deliver consistent, evidence-based care for children and young people experiencing gender incongruence or dysphoria. This report summarises progress and success during the first operational year, the challenges encountered, and key priorities for the year ahead.

Over the past 12 months, the NPN has consolidated the foundations laid by the [Cass Review](#) and [NHS England's Implementation Plan](#). Major achievements include establishing the NPN governance framework, launching and operationalising the National Multi-Disciplinary Team (NMDT), expanding NPN membership to mobilising providers, and implementing core workstreams across clinical pathways, training, quality improvement, communications and research oversight. Strong engagement across member organisations has supported consistent practice, shared learning and collective decision-making.

The NMDT has become central to national clinical consistency, ensuring transparent and equitable recommendations regarding endocrine referrals, and providing a forum for complex case review at national level. The Clinical Reference Group and its subgroups have standardised key Standard Operating Procedures (SOPs), pathways and clinical guidance, while 13 Quality Improvement (QI) pilots have demonstrated providers' commitment to improving outcomes and reducing unwarranted variation.

Alongside clinical development, the NPN has supported NHS England's wider programme requirements, contributed to national training delivered with the Academy of Medical Royal Colleges, and strengthened engagement across clinical, operational and communications networks. Collaboration with mobilising services and international peers has increased, and initial planning is underway for a national CYPGS microsite to provide trusted online information for families and professionals. Financial governance has remained stable, with the Host organisation, Alder Hey Children's NHS Foundation Trust (Alder Hey), providing clear oversight.

The first year has also highlighted areas requiring continued focus, including the future commissioning model for endocrine services, ensuring sufficient NMDT capacity, supporting alignment for new providers and clarifying the NPN's future role in research governance. There is also growing need for more standardised data, dashboards and reporting mechanisms to enhance assurance and improvement.

In 2026/27, priorities will include embedding workstreams, appointing dedicated leadership for Training and Education and Communications and Engagement, maturing the NMDT

model, strengthening QI and research alignment, supporting further CYPGS mobilisation, and developing nationally accessible resources, including the CYPGS microsite. Workforce development - delivered in partnership with the Academy of Medical Royal Colleges - will remain a core focus.

The achievements of 2025/26 reflect the collective effort of all member organisations. As national arrangements continue to evolve, the NPN remains committed to delivering consistent, safe and high-quality care for children and young people across England, in line with the principles of the Cass Review.

2. Introduction

2.1 National Context

In September 2020, NHS England commissioned an independent and wide-ranging expert review of gender identity services for children and young people, led by Dr Hilary Cass. The final report was published April 2024. NHS England established a national programme to develop CYPGS. The locations of live and mobilising CYPGS providers, endocrinology partners and the NPN are shown in Figure 1 below:

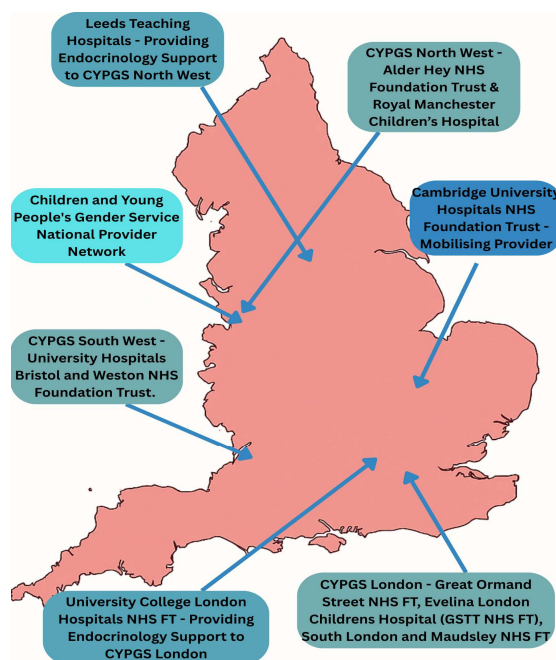


Figure 1: Map showing live and mobilising CYPGS locations and endocrinology providers.

The CYPGS regional centres are led by experienced providers of tertiary paediatric care to ensure a focus on child health and development, with strong links to mental health services,

in line with the Cass Review recommendations, which have been endorsed by NHS England in an [implementation plan](#) published August 2024.

The Cass Review recommended the establishment of a national provider collaborative with the overarching aim that, “no matter where in the country the child/young person is seen, they will receive the same high standards of evidence-based care”.

It states that the regional centres should operate to shared standards and operating procedures, developing joint protocols for assessment and treatment and working to achieve consistency across providers. It notes that the collaborative should have a role in overseeing ethics, training and professional development, data and audit, quality improvement and research requirements, as well as providing a forum for the discussion of complex cases and a NMDT.

Following the publication of the Cass Review Final Report and the NHSE Implementation Plan, the NPN mobilisation team successfully reconciled all recommendations with the interim service specification and developed a comprehensive proposal. The NPN was subsequently established in October 2024 in shadow form and formally established on 19 March 2025, following the appointment of the independent Chair and the establishment of the NPN Board.

The proposal for the initial period of the NPN covered 01 October 2024 -31 March 2026; this was formally endorsed by NHS England’s National Portfolio Board and the Alder Hey’s Board in September 2024, marking a critical step in shaping the future of CYPGS. gender services.

Since inception, the NPN has achieved significant milestones in establishing a coordinated and high-quality approach to CYPGS, both for established and mobilising providers.

3. Year 1 Overview

The NPN committed to creating a robust governance structure that would bring all workstreams under a single, coordinated framework. This included forming the CYPGS NPN Board, supported by groups with a focus on clinical development, research, quality improvement, education and training, communications, and standard operating procedures. Each live workstream was tasked with maximising consistency, aligning processes, reducing duplication, and ensuring transparency.

The governance model was designed to enable shared learning, escalate risks, and provide oversight of progress. Membership of the NPN was made mandatory for all CYPGS providers commissioned by NHS England, with entry formalised through a Memorandum of Understanding (MoU). Alder Hey Children’s NHS Foundation Trust agreed to function as the

Host organisation for the first two years, and responsibilities related to that function were clearly defined.

The NPN outlined a resource plan to support mobilisation and ongoing management, including roles such as NPN Director, Programme Manager, Network Manager, and administrative support. CYPGS clinical leadership was embedded across workstreams, and dedicated time was allocated for NMDT members.

The anticipated annual cost for the NPN was **£621,907**, covering salaries, on-costs, and overheads. The NPN committed to using underspend from the existing CYPGS budget for initial mobilisation, with quarterly financial reconciliation to NHS England. Additional funding requirements would be agreed as the NPN's scope expanded.

The NPN committed to a phased approach to scoping and development before going live in shadow form in October 2024:

- **Exploration and Scoping (Summer 2024):** Review existing programmes of work, map stakeholders, and draft governance proposals.
- **Mobilisation (Autumn 2024):** Agree MoU, recruit Chair and key personnel, establish shadow NPN meetings, and prepare administrative infrastructure.
- **Implementation (Late 2024 onwards):** Launch inaugural NPN Board meetings, operationalise workstreams, and embed governance processes.

3.1 Reflections

The NPN has brought together respected tertiary paediatric, mental health and specialist providers across England, enabling a genuinely national model with representation from the North West, South East, South West, London, and endocrinology partners. This collective expertise has created a solid foundation for shared standards and collaboration.

Following initial scoping, the NPN met in shadow form from October 2024, working closely with NHS England to prepare for formal establishment. The appointment of an independent Chair for both the NPN and NMDT strengthened governance and accountability.

The NMDT was mobilised in shadow form from September 2024 and opened to referrals in January 2025, providing a robust mechanism for consistent, evidence-based clinical advice. Since May 2025, it has reviewed submissions from CYPGS providers and endocrinology partners, as well as selected cases from the Nottingham Young Person's Gender Service, a service commissioned by NHS England to support a cohort of children and young people from the previous service. Its role in safeguarding and standardising recommendations has strengthened system confidence and equity of care.

Operationally, 2025 saw the NPN transition from planning to full delivery. Recruitment progressed well, workstreams mobilised, and 13 QI pilots were launched and approved by NHS England. Engagement across providers has been consistently strong, with collaborative development of shared pathways, operating procedures, and governance processes. Financial stewardship has remained sound, with clear reporting and a small underspend at year-end. Feedback from children, young people and families has been overwhelmingly positive across all three live services, each receiving their commissioned allocation of referrals from the national waiting list.

The NPN continues to embed the recommendations of the Cass Review, ensuring continuous learning and adaptation as evidence and national expectations evolve.

3.2 Challenges

While considerable progress has been made, several challenges have occurred which will shape future priorities.

Clarity of scope and priorities have, at times, been affected by differing expectations across NHS England, providers, and wider stakeholders, emphasising the need for continued alignment and consistent communication. Operationally, the time and resource demands of the NMDT have been greater than initially forecast. As the sole route to endocrine referral for CYP gender services in England, the NMDT process must withstand scrutiny yet remain efficient, and as such, all NMDT documents and processes are under regular review.

Demand pressures continue to rise. There is increasing interest in whether the NMDT may need to expand to support cases from other territories linked to PATHWAYS research, such as Northern Ireland. This would require a more scalable model and potentially additional resource to maintain timeliness.

Broader system challenges also persist, including variation in local service approach and the complexity of embedding consistent national pathways. Strengthening shared learning, alignment, and transparency will remain essential.

Despite these challenges, collaboration across the NPN remains strong. The first year has demonstrated what can be achieved through joint working, even within a complex and evolving policy landscape.

3.3 Our year in figures

2025/26 has been a year of significant growth, collaboration, and activity across the NPN. The scale of engagement reflects the commitment of CYPGS providers and partners to building a consistent, evidence-based national model.

From March 2025 to February 2026 the NPN facilitated over 238 meetings, workshops, and clinical discussions, including:

- 38 Complex Case Peer Review Groups
- 18 SOPs & Pathways Groups
- 10 National MDT Meetings
- 11 Clinical Reference Groups
- 5 meetings of the NPN Board
- 1 2-day clinical leaders' workshop

4. Scope and Structure

4.1 Governance

The initial proposal established an NPN Board supported by a set of core reporting groups and subgroups. Following engagement with NPN members and agreement of the NPN Board, the below image shows the current governance structure:

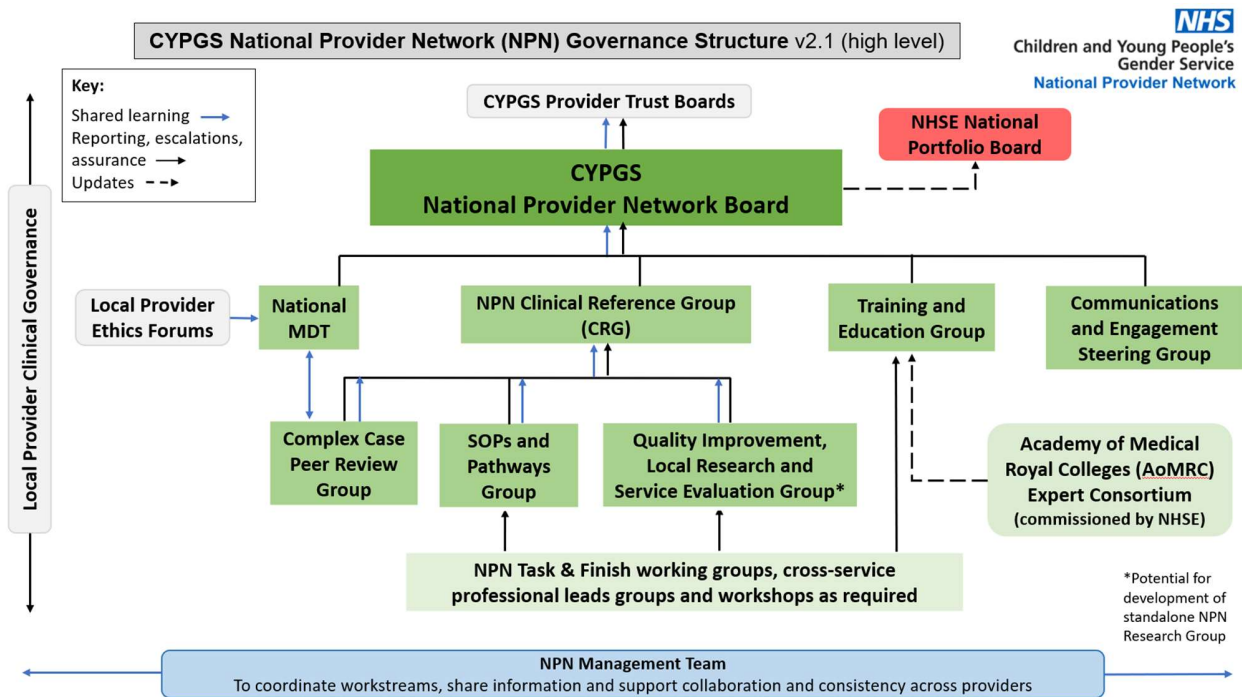


Figure 2 NPN high level governance structure, as of February 2026

4.2 Governance Mobilisation

A phased mobilisation approach supported the NPN's transition from shadow operation to full establishment:

- **NPN Board establishment:**
Operating in shadow form from October 2024 and becoming fully established on 19 March 2025, with governance for the NMDT transferring from NHS England on the same date.
- **CRG integration:**
The shared provider CRG moved into the NPN governance structure, shifting from a weekly reactive meeting to a monthly strategic clinical governance forum.
- **Workstream activation:**
 - Weekly Complex Case Peer Review Group and fortnightly SOPs & Pathways Group established, with full membership and Terms of Reference in place by August 2025.
 - Communications & Engagement workstream paused initially, with provider communications leads continuing to coordinate reactive activity. A formal NPN Communications & Engagement Group was mobilised in February 2026, with plans to potentially recruit an NPN Comms Lead.
 - Development of a standalone NPN Ethics Forum paused, with providers continuing to use local Clinical Ethics Advisory Groups (CEAGs). Shared learning from CEAGs is reported into the CRG, and options for periodic ethics “in-reach” are being explored, for example through workshops. Development of an NPN Ethics Forum is to be kept under review.
- **Quality Improvement & Research:**
The NPN Board agreed the approach to a QI Network, and a joint QI, Local Research and Service Evaluation Group was established as a CRG subgroup to coordinate pilots and local evaluation work. Scoping continues for a future Research Steering Group, aligned to NHS England's evolving research governance arrangements.
- **Training & Education handover:**
NHS England continued to lead this workstream until September 2025, after which responsibility transferred to the NPN. The NPN Training & Education Group was formally established in December 2025, with membership, Terms of Reference and an initial workplan agreed.

5. NHS England Programme

The NPN continually reviews progress against two key national documents, the Cass Review Final Report and the NHS England Implementation Plan. NHS England published its Implementation Plan during August 2024 in response to the Cass Review.

The NPN has successfully delivered the core structural elements recommended by the Cass Review, including establishing a fully functioning NPN, launching the NMDT, embedding shared clinical standards, and implementing cross-provider peer review, creating a consistent and coordinated national model of care.

The NPN has also made strong progress against delivering the core early-stage “building blocks” by bringing all live services into the MoU, supporting new patient pathways; progressing into the evidence-gathering phase by operationalising the NMDT, embedding QI alongside local research.

Several Cass-recommended functions remain dependent on NHS England (such as national dataset governance and research oversight), highlighting that while the foundations are firmly in place, the wider system architecture is still evolving.

The NPN is working closely with NHS England and the Department of Health and Social Care to understand how the impending changes with the structure and remit of NHS England nationally will impact on the governance and ways of working of the NPN and CYPGS providers.

6. Memorandum of Understanding

The Memorandum of Understanding (MoU) for the CYPGS NPN sets out the framework for collaboration between NHS Trusts that provide Children and Young People’s Gender Services. Members who joined after the original MoU was signed become signatories to the Memorandum of Adherence (MoA). As of February 2025, the current members of the NPN are:

- Alder Hey Children’s NHS Foundation Trust
- Royal Manchester Children’s Hospital, Manchester University NHS Foundation Trust.
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Evelina London Children’s Hospital, Guy’s and St Thomas’ NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- University Hospitals Bristol and Weston NHS Foundation Trust
- Cambridge University Hospitals NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust

- Leeds Teaching Hospitals NHS Trust

The MoU defines the scope, the roles and responsibilities of its members, and the governance arrangements required to deliver high-quality services. It also formalises the appointment of a Host organisation to manage operational and administrative functions on behalf of the NPN. While most provisions are not legally binding, specific clauses relating to confidentiality, data protection, liability, and termination carry legal weighting.

The overarching goal is to create a responsive, evidence-based healthcare system for children and young people experiencing gender dysphoria or incongruence. The NPN aims to:

- Ensure consistent standards of care nationwide, regardless of location.
- Promote integrated care pathways through multidisciplinary teams (MDTs).
- Coordinate and deliver the NMDT, which provides clinical advice on complex cases.
- Support training and education for healthcare professionals to improve understanding and sensitivity.
- Enhance data collection and research to inform best practice and improve outcomes.
- Prioritise patient-centered care, safeguarding, and collaboration across health, education, and social care sectors.

Members commit to working together under principles of openness, accountability, and shared learning, including:

- Communicate transparently about issues and opportunities.
- Share resources and expertise to avoid duplication and reduce costs.
- Act in good faith and respond promptly to requests for support.
- Deploy appropriate resources to fulfil responsibilities.

Membership is mandatory for CYPGS providers commissioned by NHS England. Governance is delivered through the NPN Board, supported by sub-groups and the NMDT. The NPN Board acts as a forum for discussion and consensus-building rather than a legal entity; decisions remain the responsibility of individual providers. The duties of Alder Hey, as host include:

- Managing NPN funding and financial reporting.
- Recruiting and employing NPN personnel.
- Coordinating meetings, workshops, and governance processes.
- Maintaining records and ensuring compliance with information governance standards.

The Host is indemnified by other members for losses incurred in its role, except in cases of fraud or willful default.

The MoU addresses confidentiality, data protection, intellectual property rights, liability, and insurance. It includes mechanisms for problem resolution and dispute management, emphasising collaborative approaches before escalation. Annual reviews will assess progress, consider amendments, and confirm the Host's role. Termination provisions allow for collective or individual exit under defined circumstances, including force majeure.

The MoU commenced on 01 February 2025 and will remain in effect until 31 March 2026, subject to extension by agreement.

6.1 Host Organisation

Alder Hey has served as Host for the NPN and NMDT since inception, providing the central administrative and operational functions that enable the NPN to run effectively. Acting on behalf of all member organisations, the Host manages NPN finances, recruits and employs hosted staff and coordinates governance processes, meetings, documentation, and information governance duties. These arrangements ensure the NPN operates smoothly, transparently and in line with NHS England requirements, while clinical decision-making and provider level responsibilities remain with individual organisations, including for the National MDT, which is an advisory body. Hosting arrangements are reviewed annually, offering flexibility as the NPN evolves.

Member organisations share collective responsibility for the success of the NPN. They participate actively in governance, apply shared standards and best practice, and work collaboratively to deliver consistent, evidence-based care. Members also indemnify the Host for relevant liabilities and support continuity by maintaining readiness to assume hosting responsibilities if required. This partnership model, combining the Host's operational backbone with the Members' clinical and strategic contribution, ensures the NPN functions as a coherent national system, delivering equitable, high-quality care across all regions.

6.2 Other partnership arrangements

The NPN also holds several other formal agreements to discharge its duties and work in collaboration with key stakeholders. For example, an MoU with the Academy of Medical Royal Colleges, in relation to the NHS England commission to support key training and education workstreams; and MoUs with developing or mobilising providers to support sensitive information sharing to inform planning and promote cross-provider consistency.

7. Risk Management

A formal NPN risk register is held by the NPN Team and monitored monthly or updated as required. Individual workstreams hold their own risk registers (for example, Training and Education) and are managed by the relevant group; higher scoring risks are reflected on the

overarching NPN Risk Register to ensure there is a clear understanding of the risks to the NPN, across workstreams.

Four of these NPN risks are classed as Alder Hey corporate risks and are monitored through Alder Hey's risk management and escalation process (see **Appendix 2** for further detail). Alder Hey has delegated day-to-day risk management to the NPN Board as the expert body for oversight in this area.

Key risks and issues have been discussed via the NPN Board agenda since its inception, however the NPN Board now has a regular standing agenda item to ensure members are clearly sighted on the corporate risks as well as emerging situations.

The NPN Team regularly updates the corporate risk register and meets monthly with Alder Hey risk managers in line with standard governance procedures.

The two highest scoring risks on the NPN Risk Register as of February 2026 are:

- There is a risk of external scrutiny and/or media attention for the NMDT from a process perspective or through a specific case raising a legal challenge (Consequence x Likelihood: 4x4=16).
- There is a risk that the NMDT function may be compromised due to the anticipated demand for NMDT meetings and case reviews. This is due to the increased number of cases anticipated from NYGS (from 10 to up to 70) combined with the launch of the PATHWAYS research study (April 2026) and anticipated increase in submissions for cross-sex hormones across CYPGS providers (Consequence x Likelihood: 4x4=16).

The highest scoring risks both relate to the NMDT, particularly the potential for increased public and media scrutiny given the sensitive national context and the cohort's history of service change, policy shifts, and delays in access to care. If the NMDT is unable to provide assured recommendations for endocrine referrals, this increases the likelihood of complaints, FOIs and SARs, heightening scrutiny and operational pressure. All NMDT members offer their time voluntarily and rising forecast demand poses a risk to timeliness, with the small pool of expert NMDT members vulnerable to overload.

To mitigate these risks, the NPN is strengthening forecasting and demand capacity planning, accelerating the mobilisation of the Communications and Engagement Group to support consistent messaging, and drawing on Alder Hey's governance infrastructure for Freedom of Information Requests, Subject Access Requests, and complaints management. Cross-provider reporting through the CRG further supports early escalation and a coordinated response.

8. Reporting and Data

The NPN Board receives monthly Highlight Reports from its subgroups which provide progress reports, summaries of key outputs, issues and risks, and shared learning:

- NMDT includes shared learning from case submissions.
- CRG
 - SOPS and Pathways Group
 - Complex Case Review Forum (cross-provider shared learning)
 - QI, Service Evaluation and Local Research Group
- Training and Education
- Communications and Engagement

Additional data is routinely shared with the NPN Board to reflect:

- Complaints, Incidents, FOIs, and Ethics Committee advice received across services and shared learning associated with these.
- Regular finance updates

Each live service also provides a service update on rotation to the NPN Board, which provides an opportunity to share best practice, key achievements, or areas of challenge.

During the next phase, the NPN will explore the development of a dashboard to support consistency across providers and the identification of trends or issues to support quality improvement initiatives.

9. Finance

The end-of-year financial position for 2025/26 shows a small overall underspend, reflecting stabilisation of the NPN budget as recruitment has progressed and core posts have now been appointed to. Earlier in the year, pay budgets showed significant underspend due to vacancies, but by year-end many roles were successfully recruited too, apart from two posts for which recruitment was paused whilst scoping was underway within specific workstreams, which reduced the variance. The remaining underspend relates to the short period where posts were vacant before staff started their roles, alongside the paused posts.

In the initial Phase 1 proposal for the NPN, there was no allocation for non-pay expenditure, there continues to be pressure in several areas relating to this. For example, non-pay costs include legal fees and costs for interim workforce cover. Other non-pay categories, such as travel, subsistence, IT equipment, and furniture, also show overspends against available budget. Because no dedicated non-pay allocation was set aside for the NPN in the current

year, these costs have been offset by the pay underspend, helping keep the overall position favourable.

Overheads remain aligned to budget, and the combined effect of stabilised pay spend and non-pay pressures results in a modest underspend at year-end.

The NPN is planning to move into 2026/27 with the same allocation and has created a small non-pay allocation due to re-banding of posts in the initial proposal to ensure projected costs are manageable. There may be cause for review of this, if the scope is amended or demand on certain areas of the NPN, such as the NMDT become untenable.

10. Contracting

The NPN and NMDT have been contracted via the CYPGS North West's standalone service contract with NHS England since inception in a shadow form in October 2024. This aligned with the agreed hosting arrangement being held by Alder Hey.

As an overview, the contract details the following responsibilities, aligned with the agreed proposal for the NPN and NMDT agreed by NHS England:

- Shadow hosting from 1 October 2024, transitioning to formal go-live on 1 February 2025.
- Coordinating NMDT meetings to ensure clinical consistency.
- Acting as the operational hub for communication and governance across the NPN.
- Supporting the development and implementation of national SOPs, protocols, and shared assets

Contract management has been led by NHS England's North West Region, Specialised Commissioning team, with quarterly contract meetings held to review progress. These meetings are attended by both the regional team and NHS England's national team, ensuring alignment between local delivery and national oversight.

Alder Hey has agreed to continue the hosting role through the next proposed contractual period, and this is supported by the NPN Board. Continuation of the existing contractual model will maintain stability whilst supporting any expansion or developments. It is proposed that the hosting role remains unchanged. It is assumed that the existing contractual oversight mechanisms will continue, led by NHS England's North West Specialised Commissioning team.

11. Workstream overview: Training and Education

The purpose of the Training and Education Workstream is to identify, coordinate, and oversee the development and delivery of nationally agreed training and educational resources for CYPGS providers, as well as for colleagues working across primary and secondary care.

In April 2024, NHS England commissioned the Academy of Medical Royal Colleges (AoMRC) to develop training materials for CYPGS providers. This commission included a comprehensive induction programme and specialist modules on the Holistic Assessment Framework (HAF), neurodevelopmental needs, and the Holistic Formulation Framework (HFF).

AoMRC subsequently delivered a full training manual, in-person workshops, and a Train-the-Trainer (TtT) handbook. By December 2025, AoMRC and CYPGS leads had trained:

- **96** CYPGS clinical staff across all live providers
- **27** staff members trained as facilitators to support ongoing local delivery
- Feedback showed **high satisfaction**, with participants rating training value at **88%**

The rollout of the TtT model has begun across CYPGS providers, and AoMRC will continue to support the onboarding of new regional hubs through induction and TtT sessions.

In September 2025, responsibility for this workstream transferred from NHS England to the NPN, in line with the Cass Review implementation plan. While NHS England continues to commission AoMRC, the NPN now provides strategic oversight and monitors key delivery milestones. A Memorandum of Understanding between the NPN and AoMRC is in place to support seamless collaboration. The inaugural NPN-led workstream meeting took place in December 2025, and both Terms of Reference (TOR) and an annual workplan have now been established.

Training and Education: Future Plans

Over the coming year, the workstream will focus on recruiting a dedicated Chair/SRO, reviewing the outputs of the AoMRC competence framework, and coordinating induction and ongoing training across CYPGS providers. Work will also progress on developing information and resources for a dedicated CYPGS microsite, delivered in collaboration with the Communications and Engagement Group, alongside establishing cross-provider CPD and networking events. These priorities will collectively support the continued development and implementation of the workstream's strategic plan

12. Workstream overview: National MDT

The foundations of the NMDT were initially developed by NHS England, with Terms of Reference and supporting documentation handed to the NPN mobilisation team in summer 2024 for refinement under an interim independent Chair. Following legal review and further development, the interim NMDT was in place by September 2024, with meetings paused until an independent Chair was appointed. The NMDT became fully operational in January 2025 under Dr Camilla Kingdon, with governance still sitting with NHS England at that stage.

The NPN formally took on governance of the NMDT at its inaugural Board meeting in March 2025, and the MDT reviewed its first case in June 2025. As of February 2026, the NMDT received fifteen submissions: three withdrawn by services, ten resulted in recommendations for referral to endocrine services for consideration of masculinising or feminising hormones, one did not result in a recommendation for medical pathway referral, and one case remained pending review. Figure 3 and Figure 4 summarise the number of submissions received and outcomes:

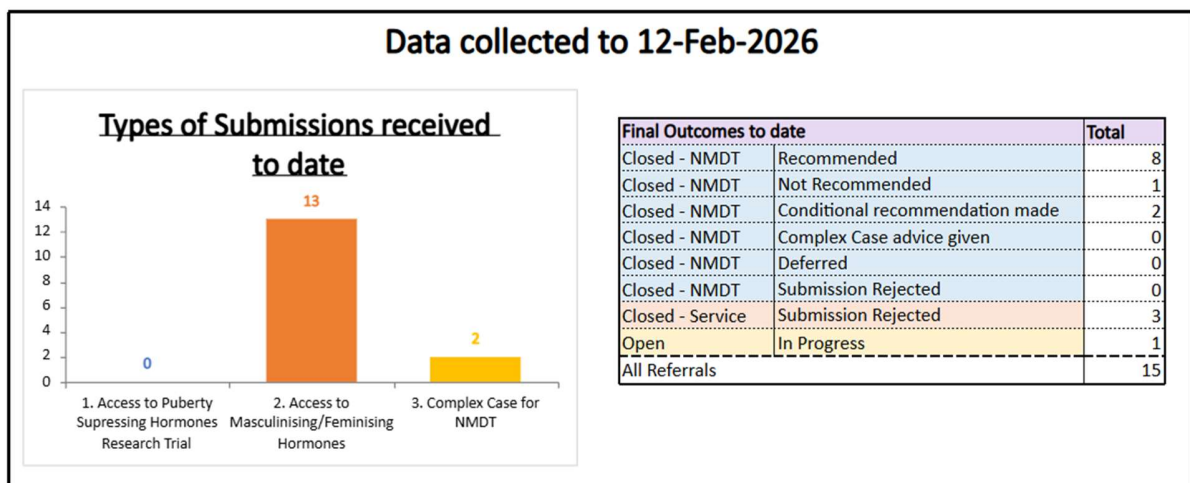


Figure 3: Summary of National MDT submissions received and outcomes.



Figure 4: Number of National MDT submissions received per month 2025/26.

NMDT Process

Of the eleven case reviews considered by the NMDT up to February 2026, the average time from receipt of case submission through admin screening, clinical screening, NMDT meeting review to the email sent to provider with the formal recommendation is 29.2 days, well within the 36-day aim (NMDT Standard Operating Procedure).

13. Workstream overview: Communication and Engagement

The purpose of the Communications and Engagement workstream is to ensure a consistent, coordinated approach to external communication and engagement across CYPGS providers, delivering clear, accurate and trusted information for children, young people, families, and stakeholders. Given the sensitivity of gender-related healthcare and the need for consistent national messaging, providers adopted a collaborative model for communications. The NPN MoU formalised this approach, with all member organisations agreeing to align all external communications.

Prior to the NPN Communications and Engagement workstream being developed, communications leads from each Trust met fortnightly and worked in a consistently collaborative approach. This assured the NPN that there was robust and aligned support for the handling of media enquiries, public statements and responses to FOIs and complaints.

This group successfully coordinated unified messaging, have drafted Terms of Reference and a workplan have been developed in preparation for the inaugural formalised workstream meeting scheduled for early March.

Communications and Engagement: Future Plans

The workstream will focus on identifying a lead to co-ordinate delivery of the workstream strategy and ensure appropriate and dedicated Communications and Engagement capacity and capability within the NPN. A major priority is commissioning and developing a dedicated CYPGS microsite that will act as a single, trusted source of evidence-based information for children, young people, families and clinicians, with content developed in collaboration with the Training and Education Group. The workstream will also oversee the review and approval of all materials for the microsite and progress the wider implementation of the communications and engagement strategy.

14. Workstream overview: Clinical Reference Group

The Clinical Reference Group has played a vital role in strengthening clinical consistency across CYPGS providers, offering an integrated forum that supports the NPN's aim of delivering a responsive, evidence-based, and high-quality national service for children and young people. Over the past year, the CRG has provided coordinated clinical leadership, guiding the development of new SOPs, clinical pathways and reviewing existing models of care to ensure alignment with NHS England's implementation plan for the Cass Review recommendations, and the CYPGS service specification.

Three active subgroups report directly to the CRG including the SOPs and Pathways Group, the Complex Case Peer Review Group, and the Quality Improvement (QI), Local Research and Service Evaluation Group. Each meets regularly, with the Complex Case Peer Review Group meeting weekly and all are typically chaired on rotation to sustain shared ownership across providers. Through this structure, the CRG has driven progress on standardising SOPs, supporting complex case discussions, sharing learning, and embedding quality improvement activity. The NPN oversees the planning and coordination of all meetings, ensuring effective governance and consistent monitoring of workstreams and associated risks.

Since its formal establishment in its current form in June 2025, the CRG has overseen the work of its subgroups and provided strategic advice on broader clinical issues affecting regional services, to provide a collaborative approach and to planning with partners. Examples of key topics include:

- National Waiting List strategic planning and review of service capacity
- Review of NHSE Waiting Well proposals
- Approach to QI Network proposal
- Feedback on clinical guidance for the research trial
- Consideration of approach to expediting cases
- Review of initial QI pilot project proposals
- Legal advice regarding informed consent
- Establishing a mechanism for shared learning from incidents and complaints
- NPN language and terminology
- Review of TOR for CRG sub-groups
- Review of recommendations from CRG sub-groups

Clinical Reference Group: Future Plans

The programme will strengthen collaboration with Adult Services and UK gender services to support smoother transitions, clinical alignment, and shared learning. It will **collate data from across CYPGS services with regards to children and young people accessing non-NHS hormone prescriptions (where this is known to the service)**. It will **analyse** thematic learning from complex cases, and outputs from quality improvement and service evaluation work to identify priority areas for development. Governance and pathway documentation will be reviewed to ensure they remain current and aligned across providers. Work will continue **with** developing cross-provider clinical resources, improving risk management processes, and creating a phased dashboard to support NPN Board assurance and provider mobilisation.

15. Workstream overview: SOPs and Pathways Group

The SOPs and Pathways Group is a CRG sub-group. It leads the development, review, and update of a standardised suite of clinical documents and pathways for all CYPGS providers, providing a shared forum that strengthens consistency, quality, and safety across services. Meeting fortnightly since June 2025, the group brings together Clinical Leads, General Managers and subject-matter experts to collaboratively refine documentation, aligning local approaches into nationally agreed standards. Once developed, recommendations are submitted to the CRG for formal approval, ensuring a coordinated and robust governance process.

Key highlights of the work completed by the SOPs and Pathways Group include:

- Review of CYPGS SOP 1 – Transfer of Care
- Review of CYPGS SOP 2 – Initial Clinical Assessment
- Review of CYPGS SOP 3 – Pathways of Care and Care Planning
- Development of a merged CYPGS Service SOP incorporating SOPs 1-3
- Development of Inter-CYPGS handover document
- Review of Joint Endocrine SOP
- Development of “Group 2” psycho-education content including consent and capacity
- Review of the Protocol for Transfer of Clinical Responsibility to Adult Services referral form
- Development and collaborative review of a Clinical Guideline for Body Wellbeing
- Review of Speech and Language Therapy Guidelines
- Review of Occupational Therapy Guidelines
- Development of Paediatrician Guidelines and Medication Monitoring Form
- Development of guidance: Managing Concerns About Access to Non-NHS Sources of Hormone Medication for Gender Incongruence in Children and Young People

SOPs and Pathways Group: Future Plans

Forward plans include progressing further documentation development in collaboration with outputs from the QI, Local Research and Service Evaluation Group, and the Training and Education Group. This will sit alongside a structured evaluation and refinement of the core content within the “Group 1” and “Group 2” pathway resources. The programme will continue supporting new provider mobilisation to promote consistent practice, such as through the review of access policies and safeguarding processes. It will further develop a formal document management system to strengthen governance and version control and embed IT infrastructure to support and shared provider access and collaborative, efficient working.

16. Workstream overview: Complex Case Peer Review Group

The Complex Case Peer Review Group explores ideas, shares learning, and provides expert cross-provider peer advice. It provides an integrated discussion forum for clinical colleagues to consider options for the management of complex clinical issues, particularly where the decision-making of one provider might impact or set a precedent for other providers.

The group considers issues relating to (but not limited to) a cohort or individual case presented by a live CYPGS provider, where peer-to-peer discussion across providers is helpful or required (for example, where services are considering making a submission to the NMDT for advice under the “complex case” criteria).

As the meeting format has matured, the learning captured in summary notes is now identified as either:

- **Case-specific learning**

- This information may include suggested actions and considerations for next steps, or confirmation that other providers would manage the issue in a similar way, for example
- The presenting provider may update their Electronic Patient Record where appropriate with this information.

- **Wider shared learning**

- Group members disseminate within their clinical teams as appropriate
- This information is also shared via the Group highlight report to the CRG and to the NPN Board, to support system learning

The thematic learning from September 2025 to January 2026 is presented in **Figure 5** and **Figure 6** below:

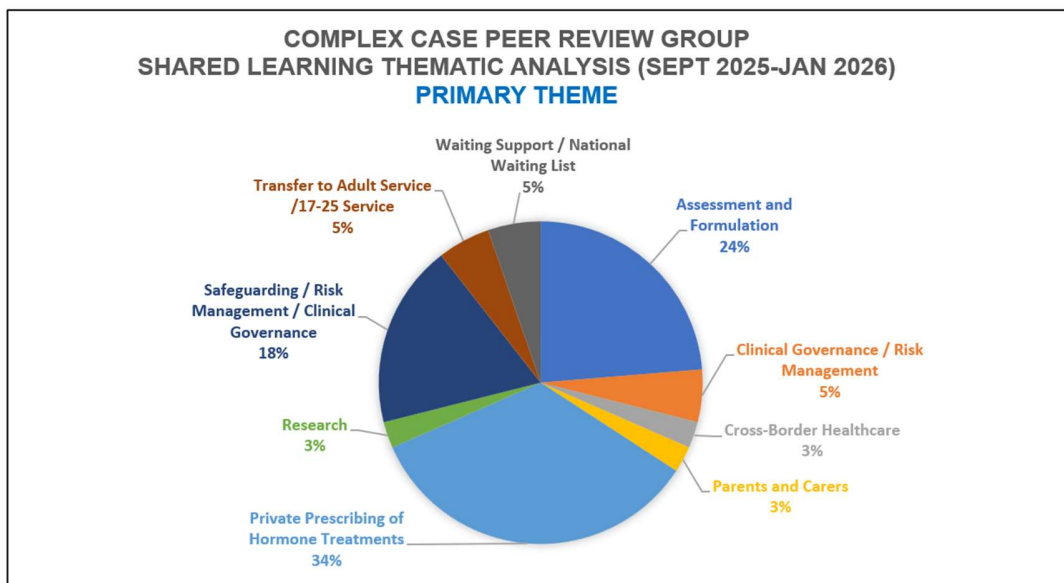


Figure 5: Thematic learning from complex case peer review group: Primary Theme

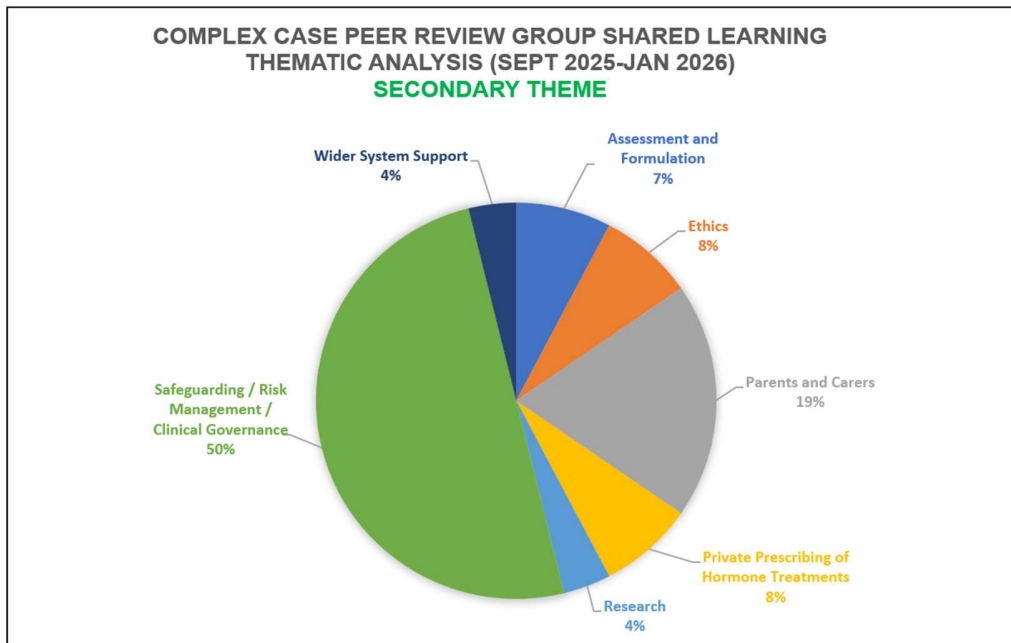


Figure 6: Thematic learning from complex case peer review group: Secondary Theme

The emerging themes highlight consistent concerns about caring for children and young people who have accessed private hormone treatments, particularly around safeguarding and risk management. Assessment and formulation issues are also prominent, including the need for effective engagement with parents and carers and the complexities of supporting neurodiverse children and young people.

This shared learning will continue to be themed and used to inform wider NPN workstreams, helping to prioritise future projects and drive continual improvement. The NPN Board may also draw on this insight to shape wider system planning, including collaboration with national safeguarding and professional bodies to strengthen safety, quality, and connectivity across services.

17. Workstream overview: QI, Local Research and Service Evaluation Group

The Quality Improvement (QI), Local Research and Service Evaluation Group strengthens consistency, collaboration, and shared learning across CYPGS providers by bringing together insights from local evaluation, research activity, and pilot initiatives to inform best practice and reduce unwarranted variation.

Since its inaugural meeting in September 2025, the group has established its Terms of Reference and workplan with an interim Chair. It has begun detailed scoping and overseen both the national demand-and-capacity modelling and the rollout of NHSE-commissioned QI pilots. Within this workstream, the Group has also completed a review of national Routine Outcome Measures (ROMs), identifying areas of alignment and variation across providers and highlighting the need for greater consistency in ROMs collection throughout the clinical pathway.

Table 1 below lists the pilots being delivered by each CYPGS provider and their duration.

CYPGS Providers	Pilot	Duration
CYPGS North West	Parents of Pre Pubertal Children Group	6 months
CYPGS North West	Puberty Groups	6 months
CYPGS North West	Psychosocial Groups	6 months
CYPGS North West	Consultation Service	18 months
CYPGS South West	Living Well Psychological Interventions	18 months
CYPGS South West	R22 Support Project	18 months
CYPGS South West	Consultation Service	18 months
CYPGS London	Advice and Guidance Hampshire and Isle of Wight	6 months
CYPGS London	Advice and Guidance Surrey and Borders NHS Partnership Trust	6 months
CYPGS London	DLSS at Brandon Centre and Well Centre GP Practice	6 months
CYPGS London	Waiting Well	18 months

Table 1: List of pilot projects being developed by each CYPGS provider.

QI, Local Research and Service Evaluation: Future Plans

The workstream will focus on recruiting a Chair/SRO, overseeing delivery of the QI pilot projects, and monitoring demand, capacity and activity across services. It will also create opportunities for peer review, service audits and evaluation, while identifying mechanisms to strengthen local research. These priorities will underpin the ongoing development and implementation of the workstream’s overarching strategy for the short-to-medium term.

18. Support for Mobilising Providers

Throughout 2025, the NPN increased engagement with mobilising providers and international peers who are mobilising children and young people’s gender services or reviewing their care. The Chair of the NPN has supported the review of gender services

within Northern Ireland and offered informal support to international colleagues who are also reviewing their services.

It will be a continued role of the NPN through 2026 and beyond to support mobilising NHS specialist paediatric providers to develop and implement CYPGS within their organisation(s). The support offered will depend on the needs of the provider and the NPN will be as flexible as possible.

The NPN has supported two in-person workshops with NHS Trusts, which include representation from NHS England and from CYPGS clinicians and clinical directors. There has also been a request from the Republic of Ireland to support with professional development via clinical supervision from CYPGS clinicians. The NPN values the opportunities to support and continue to learn from clinical peers, and this will continue to be prioritised.

19. Engagement with NPN Members

During December 2025 a wide-ranging series of stakeholder engagement sessions, bringing together CYPGS clinical directors, clinical leads, general managers, and communications leads, provided valuable insight to shape future NPN planning. Providers gave strong positive feedback on the NPN's development, particularly the establishment of clear governance structures and key groups such as the NPN Board, NMDT, SOPs and Pathways Group, Complex Case Peer Review Group, and the CRG. Looking ahead, providers highlighted the importance of embedding all workstreams with clear deliverables and key infrastructure to strengthen cross-provider collaboration.

Key priorities expressed by providers for the next year include ensuring the NMDT can meet rising demand through streamlined processes; developing a trusted CYPGS website to counter misinformation and improve access to reliable information; and implementing a coordinated communication and engagement strategy as services expand.

Broader themes also emerged around the need for data standardisation, enhanced shared learning, continued workforce development through the competence framework, and strengthened support for onboarding new providers and managing activity across borders.

20. Alignment with the NHS England Implementation Plan

The NHS England Implementation Plan sets out a comprehensive transformation programme to operationalise the Cass Review recommendations. This report demonstrates significant progress against the outlined plan. A comparative review shows substantial

alignment in governance, clinical consistency, and early workforce development, while also revealing several areas of the Implementation Plan that remain unaddressed or only partially progressed within the current reporting period.

Recommendations which are either delivered in full or projected to deliver in full are as follows:

- Creation of a National Provider Collaborative to ensure standards, equity and shared governance.
- Shared standards, pathways, and operating procedures across all CYPGS providers.
- Establishment of the National MDT
- Provider-to-provider peer learning and thematic cross-system discussion of complex cases.
- Strong governance architecture
- National training resources, competence frameworks and CPD programmes via the AoMRC
- Development of a QI Network
- Consistent communications agreed across the member organisations
- Support for Mobilising Providers
- Engagement with the emerging network related to gender care for adults
- National critical event reporting framework

Despite substantial progress, there are recommendations which remain in progress, both under the leadership of NHS England and CYPGS providers. These include:

- National research programmes, which are currently under the remit of NHS England, though with substantial input from CYPGS providers. This includes PATHWAYS, James Lind Alliance and National Dataset Governance and Data Repository.
- Development of information and advice resources for CYPGS providers, primary and secondary care, which fall under the scope of the NPN Communications and Engagement workstream and the planned development of a microsite.

- Development of a bespoke national pre-pubertal pathway (though all live providers provide a personalised care pathway for children and young people of all ages in their services)
- Development of appropriate de-transition pathways (though all live providers provide a personalised care pathway to address need as appropriate).
- Designated local secondary care services and local lead provider model (though this is in a pilot phase).

Some of the areas which remain in progress were out of scope for delivery within the first phase of the NPN development (for example, elements of the research programme which currently sit under the governance of NHS England's Research Oversight Board). In these areas the NPN has supported collaboration and forward planning for the next phase and transition/handover planning where appropriate.

Overall, the NPN Annual Report demonstrates substantial progress against NHS England's Implementation Plan's core expectations, particularly in establishing national governance, clinical alignment, MDT delivery, training, QI, and communications.

21. Final Word

Our final word comes from the Clinical Director of a CYPGS provider. Clinical Directors lead their services and are a pivotal component of the NPN's work, both strategically and operationally:

The National Provider Network as envisioned by The Cass Review is the structural framework of the Children and Young People's Gender Services in England. Its dynamic development has been faithful to the vision whilst responding to the needs of the new services as they establish and realise their mission.

The first year has been a time of great development and relationship building. The work of the NPN is the vehicle for communication, collaboration, and consensus building. Together the services share the work, share innovation and learning, and importantly share the unique pressures that come with working in such a contested domain.

Service, system and professional peer support are present at every level, general management, clinical leadership, and via professional groups. Collaboration in training provision and developing the means for the agreed transfer of patients between services have been first-year highlights.

As the CYPGS providers increase in number with a revised and expanded service specification, the recommendations of the Cass Review will be further delivered. Each CYPGS is constantly developing expertise in the needs of this patient group, how to meet these needs efficiently, and monitoring effectiveness and patient experience. This growth is sustained by the National Provider Network, for the benefit of all.

Clinical Director, Children and Young People's Gender Service South West, March 2026.

BOARD OF DIRECTORS

Thursday, 2nd April 2026

Paper Title:	Trust Mortality Report Quarter 3 2025-26
Report of:	Hospital Mortality Review Group (HMRG)
Paper Prepared by:	Alfie Bass/Julie Grice

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

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

Risk number	Risk description	Score

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



TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY Medical Director's Mortality Report

The report is split into two sections. Section one provides a review of the Hospital Mortality Review Group (HMRG) data, summarising the number and types of deaths at Alder Hey during the calendar year to date. It also evaluates how effectively the HMRG is meeting its stated aims.

Section two is the Quarter 3 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

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

The number of deaths monthly at Alder Hey from 2020 to 2026 shows overall consistency, with most months recording between four and ten deaths. Some seasonal peaks are apparent, particularly in March, September, and November, which consistently recorded higher numbers in several years. Notable variations include a low of two deaths in May 2020 and in October 2025, and a high of eleven deaths in September 2021. While there are occasional fluctuations from year to year, the data does not suggest a long-term upward or downward trend, indicating that mortality rates have remained relatively stable over the period.

Figure 1

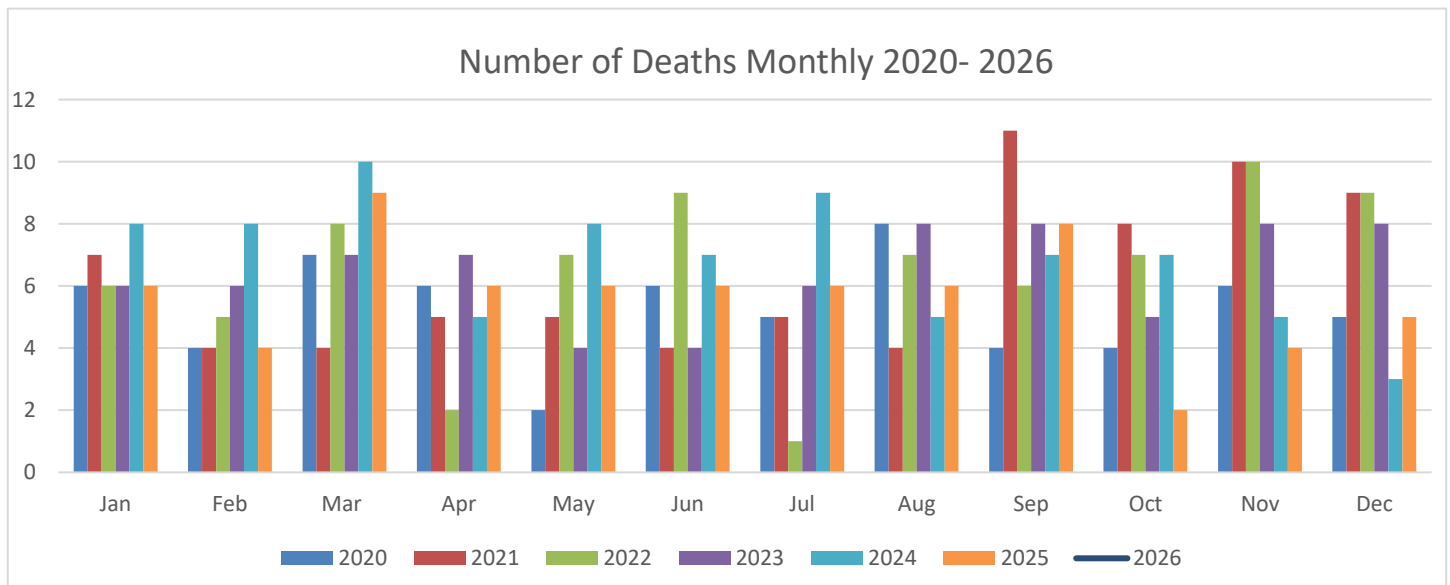
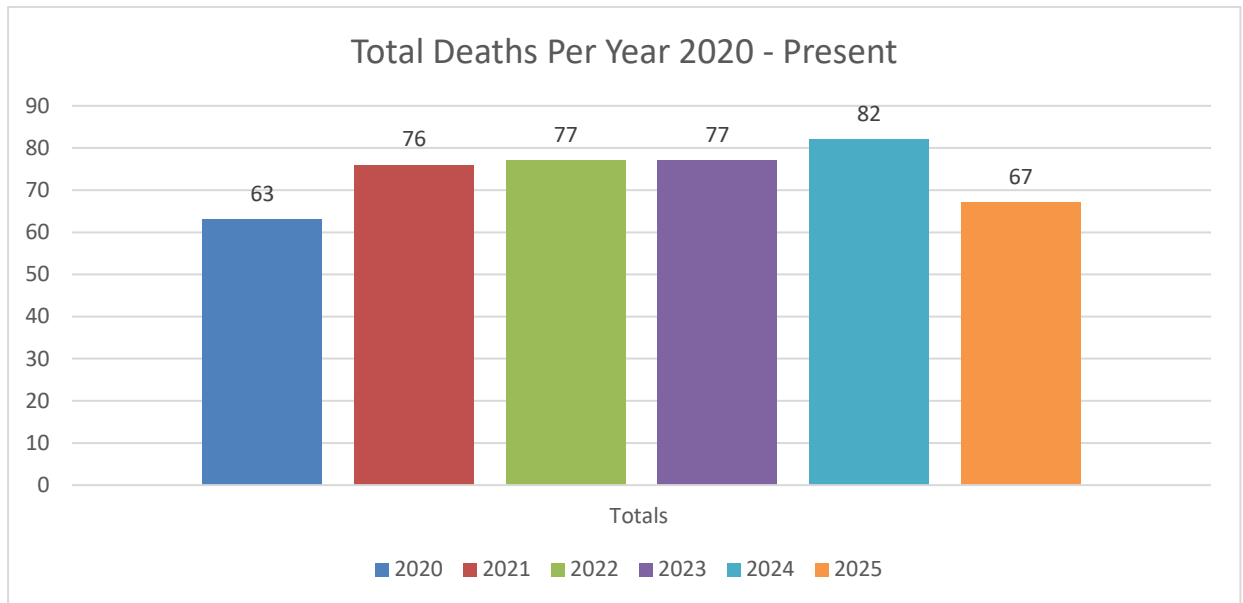


Figure 2



Shows the total deaths per year from 2020 to 2026. The number of deaths peaked in 2024 at 82, before dropping to 68 in 2025, the lowest in the period. Overall, the data shows fluctuations rather than a consistent trend, with a notable peak in 2024.

Core service updates:

The Child Death Review (CDR) Process in the trust continues to evolve because of issues identified by HMRG members and bereaved families, plus external changes. Here are the January 2026 updates.

- 1) The Medical Examiner (ME) process 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 paediatricians (one actively working and one recently retired from AHCH). To date, approximately 120 paediatric deaths have been reviewed by the ME team. This quarter, there were no reported incidents. The SOP is written, approved by the lead service and awaiting governance processes.
- 2) The HMRG team faces a significant and growing workload handling family feedback received via email, as cases often involve lengthy, detailed concerns after months of engagement with the Trust. While the current system is robust and effective, response delays occur due to high demand and limited capacity. HMRG ensures relevant staff address issues to minimise distress for families and clinicians.
- 3) During this quarter, several unstable neonates have required transfers.

Often, by the time these infants arrive, the AHCH teams cannot help as their condition worsens during transport. Nevertheless, clear records exist regarding decisions about whether transferring was appropriate. Families, who receive counselling, are understandably eager to consider every possible option despite knowing the prognosis is poor. Additionally, at such a young age, an infant's clinical status can shift quickly—sometimes improving temporarily after resuscitation, only to decline again while en route. The ongoing neonatal audit will offer evidence about current and recent practices.

- 4) Throughout this period, a recurring theme has been the challenges encountered in interactions between clinicians and families. Contributing factors include rare diagnoses, which often require extensive time and multiple tests to identify accurately. Additionally, some families possess strong preferences regarding their child's treatment, sometimes influenced by external factors, which can complicate the situation for all parties involved. Review findings indicate that clinicians consistently endeavoured to accommodate and communicate effectively with families; however, in certain instances, these efforts proved insufficient.
- 5) The review also highlighted that, given the often-complex nature of family dynamics, inviting the Snowdrop (Bereavement) Team to attend rapid review meetings after an unexpected death would be helpful. This approach would allow the team to keep an overview and provide optimal support to all affected family members.
- 6) During this quarter, the Liverpool area experienced an increase in measles cases, which had a considerable impact on the Trust and the vulnerable children and young people under our care. Consequently, immediate adjustments were made to infection prevention and control measures to minimise exposure risk. Communications efforts were intensified to raise awareness and promote immunisation, with vaccines made readily accessible to families within the Trust. Due to exposure among immunosuppressed children and young people, multiple samples were collected; this should facilitate valid research that will contribute to improved protection for this vulnerable group against measles in the future.
- 7) HMRG has enhanced its protocols to facilitate external partners' (e.g. GPs and DGH paediatricians) participation in virtual meetings, in accordance with CDR guidance and insights gained from prior experiences.

Current Performance of HMRG - Summary of 2025 Deaths

Figure 3

Number of deaths (Jan. 2025 – Sept 2025)	67 +1 reviewed in LWH
Number of deaths reviewed	54
HMRG Primary Reviews within 4 months (standard)	52/54 (96%)

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 due to various factors and typically necessitate multiple discussions, which require a significant investment of time. The rationale for holding several meetings is to ensure that an initial discussion can occur promptly; however, the CDR cannot be concluded until all related investigative processes—such as patient safety reviews and coronial proceedings—are completed. Nevertheless, this process is essential for reaching appropriate conclusions and facilitating effective learning. Meetings are conducted monthly via Teams, promoting broader participation and providing DGH clinicians with the opportunity to be involved if desired.

New InPhase Mortality Module

Members of HMRG collaborated with InPhase developers to develop the mortality module. This advancement will facilitate more efficient workflows in the future and serve as a central repository for all mortality-related data. All cases for the January 2026 meeting were processed within this module, providing comprehensive oversight of case progress throughout the CDOP process.

Outcomes of the HMRG process 2025

Figure 4: Outcome table

Month	Number of Inpatient Deaths	HMRG Review Completed	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
					Internal	External		
Jan	6	6	6	6				1
Feb	4	4	4	4				1
Mar	8*1	7	7	7			1	1
April	6	6	6	6		1		1
May	6	6	6	6		1		
June	6	6	6	6				
July	6	6	6	6				3
Aug	6	6	6	6			1	
Sept	8	7	7					
Oct	2							
Nov	4							
Dec	5							

*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 lower number of LD cases than usual at 13%. The deep dive will be undertaken in the next quarterly /end of year mortality report.

Figure 5

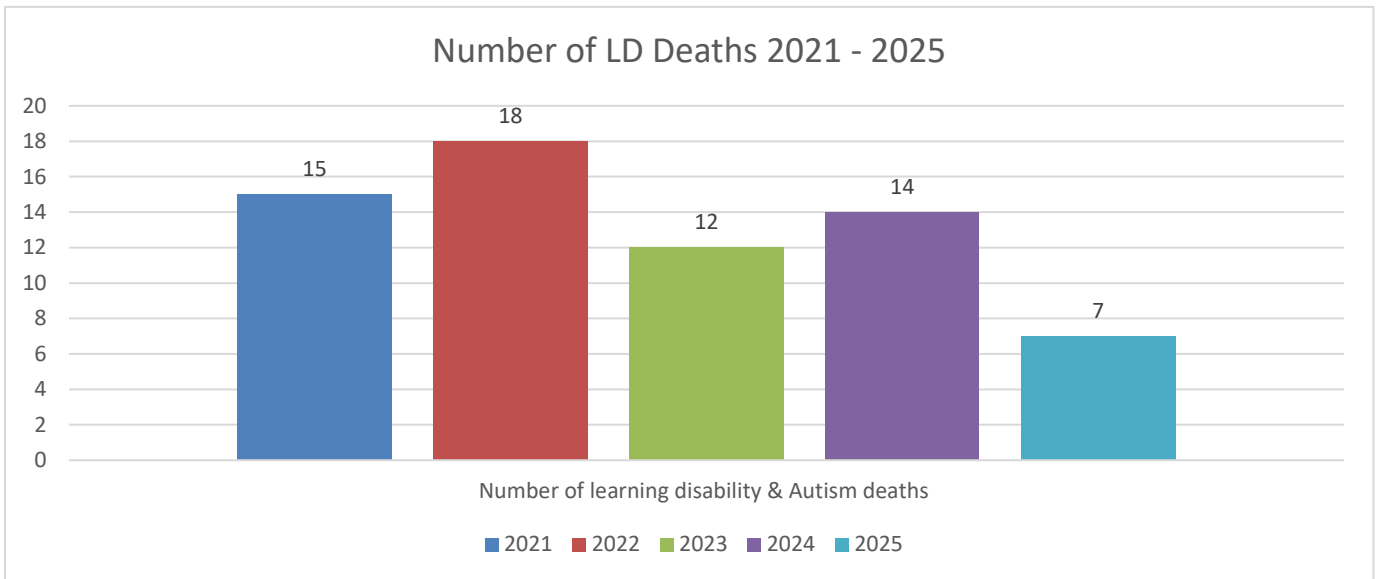
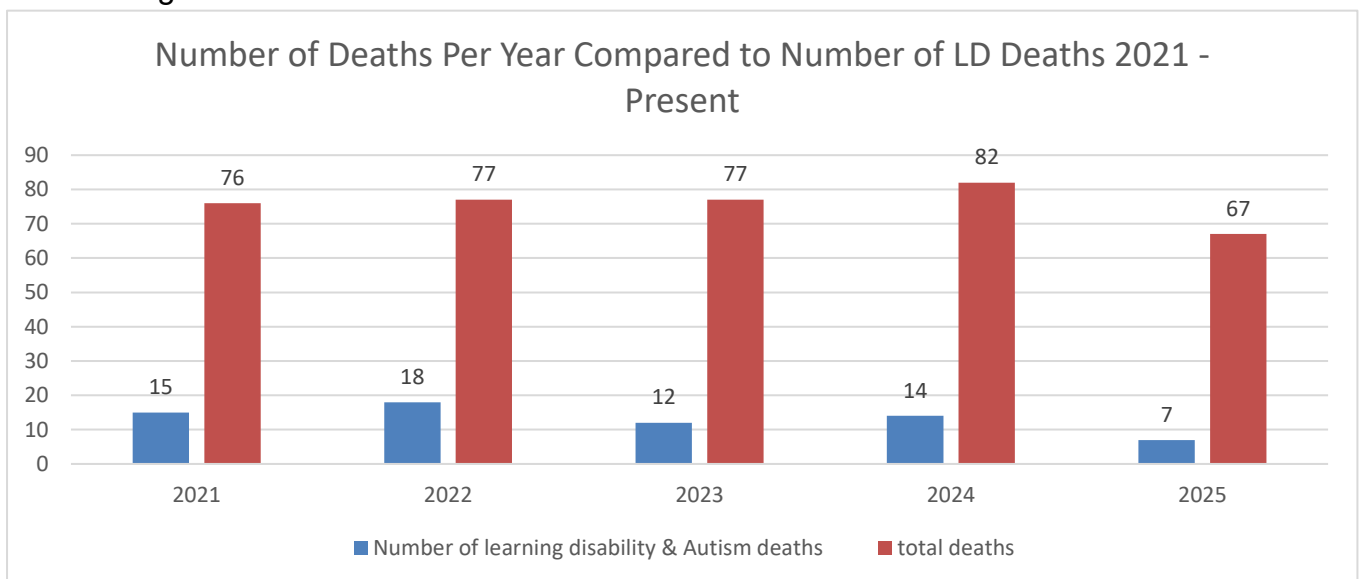


Figure 6



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 7

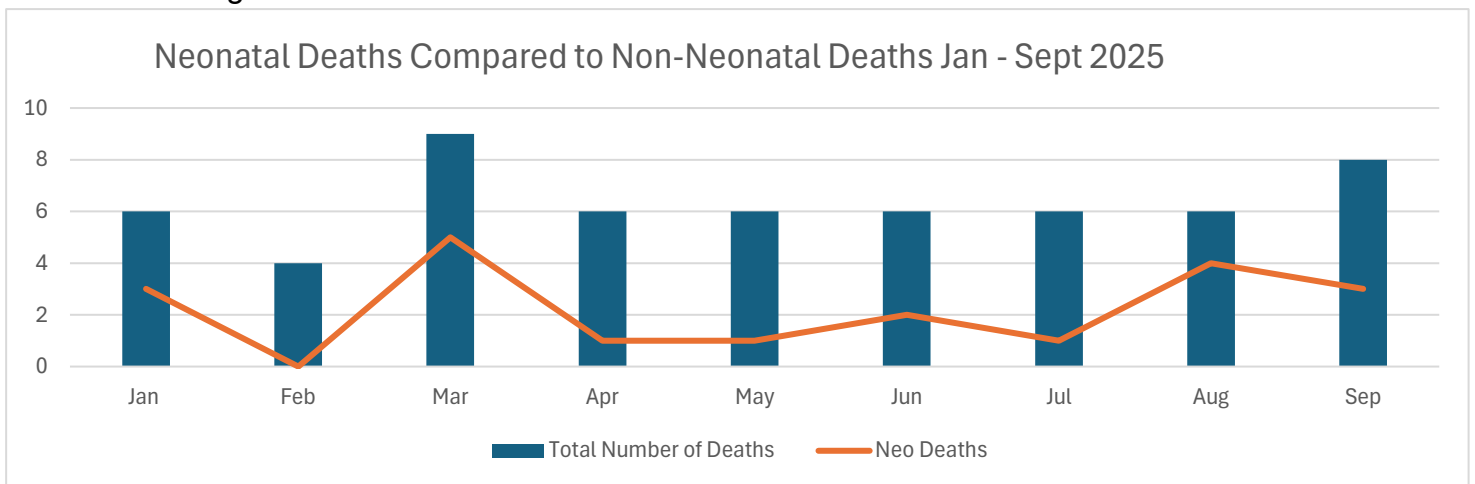


Figure 8

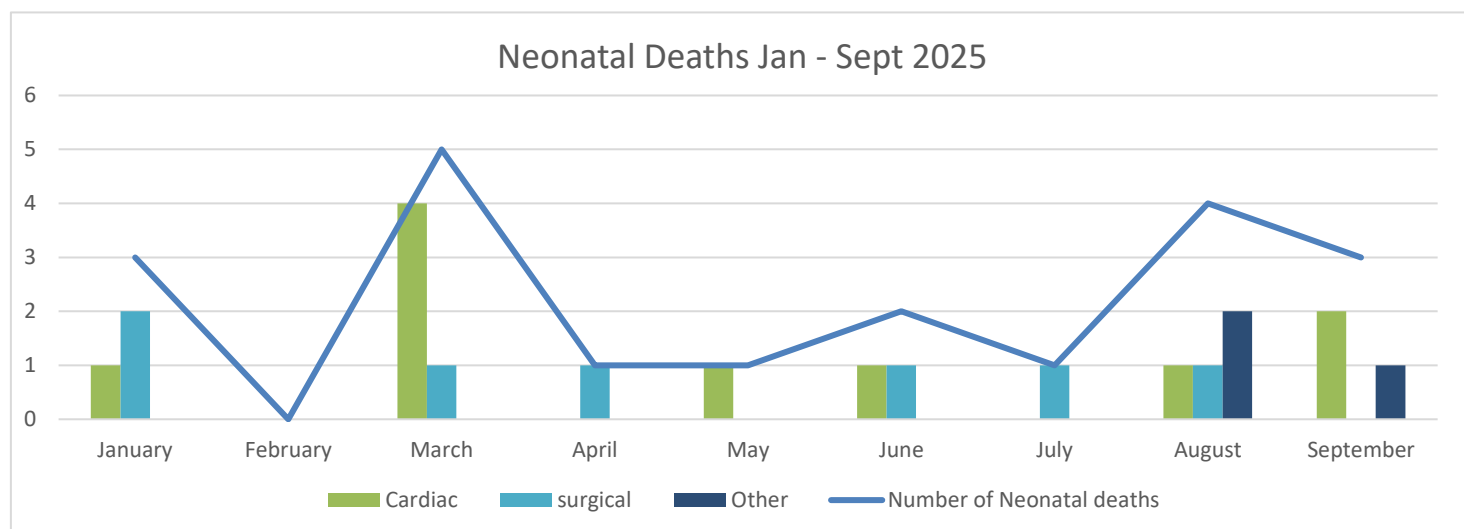


Figure 8 presents a breakdown of the caseload into complex congenital cardiac heart defects, surgical interventions, and other categories, in comparison with the overall number of neonatal deaths. Surgical cases primarily involve premature infants diagnosed with necrotising enterocolitis (NEC), a recognised complication among this population. In 66% of these neonatal cases, it was determined—following thorough investigations or due to the patients' condition—that no further treatment options were available. Subsequently, after multidisciplinary discussions and in agreement with the families, care was transitioned to palliative pathways.

In August, the majority of deaths were neonatal with half being other – medical which were very complex cases where all possible treatment was given. There were no concerning features or themes with these cases. 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 support

The Snowdrop bereavement team at Alder Hey offers essential support to families following the death of a patient. Continued collaboration among HMRG, the palliative care team, and the bereavement team seeks to improve the quality of feedback gathered from families, thereby informing and guiding ongoing enhancements in the care provided. Designated HMRG members have access to a shared inbox, enabling families to request feedback after an HMRG review, raise concerns, or share both positive and negative feedback.

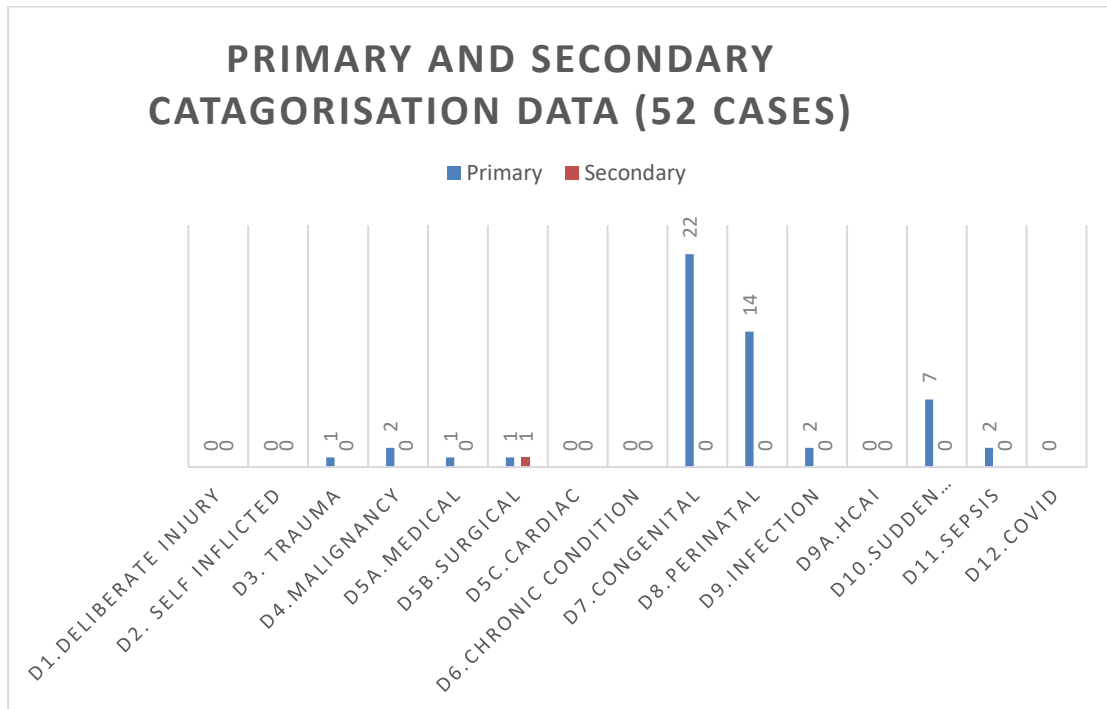
There has been a noticeable increase in the number of families requesting summaries of the HMRG review pertaining to their child or young person, which are provided upon request. In accordance with child death review guidance, the HMRG audit tool is not distributed to families; instead, a plain English summary is prepared to minimize potential distress. These summaries undergo review by the palliative care and psychology teams to ensure they meet high standards of clarity and compassion. Nationally, there has been a recognized trend of bereaved families seeking written summaries, and discussions are ongoing regarding how best to provide these without causing additional trauma.

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 9

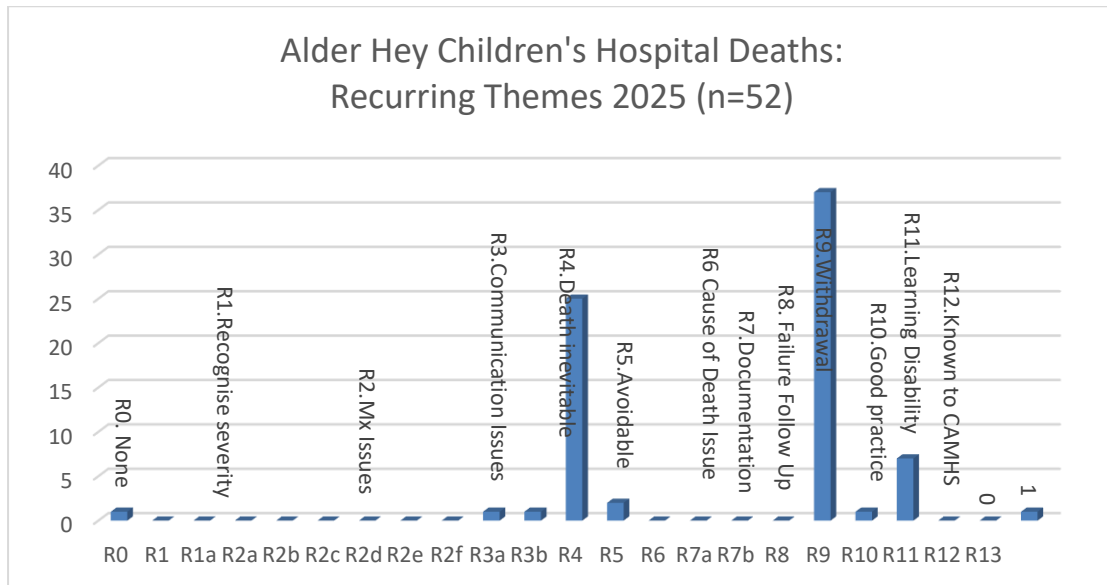


The cases reviewed so far in 2025, show that the highest diagnostic code is D7 or children with underlying chromosomal, genetic and congenital conditions (42%), with D8 perinatal or infants where the cause of death is a complication of prematurity or neonatal causes (27%). This group are covered in more detail in the neonatal section above.

Chromosomal, genetic, and congenital conditions are often complex and affect vulnerable patients. Depending on the case, these conditions can be life-limiting or life-threatening. However, care from AHCH, health professionals, and families has enabled many to live longer than once expected.

Recurrent Themes

Figure 10



The primary recurring theme so far in 2025 is the withdrawal of life-sustaining care, accounting for 71% of cases. This indicates that the intensive care team collaborates with families to prevent any child or young person (CYP) from suffering unnecessarily when available treatments or continued interventions are no longer considered in the CYP's best interests.

The next most frequent theme appears in 48% of cases, where death was determined to be inevitable, regardless of the care and expertise provided at AHCH. This category also includes instances where, in retrospect, death was unavoidable. These examples are included to clarify that this outcome is not a reflection on the quality of care at AHCH, as some children are transferred for further investigations that later reveal life-limiting conditions.

Earlier sections of the report discuss both learning disability and avoidable deaths.

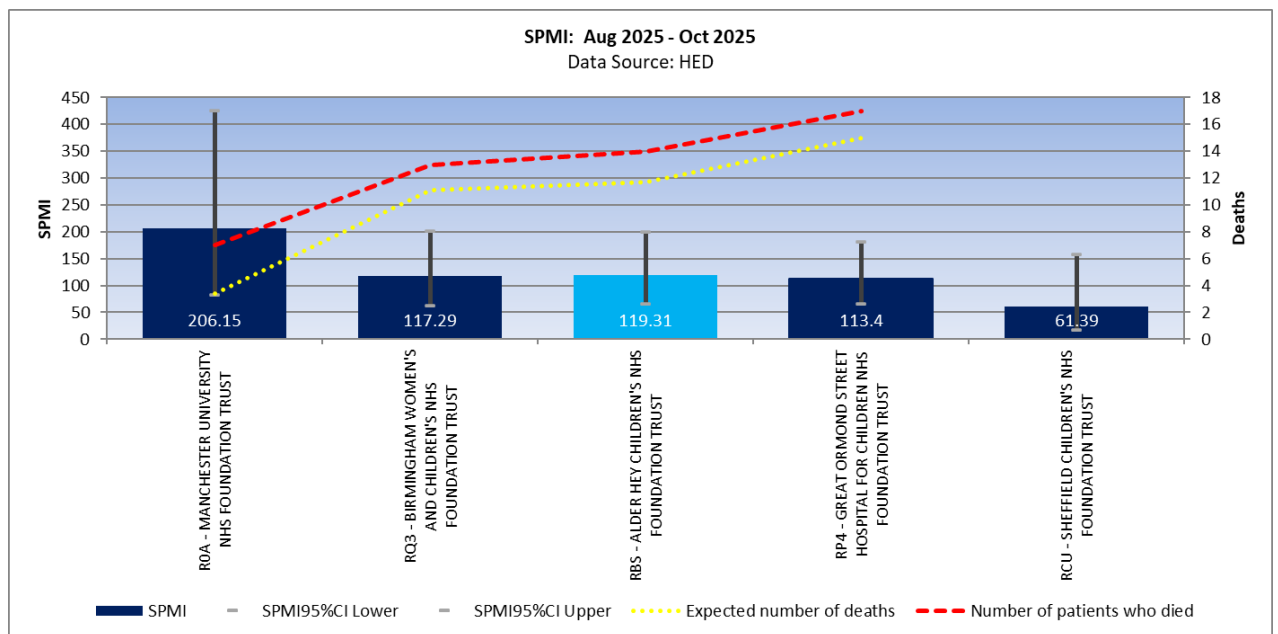
Section 2: Quarter 2 Mortality Report: Oct 2025 – Dec 2025

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 August 2025 to October 2025.

Figure 11



The chart indicates that Alder Hey reported 14 deaths compared to an expected 11.7 in the latest figures. Once again, as with the last report, actual deaths were higher than expected. However, for this quarter, it appears that all other Trusts displayed have death rates above what was anticipated. This graph differs noticeably from prior reports and brings up concerns about possible issues with the data.

In the previous quarter, data coding problems were identified. Many cases were not coded correctly, resulting in submissions using the lowest risk codes for all cases, regardless of their real risk levels. While the cause is less apparent this time, ongoing issues are evidently affecting the Trust's reported mortality data. These concerns have been brought to the Board's attention and are listed on the risk register.

As indicated earlier in this report, and illustrated by previous graphs—specifically Figure 2—the number of deaths reported is lower than the typical average. Additionally, figure 10 demonstrates that mortality is unavoidable in a considerable proportion of cases. Therefore, it is inconsistent for the death rate to appear higher than anticipated, suggesting potential issues with the data under review. Once the data has been submitted, amendments are not permitted. As such, although it is recognised that the data from the last quarter was incomplete, it remains uncorrected.

Figure 12

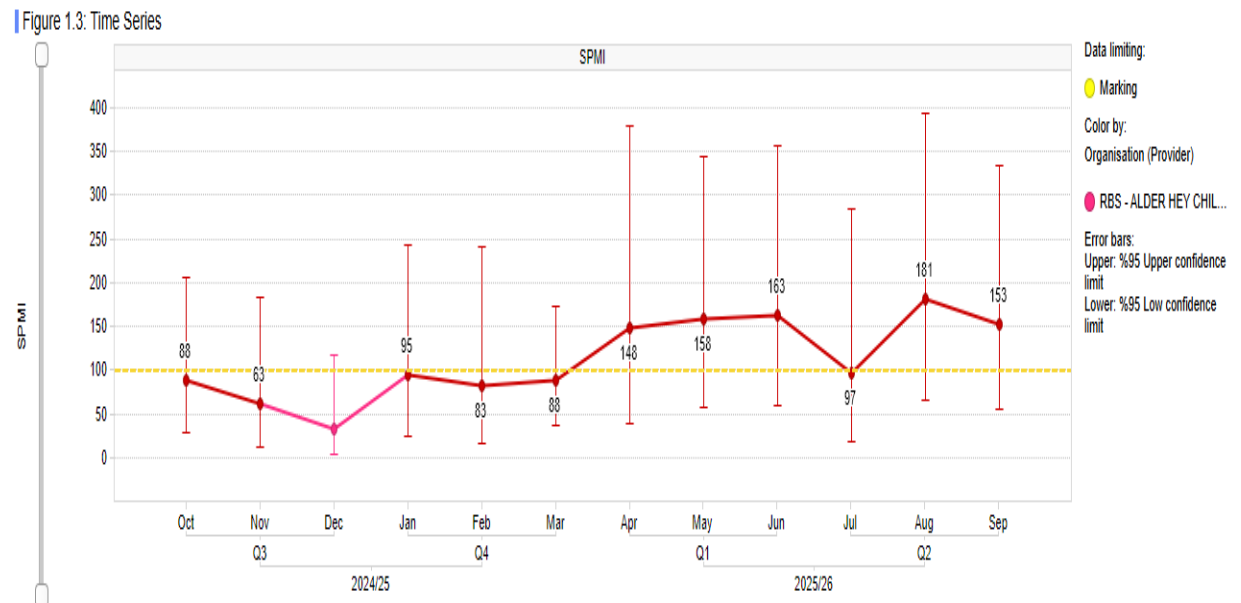


Figure 12 clearly shows that there was a change between March and April, with a brief correction in July.

PICU

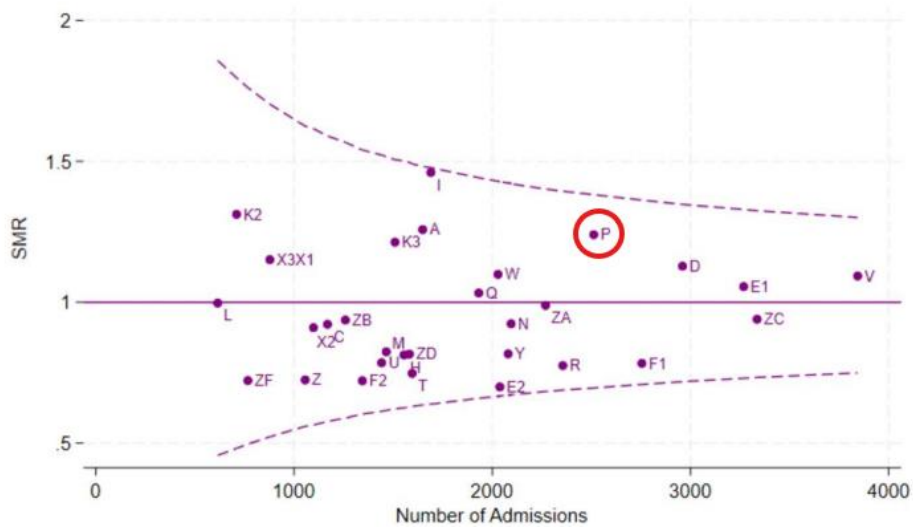
85-90% of the deaths in AHCH occur in PICU as in other children's trusts. In the most recent PICANet report (2024), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.

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 13 / Metric 5 based on inclusion of all SMR estimates being contained within the control chart limits.

Figure 13

Metric 5: Risk adjusted in-PICU mortality

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



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

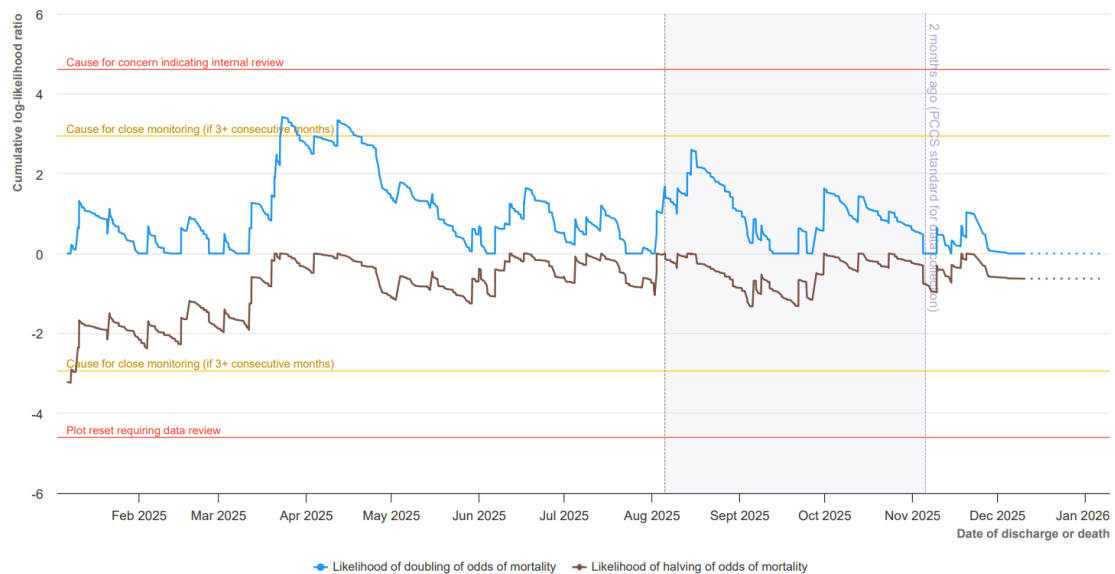
Statistical analysis of mortality:

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

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

Figure 14

PICANet RSPRT chart for Liverpool Alder Hey
based on discharges and deaths between 06 Jan 2025 and 05 Jan 2026

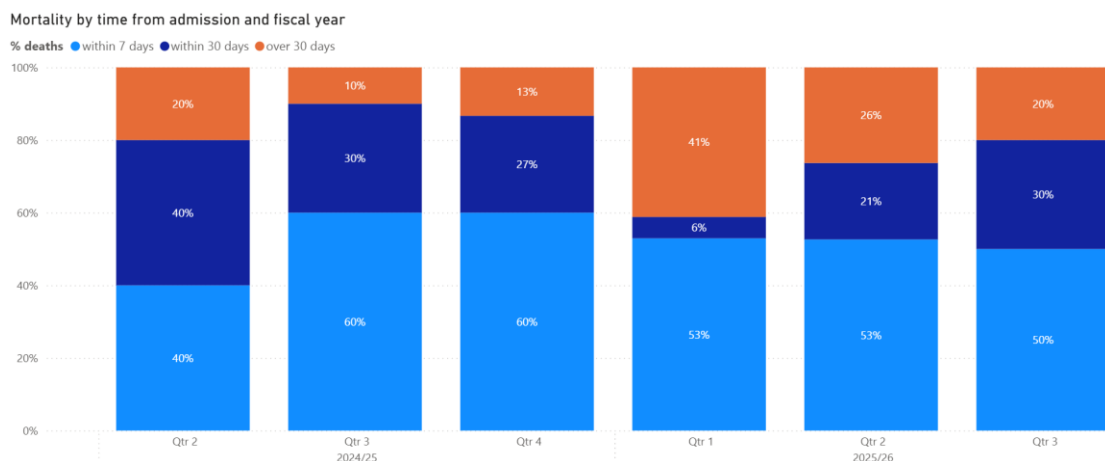


The above graph shows that the PICU figures have stayed within the safe zone over this period which is reassuring. In the period between October to December 2025, there were 8 deaths (October n=2; November n=3 and December n=3). There were 235 admissions equating to a crude mortality of 3.4%. Patients' length of stay was between 1 and 80 days with 3 dying within the first 24hrs of admission and 5 dying within the first week.

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.

Figure 15 - shows mortality broken down by the time from admission to death, mortality within 7 days, 30 days and over 30 days from admission.



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, 40-60% of deaths occur within this time frame. In the recent quarter September 2025 – December 2025, 50% of deaths occurred within 7 days of admission, 30% occurred within 8-30 days from admission, and 20% of deaths occurred over 30 days from admission.

Conclusion

The HMRG consistently meets the 4-month target for mortality reviews, even as case complexity and workload rise. The review process has matured, with learning and feedback shared; and stakeholder engagement—including GPs, DGHs, and external services—strengthened to improve review quality.

Across Alder Hey Children's NHS Foundation Trust, analysis of mortality data and governance shows strong transparency and commitment to improvement. Recent unexpected differences between actual and expected deaths likely result from inaccurate HED data submissions and should be continually reviewed.

Digital paperwork is being introduced to streamline processes and speed up form handling. The Trust's quick response to measles cases is hoped to benefit immunosuppressed children in the future.

Family feedback on child death reviews remains challenging due to its volume and complexity and requires sensitive handling. Neonatal transfers are carefully monitored, supported by ongoing audits. No significant concerns have been found in learning disability, neonatal, or general pediatric deaths. The Trust's continued neonatal audits and comprehensive death reviews reflect a proactive approach to mortality governance.

References

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 12**

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

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 15**

BOARD OF DIRECTORS

Thursday, 2nd April 2026

Paper Title:	Chair's Report from the Safety and Quality Assurance Committee meeting held on 25th March
Report of:	Fiona Beveridge, Committee Chair
Paper Prepared by:	SQAC Committee Administrator

Purpose of Paper:	Decision <input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Information <input checked="" type="checkbox"/> Regulation <input type="checkbox"/>
Action/Decision Required:	To note <input checked="" type="checkbox"/> To approve <input type="checkbox"/>
Summary / supporting information	This paper provides a summary from the Safety Quality Assurance Committee meeting held on 25 th March 2026, along with the approved minutes from the 25 th February 2026 meeting.
Strategic Context	
This paper links to the following:	Outstanding care and experience <input checked="" type="checkbox"/> Collaborate for children & young people <input checked="" type="checkbox"/> Revolutionise care <input checked="" type="checkbox"/> Support our people <input checked="" type="checkbox"/> Pioneering breakthroughs <input checked="" type="checkbox"/> Strong Foundations <input checked="" type="checkbox"/>
Resource Implications:	

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

Risk number	Risk description	Score
BAF Risks		
1.1	• Inability to deliver safe and high-quality services	3 x 3 = 9
1.2	• Children and young people waiting beyond the national standard to access planned care and urgent care	4 x 5 = 20
1.4	• 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 5 = 15

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



1. Executive Summary

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

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

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

Minutes of the meeting held on 25.02.26	Minutes Approved
Divisional updates	Reports x4 noted
Liverpool Neonatal Partnership Monthly update	Report noted
Patient Safety update	Report noted
Quarter 3 Infection Prevention Control Report	Report noted
Quality Assurance Rounds Themes and Risks Biannual Report	
QAR Annual Report February 2025-February 2026	Report noted
Transcription update and future options report	Report noted
Patient Safety Incident Report (PSII) Retained swab following Cardiac Surgery	Report noted
Patient Safety Incident Report (PSII) – Retained swab following Neurosurgery	Report noted
Northwest 2026 Controlled Drugs Accountable Officer (CDAO) Self-Assessment and Designated Body Improvement Framework	Report endorsed
Diagnostics notification update	Report noted
Southport AR Learning Review Action Plan	Report noted
Clinical Effectiveness and Outcomes Board Chairs Highlight report	Report noted
Board Assurance Framework including reframe for 2026/27	Report noted
Trust Mortality Report – Quarter 3	Report noted
Review of Externally Sourced Service Provision – Final report	Report noted
Experience of Care Improvement Framework	Report noted
Integrated Observation Update	Report noted
Ward Accreditation Report	Report noted

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 progress in various areas, whilst also recognising the presence of ongoing challenges.
- SQAC obtained assurance that the Divisions are cited on their risks and are actively addressing those risks.
- Southport AR Learning Review Action plan -SQAC considered and approved the request for extension for target completion dates in relation to actions 1c, 1d 1i, 3e and 6f to enable required work to be completed.

- SQAC noted the Experience of Care improvement self-assessment and endorsed the framework, which would support the development of the new Experience Strategy.

Issues for other committees

None

5. Recommendations

The Board is asked to note the contents of the report

Safety and Quality Assurance Committee
Minutes of the meeting held on Wednesday 25th February 2026
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair/Non-Executive Director	FB
	Nathan Askew	Chief Nursing Officer	NA
	Alfie Bass	Chief Medical Officer	AB
	Adam Bateman	Deputy Chief Executive & Chief Operating Officer	Aba
	Kerry Byrne	Non-Executive Director	KB
	Gerald Meehan	Non-Executive Director	GM
	Laura Rad	Head of Nursing – Clinical Research	LR
	Jackie Pointon	Associate Chief Nurse, Community & Mental Health Division	JP
	Rachael Pennington	Associate Chief Nurse – Surgical Division	RP
	Erica Saunders	Chief Corporate Affairs Officer	ES
	Cathy Wardell	Associate Chief Nurse – Medicine	CW

In Attendance:	Julie Creevy	Executive Assistant (minutes)	JC
	Veronica Greenwood	Director of Allied Health Professionals (AHP's)	VG
25-26-249	Kelly Black	Deputy Head of Neonatal Nursing, LNP	KBL
25-26-251	Nichola Osborne	Associate Director for Safeguarding and Statutory Service	NO
25-26-253	Jacob Gray	Emergency Preparedness, Resilience & Response Manager	JG
25-26-257	Angie Ditchfield	Head of Equality, Diversity and Inclusion	AD
25-26-258	Dr. Edmund Horowicz	Clinical Ethics Co-Chair, Senior Lecturer in Healthcare Law and Bioethics, School of Law, University of Liverpool	EH
25-26-263	Rachel Thompson	General Manager, NHS Children & Young Peoples Gender Service (North West) and Clinical Health Psychology	RT
Apologies:	Lisa Cooper	Divisional Director, Community & Mental Health Division	LC
	Jenny Devine	Governor	JD
	Ava Kilbride	Governor	AK
	Jill Preece	Governance Manager	JP
	Jackie Rooney	Associate Director of Nursing & Governance	JR

25/26/244 Welcome and Apologies

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

25/26/245 Declarations of Interest - GM declared that he is the Independent Chair of the Improvement Board for Children's services in Liverpool.

25/26/246 Minutes of the Previous Meeting

The Committee members were content to **APPROVE** the minutes of the meeting held on 21st January 2026

25/26/247 Matters Arising/Review of Action log

The Action log was reviewed and updated.

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

25/26/248 Divisional Updates
Division of Medicine

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

Highlights:-

- Overall Safety & Quality performance remains strong, with the division performing consistently across most KPIs.
- The division have 100% sepsis compliance in the inpatient setting.
- ED performance remains high: >90% antibiotics within 60 minutes for 8 consecutive months, with only one exception in the last 12 months. CW attributed this to stronger clinical oversight,

faster escalation, more reliable multidisciplinary team (MDT) response in ED.

- Stabilisation of High-Risk Services, with positive progress reported in critical service areas:
 - Radiology-capacity had been strengthened with recruitment of 2.2 WTE posts.
 - Metabolic Service - A new Clinical Nurse Specialist had been appointed; recruitment is underway for a paediatrician with metabolic interest. Risks are now improving; service redesign planning had commenced.
 - Neurology Workforce had been strengthened by recruitment of two consultants plus additional locum support.
- Mobile Cancer Unit Launch which is a significant milestone bringing cancer care closer to families across the region; this is currently in pilot phase.

Challenges:-

- The division continues to experience a significant rise in complaints, with an increase of approximately 30 complaints compared with the same period in 2025. The trend mirrors a trust-wide rise and is understood to be consistent with national trends. Comprehensive discussion took place regarding AI generated and AI enhanced complaints which are becoming more complex, often referencing legislation, CQC standards and frameworks, and are taking longer with technical and more detailed responses. The Medicine division is exploring triage of complaints within 48 hours to identify high-complexity complaints earlier.
- A temporary decline in NICE guideline compliance was evident, attributed to difficulty completing baseline assessments due to clinical time pressures. This issue had been escalated to the Divisional Director for Medicine. CW advised that the majority of outstanding assessments had been completed, with improvements expected in March 2026.
- Gastroenterology performance had decreased in December and January due to: Winter pressures, Annual leave, Increased ED attendances. Improvements are already evident with performance expected to stabilise by next month's reporting cycle.

FB praised the Medicine Divisional update and requested clarification on AI-related complaints, asking if the increase aligns with Ombudsman (PHSO) trends. CW confirmed this trend was correct and aligns with PHSO trends. CW stated that AI makes formal complaint drafting easier and faster for families who now submit more detailed written complaints instead of voicing concerns verbally. CW emphasised that personalised explanations/responses are essential when responding to complaints.

JP noted that AI-generated complaint letters are easily recognised and highlighted the need for personalised replies, as families can spot and dislike generic or impersonal responses. Despite challenges from complex AI submissions, ensuring thoughtful, individual responses remains a priority.

GM suggested exploring similar tools used by secondary schools/colleges to support the Trust's approach to identifying and managing AI-generated complaints. CW acknowledged the suggestion and agreed this is an area requiring further exploration.

NA recommended placing greater emphasis on addressing the substance of complaints rather than determining whether they are AI-generated and suggested that the focus should be on adapting procedures to contemporary communication modes and evolving alongside technological advancements, drawing parallels with how healthcare responded to the emergence of internet-informed patients. NA recommended triaging complaints by complexity, ensuring high-quality early contact with families, using the Patient Experience Group to review policy updates related to complaints handling.

Division of Surgery:-

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

Highlights:-

- The Medical Illustration Team had been selected to take part in Reframe; a national project focused on improving representation of under-represented groups.
- The team also completed the Fabric of Courage exhibition currently displayed in the atrium, showcasing children's theatre companions and enhancing visibility of children's experiences.
- Orthopaedics successfully completed the first implantation in the UK of a magnetic limb-lengthening nail, replacing the previously invasive external frame approach. The first patient is reported to be recovering very well.

- Referral-to-treatment (RTT) performance is strong, with sustained improvement.
- All required Business Continuity Plans are complete except two areas that do not require them by definition. A Final staff exercise is due to be scheduled to conclude training.

Challenges:-

- Risk 516 – A legacy dataset containing historic echocardiogram reports, stored on an inaccessible server, had been irretrievably lost following unsuccessful data migration and restoration efforts. RP stated that there is no immediate clinical risk to current patients, however families seeking comprehensive historic medical records may encounter incomplete documentation. Advice regarding GDPR and Information Governance had been obtained, and it had been agreed that there is no requirement to proactively notify affected families at this time. Nevertheless, the division must maintain an accurate list of impacted patients for potential future access requests.
- Out-of-hours theatre support for Ophthalmology is currently provided to non-resident ophthalmologists – this is under review following the submission of an audit to the Medical Education Board; a response is pending. Presently, emergency ophthalmology cover after hours depends on clinicians traveling from St. Paul's, who may not be familiar with Alder Hey's environment or equipment.
- RP referenced the Burns Peer Review Action Plan, noting that while preparing for reporting, the Division of Surgery saw the need for a broader MDT to review the plan. Many listed actions are now complete and should be closed, while some items are ongoing with risks requiring organisation-wide efforts (e.g., psychology support, ongoing trauma-informed training). The MDT group were unable to assemble all stakeholders due to scheduling issues.

Resolved: The Division to present a fully updated and accurate action plan at the March SQAC meeting.

RP noted that the Burns review highlighted inconsistencies in the tracking of peer reviews across the organisation. Specifically, these reviews do not always involve the appropriate stakeholders, timely feedback is not consistently provided, and there is a lack of a clear and robust oversight mechanism. RP further emphasised that this issue extends beyond the Division of Surgery, representing a wider gap throughout the Trust.

- The division have 22 open formal complaints, with an increase in complaints noted, challenges were noted regarding the complexity, referencing legislation or statutory frameworks, demanding significant staff support to respond adequately.
- Division are experiencing challenges relating to severe delays in transcription and sign-off processes, with very low completion rates for letters within 10 days.

ES referenced the Burns Peer Review and External Peer Review oversight, noting challenges encountered within Surgery. ES stated that these challenges underscore the necessity for a more robust, Trust-wide system to effectively manage external inspections and peer reviews across the organisation. Issues identified include colleagues not always being aware of upcoming reviews, inadequate team representation, delayed feedback, and insufficient oversight of action plans. SQAC recognised the importance of establishing a strengthened, centralised process to better support divisions.

FB confirmed that the Burns review revealed an opportunity to create clearer support for divisions, improved resources for complex action implementation and stronger cross-divisional coordination.

Resolved: FB requested a detailed update at the March SQAC meeting once the Burns MDT review had been completed.

FB acknowledged the strong RTT improvement and notable clinical achievements.

Clinical Research Division

LR presented the Clinical Research Division update and drew attention to a few key issues within the report:-

Highlights:-

- Fixed-term staff whose contracts were due to end had now been successfully secured into permanent roles, resulting in greater continuity for patients involved in research and increased workforce stability within the division.
- GCP training compliance for Principal Investigators is 100%, with 20 investigators having completed the new GCP R3 training, effective April 2026.

- The Division had met its annual NIHR Participant Research Experience Survey response goal and is now working to achieve a higher target and remain amongst the top 10 organisations in the North West.

Challenges:-

- The Division are experiencing challenges regarding laboratory support for clinical research samples, resulting in ongoing delays in study initiation. Colleagues are collaborating with the laboratory senior team to resolve these issues; however, clinical pressures continue to present difficulties. To mitigate some of these delays, pre-analytical biochemistry processing had been relocated to the CRF, and research staff had been trained to perform this basic processing. Nevertheless, delays persist for studies requiring additional pathology department support. These risks are being managed under risk 00000424, which presently has a score of 9.
- Division had experienced issues with consent Procedures - relating to an incident involving incorrect or incomplete documentation of consent. LR Highlighted a recurring challenge around ensuring: Principal Investigators (PIs), Consultants, Nurse and AHP PIs all fully follow Good Clinical Practice (GCP) requirements.
- Division had experienced a delay in communicating an Urgent measures notification to a family which exposed gaps in oversight and adherence to processes during periods of clinical pressure. Planned mitigation includes Strengthened training, Improved oversight, more frequent shared learning activities.
LR noted that mandatory GCP training every three years alone is not sufficient, and new support mechanisms are under consideration.

Community and Mental Health Division:-

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

Sunflower House update:-

- A key consultant psychiatry post attracted no applicants in the previous recruitment round. The role has been re-advertised. In the interim, a doctor transitioning to their first consultant post will provide cover to support safe reopening of Sunflower House.
- A second Away day was recently held, which was described as really vibrant, positive and proactive. Following the away day five working groups established to lead core improvement areas. A sixth group to be added focusing on sustainability, following suggestions from staff. With strong emphasis on: Young person involvement in all workstreams and staff wellbeing.
- Plans are underway to ensure all ongoing work across the service is visible, easily accessible, ensuring whole-team awareness of improvements and progress.
- During the away a door demonstration was held showcasing a new specialist door system which was brought onsite which offered significant safety improvements for the unit. With plans to explore the feasibility and cost of replacing existing doors with the new system.

Highlights:-

- Two separate nominations for SEND (Special Educational Needs & Disabilities) awards were received. The Specialist Physiotherapist and Specialist Occupational Therapy Teams were shortlisted for the Sefton Parent Carer Forum SEND Award. Additionally, the Sefton Mental Health in Schools Team (MHST) was nominated for the National SEND Award in the category of Best Integrated Service or Team.
- Referral to Treatment (RTT) and Waiting Times for Community Therapies - Dietetics, OT and physiotherapy at 100% compliance. Speech & Language Therapy (SALT) at 99%, with work underway to address the remaining 1%.
- Mental Health and Learning Disability acute liaison teams had merged, creating a holistic "reasonable adjustments" team. This has improved support for CYP with LD or MH needs in acute settings and established digital support and a bleep system for rapid response.

Challenges:-

- Incidents involving transcription, timing, letter dispatch, administration, and record misfiling had increased, possibly due to recent administrative restructuring. Administrative teams are now receiving extra support and undergoing review, with further analysis underway.
- Sepsis Training compliance had declined in January 2026. A new training package is set to launch and should improve results. Interim measures are increasing completion of current training.
- The Division observed similar theme as other divisions: higher volume and complexity of complaints, more references to legislation, and added challenges from AI-supported complaints.

FB acknowledged the positive update regarding the SEND nominations.

FB addressed the delays in Clinical Letters and expressed concerns about the significantly reduced completion rate of clinical letters within 10 days. FB requested an explanation for this decline and clarification on the measures being implemented to address the issue.

ABa responded by noting that this is a systemic, trust-wide issue and not limited to the Surgery department. ABa confirmed that the matter was discussed at FTPC on 23 February 2026 and recognised as a major organisational concern. The primary causes identified include delays in transcription, delays in clinician sign-off, and workflow inefficiencies.

ABa stated that there are solutions underway: which include the use of Lyrebird and auto-signoff features, rapid implementation of new processes, aim for “same-day letters” for families as the future standard.

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

25/26/249

Liverpool Neonatal Partnership Monthly update

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

Highlights:-

- Governance and Medication Safety Teams completed a 12-month thematic analysis across high-incidence categories. This enables a deeper understanding of incident causation and supports proactive mitigation ahead of changes expected when the new unit opens.
- Gentamicin Improvement Programme -Targeted improvement work alongside Pharmacy resulted in a substantial reduction in gentamicin-related drug errors. This work had been nominated for presentation at the BAPM conference, demonstrating national recognition. The methodology will be used as the model for future theme-based improvement cycles.
- VR-Based Education Programme - A Consultant, ANNP and Senior Nurse jointly developed 18 virtual-reality training videos. Modules cover ventilation, consumable set-up, neonatal life support (NLS), bereavement processes, and scenario-based troubleshooting. Benefits include: Reduced face-to-face training time; Increased staff readiness across both sites; More effective upskilling ahead of the unit move.
- The LNP dashboard continues to progress well, supported by weekly BI meetings. Most datasets are reliable; HR data currently requires manual extraction, but this is being resolved. The dashboard is now providing clearer trends and assurance.

Challenges and Risks

- New Build Delay – the June handover date is unlikely and is now expected in August 2026, with full opening projected for September/October. Implications: Need to adjust workforce training and mobilisation plans; potential impact on staff morale due to extended timelines; additional time may enable further preparation, though the delay is disappointing.
- Sickness absence – an improvement was noted for Alder Hey site; however, LWH site remains high at 10%. Long-term sickness is complex, legitimate medical causes, none linked to work-related stress. Short-term sickness is undergoing a detailed review; and has been supported by a recent NHSI problem-solving session; Quick-win actions include end-of-shift huddles and enhanced staff support following bereavement or high-acuity events.
- One SPC chart incorrectly showed >100% compliance for antibiotics administered within 60 minutes, This reflects a data reporting issue, not clinical performance. Significant manual validation is ongoing, with corrective work planned through BI.
- Extremely low Family Feedback Returns of survey responses last quarter (16 and 11 per site) was noted. Planned improvements: Deployment of the newly appointed Neonatal Parent Representative; Cross-site family engagement sessions starting in March; Involvement from Senior Nursing and Psychology colleagues.

FB commended the clarity and structure of the report, noting that the improved dashboard and trend analysis provided stronger assurance and transparency.

AB referred to the SPC chart showing 116% antibiotic compliance, noting it appeared incorrect. KBI agreed and confirmed that the metric is inaccurate, Root cause is data extraction/report logic and advised that Sepsis data is undergoing full validation and correction.

GM praised the report as highlighting clear and helpful structure. GM referred to Cannulation challenges and queried whether difficulty cannulating preterm babies contributed to sepsis compliance issues. KBI advised that preterm infants often require long lines/central access; and

advised that line failures can cause delay and that these events do occasionally affect timing metrics.

GM queried whether LNP is experiencing challenges with Trust-wide rise in complaints. KB advised that the LNP have low formal complaint volumes and that many issues are resolved locally, however LNP recognises gaps in capturing parent feedback and is taking steps to improve this.

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

---- Safe ----

25/26/250

Patient Safety Update

NA presented the Patient Safety update and drew attention to a few key points within the report:- The Patient Safety Programme Board met on 29th January 2026.

Highlights:-

- Recent monitoring showed an increase in ten-fold medication errors. Mitigation had progressed with full deployment of Guardrails, the infusion-pump safety software. Guardrails is expected to significantly prevent future ten-fold errors, and the Safety team will closely monitor trends.
- 96% of HMRG reviews had been completed on time, exceeding the 90% target and had been consistently maintained over the last four months.
- There had been a continued reduction in pressure damage incidents, the Tissue Viability team had expanded its remit over the last 12 months, and had shown demonstrable impact on prevention and oversight.

Challenges:-

- Transfusion safety - main challenge relate to obtaining and evidencing E-consent for transfusions, a Trust-wide newly launched improvement programme had commenced,
- Continued challenges were noted regarding in completing reviews as part of the PSIRI and PSIRF process within the appropriate timeframes. NA confirmed that the Associate Chief Nurse, Community & MH Division will work with the Associate Chief Nurse to strengthen processes.

FB highlighted the positive engagement work undertaken with Patient Safety Partners, particularly the work regarding battery-related incidents. FB welcomed seeing this practical, collaborative safety improvement included within the Patient Safety report.

FB referred to unacknowledged safety notices and sought clarity regarding what next steps will be taken to address the outstanding number of unacknowledged safety notices, which continue to be highlighted in multiple committees. NA referred to earlier agreement that the issue be presented to SQAC with a clearer action plan once available.

AB confirmed that the unacknowledged Lead Consultant would present a formal update to SQAC once the report is ready. AB confirmed that the unacknowledged Lead Consultant had been engaging with a Trust in the North East with similar challenges and that any shared learning would be included within a future report to SQAC. AB advised that early evidence suggests their approach had significantly improved.

SQAC NOTED that this issue is particularly challenging within the Division of Surgery and will require sustained engagement.

KB referred to the lack of timeframe indicators under the “Vision and Goals” section of slides and advised that it is not always clear how long initiatives are expected to take, Tactical actions are visible, but the broader timeline and progress are harder to interpret.

NA agreed this is an important point and acknowledged that often, improvement cycles do not have clear end dates at the outset, however the team will explore ways to offer indicative timeframes where helpful.

Resolved: NA committed to providing feedback to the Chair of Patient Safety Committee and the wider Patient Safety Team.

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

25/26/251

Quarter 3 Safeguarding Report

NO presented the Quarter 3 Safeguarding Report, and drew attention to a few key points from the report including:-

- Safeguarding Children Level 2 training compliance – there is a notable decrease in Level 2 safeguarding training compliance occurred this quarter. NO reminded the committee this was anticipated due to the ongoing data cleanse, aimed at ensuring staff are matched to the correct

training requirements. A phased approach is being used to avoid a sudden decrease in compliance rates; continuous monitoring is ongoing.

- Work is ongoing to improve Level 3 compliance.
- Changes to MASH (Multi-Agency Safeguarding Hub) reporting due to digitalisation within MASH, reporting will now capture: Number of children, rather than both the number of children and the number of requests. This improves accuracy, since individual requests may concern multiple children.

Highlights:-

- Digitalisation of Safeguarding documentation: Quarter 3 saw the successful digitalisation of safeguarding templates within Meditech. NO confirmed early implementation challenges had been addressed, with revised templates now fully optimised.
- Trust review of safeguarding supervision was completed which had resulted in: updated safeguarding supervision policy, development of a robust safeguarding supervision template in Meditech, integration of cultural considerations as recommended by the National Safeguarding Panel, introduction of supervision agreements linked to Trust values.
- The new template is now live and already being utilised following successful piloting.
- The core safeguarding policy has been updated in line with national guidance.
- SOPs continue to be reviewed and modernised.

Ongoing Challenges:-

- Challenges remain regarding Safeguarding training Compliance and ensuring adequate training completion particularly Level 3 which remains a priority.
- Safeguarding team capacity continues to be strained due to increasing multi-agency workstreams, Requirements from Safeguarding Partnerships, Contributions to Families First Boards & Multi-Agency Engagement. Growing commitments from Local Authority partnership structures continue to put pressure on team capacity.

Key priorities:

- Phase 2 of Safeguarding Digital Programme - Modernising digital pathways for: Child Death processes, and Sexual Assault Referral Centre (SARC) psychology documentation.
- Embedding Safeguarding Supervision - Ensuring Trust-wide implementation of the new templates and supervision standards.
- Business Case progression - Continued work on securing appropriate resourcing for the safeguarding team.

FB raised a concern about the level of personal detail contained in the “local review cases” table and advised that at least once case contained excessive detail and requested that future reports would focus on broader themes, and detailed case information would be provided separately only if explicitly required.

GM sought clarity on Alder Hey’s readiness for an upcoming Ofsted inspection of Liverpool Children’s Services, which is envisaged by May and sought clarity on how prepared the Trust was for the health component of the inspection. NO advised that the Trust works closely with all three main Local Authorities (Liverpool, Sefton, Knowsley) and each authority has its own improvement plan and readiness programme. Regular meetings take place monthly with Liverpool Children’s Social Care to monitor joint risks. Current concerns relate to ensuring Alder Hey is appropriately included in strategy meetings, maintaining high-quality communication across multi-agency boundaries, ensuring CYP are referred promptly for safeguarding medicals, SARC exams, or strategy involvement.

GM queried whether NO had any particular areas of concern ahead of the Ofsted inspection. NO advised that the main risk relates to multi-agency communication, particularly ensuring timely referrals, full understanding of SARC referral pathways, clear processes around strategy decision-making. NO advised that a SARC nurse manager is proactively providing spotlight training to Local Authorities to address this.

Resolved: SQAC received and **NOTED** the Quarter 3 Safeguarding Report

5/26/252

Safe waiting list update

ABa presented the Safe Waiting List update and drew attention to a few key points from the report including:-

- The Trust’s waiting list data quality scores, independently assessed nationally, remain high, providing confidence in the integrity of the elective waiting list.

- ABa advised that while there are areas for improvement, the overall position is robust.
- Minor gaps remain in data validation and assurance processes; however, work is underway to close these.
- Previously follow-up backlogs had notably decreased, however current figures indicate a rising trend, with the greatest pressures noted within the Division of Surgery. ABa stated that this is the main risk area for the Safe Waiting List process and to address this ABa had reached out to Surgery leadership to convene discussions on accelerating improvement actions. ABa emphasised the need for “breakthrough solutions” to address sustained follow-up breaches.
- The new outcome capture form introduced in 2025 is now fully integrated. Recorded outcome accuracy had improved to 90%, however further efforts are required to achieve 100% target and enhance compliance and reliability.
- A new fail-safe process with formal risk stratification for children awaiting follow-up is being rolled out across specialties. Some specialties had fully implemented this system; however paediatric surgery remains the highest risk area and is progressing slower than anticipated. ABa emphasised that early risk identification, clinical-led reviews and safety netting during backlog periods.

FB queried whether there had been any progress regarding funding arrangements for the clinical lead role for 2026 - 27, given this role’s importance to the safe waiting list process.

ABa advised that The funding sits within the broader review of clinical leadership roles currently underway and stated that he believed that this is an essential role, and one he hoped would be maintained in the new structure, a final decision will be taken as part of the leadership redesign.

FB noted that the FDP element of the programme appears to be a “bigger system issue” and asked if this was something the organisation could influence.

ABa advised that the FDP is a national directive and Alder Hey already uses this in theatre and now must: prepare for rollout in outpatient clinic contexts, ensure data structures and workflows can align with national expectations. ABa clarified that while the Trust cannot change the national requirement, it is preparing internally to ensure readiness.

Resolved: SQAC received and **NOTED** the Safe waiting list update

25/26/253

EPRR Quarterly update

JG presented the quarterly EPRR update, and drew attention to a few key points within the report including:-

- Five moderate business continuity incidents occurred this quarter, all successfully managed internally without requiring a formal declaration. JG stated that this indicates improvements in: organisational responsiveness, local capability to manage incidents, internal escalation pathways being used appropriately.
- All lockdown actions from exercises/incidents are fully completed, pending formal policy ratification at SQAC at today’s meeting.
- Southport incident: 11 of the 14 actions are now complete.
- Major Incident Plan: A comprehensive project plan is now in place, with an updated version scheduled for review at June SQAC, followed by Board approval. JG highlighted that certain actions necessitate stronger leadership and accountability to ensure more effective progress.
- The EPRR function continues to shoulder a disproportionate amount of responsibility for: formal debriefs, action tracking and monitoring progress. JG reiterated the risk that this may compromise local ownership, engagement, and timely delivery of actions.
- Strong engagement is noted in: internal trust-led exercises, ICB-led cascade exercises focusing on incident notification pathways. Lessons from these exercises will feature in the next formal SQAC report.
- JG advised that business continuity remains a key challenge with ongoing work across divisions, compliance is currently consistently low, with operational challenges. Data shows improved reporting from divisions, however overall maturity remains underdeveloped.
- Core Standards Compliance (NHS EPRR) - the Trust is currently Partially Compliant. Projection for the next submission (September) is Substantial Compliance, contingent on: completion of key workstreams, full delivery of the major incident plan refresh, strengthening of business continuity arrangements.

KB sought clarity whether the Annual Core Standards submission is a self-assessment, and whether the region would return to conduct a formal assessment. JG confirmed the process includes: submission of extensive evidence (100–1000 documents), a meeting with the ICB, a

dip-sample review of 5–10 standards. The ICB then determines compliance based on the sampled evidence. JG confirmed that this is the standard process, and the Trust is now better positioned to prepare throughout the year rather than reactively.

KB expressed concern regarding The Meditech system downtime incident, stating that the Action Plan in the report displayed multiple actions which had not yet commenced, despite the incident having occurred in November 2025. JG confirmed that progress has since been made: IT colleagues had taken ownership of the action plan. JG confirmed that a number of actions had already been closed following local learning. Monthly updates would be presented to the EPG (Emergency Planning Group) and reflected in future SQAC reports.

FB noted links to earlier agenda items (e.g., Burns peer review, patient safety notices), highlighting ongoing concerns regarding lack of local ownership of actions arising from incidents and reinforced that action plans must be owned by operational leaders, not solely the EPRR function. JG agreed and noted this as a significant cultural challenge being addressed.

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

---- *Caring* ----

25/26/254 Compliments, Complaints & PALS Quarter 3 Report

NA presented the Compliments, Complaints & PALS Quarter 3 report and drew attention to a few key points from the report including:-

NA confirmed high compliance with all three internal metrics used to track complaint performance. which includes: Acknowledgement timescales, Response timescales & Quality of investigations.

- Performance remains consistent and strong, despite rising complaint volume and complexity noted earlier in the meeting by several divisions.
- Of the three PHSO enquiries open during the period: Two had now been closed, one remains open and is being managed appropriately.
- The Trust's complaints policy is undergoing a full review to align with new PHSO 2025 complaints standards, updated expectations for responsiveness, quality, and communication. NA confirmed that stakeholder engagement will take place during the review and that there may be opportunities to refine the policy in light of discussion earlier in the meeting regarding AI-generated complaints and triage approaches.

NA acknowledged the themes shared earlier across each of the divisions with regards to increased complexity and volume of complaints, greater use of AI tools by families when drafting complaints, the need for enhanced early triage, and the rising expectations around legislative referencing within submissions. NA linked these conversations to the importance of aligning the updated Complaints Policy with current realities.

Resolved: SQAC received and **NOTED** the PALS & complaints quarterly report

25/26/255 Patient Experience and Engagement/Family Feedback Report Quarter 3 2025/26

NA presented the Patient Experience and Engagement/Family Feedback Quarter 3 report and drew attention to a few key points from the report including:-

- Trust-wide FFT score is 91%, indicating continued positive patient and family satisfaction. The upward trend is "slow but steady."
- NA noted variation by service, with Emergency Department (ED) scoring lower than inpatient areas. Lower ED satisfaction relates mainly to waiting times and environment limitations, especially during winter pressures.
- The Wellbeing Hub continues to be an important support resource for families: 113 families accessed the service this quarter, of these: 40 accessed Citizens Advice, 73 accessed Health Junction. Data shows 55% of social prescribing contacts are for families living in the lowest 10% nationally for deprivation, demonstrating the Hub's role in meeting significant socioeconomic needs.
- Two workshops had taken place to gather feedback for the new Patient Experience Strategy, due in 2026. Engagement includes Youth Forum, other young people and cross-divisional representation. NA emphasised that co-production remains central to shaping the new strategy.
- Play service changes implemented earlier in the year are showing positive impact.
- Early evaluation feedback is strong, reflecting improved patient experience for children and families.

- Arts for Health programme marked its birthday milestone and continues to deliver high-impact initiatives. An artist had now been appointed for the redesign of the ICU corridor; installation is expected within six months (supported by Charity funding).
- The Patient Experience Group will transition to a new structure in April, aligning with: increased oversight of experience-related workstreams, updated Terms of Reference, improved integrated approach to capturing and responding to family feedback.

FB referred to the 6% of FFT respondents who did not report a positive experience and sought clarity whether more information is known about who is represented in the 6% and whether there are particular demographic groups over-represented and queried how well does FFT reporting capture protected characteristics and parity of esteem issues.

NA acknowledged this as a critical point and confirmed that analysis of FFT by protected characteristics is required and this would be explored. NA highlighted ED as a clear outlier area for lower scores due to environmental and waiting-time pressures.

Resolved: NA committed to reviewing what analysis can be drawn from available systems and processes.

JP highlighted the strong evidence of youth voice and engagement in the report, commending the incorporation of young people in service development, support for independence and adulthood preparation, and recognition that “life opportunities” form an important part of Alder Hey’s wider purpose.

Resolved: SQAC received & **NOTED** the Patient & Family Feedback quarterly report

25/26/256 Quarter 3 Children & Young People Engagement Report

SQAC **NOTED** the Quarter 3 Children & Young People Engagement Report, which highlighted key stories capturing youth perspectives and their contributions to service development at the Trust, as well as support provided after their engagement with Alder Hey.

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

25/26/257 EDS22 Summary Report

AD presented the EDS22 Summary report and drew attention to a few key points from the report including:-

Three clinical areas were selected for this year’s EDS assessment: Gender Service, Diabetes Service & Pre-Surgical Assessment. These were chosen based on: Demographic representation, Variation in patient needs, Opportunities to review equality considerations across contrasting service types. Excellent practice was noted in each of these areas, supported by strong evidence of inclusive service delivery.

- Across the three EDS domains, the Trust achieved a score of 26, which places Alder Hey in the “Achieving” category. This marks an improvement from the score of 23 in 2025, demonstrating progression in EDI integration and assurance.
- The result reflects the organisation’s ongoing commitment to fairness, inclusion, and reducing inequalities.
- AD advised that following feedback from last year’s SQAC, the Trust had now: aligned EDS work with health inequalities priorities, to ensure health inequality themes were explicitly captured, set a clearer foundation for embedding health equity considerations into future EDS cycles and service improvement plans.
- This year’s improvements include earlier service identification, broader stakeholder involvement, collaborative evidence collection and thorough review and validation.
- Following this year’s assessment, an EDS action plan is being developed to: address areas requiring improvement, clarify accountability, ensure progress is embedded in operational planning. This action plan will be brought forward through appropriate governance routes.

FB acknowledged the positive improvements and referred to the reporting period requesting clarity as the current report references the date it was completed (2026) but does not clearly specify the reporting period being assessed. FB stated that as EDS22 is a retrospective annual review, FB suggested that the report should specify whether it reflects the 2025 performance year, and that the title should be adjusted to reflect the correct year, and all future reports should explicitly define the period reviewed for consistency with other assurance frameworks.

AD acknowledged this and agreed this is an area for improvement, AD confirmed that future

reports will specify the exact review period, will align the naming convention with the performance year, and would provide clearer framing in both the summary and full report.

Resolved: SQAC received and **NOTED** the EDS22 Summary Report

25/26/258

Clinical Ethics Report

EH presented the Clinical Ethics Report, covering progress in clinical ethics support, education, and policy development. Key updates included:-

- The Clinical Ethics Service showed marked progress in its second year, with increased Trust-wide engagement and growing external recognition. It supports clinicians and teams and facilitates ethical discussions for complex cases through both formal forums and informal advice.
- The service has rebranded as the 'Clinical Ethics Forum' to emphasize its supportive, non-authoritative role and encourage broader early clinician involvement.
- Educational initiatives include a new LLM/PGCert/PGDip in Law and Ethics in Child Health (in partnership with the University of Liverpool Law School), continued "Talk in Law and Ethics" sessions with high staff engagement, and funding for a major event marking 40 years since the Gillick ruling.
- Alder Hey is being considered as a regional centre for ethical support, handling referrals from neighbouring trusts and collaborating with national and regional ethics teams.
- The Forum provides a neutral space for sensitive cases, especially where internal tensions exist, and contributes to care pathways and policy guidance for specialist services.
- RP discussed plans for a Best-Interest Decision-Making Framework, including workshops to distinguish best-interest discussions from mediation and enhance family-related ethical support.
- Forums address trending ethical issues (e.g., compliance challenges for autistic children) to promote systemic learning across the Trust.

FB supported the update and asked for future reports to include quantitative metrics, such as cases supported, forums held, issue types, and participation rates to help SQAC assess volume, demand, engagement, trends, and impact. EH confirmed that these data are tracked and can be added to the next report. KB suggested also reporting on referral nature, case complexity, and system-related demand increases. RP noted that the team tracks case themes, clinical contexts, and referral reasons, and will incorporate this information in future reports for transparency and trend analysis. RP added that while some cases escalate to ethics forums, many are resolved through informal clinician consultations.

Resolved: Qualitative data and clear categorisation of complexity levels to be included within future Clinical Ethics Report

Resolved: SQAC received and **NOTED** the Clinical Ethics Report

25/26/259

Southport Learning AR Review

NA presented the Southport Learning AR Review report and drew attention to a few key points from the report including:-

- There are 39 actions in the Southport Learning AR action plan, 26 actions had been completed, 7 actions are on trajectory; 2 actions had been delayed and 4 actions showing limited progress.

NA emphasised that the majority of delays are attributable not to a lack of activity, but rather to delays in obtaining robust evidence required to officially close actions. A recurring concern is that divisions had not consistently provided the necessary documentation to mark actions as complete, which had led to slower overall progress and reduced assurance for certain items. NA highlighted the importance of Divisional Leads providing regular updates and ensuring any evidence is uploaded in a timely manner and ensure actions progress through governance.

NA advised that National Inquiry Report linked to the Southport incident is due to be published in April 2026 and once this had been released the Trust would review the recommendations, compare them to the current action plan, and identify additional actions required, with a refresh of the action plan as needed. NA confirmed that a revised action plan will be brought to SQAC in April/May once that work is complete.

NA recommended that this report continues to be presented to SQAC monthly until all actions are fully evidenced and closed, and the refreshed post-inquiry action plan is established.

FB expressed concern that some divisions had not provided required updates on their actions and that the lack of response is unacceptable for a safety-critical action plan. FB highlighted that divisions must understand the urgency and accountability required, and that clear direction should be given to improve responsiveness.

Resolved: FB requested Divisional Triumvirates to ensure this message is reinforced internally.

Resolved: SQAC received and **NOTED** the Southport Learning AR Review report.

25/26/260

Clinical Effectiveness & Outcomes Board Chairs Highlight report

NA presented the Clinical Effectiveness & Outcomes Board Chairs Highlight report and drew attention to a few key points from the report including:-

- Significant trust-wide improvement in document management was **NOTED**, particularly: Increased rates of policy and guideline review, better alignment of documentation oversight within divisions.
- The Trust achieved full (100%) compliance with CAS alerts: All alerts were received, triaged, and responded to within required timescales.
- NICE Guideline compliance - Positive Progress is evident
- The new NICE app introduced to improve guideline tracking is “receiving positive feedback”.
- Early signs indicate clearer compliance, easier divisional tracking and a projected steady increase in assurance of the next quarters.
- The Medicine Division have an outstanding update relating to the National Epilepsy Audit. The Clinical Effectiveness Board noted a lack of progress update from the division, and a need for clarity on actions being taken to improve epilepsy audit compliance. NA escalated this issue to SQAC as an issue requiring follow-up.

FB queried whether SQAC was being asked to take any action in relation to the escalated epilepsy audit issue, or to note the concern. NA confirmed that SQAC were requested to note the concern and that the specific requirement is that the Medicine Division must provide an overdue update to the Clinical Effectiveness Committee and address the gap in epilepsy audit reporting.

CW confirmed that the Medicine Division would provide the required update and acknowledged the need to resolve the outstanding reporting issue.

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

25/26/261

Board Assurance Framework

NA presented Board Assurance Framework focusing on current risk positions, cross-cutting themes, and upcoming work relating to risk appetite and reframing the Safety & Quality risk.

- Meetings had been arranged with the Chairs of all Board subcommittees to: review the organisation’s risk appetite, ensure risk appetite statements reflect current internal and external conditions. These sessions will help recalibrate appetite where emerging pressures or strategic changes require Board-level adjustment.
- A focused session is scheduled with the Director of Corporate Affairs, Governance Manager and the Chief Nursing, AHP & Experience Officer to re-articulate the overarching Safety & Quality risk, ensuring it fully reflects: the challenges discussed during SQAC, broader operational pressures and learning from recent risk escalations.

NA advised that changes will significantly refine how Safety & Quality is represented in the BAF and advised that the aim is to present the re-articulated Safety & Quality risk to: The next reporting period, if timing allows, if this is not possible it would be presented at the start of the new financial year. This ensures appropriate time for drafting, review, and alignment with Board governance cycles.

NA highlighted that the work undertaken on Section 5 of the BAF- mapping cross linkages between risks had already yielded improvements, this cross-risk visibility: helps identify shared contributors (e.g., workforce, fragile services), encourages divisions to engage collectively, provides a clearer picture of how risks interact and compound.

FB welcomed the refinement of cross-linkages between risks, noting it is helping the organisation recognise where risks overlap, It is driving improved joint working across divisions, e.g. progress on fragile services in Medicine can now be seen in relation to the People Risk.

FB observed that the BAF work is now “galvanising action” by revealing interdependencies more clearly.

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

25/25/262 **Biannual Aggregated Analysis Report**

NA introduced the Bi-Annual Aggregate Analysis (BAA) report, confirming that it is a mandated report required under the Trust’s Quality Schedule. The BAA summarises key trends and insights across a range of quality and safety indicators for the previous six-month period.

- The Trust is fully compliant with the requirement to produce and submit the BAA. This reporting structure is consistent with contractual obligations and is reviewed at defined intervals.
- The BAA follows a set template dictated by commissioners and includes cross-organisational data and narrative relating to: patient safety indicators, quality improvement themes, clinical effectiveness measures, staffing and workforce trends & patient experience themes.

FB highlighted that the front-page summary was particularly useful in providing a clear high-level overview of Trust performance across domains.

Resolved: SQAC received and **NOTED** the Biannual Aggregated Analysis Report

25/26/263 **Children & Young People’s Gender Service (North) Quarter 3 Report**

RT presented the Children & Young Peoples Gender Service (North) Quarter 3 Report and drew attention to a few key points from the report including:-

- The service consistently receives 25 new referrals each month, meeting contractual requirements, with a total of 75 referrals recorded this quarter. Two previously discharged young people have re-engaged with the service.
- Initial assessments were completed for 90.47% of clients within six weeks, representing a significant improvement.
- Implementation of Group 2 (medical pathway stage) is progressing.
- An increasing number of individuals over the age of 18 require transition to Adult Services; while referrals are initiated promptly, acceptance is subject to delay, necessitating extended support during the transition period.
- A total of 14 incidents were reported, including phone line disruptions, challenges with virtual appointments and administration, delays in letter generation and VPN access impacting documentation, and expired DBS certificates due to auto-renewal issues. The latter is currently under review.
- During a face to face workshop the workshop was prematurely terminated due to a parent causing disruption; subsequent analysis has led to enhanced preparation protocols and pre-emptive support measures.
- Safeguarding and clinical interventions were initiated in response to a case involving unregulated hormone access via a parent.
- Notable improvements include refined workshop attendance screening, strengthened DBS monitoring, and upgrades to communication platforms. Efforts continue to ensure timely documentation despite staffing or IT limitations.
- Persistent staffing gaps remain due to turnover; recruitment activities are underway to restore operational capacity.
- RT advised that the service is preparing to support the research arm for the Research Trial: Pathways Horizon Branch and had begun consenting families for contact. The Randomised Controlled Trial (RCT) arm of the broader PATHWAYS Trial has been paused nationally due to new MHRA guidance (as reported later in the meeting). The service is proactively contacting potentially affected young people to offer support/ The focus is on supporting those who may be vulnerable or anxious about changes in their planned care or research involvement.

LR referred to the trial Regulatory pause regarding the PATHWAYS Randomised Controlled Trial: and advised that although previous discussions suggested the trial’s RCT arm was preparing to open, LR stated that the MHRA had raised concerns resulting in the RCT component of the trial being paused nationally. This aligns with national media coverage earlier in the week. LR confirmed that Alder Hey had progressed the set-up appropriately and was awaiting clearance.

FB acknowledged the thoroughness of the update

Resolved: SQAC received and **NOTED** the Gender Development Service Report

---- *Well Led* ----

- 25/26/264** **Medicine Management Policy – C37** -SQAC received, **NOTED** and **RATIFIED** the Medicine Management Policy – C37.
- 25/26/265** **Merseyside Joint Agency Protocol Acute Life-Threatening Event (ALTE)** - SQAC received, **NOTED** and **RATIFIED** the Merseyside Joint Agency Protocol Life-Threatening Event (ALTE)
- 25/26/266** **Merseyside Joint Agency Protocol Sudden Unexpected Death in Childhood (SUDIC) for Children aged 0 – under 18 years** - SQAC received, **NOTED** and **RATIFIED** the Merseyside Joint Agency Protocol Sudden Unexpected Death in Childhood (SUDIC) for Children aged 0 – under 18 years
- 25/26/267** **Safeguarding Supervision Policy** - SQAC received, **NOTED** and **RATIFIED** the Safeguarding Supervision Policy
- 25/26/268** **Rub don't scrub – Standard Operating Procedure** - SQAC received, **NOTED** and **RATIFIED** the Rub don't scrub – Standard Operating Procedure
- 25/26/269** **RM50 – Labelling, packaging, handling and delivery of Laboratory Specimens Policy** -SQAC received, **NOTED** and **RATIFIED** RM50 – Labelling, packaging, handling and delivery of Laboratory Specimens Policy
- 25/26/270** **Isolation Precautions Policy–C17** – SQAC received, **NOTED** and **RATIFIED** the Isolation Precautions Policy – C17
- 25/26/271** **Lockdown Plan** – JP referred to a separate lockdown plan specifically for Community & MH services and queried why it was not incorporated or referenced within the Lockdown Plan. CW stated that her understanding was that the action cards are generic applying to both clinical and non clinical settings.
FB stated that if a separate Lockdown Policy exists for Community & MH Services then it must be explicitly referenced in the main Lockdown plan to ensure clarity. FB requested JP to liaise with JG to ensure that JG confirm the correct structure of documents.
Resolved: SQAC received, **NOTED** and **RATIFIED** the Lockdown Plan subject to JP liaising with JG to ensure the correct structure of the Lockdown Plan to include appropriate reference to Community & MH lockdown plan.

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

- 25/26/272** **Any Other Business**
None received

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

- 25/26/275** The key assurances and highlights report was presented to the Board meeting held on 8th January 2026

Date and Time of Next Meeting: 25th March 2026 at 9.30 – 11.30 am via Microsoft teams

BOARD OF DIRECTORS

Thursday, 2nd April 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

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

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

Risk number	Risk description	Score

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



LIVERPOOL NEONATAL PARTNERSHIP BOARD

April 2026

Paper title:	Chairs report to LNP for onward reporting to Trust Board
Report to LNP Board:	Kelly Black
Report to Trust Boards:	Co-Chairs of the LNP, Alfie Bass and Chris Dewhurst
Paper prepared by:	Natalie Rixon, Management Consultant and Kelly Black Head of Neonatal Nursing

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 autumn 2026.

2. Overview of partnership & activities in month

Programme overview

There are several items to highlight including:

- There are a number of changes anticipated with the LNP Senior Tea, and the wider membership of the LNP Board. The Clinical Directors and Chief Medical Officers (LNP Board Chairs) are scheduled to meet to review the current programme, re-prioritise where necessary and address gaps as they occur. The updates will be presented to the LNP Board
- The LNP Clinical Leads for Neonatal Surgery (2PAs) have been appointed to.
- The LNP have successfully appointed a neonatal speech and language therapist, who is now in post.
- The LNP joint governance arrangements have been approved by the Trust Board at Liverpool University Hospitals Groups and Alder Hey Children's Hospital. The development of the LNP operational policy and governance framework is now under development supported by colleagues from MIAA, the completion date for presentation to Trust Boards in July 2026.

- 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 August, with full occupation of the surgical NICU by December 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 remain a concern. The LNP senior team have provided details to highlight the gaps in delivery of the national service specification, specifically in relation to Allied Health Professionals, Psychology and Pharmacy and Medicines Management. This will be raised as a concern at the May LNP Board meeting
- The phase 2 integrated performance report has been developed and presented to the LNP Board, the IPR will now be used to support production of all future reporting across both organisations
- The LNP has recruited to all medical and nursing posts and is holding 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 has been appointed to
- Leads from across the partnership have planned a visit to Nottingham later in April, to learn from their digital integration programme with Mindray and badgernet/ System C.

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

The LNP Chief Nurse, supported by the Associate Director of Continuous Improvements from MIAA and the Chief Corporate Governance Officers are developing the LNP Operational Policy and Governance Framework. The Framework will cover all core activities provided within the partnership and provide clarity in key areas that require a local agreement to be in place.

Subject leads have been identified to support each element of the policy, with a view to complete and circulate to Trust Boards in July 2026.

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 end of October 2026

Occupation of surgical NICU	Start date	End date
1st baby to transfer (1c cot)	22/09/2026	22/09/2026
Safety checks complete	22/09/2026	22/09/2026
8 cots transfer to NICU (1c cots)	22/09/2026	06/10/2026
SLT review and agree safe to increase capacity	06/10/2026	06/10/2026
4 cots transfer (PICU and HDU activity)	06/10/2026	13/10/2026
6 cots transfer (LWH transfer)	13/10/2026	27/10/2026
3 cots transfer (other wards)	27/10/2026	30/10/2026
Unit fully occupied	20/10/2026	20/10/2026

Changes to the senior leadership team

The senior leadership team would like thank Christopher Dewhurst for the significant contribution made to the partnership in his role as Co-Chair for the LNP Board. Chris has strengthened the partnership through his belief in the model and his vision for

working collectively in the interest of enhancing patient care, which has helped shape the future direction of the partnership.

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.
- There is a funding gap associated with AHP&P and Pharmacy and Medicines Management to deliver the neonatal critical care service specification that requires review and action to be taken to address.

4. Recommendations

The LNP Board are asked to:

- Note the content of the report and key updates

BOARD OF DIRECTORS

Thursday, 2nd April 2026

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

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



Introduction

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

1. Thriving Culture

The Thriving Culture programme of work continues to progress with most recent activity and focus concentrated on the new values implementation, staff experience, safety culture and responsive interventions to support the organisation through change (thriving organisation).

New values

A draft version of the new Values in Action framework was agreed by the values working group on the 3rd March. The framework will now be shared with a wider reference group comprising clinical and non-clinical staff. This will be a focussed consultation exercise with a focus on the following questions:

- When you read the value framework, what are your initial thoughts on it?
- How clear and easy to understand are the behaviours listed under each value?
- Are there any behaviours that might be difficult to apply (in your area/professional group etc)?
- Would you use the framework?
- What would you need to confidently use this in real situations? (e.g. toolkit/training)
- Would you make any changes? If so, what.....

Feedback and any changes will be incorporated into a final draft version on 31st March. The framework will then be shared with the executive team before sharing with the People Committee in April/May.

The wider implementation plan continues to develop with input and support from the values working group. Work is already underway ensuring that the new values are represented in people processes, papers and practices and in the organisational design process underpinning the new organisational structure.

Staff experience

The results of the 2025 NHS Staff Survey have now been formally published and shared with staff. Reflective of both national and local challenges, the results for our 2025 Staff Survey show that our scores have fallen across all the People Promises (each an area of staff experience) compared with 2024. In addition, fewer staff (66.8%) this year would recommend Alder Hey as a place to work.

However, we also continue to remain above the average for our comparator group (121 Acute and Acute & Community organisations) in almost all areas of staff experience except for one related to learning. At the same time, Alder Hey has the best results nationally in our comparator group for the percentage of staff who would recommend this as a place for care for friends and families.

Over the coming weeks, each team will receive their team level data embedded in a new Thriving Teams Conversation pack which will also include sickness and turnover data. Teams will be guided through their conversation using a solution-focussed coaching model to enable them to agree and share actions reflecting areas for improvement. These actions will be captured on a Microsoft Teams form which will enable the OD team to analyse and track themes and for the HR teams to support completion of the conversations.

Safety Culture

The safety culture training group met to share and agree the content for the new safety culture team-based development programme. Pilot sites have been chosen using the Thriving Teams Staff Survey data with a focus on the teams who are in the bottom quartile with regards to safety culture metrics.

Safety culture data is now available from the Staff Survey and will be used alongside other metrics to ensure that teams who need more support in this area are given targeted support during the transition to the new system structures.

Working through change

The OD team continues to support the HWWWITF programme with a strong focus on leadership development and colleague support throughout the transition.

The intranet-based Change Hub is now live offering staff a range of practical and emotional resources to navigate change, including focussed support for leaders who are leading others through change. The site includes links to other relevant resources in the Learning and Development hub and Careers, Advice and Guidance intranet pages.

The OD Plan to support the next phased in the organisational design process is in development for discussion at the How We Work in the Future Steering group on the 24th March. The plan will outline how OD interventions, leadership actions, and behaviour change mechanisms can embed the three strategic goals (clinically led, empowered & reducing silos) into everyday ways of working.

1. Equality, Diversity, and Inclusion

This provides an update on key Equality, Diversity and Inclusion (EDI) activity and progress during March, aligned to the Trust's strategic objectives and commitment to fostering an inclusive culture for both staff and patients.

Grow to Lead Development Programme

The Grow to Lead Development Programme, specifically designed to support internationally educated staff, has been successfully launched. We have received over 25 applications, indicating strong interest and engagement. The programme will support leadership development, inclusion, and career progression. Participants will undertake Quality Improvement (QI) projects and be supported by senior leader sponsors. This programme responds directly to national and local evidence highlighting inequalities in access to opportunities and progression.

NW BAME Assembly Anti-Racism Framework

The Trust has submitted evidence to the North West BAME Assembly in support of achieving bronze status under the Anti-Racist Framework. This reflects continued progress in embedding anti-racist practice across the organisation and demonstrates commitment to addressing racial inequalities in line with regional priorities.

Active Bystander Training & Development of Hub

The Active Bystander Train the Trainer programme has now been completed, with 12 staff trained to deliver this work across the organisation. A sustainability plan is currently being developed with the trained cohort and plans are in place to roll out Active Bystander training Trust-wide. Work is underway to develop an Active Bystander Hub on the Trust intranet; by creating an Active Bystander Hub, we can provide a structured, preventative intervention that will help to support staff:

- Building confidence to challenge inappropriate behaviour safely
- Reinforcing collective responsibility for culture
- Reduces escalation to formal HR processes
- Strengthens psychological safety and retention

The proposed Active Bystander Hub will provide staff with practical resources and support using the 5Ds intervention model, scenario-based scripts, guidance on challenging across hierarchy, training offers, Active Bystander Champion network, advise and signposting. It will be a centralised resource portal hosted on our Intranet. The Hub will provide clear reporting pathways and align with HR, Freedom to Speak up and our commitment to the Sexual Safety Charter. This initiative moves us from a model where individuals carry the burden of reporting harm, to one where the organisation shares responsibility for preventing it. This initiative supports the development of a culture where staff feel empowered to challenge inappropriate behaviours and promote inclusion.

Day of Inclusion

Planning is progressing for the Trust's Day of Inclusion on 28 May, which we are delivering in partnership with the Youth Forum. The event will celebrate diversity, increase awareness, and strengthen engagement with our staff and the communities we support. We aim to highlight the positive work taking place across Alder Hey that benefits both our workforce and the children and young people in our care. Working closely with the Youth Forum, we are developing an agenda that brings in lived experiences, shares key messages, and identifies clear actions to take forward.

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:

Mandatory Training

As reported previously a review of mandatory training compliance continues as although overall Trust compliance remains over 90% (as at 3.3.26 the figure was 93.15%) there are pockets of non-compliance linked to specific staff groups, teams, individuals and topics. The mandatory training task and finish group meets on a regular basis to discuss a range of factors impacting on compliance and to explore / action solutions, including attendance, delivery method and content review.

Divisional reports continue to be distributed across the Trust in the first week of each month. These are distributed to each SLT (Director, ACOO and Associate Chief Nurse) and the associated HR Business Partner by the end of week one. During week two divisional reports are distributed to divisional and departmental managers and leaders, totaling over 270 contacts. Subject Matter Experts (SMEs) are also updated with reports to enable them to be aware of the current position and instigate corrective action if compliance is not maintained, or there are areas of emerging or continuing concern.

To note also, EGC requires regular updates on Volunteer Mandatory Training in addition to employed staffs' mandatory training / resident doctor compliance. The Board is advised that volunteer mandatory training has increased this quarter to 89%. This increase follows the volunteer welcome event in November, which included face-to-face training delivery. Our new trust patient safety partners have also completed full mandatory training with the addition module of Patient Safety Syllabus training L1: Essentials for Patient Safety"

Widening Participation (WP)

During the Spring Term our Schools Innovation Competition has been running, with the winners being announced by The Children's Commissioner for England during the 10th Anniversary Celebrations for our Innovation Team. Our total social value across years 1 and 2 now exceeds £425,000.

Apprenticeships

A refreshed Apprenticeship Strategy and Apprenticeship Policy have been received by People Committee (ratification expected March 26), reflecting the changes in national policy and the attendant changes to the funding / management of apprenticeships. To note, a number of apprenticeships have been **de-funded**, and of particular significance for us are the level 3 team leader, level 5 operations manager, level 4 lead practitioner in adult care, level 5 coaching professional, and level 6 chartered manager.

Undergraduate Medical Education

Feedback from our UGME students on placement has improved during Rotation 4 (UoL) and remains high for EHU medical students. We are currently in discussion with all UGME partners re the 26/27 academic year

A summer school is currently being planned for 2027 for international medical students (in conjunction with the University of Liverpool and London Medical Exchange)

Post Graduate Medical Education

Senior leads from across medical education continue to work with our Resident Doctor Peer Lead (PDPL) and the wider resident doctor cohort/s to ensure we are focused on their experiences at Alder Hey and our position against the national 10-point plan.

To note also, we continue to work with resident doctors coming to us on rotation to ensure they address any gaps in their mandatory training. Whilst this remains challenging, we have seen improvement and are currently 7th in the Region.

NW Region League Table March 26					
Organisation	Employees	Percentage	Target	Variance	Rank
096 NW Lancashire Teaching Hospitals NHS Foundation Trust	266	95.89%	85.00%	10.89%	1st
096 NW Countess of Chester NHS Foundation Trust	128	88.43%	85.00%	3.43%	2nd
096 NW Liverpool Heart and Chest NHS Foundation Trust	45	84.64%	85.00%	-0.36%	3rd
096 NW The Christie Hospital NHS Foundation Trust	76	82.30%	85.00%	-2.70%	4th
096 NW East Lancashire Hospitals NHS Trust	181	82.17%	85.00%	-2.83%	5th
096 NW Clatterbridge Centre for Oncology	53	81.72%	85.00%	-3.28%	6th
096 NW Alder Hey Children's NHS Foundation Trust	155	81.48%	85.00%	-3.52%	7th
096 NW Greater Manchester Mental Health NHS Foundation Trust	133	80.41%	85.00%	-4.59%	8th

PDR Update

PDR Band 7+ is at 90.48% compliance as of 2 March 2026. Organisational wide compliance for all levels (excluding medics) stands at 76.07%, and work is ongoing within teams / Divisions to address this.

Training Needs Analysis (TNA)

In March, the L&D team commenced the annual TNA process across the trust to gather and collate job specific learning requirements and organisational priorities for the 2026/27 period. The appetite for and requests regarding learning opportunities, including those that have an external cost element, continues to be high. An assessment linked to outcomes will take place following the data gathering exercise, with support from senior leaders. Robust PDR discussions inform these needs, ensuring alignment to outcomes.

2. Employee Relations & Wellbeing

The Trust's sickness absence rate for February 2026 stands at 5.88%. This represents a notable improvement compared to the previous month's figure of 6.69%, and an overall reduction of 1.5% over the last two months, falling from 7.36% in December 2025. Although these figures indicate a positive trend, the current sickness rate remains just over 1% higher than the Trust's target of 4.5%. When examining the breakdown of absence, the most significant improvement has been observed in long-term sickness, which is now at 3.46% against a target of 2.5%. Short-term sickness has also improved, now recorded at 2.42%, approaching the Trust's target of 2% for short-term absence.

Alder Hey is not an outlier; these sickness rates are comparable with other Trusts across Cheshire and Mersey where sickness rates across C&M range between 5.6 % and 8.69 % (based on January 2026 data).

The Trust's dedicated HR sickness support team continue to provide tailored support to improve levels of absence across the Trust. Focus remains on prevention, working with SALS, OH and TU colleagues, with support for stress risk assessments, reasonable adjustments, enhanced wellbeing support from OH, management training, and targeted support for areas with higher absence.

Workforce Medium Term plan

The Trust medium term workforce plan for 2026/27 to 2028/29 was submitted on 11th February 2026, with plans fully aligned to financial and operational activity plans.

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

- Building sustainable workforce models in all services
- Increase staff availability by reducing sickness absence by 1%
- Reducing temporary spend in bank (by 10%) and agency (by 30%) staff
- Embedding Trust values, tackling discrimination and sexual misconduct

- High quality leadership and reducing spans of control
- Improving Resident Doctors' working lives ensuring compliance against the 10-point plan
- Improved and compliant Consultant job planning
- Statutory mandatory training reforms

SUMMARY STAFF WTE DETAIL	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
	30/04/2025	31/05/2025	30/06/2025	31/07/2025	31/08/2025	30/09/2025	31/10/2025	30/11/2025	31/12/2025	31/01/2026	28/02/2026
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Total Non Medical - Clinical Substantive Staff	2,643.41	2,634.10	2,636.79	2,637.79	2,638.01	2,633.94	2,638.17	2,650.79	2,647.64	2,641.52	2,639.38
Total Non Medical - Non-Clinical Substantive Staff	1,033.56	1,018.55	1,013.04	1,016.01	1,018.41	1,008.75	1,004.44	998.84	989.05	968.47	965.26
Total Medical and Dental Substantive Staff	559.79	564.32	570.09	562.92	575.35	575.01	572.87	574.37	576.28	569.28	550.92
Total WTE Substantive Staff	4,238.47	4,218.67	4,221.78	4,218.58	4,233.46	4,219.31	4,217.18	4,225.80	4,214.77	4,181.07	4,157.36
Bank Staff	101.17	98.54	91.03	94.18	88.69	94.16	95.25	78.37	79.87	87.53	107.19
Agency Staff (including, agency and contract)	6.49	4.64	5.69	5.76	4.61	3.33	2.91	2.96	3.56	2.90	2.78
Total WTE all Staff	4,346.13	4,321.85	4,318.50	4,318.52	4,326.76	4,316.80	4,315.34	4,307.13	4,298.20	4,271.50	4,267.33
Budget Plan	4,337.18	4,311.51	4,328.04	4,328.82	4,327.81	4,297.25	4,273.41	4,250.36	4,227.51	4,170.40	4,147.37
<i>Difference</i>	<i>-8.95</i>	<i>-10.34</i>	<i>9.54</i>	<i>10.30</i>	<i>1.05</i>	<i>-19.55</i>	<i>-41.93</i>	<i>-56.77</i>	<i>-70.69</i>	<i>-101.10</i>	<i>-119.96</i>

Management of Workforce Variance

Currently, there is a variance of 119.96 Whole Time Equivalent (WTE) staff against the planned figures. This gap between actual staffing levels and the workforce plan will be addressed through a number of measures:

- **Bank Staff Reductions:** Efforts will be made to reduce reliance on bank staff. Although increased acuity and activity resulted in a higher bank position during February, the recent improvement in sickness absence rates—down by 1.5% over the past two months—should help to further decrease the need for bank staff.
- **Recruitment Pauses:** Recruitment pauses will continue to be implemented where appropriate, helping to control workforce numbers and manage costs.
- **Voluntary Redundancies:** The facilitation of voluntary redundancies will enable eligible colleagues to leave the Trust voluntarily, thereby contributing to the alignment of actual staffing with the planned workforce.
- **Organisational Change:** Ongoing organisational changes will support the management of workforce variance, ensuring that staffing levels are maintained in line with operational requirements and strategic objectives.

Collectively, these actions are aimed at closing the gap between actual and planned workforce numbers, supporting the Trust's operational and financial goals.

Between March 2026 and March 2027, analysis of the WTE (Whole Time Equivalent) movement indicates a projected overall reduction. The reduction is to be achieved through the Trust's consistently low vacancy rate, alongside continued robust controls on bank and agency expenditure, service re-design and innovation, specifically linked to the HWWITF programme, and enhancement of digital capabilities.

Voluntary Redundancy Scheme

The Trust has launched a Voluntary redundancy Scheme effective from 4th March 2026 until 30th April 2026. The purpose of the scheme is to provide an opportunity for colleagues who are considering leaving the Trust to leave voluntarily and to receive a severance payment. This approach also enables the Trust to minimise the requirement for any future compulsory redundancies, in part due to the current organisational changes being discussed.

The scheme is based on the nationally established NHS model voluntary redundancy framework, has been approved by NHS England

Colleagues eligible to apply for voluntary redundancy in the first round will be in the following groups:

- those colleagues who may be subject to organisational change
- in management and leadership roles
- non-patient facing roles

Since the launch of the Voluntary Redundancy Scheme, there has been significant interest from eligible colleagues, resulting in a substantial number of applications. The scheme also allows for certain colleagues to leave the Trust before 31st March 2026. Applications from those seeking early departure are currently under review and being processed by the relevant teams.

Recommendations & Board Actions

The board are asked to note the content of the report and support the actions being taken by the people services teams to support colleagues and mitigate the risks.

BOARD OF DIRECTORS

Thursday, 2nd April 2026

Paper Title:	People Committee - Chair's Highlight Report from the meeting held on the 26.3.26
Report of:	Jo Revill, Chair of the People Committee
Paper Prepared by:	People Committee Administrator

Purpose of Paper:	Decision <input type="checkbox"/> Assurance <input type="checkbox"/> Information <input checked="" type="checkbox"/> Regulation <input type="checkbox"/>
Action/Decision Required:	To note <input checked="" type="checkbox"/> To approve <input type="checkbox"/>
Summary / supporting information	This paper provides a summary from the People Committee held on the 26th March 2026, along with the approved minutes from the 29 th January 2026.
Strategic Context	
This paper links to the following:	Outstanding care and experience <input checked="" type="checkbox"/> Collaborate for children & young people <input type="checkbox"/> Revolutionise care <input type="checkbox"/> Support our people <input checked="" type="checkbox"/> Pioneering breakthroughs <input type="checkbox"/> Strong Foundations <input checked="" type="checkbox"/>
Resource Implications:	

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

Risk number	Risk description	Score

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



1. Introduction

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

2. Agenda Items Received and Discussed

The Committee received and discussed the following key items:

- **Board Assurance Framework – People Risks:**
Approval of the reframing of all three People strategic risks covering:
 - Workforce sustainability
 - Organisational culture and wellbeing during change
 - Equity, Diversity and Inclusion (expanded to include patients and families)
- **Strategic People Update:**
Workforce performance, including sickness absence, PDR compliance, industrial action preparedness and people risks.
- **Workforce Metrics:**
Divisional updates on sickness, vacancies, agency/bank usage and PDR compliance, with actions in place for hotspot areas.
- **NHS Staff Survey 2025:**
National benchmarking, headline themes, free-text analysis and planned Trust-wide and team-level actions.
- **How We Work in the Future Programme:**
Progress update on organisational design, workforce change waves, transition planning and programme risks.
- **Voluntary Redundancy (VR) Scheme:**
Uptake, approvals to date, funding position and staff experience considerations.
- **Belonging, EDI and Inclusion:**
Active bystander training rollout, North West BAME Framework submission and inclusion initiatives.
- **Policy Approvals:**
Ratification of updated Apprenticeship, Study Leave, Disciplinary and Resolution policies.

3. Key Risks / Matters Escalated to the Board

- **Sickness Absence:**
Although performance is improving in February, Q2 data positions the Trust as a national outlier within the NHS Oversight Framework. Sickness remains a significant strategic workforce risk.
- **Reframed People Risks:**
Revised risk definitions and target scores better reflect current risk appetite, including expansion of EDI risk beyond the workforce.

- **Organisational Change Impact:**
Risk of cultural and wellbeing pressures during workforce and system redesign remains under close oversight.
- **Voluntary Redundancy Scheme:**
Risk to morale if eligibility decisions are not consistently understood or communicated.

4. Positive Highlights

- Early improvement in sickness absence and long-term sickness trends.
- Strong staff pride in delivering care, with Alder Hey again ranked highly for recommending as a place for care. (staff survey)
- Successful pilot and planned scale-up of active bystander training.
- High PDR compliance at Band 7+ with improving performance overall.
- Good progress on workforce redesign with strong governance and transition planning.
- Modernised people policies aligned with best practice and ACAS guidance.

5. Issues for Other Committees

- **Quality & Safety Committee:**
Increasing overlap between People risks, culture, safety and patient equity.
- **Finance & Performance Committee:**
Workforce cost pressures and alignment of workforce redesign savings.
- **Trust Board:**
People Committee discussions will inform forthcoming risk appetite conversations.

6. Recommendations

The Trust Board is asked to:

1. **Note and endorse** the reframed People risks.
2. **Continue close oversight** of sickness absence as a strategic risk.
3. **Support focus on culture and wellbeing** during organisational change.
4. **Note progress and risks** associated with workforce redesign and the VR scheme.
5. **Receive assurance** on strengthened policy governance and staff engagement arrangements.

People Committee
Minutes of the last meeting held on 29th January 2026
Teams

Present:

Jo Revill	Non-Executive Director (Chair)	(JR)
Nathan Askew	Chief Nursing Officer	(NA)
Fiona Beveridge	Non-Executive Director	(FB)
Adam Bateman	Deputy Chief Executive/COO	(AB)
Garth Dallas	Non-Executive Director	(GD)
Rachel Greer	Associate Chief of Operations – CAMHS	(RG)
John Grinnell	Chief Executive	(JG)
Sarah Leo	Associate Chief Operating Officer	(SL)
Jo Potier	Associate Director of Organisational Development	(JP)
Erica Saunders	Director of Corporate Affairs	(ES)
Melissa Swindell	Chief People Officer	(MS)
Sharon Owen	Deputy Chief People Officer	(SO)

In attendance:

Katherine Birch	Director of Alder Hey Academy	(KB)
Audrey Chindiya	Finance Manager	(AC)
Angela Ditchfield	EDI Lead	(AD)
Joe Fitzpatrick	Internal Communications Manager	(JF)
Katie Jones	Head of Operational HR	(KJ)
Rebecca Murphy	Head of Marketing & Communications	(RM)
Nicola Norris	E-Roster Manager	(NN)
Christine Pope	Interim General Manager	(CP)
Jill Preece	Governance Manager	(JP)
Darren Shaw	Head of Organisational Development	(DS)
Neil Thomas	Interim Health & Safety Manager	(NT)
Kerry Turner	FTSU Guardian	(KT)
Catherine Wardell	Associate Chief Nurse for Medicine	(CW)
Julie Worthington	Staff Side Secretary	(JW)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)

Observing:

Christian Laidlaw	NHSE	(CL)
Su De	Governor	(SD)

Apologies:

Alfie Bass	Chief Medical Officer	(AB)
Pauline Brown	Deputy Director of Nursing	(PB)
Sian Calderwood	Associate Chief Operating Officer, Medicine	(SC)
Chloe Lee	Associate COO – Surgery	(CL)
Urmi Das	Director, Division of Medicine	(UD)
Adrian Hughes	Deputy Medical Director	(AH)
Lisa Cooper	Director of Community & Mental Health Services	(LC)
Jacqui Lyons-Killey	Associate Chief Nurse – Research	(JLK)

The Chair welcomed the observers to the meeting; colleagues from NHSE and Su De, one of our staff Governors.

25/26/161 **Declarations of Interest**
No declarations were declared.

25/26/162 **Minutes of the previous meeting held on 19th November 2025.**
The minutes of the last meeting were approved as an accurate record.

25/26/163 **Matters Arising and Action Log**
Action log was updated accordingly.

25/26/164 **Internal Communications Update:**

The Committee received the Internal Communications update report. RM provided a detailed overview of the key highlights for the committee's attention:

The Internal Communications report highlights the diverse range of communication channels currently utilised within the organisation, including email, intranet, instant messaging platforms, and face-to-face meetings. It evaluates the effectiveness of each channel, noting a general preference for digital communication methods due to their speed and accessibility. However, face-to-face meetings remain crucial for complex discussions and team cohesion.

The survey undertaken by the comms team indicate that while most employees feel adequately informed, there is room for improvement in two-way communication and feedback mechanisms. Employees express a desire for more opportunities to share their insights and for leadership to be more responsive to feedback.

The report reviewed recent internal campaigns and messaging, measuring their reach and impact. Notably, participation rates in internal initiatives have increased, suggesting improved message clarity and dissemination. However, some departments report lower engagement, highlighting the need for tailored communication strategies. Leadership visibility and communication are identified as pivotal factors in shaping organisational culture. The report notes a positive trend in leaders actively sharing updates and strategic priorities, fostering greater trust and transparency across the organisation. Nevertheless, employees seek even more frequent and informal updates from senior management.

RM identified several challenges, including information overload, inconsistent messaging between departments, and varying communication skills among managers. Recommendations include further training for managers, streamlining communication flows, and implementing regular audits of internal messaging.

Next Steps

- Enhance feedback channels to encourage more employee participation and dialogue.
- Develop tailored communication plans for departments with lower engagement.
- Increase leadership visibility through regular, informal updates.
- Provide communication skills training for all managers.
- Regularly evaluate the effectiveness of communication channels and adapt as necessary.

Resolved: The Committee noted the contents of the Internal Communications Report.

25/26/165

Strategic People Update – Key People Issues

The Committee received the Strategic People Report, which provided an update across colleague engagement, culture, equality, education, wellbeing, and workforce risks.

1. Colleague Engagement & Culture

The Committee noted ongoing delivery of the *Thriving Culture* programme, including implementation of the new organisational values and development of a values-in-action framework.

Progress was reported on the creation of the *Thriving Teams Index*, due for pilot in Q1 and full implementation in Q3 2026. Phase 2 of the Connected Leadership approach (Team Connect and New Leader Connect) will commence during the year, with monthly reporting to the Executive Team.

2. Staff Morale & Support

The Committee noted continued pressure on morale linked to winter demand and rising sickness absence, with stress/anxiety/depression accounting for 35% of all absences. SALS referrals have increased, with 94 new cases in the last month. Targeted stress interventions, training and supportive sessions continue to be offered.

3. 2025 Staff Survey

Fieldwork closed with a 52% response rate. Initial embargoed results were received in December and are being analysed internally to shape action planning. Full results remain due in early 2026.

4. Equality, Diversity & Inclusion

The Committee received assurance that EDI activity remains a strategic priority. New staff support groups (Carers; Endometriosis) have been launched, and work continues to implement the NHS EDI Improvement Plan.

The Gender Pay Gap Report and EDS22 assessments are underway. Funding has been secured for Active Bystander training, and the *Grow to Lead* programme for internationally recruited staff will launch in February. A Day of Inclusion will take place in April.

5. Education, Learning & Development

Mandatory training compliance remains above 90%, though areas of non-compliance are being addressed through a new subcommittee.

Progress was noted on the Professional Development Hub, skills scan tool, and development of career pathways. Automation of PDR processes will go live in January 2026.

A new partnership with Edge Hill University is being formalised, with Alder Hey contributing to their new mental health PGCE and teacher training provision.

The Board also noted the appointment of Dr Lakshmi Ramasubramian as Director of Medical Education.

6. Employee Relations & Workforce Wellbeing

The sickness absence rate remains significantly above target at 6.98%, impacting service delivery. The HR sickness support team is providing targeted interventions, with further stress-related support in place.

The flu vaccination target was met, with 53% uptake of frontline staff.

The Board received a summary of Resident Doctor industrial action in December, along with assurance that operational oversight arrangements maintained patient safety.

7. Recommendations

The Board noted the report and supported the ongoing actions being taken across People & OD, including the targeted sickness interventions, continued development of culture and leadership programmes, and delivery of key EDI and education priorities.

Resolved: The Committee noted the contents of the Strategic People Plan Update Issues.

25/26/166

Trust wide Metrics

The Committee received the Trust Wide Metrics report. (December 2025) data.

Mandatory Training: The trust maintains a 90% target for mandatory training completion. This reflects the organisation's sustained dedication to staff development and adherence to regulatory requirements.

PDR: Band 7 and above have improved, currently reaching 85%, while overall PDR completion stands at 77%.

Sickness: Long term sickness shows a reduction compared to December's data with a slight uptake in short term sickness figures. Senior Leaders continue to manage accordingly support by HRBPs.

Resolved: The Committee received and noted the Trust Wide Metric report.

- **Divisional Metrics**

Corporate

The Committee received the corporate metrics report (October 2025) data.

Mandatory Training: Compliance remains consistently at 90% to date.

PDR: Compliance is on an upward trend across all roles, currently standing at 83%. Regular reports are distributed to support teams and highlight any outstanding PDR completions required.

Sickness: There has been an observed increase in both long-term and short-term sickness absence across teams. Support mechanisms are actively in place for staff who are currently absent, with a particular emphasis on preventative measures. These include targeted training and the provision of support for reasonable adjustments where appropriate, to foster a healthier working environment.

Recruitment: Teams are also feeling the effects of the ongoing corporate and non-patient-facing vacancy freeze. To address essential staffing needs, the break glass process remains operational, with all submitted posts being reviewed by the executive vacancy panel to ensure critical roles are filled where necessary.

Resolved: The Committee noted the contents of the Corporate Metric Report.

Surgery Division

The Committee received the Surgery Division metrics report (December 2025) data.

Mandatory Training: Compliance remains above trust target at 92% to date, indicating strong baseline compliance across the division.

Agency and Agency Spend: Remains at 0% since June 2025, reflecting effective workforce planning and cost control.

Sickness: Sickness continues to increase showing at 8%. Hot spots identified and the HR sickness team remains focused on addressing sickness absence in these areas.

Bank usage and spend increased during the month, following a sustained decrease since September. Levels have not returned to the September 2025 peak.

PDR: Continued focus on PDR delivery and deep dives into long-term sickness (LTS) cases, working closely with the HR sickness team to support colleagues back into the workplace.

Return to Work: Ongoing emphasis on Return-to-Work completion, particularly in light of rising sickness absence.

Staff Survey: Results are being reviewed and Big Conversations implemented with divisional teams. Final response rate: 43% (596 surveys).

Resolved: The Committee noted the contents of the Surgery Metrics Report.

Clinical Research Division

The Committee received The Clinical Research Division metrics report (October 2025) data.

Mandatory training compliance has dropped slightly from 100% to 94% but still meets the Trust target.

Overall sickness increased to 6.75%, exceeding the Trust target of 4.5%. Long-term and short-term sickness show an increase. Senior leaders continue to manage accordingly.

Return to Work (RTW) completion met the Trust target at 100% to date.

Staff turnover increased slightly to 9.5%, though it remains within trust target.

PDR compliance remains strong at 92% overall, with Band 7 PDRs at 94%.

Sickness: Active sickness management will continue, led by the Sickness Project Team, with targeted work to reduce sickness over specific months.

Resolved: The Committee noted the contents of the Clinical Research Metrics Report.

Community & Mental Health

The Committee received the Community & Mental Health Division metrics report (October 2025) data.

Sickness Absence: has reduced and is currently 6.57%, made up of:

- 4.36% long-term sickness (LTS)
- 2.21% short-term sickness (STS)

Short-term sickness peaked in October 2025, aligning with winter pressures, while long-term sickness is decreasing and expected to continue reducing if current management continues in line with Trust policy.

Mandatory training compliance remains strong at 96%, which is above the Trust target.

PDR Compliance is 85.31%, which is below the Trust target. Ensuring all colleagues receive a meaningful appraisal is identified as a priority.

Return to Work Compliance is 53%, highlighted as a key area of concern requiring focused action within the Division.

Resolved: The Committee noted the contents of the Community and Mental Health

Medicine

The Committee received the Medicine Division metrics report (October 2025) data.

Mandatory training compliance: Remains strong at 92%, which is above the Trust target, with targeted action on red and amber compliance areas.

Overpayments: Has continued to decrease since October 2025 and are now £4k for December 2025.

Bank and Agency Usage: continues to reduce across the Division. Agency staff use is being tightly controlled and approved as a last resort only, while overtime spend has reduced further compared to last month.

Sickness absence: has increased to 7.17%, exceeding the Trust KPI. Both short-term and long-term sickness have risen. Senior Leaders continue to be supported by HR.

compliance: Reported at 59%, which is significantly below the Trust target. While data entry issues may contribute, the report highlights a workforce support risk, requiring urgent action by senior leaders and HR.

Laboratory Services continue to face workforce risks in Biochemistry and Haematology/Transfusion, with bi-weekly strategy meetings in place to manage ongoing risk.

PDR compliance remains below the Trust target of 90%:

- **Band 7+: 77.96% (67 staff)**
- **All staff: 71.04% (285 staff)**

Pharmacy: faces ongoing challenges relating to vacancies, recruitment delays, sickness, and holding vacancies pending an outpatient pharmacy provider decision.

Staff Survey: 47% completion rate for Medicine, lower than last year, reflecting current pressures within the Division.

Resolved: The Committee noted the contents of the Medicine Metric Report.

25/26/167

Initial 2025 Staff Survey Results (For internal use only)

The committee received the initial 2025 Staff Survey Results update and noted the contents. The committee's attention was drawn to the following:

The Committee received and noted the 2025 Staff Survey results, with data provided by IQVIA in December 2025. Members were advised that results remain embargoed until national publication in early March 2026 and that all comparisons within the paper are based on only those Trusts who use IQVIA as their survey provider.

- There has been decline in overall response rates in 2025, returning engagement levels to those seen during the COVID period. Despite this reduction, the Trust achieved its third highest number of responses on record (2,426), reflecting ongoing workforce growth. Trust performance remains, in most areas, above comparator averages.
- The Committee noted a small decline across all People Promise themes and staff engagement measures. However, the Trust continues to outperform comparator organisations in six of the seven People Promises and both overarching themes, with 'We are always learning' identified as the sole area performing below comparator benchmarks.
- The Friends and Family test results showed a decline in staff recommending the Trust as a place to work. Despite this, staff confidence in the standard of care provided by the Trust remains strong, with the Trust's margin above comparators increasing significantly.
- Areas of negative change were highlighted, including perceptions of musculoskeletal health impacts, access to equipment and resources, career development opportunities, and confidence that concerns will be addressed.

Conversely, improvements were noted in areas including paid additional hours worked, reporting of incidents, team effectiveness discussions, and respectful behaviours between colleagues.

- The Committee noted the NHS Oversight Framework scores, with both Staff Engagement and Raising Concerns sub-scores declining compared to 2024, while remaining above comparator averages. Members acknowledged the importance of these metrics given their regulatory significance.
- Equality and diversity findings were presented, with declines noted in perceptions of fair career progression and respect for individual differences, although reported experiences of discrimination remained broadly stable. Members were reminded that due to changes in question wording, year-on-year comparisons for discrimination grounds should not be drawn.
- The Committee received a detailed overview of the Thriving Teams framework, which has been developed using the staff survey data, noting that 75 teams (representing 69% of the workforce) were categorised as Struggling, Functioning or Thriving. Nineteen teams were identified in the Struggling category, alongside 12 teams with missing engagement data, which may indicate emerging engagement or psychological safety concerns.
- Members noted teams with significant decline and improvement, recognising the value of early identification to enable timely support and intervention. The Committee welcomed evidence of improvement in several teams despite some remaining below Trust averages.
- The Committee noted the ongoing Big Conversations programme, with all eligible teams receiving tailored packs to support local discussion and action planning. Progress against the Staff Survey Action Plan was highlighted, including development of the Thriving Teams model, appraisal reforms, leadership development initiatives, enhanced support for reasonable adjustments, and targeted equality and inclusion activity.

The Committee noted the proposed next steps, including sharing results with Executive colleagues, re-establishing the Staff Survey action planning group, undertaking divisional discussions, and incorporating the data into the developing Thriving Teams Index.

Resolved: The Committee noted the contents of the report.

25/26/1668

Raising Concerns FTSU Update

The Committee received the Raising Concerns FTSU Update and noted the contents. KT drew the committee's attention to the following:

The Committee received and noted the Freedom to Speak Up (FTSU) progress update for Quarter 3, presented by the FTSU Guardian. The purpose of the report was to provide assurance on progress to date in strengthening mechanisms for staff to raise

concerns and to outline planned actions for the coming period. The Committee was asked to note the progress made and support the direction of travel.

- All activity during Quarter 3, including analysis of concerns raised by staff group and division. Concerns were raised by a broad cross-section of the workforce, with the highest proportion raised by nursing staff. Divisional data indicated that concerns were most frequently raised within Surgical and Community services, with smaller numbers from other divisions.
- KT noted the key themes of concerns raised, with the majority relating to inappropriate attitudes and behaviours and policies, processes and systems. These themes continue to represent the most frequently reported issues within the Trust and are consistent with the national picture. It was highlighted that Speak Up cases often include multiple themes and are recorded based on the individual's description of their concern.
- The Committee received assurance on case management, noting that of the cases open during Quarter 3, a number were progressing through formal HR processes, mediation, or were pending meetings with staff and managers to confirm that concerns had been appropriately addressed. Ongoing monitoring arrangements were described to ensure cases progress to resolution.
- KT shared the position regarding detriment, including the Trust's obligations under the Public Interest Disclosure Act. It was reported that the number of cases where staff believed they had suffered detriment remained low. Monitoring continues throughout the lifecycle of cases and post-closure monitoring is maintained for a 12-month period.
- KT shared the learning emerging from Speak Up cases, particularly in relation to behaviours, civility and the application of policies, including sickness absence and reasonable adjustments. It was highlighted that intelligence from FTSU cases is triangulated with other sources, including Staff Survey data and the Thriving Teams process, to identify areas requiring targeted intervention.
- The Committee took note of the progress in strengthening FTSU capacity, including the successful recruitment of a Deputy FTSU Guardian, to improve sustainability, consistency and proactive engagement, and to support the development of the FTSU champion's network.
- The FTSU visibility programme continues to show positive engagement across the organisation. Monthly walkabouts with Executive and Non-Executive colleagues, including the CEO, were reported to be well received, providing staff with opportunities to raise concerns directly. Further visits, including to theatre and community services, are planned.
- There remains ongoing collaborative working, including with staff networks, HR, Staff Side, SALS, OD, Patient Safety and Equality, Diversity and Inclusion colleagues, to share intelligence, prevent duplication and strengthen organisational learning.
- KT noted a decline in mandatory Speak Up training compliance, reported at 89.66% as 31 December 2025, with work underway to understand and address the

reduction. Limitations within ESR preventing rollout of the Listen Up, Follow Up module were highlighted, with options under review.

- The Committee noted that the Speak Up Policy is under review, aligned to National Guardian's Office guidance, following learning from internal case reviews. The review is being undertaken with representation from Staff Side, HR, SALS and EDI.

The Committee noted an update on the FTSU App, including the requirement to determine whether further development is feasible. It was reported that, if development cannot progress, consideration will be given to adopting an alternative system to enable anonymous reporting.

Resolved: The Committee noted the contents of the FTSU Report.

25/26/169 **Veteran Aware – Year 2 Progress Report (For information)**

The Committee received the Veteran Aware – Year 2 Progress Report and noted the contents. The report was shared for information purposes and was taken as read.

The Committee received and noted the Veteran Aware Year Two Review, which provided an overview of progress, achievements, and future priorities since the Trust's initial Veteran Aware accreditation. The report set out the Trust's ongoing commitment to the Armed Forces Covenant and to being a Forces-friendly employer and healthcare provider.

Resolved: The Committee received and noted the contents of the report.

25/26/170 **Sickness Absence Programme Update**

The Committee received the Sickness Absence Programme Update. The committee's attention was drawn to the following:

The Committee received and noted the Trust Sickness Update, which provided an overview of Trust-wide sickness absence, trends, and the additional supportive measures in place to reduce absence and improve staff wellbeing. The paper was presented for assurance and information.

- The Trust sickness absence target remains 4.5%, comprising 2% short-term and 2.5% long-term absence. While sickness absence had reduced year-on-year prior to 2025/26, Members noted an increase during the current financial year, with sickness absence reported at 6.45% across April to December 2025, remaining above the Trust target. Key drivers of sickness absence, with anxiety, stress, depression and other psychiatric illnesses identified as the most significant cause, accounting for 34.4% of absence, followed by musculoskeletal conditions and injury or fracture.

- The Committee received assurance on actions to strengthen sickness management, including the establishment of a dedicated HR sickness support team in September 2025, providing targeted support across the Trust and continuing delivery of the 90-Day Sickness Absence Improvement Programme. It was noted that the programme has expanded from reactive case management to include a stronger focus on prevention and supporting colleagues to remain well at work.
- Highlights on improvements to Return to Work (RTW) processes, including a refreshed RTW template with a greater emphasis on wellbeing and reasonable adjustments were noted. RTW compliance reporting has moved to a rolling 12-month position to provide a more representative view of performance, with Surgical Care noted as having the highest completion rates.
- Developments in Occupational Health provision, including the appointment of a new provider in May 2025, offering faster access to appointments, expanded wellbeing resources, and targeted health campaigns. Members noted an increase in DNAs in December, attributed primarily to missed physiotherapy appointments, with actions underway to address this.
- Progress against the 90-Day Sickness Absence Improvement Programme was noted that 7 of 11 actions have been completed, with the remainder in progress. Actions include the rollout of sickness absence training for managers, development of a sickness absence Power BI dashboard, progress on reasonable adjustment assessor training, and updates to the Supporting Sickness and Attendance Policy.

The Committee noted divisional sickness absence positions for December 2025, including:

- Community & Mental Health: 6.57%
- Corporate: 7.72%
- Clinical Research Division: 6.76%
- Medicine: 7.17%
- Surgery: 8.0%

Areas with the highest sickness absence within each division were highlighted in the paper.

- Members noted the range of local actions in place to support absence management and prevention, including targeted sickness management training, delivery of the flu vaccination programme, establishment of a Managers Reasonable Adjustments Guidance Group, and enhanced collaboration with the Staff Advice and Liaison Service (SALS), particularly in relation to stress-related absences.
- The Committee received assurance on the management of long-term sickness absence, noting that all colleagues absent for six months or more have support and action plans in place, with a combination of review meetings, treatment pathways, and planned return-to-work dates. Members noted a reduction in very long-term cases compared to the previous report.

The Committee noted that actions from the previous report have either been embedded into business-as-usual arrangements or are being progressed through the current improvement programmes. The Committee noted that the central sickness support team will remain in place until at least March 2026 to provide continued capacity, oversight, and learning.

Resolved: The Committee noted the contents of the report.

25/26/171 **Apprenticeship Update**

The Committee received the Apprenticeship Update. The committee's attention was drawn to the following:

The Committee received and noted the Apprenticeship Update, presented for assurance, which provided an overview of the Trust's apprenticeship provision, strategic intent, performance, and quality assurance arrangements.

- The Committee noted the strategic role of apprenticeships within the Trust's workforce and succession planning, underpinned by the Apprenticeship Strategic Plan 2025–2027. It was highlighted that apprenticeships are intended to address short-, medium- and long-term workforce gaps, raise productivity, and support Vision 2030, particularly through opportunities in Band 2–4 entry-level roles and engagement with the local Liverpool City Region community.
- Members noted continued assurance regarding the quality of Information, Advice and Guidance (IAG), with the Apprenticeship IAG Service maintaining the Matrix Standard accreditation, first awarded in 2022, and successfully completing annual improvement checks in 2023 and 2024. The Committee noted that the full reassessment is scheduled for January 2026.
- Impact of national apprenticeship reforms introduced during 2025/26, including changes to Functional Skills requirements, Level 7 restrictions, levy usage timescales, and the forthcoming Growth and Skills Levy. It was noted that the Trust has adopted a two-year strategy to manage uncertainty arising from these reforms.
- Members noted current apprenticeship activity, including that 32 staff commenced an apprenticeship between April and December 2025, of whom six were new starters, representing a reduction compared to the previous year. It was highlighted that reduced Band 2–4 vacancies have contributed to fewer opportunities being advertised as apprenticeships, with only eight potential missed opportunities identified in 2025 compared to 54 in the previous year.
- The Committee noted the overall scale of the apprenticeship programme, with 327 staff enrolled across 50 apprenticeship standards, ranging from Level 2 to Level 7, supported by 42 training providers across higher education, further education and independent training providers. New and emerging apprenticeship subjects aligned to workforce needs were highlighted.
- The Trust's apprenticeship levy position, including cumulative levy contributions since 2017, expenditure on apprenticeship training, and the requirement to

manage levy funds over time due to monthly payment structures. The Committee noted the use of levy gifting, including support provided to Alder Hey Charity.

- The Committee noted apprentice demographic data, including encouraging uptake by male staff relative to overall workforce composition, as well as data relating to age, disability and ethnicity. Members noted this as supporting inclusion and access objectives.
- Assurance was received on apprentice outcomes, noting that of 149 apprentices who have completed, many reported positive career development outcomes including promotion, further study, or remaining in post. It was noted that timely achievement rates have improved compared to the previous year, despite ongoing challenges such as sickness absence and workforce pressures.
- The Committee noted withdrawal data, including that most historic withdrawals occurred prior to the establishment of the dedicated IAG service, and that the most common reasons for withdrawal relate to staff leaving the Trust or provider-related issues. It was noted that enhanced monitoring and provider management are now in place to mitigate these risks.
- Members received assurance on quality assurance, compliance and safeguarding, including robust record-keeping, provider performance management, apprenticeship agreement meetings with line managers, escalation processes, and safeguarding arrangements supported by regular caseload reviews.
- The Committee noted governance arrangements, including oversight through the Academy, the Education Governance Committee, and use of the Salisbury Procurement Framework to ensure compliance and value for money. The Apprenticeship Policy was noted to be in place and accessible via the Trust intranet and document management system.

The Committee noted positive feedback from training providers and managers, highlighting the strength of the Trust's IAG service, provider relationships, and the positive impact of apprenticeships on individual development, team productivity, and leadership capability. The Committee noted this as evidence of a mature and effective apprenticeship offer.

Resolved: The committee received and noted the contents of the report.

25/26/172 **Strategic Workforce Planning Update**

The Committee received the Strategic Workforce Planning update and noted the contents. The committee's attention was drawn to the following:

The Committee received and noted the Non-Medical Workforce Workstream update, which provided an overview of the Trust's total workforce Whole Time Equivalent (WTE) position, current controls, and the approach to workforce planning for 2025/26 and the medium-term period 2026/27 to 2028/29. The paper was presented for decision, assurance and information.

The Committee noted the strategic context for workforce planning, including the requirement to submit both an annual workforce plan and a medium-term plan to Cheshire & Mersey ICB, aligned to national planning guidance. Members noted that the guidance sets clear expectations around no workforce growth, reductions in temporary staffing, and improvement priorities including reduced sickness absence, bank and agency usage, and implementation of national workforce reforms.

The definition of Total Workforce WTE, including which staff groups and roles are included and excluded from reporting, and that workforce numbers are monitored both through the annual planning process and via the monthly Provider Workforce Return (PWR) was noted by the committee.

The Committee noted the current workforce position, with total WTE for 2025/26 remaining largely static. It was highlighted that the Trust continues to face a significant Cost Improvement Programme (CIP) requirement, with a forecast 102 WTE gap against the budgeted establishment target and a 52 WTE gap against the staff-in-post target for March 2026.

Control measures have been implemented as part of the Non-Medical Workforce (including Nursing and AHP) workstream, which were approved through the Financial Improvement Programme. These include:

- A recruitment pause for corporate and managerial non-patient-facing roles from 1 August 2025 to 31 March 2026
- A 50% reduction in new starters until 31 March 2026
- Implementation of the Mutually Agreed Resignation Scheme (MARS) between September and October 2025
- A targeted 1% reduction in sickness absence, supported by a dedicated HR sickness support team

The Committee received an update on bank, agency and overtime usage and spend, with divisional narratives provided for December 2025. Members noted that bank and overtime usage continues to be driven by a combination of vacancies, training requirements, and sickness absence, with varying pressures across Community & Mental Health, Corporate, Medicine and Surgical Care divisions.

Members noted that total workforce WTE remains challenging and continues to be subject to external monitoring by the ICB, alongside regular internal reporting for assurance.

The Committee noted the forward look and next steps, including:

- Continued delivery of the 2025/26 annual plan
- Ongoing development of the medium-term workforce plan for 2026/27 to 2028/29

- Sustained focus on reducing sickness absence, bank and agency spend, and identifying opportunities for service redesign and productivity improvements
- Continued review of workforce controls and maximising the benefits of e-rostering
- Further development of robust workforce planning to support a sustainable non-medical workforce

Resolved: The Committee received and noted the contents of the report.

25/26/173 **Health & Safety Dashboard**

The Committee received the Health & Safety Dashboard update. The committee's attention was drawn to the following:

- The Committee received and noted the Health and Safety Dashboard for Quarter 3 2025, which provided assurance on health, safety and welfare performance across the Trust, including mandatory training compliance, incident reporting, and audit activity.
- Strong performance was noted against mandatory training targets, with Health, Safety & Welfare training compliance at 95.66%, exceeding the 90% target. Compliance for Practical Manual Handling (Level 2) was reported at 92.48%, and Theory Manual Handling (Level 1) at 97.08%, both above target.
- Risk Assessment training continues to be delivered on an ongoing, on-demand basis, with no regulatory target set, ensuring flexibility to meet service need.
- The Committee noted assurance regarding First Aid training, with training and refresher sessions continuing to be provided across the Trust as required, aligned to workforce structure and location.
- Full compliance with RAMS (Risk Assessments and Method Statements), with 100% compliance achieved. It was reported that 20 sets of RAMS were reviewed and approved during Q3, with no incidents reported in relation to these activities.
- The Committee received an update on RIDDOR reporting, noting that while the acceptable target is zero incidents, the Trust reported four RIDDOR incidents during Q3. All incidents were classified as seven-day injuries, with no serious injuries reported, and were appropriately reported to the Health and Safety Executive.
- Progress on audits and inspections, with 25% of planned audits completed during the period was noted as positive. A full ladder audit was undertaken in November and December 2025, with further audits planned, including COSHH, environmental and manual handling equipment audits. It was also noted that a sharps audit will be undertaken in collaboration with Sharpsmart to identify contributory factors to sharps incidents, followed by a quality round to assess staff awareness and understanding of sharps safety.

Resolved: The committee received and noted the contents of the report.

25/26/174 **Equality, Diversity & Inclusion Update**
- **EDS22**

The Committee received the Equality, Diversity & Inclusion update. The committee's attention was drawn to the following:

- The Committee received and approved the Equality Delivery System 2022 (EDS22) Summary Report, which set out how the Trust has performed against the national EDS22 Improvement Framework. The Committee noted that implementation of EDS is a contractual requirement for NHS providers and supports compliance with the Equality Act 2010.
- The purpose and scope of EDS22, including its focus on identifying and addressing inequalities in access, experience and outcomes for patients, carers, communities and the workforce, and on fostering inclusive, discrimination-free working environments. Members noted that EDS22 is structured around three domains: Commissioned or Provided Services, Workforce Health and Wellbeing, and Inclusive Leadership.
- Members noted the methodology used, including the collection of robust quantitative and qualitative evidence and engagement with a wide range of stakeholders, including service leads, Human Resources, Staff Advice and Liaison Service, Freedom to Speak Up, staff networks and trade union representatives. The Committee noted that scores were agreed with senior leaders and shared with stakeholders to support transparency and assurance.
- The Committee noted the Domain 1 assessment of commissioned or provided services, which focused on three services: the National Gender Identity Service, Diabetes Service, and Surgical Pre-Assessment Service. Members noted that these services achieved ratings ranging from Developing to Excelling, with an overall Domain 1 score of 9, reflecting generally strong performance in access, experience and safety, alongside areas for further improvement.
- Members noted the Domain 2 assessment relating to workforce health and wellbeing, supported by evidence from HR, SALS, FTSU, Learning and Development, staff networks and trade unions. The Committee noted strong performance in supporting staff with health conditions and wellbeing, access to independent support, and staff recommendation of the organisation as a place to work, resulting in a Domain 2 score of 10.
- The Committee noted the Domain 3 assessment of inclusive leadership, which demonstrated that equality, diversity and inclusion are embedded within governance, leadership behaviours and decision-making. Members noted leadership accountability supported by routine use of workforce and equality data, with a Domain 3 score of 7, reflecting positive leadership practice with scope for further development.
- The Committee noted the Trust's overall EDS22 score of 26, confirming an overall rating of "Achieving". Members noted that this outcome reflects continued progress in embedding equality, diversity and inclusion across services, workforce wellbeing and leadership, while also identifying priority areas for further improvement.

The Committee noted the proposed next steps, including the development of targeted action plans for each domain with clear ownership, continued co-production with staff networks and trade union representatives, ongoing engagement with external partners for peer review and shared learning, and alignment with regional and national NHS priorities to support continuous improvement.

Resolved: The committee received and noted the contents of the report.

25/26/175 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

- **BAF Risks: 2.1 2.2 & 2.3**

The Committee received the Board Assurance Framework and noted the contents. ES drew the committee's attention to the following:

The Committee received and noted the update from the Board Assurance Framework (BAF) relating to People risks 2.1, 2.2 and 2.3, all of which continue to be overseen by the People Committee and align to the strategic objective "Support our People".

The Committee received and noted the Board Assurance Framework (BAF) update for December 2025, which provides an overview of the Trust's principal strategic risks, associated controls, gaps in assurance, and mitigating actions. Members noted that the BAF continues to provide a comprehensive view of risk across the Trust's strategic objectives, with assurance drawn from multiple governance routes including Board sub-committees, executive oversight and external regulators.

The Committee noted that a number of strategic risks remain above target, reflecting sustained pressures across the NHS, including financial constraints, workforce availability, rising demand, and system-wide reform. Members acknowledged that these pressures continue to impact delivery of quality, access, workforce sustainability and long-term strategic ambitions.

Members noted strong and well-established control frameworks across the majority of risks, including clear governance arrangements, regular performance and risk reporting, and defined assurance mechanisms through Board committees. It was noted that risks are actively monitored through routine review of integrated performance data, risk registers, action plans and committee reporting cycles.

The Committee noted recurring themes across the BAF, including:

- Workforce capacity, sickness absence and recruitment challenges
- The impact of financial pressures on service delivery and transformation
- The need for continued cultural development, inclusive leadership and staff wellbeing
- Capacity constraints affecting access, waiting times and productivity

- System dependency risks linked to commissioning, capital and partnership working

Members recognised that these themes are inter-related and require coordinated organisational and system-level responses.

The Committee received assurance that mitigation actions are in place for all principal risks, with clear ownership, defined milestones and escalation routes. Members noted that many actions are focused on medium- to long-term improvement, including workforce planning, service redesign, productivity initiatives, leadership development, safety culture programmes and system collaboration.

Members noted the importance of continued alignment between strategic risks and enabling programmes, including the People Plan, Vision 2030, financial recovery plans, workforce transformation, digital and data strategies, and equality, diversity and inclusion initiatives. It was noted that these programmes collectively underpin the Trust's ability to reduce risk over time.

The Committee noted that assurance continues to be strengthened through triangulation of data, including staff survey results, patient experience, safety intelligence, workforce metrics, audit findings and external review. This was recognised as critical to identifying emerging risks early and supporting timely intervention.

The Committee noted that the BAF will continue to be reviewed regularly, with updates reported through the appropriate committees and to Trust Board, ensuring ongoing oversight of risk trajectory, effectiveness of controls, and delivery of mitigating actions. Members reaffirmed the importance of maintaining a clear line of sight between operational pressures, strategic risks and organisational priorities.

Resolved: The committee received and noted the contents of the BAF report.

25/26/178 **Policies for ratification:**

- **Organisational Change Policy**

The Committee received the Organisational Change Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Organisational Change Policy.

- **Domestic Abuse Policy**

The Committee received the Domestic Abuse Policy and was provided with a detailed overview of recent developments / updates. The Committee noted that this was a new policy, developed in conjunction with a range of agencies and staff with lived experience who helped shape a relevant and supportive policy framework, and was approved by the membership.

Resolved: The Committee APPROVED the Domestic Abuse Policy

- **Consultant and SAS Doctors Job Planning Policy**

- The Committee received the Consultant and SAS Doctors Job Planning Policy and was provided with a detailed overview of recent developments / updates and was approved by the membership.

Resolved: The Committee APPROVED the Consultant and SAS Doctors Job Planning Policy

25/26/179 **Staff Partnership Forum Committee (SPF) Minutes**

The Committee received the approved minutes of the SPF meeting held on (November 2025)

25/26/182 **Education Governance Committee (EGC) Minutes**

The Committee received the approved minutes of the EGC meeting held on (November 2025)

24/26/183 **Any Other Business**

There were no items of AOB

25/26/184 **Review of Meeting – Chair's Report to Board**

Overall Position

The Committee considered a wide range of items reflecting continued pressure on workforce, culture, and wellbeing. Assurance was provided that actions and controls remain in place, although sickness absence, workforce constraints and staff survey findings require continued focus.

1. Strategic People Update

- Good progress on cultural programmes, including implementation of new values and development of the Thriving Teams Index.
- Staff morale remains affected by winter pressures and sickness; SALS referrals remain elevated.
- EDI work progressing well with new support groups, Active Bystander training and the Grow to Lead programme launching shortly.
- Mandatory training performance remains above 90%; education partnerships continue to mature.
- Sickness absence remains significantly above target, but strengthened interventions are in place.

2. Communications, Engagement and Insight

- Internal communications improving, with increased campaign reach and leadership visibility.
- Staff are seeking stronger two-way feedback channels; work is in train to address this.

3. Workforce Metrics & Divisional Performance

- Mandatory training and elements of PDR compliance remain strong in most divisions.
- Sickness remains above target Trust-wide, with variation by division.
- Recruitment controls and vacancy freezes continue to shape workforce supply, with break-glass processes used for essential posts.
- Surgery remains a notable outlier for positive agency performance (0% usage).

4. Staff Survey (Initial Embargoed Results)

- Response rates fell but absolute numbers remain high.
- Small declines across all themes, though the Trust continues to outperform comparator organisations in most areas.
- Areas requiring action include musculoskeletal health, equipment/resources, career development and confidence that concerns are addressed.
- Big Conversations and the Thriving Teams framework are being used to guide team-level improvement.

5. Freedom to Speak Up

- Strong FTSU visibility and improved capacity with the new Deputy Guardian.
- Themes remain consistent: behaviours, civility, and policy application.
- Mandatory Speak Up training compliance dipped and is being addressed

6. Sickness Absence Programme

- Trust sickness remains high (driven primarily by stress/anxiety), despite targeted support and a strengthened HR sickness support team.
- Improvements noted in RTW processes and OH provision, though DNAs require attention.
- Majority of actions within the 90-Day Improvement Programme are complete or embedded

7. Apprenticeships & Workforce Planning

- Apprenticeship offer remains high-quality, with strong IAG and provider assurance.
- Activity levels slightly reduced due to fewer entry-level vacancies.
- Workforce planning constrained by national expectations and local WTE gaps; controls continue through recruitment pauses and reduced new starter volumes.

8. Health, Safety & EDI

- Health & Safety compliance remains strong; four RIDDOR incidents reported with no serious injuries.
- EDS22 assessment completed with an overall rating of *Achieving*.

9. Policies Approved

- Organisational Change Policy
 - Domestic Abuse Policy
 - Consultant & SAS Doctors Job Planning Policy
- All approved following full review.

Chair's Assurance Statement

The Committee provides assurance that the Trust is actively managing key workforce and cultural risks. While challenges remain—particularly around sickness, staff experience and workforce constraints—there is clear grip, strong governance, and continued progress across culture, learning and inclusion.

Date and Time of Next meeting.

Thursday 26th March 2026 at 2pm – 4:30pm onsite: Room LT1

**MEETING OF THE FINANCE, TRANSFORMATION AND PERFORMANCE
COMMITTEE**

Minutes of the meeting held on **Monday 23rd February 2026 at 1pm**

Via Teams

Present:	Mr J. Kelly	Non-Executive Director (Chair)	(JK)
	Dame. J. Williams	Non-Executive Director	(JW)
	Mr. M. Jennings	Non-Executive Director	(MJ)
	Mr. N. Askew	Chief Nursing Officer	(NA)
	Mr. A. Bateman	Deputy Chief Executive/ Chief Operating Officer	(AB)
	Mr. J. Grinnell	Chief Executive Officer	(JG)
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 A Prendergast	Associate Director of Strategy and Partnerships	
	Mr I Gilbertson	Deputy Chief Digital and Information Officer	(IG)
	Mrs E. Matthews	Head of Service Development and Development	(EM)
	Ms. N. Palin	Director of Transformation	(NP)
	Ms. E. Saunders	Chief Corporate Affairs Officer	(ES)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Mrs. J Tsao	Executive Assistant (Minutes)	(JT)
Agenda item:			
165	Mrs J Holloran	Deputy Development & Estates Director	(JH)
168	Mr C McNally	Costing Accountant	(CMc)
Apologies:			
	Mrs. R. Lea	Chief Financial Officer	(RL)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Mr A McColl	Deputy Director of Finance	(AMc)
	Mrs. D. Jones	Chief Strategy and Partnerships Officer	(DJ)

25/26/161	Welcome and Apologies The Chair welcomed everyone to the meeting and noted the apologies received.
25/26/162	Minutes of the Last Meeting The minutes of the last meeting held on 21 st January 2026 were approved.
25/26/163	Matter Arising and Action Log FTPC went through the discussed outstanding actions: Pharmacy Outsourcing Two bids are being reviewed before formally starting the tender process.
25/26/164	Declarations of Interest The following declarations were made: <ul style="list-style-type: none"> Non-Executive Director, Mark Jennings, declared that he is the Chief Solutions and Services Officer for Strasys.
25/26/165	Top 5 Risks The committee received an overview of the top 5 risks for the month.

	<p>1. Trust Financial Performance M10 reported £1.2m surplus to date, £0.2m behind plan mainly driven by a slight underperformance in ERF as in prior months. Plans to improve are ongoing.</p> <p>ICB discussions continue in relation to the PFI adjustment. Funding has been confirmed in relation to the Southport inquiry.</p> <p>2. System Financial Performance Five Trust's reported off plan for M10. ICB are working with Trust's to agree if forecast for the remainder of the year will need to change.</p> <p>3. Campus & Capital Programme JH provided the highlights below:</p> <ul style="list-style-type: none"> • NICU build, external work is due to be completed August 2026. • Meetings have been ongoing in relation to CT Scanners. Construction is hoped to start April 2026, with approval awaited. <p>4. Transforming Alder Hey (ways of working, futures, AI & Digital) Update included under Transformation update.</p> <p>5. Operational performance (productivity, access, targets, benchmarking) Updated included under M10 Integrated Performance Report.</p>
<p>25/26/166</p>	<p>M10 Finance Report M10 Divisional position is £0.6m behind plan mainly a combination of ERF and pay pressures coming through. This was offset by bringing forward some revenue to capital that was planned.</p> <p>Discussions are taking place with the charity to see if they are able to support revenue costs in year.</p> <p>A paper was presented to Audit committee on 12th February 2026 outlining any concerns in the end of year audit.</p> <p>The recurrent CIP gap is currently £12m delivered against a £22m recurrent target.</p> <p>Resolved: FTPC noted the M10 Finance report.</p>
<p>25/26/167</p>	<p>M10 Integrated Performance Report Key operational challenges were highlighted, including RTT performance, CAMHS long waits, gastroscopy delays, transcription backlogs, and clinical coding delays.</p> <p>Positive performance was noted in emergency care, surgical activity, theatre utilisation, and reduced cancelled operations.</p> <p>ED target for all Trusts in March 2026 is 78% for patients to have been seen within 4 hours. To support this a bid for primary care consultant covering ED has been submitted and approval is awaited.</p> <p>AB provided an update on Lyrebird that transcripts clinical letters through ambient voice technology. IG said the back log was originally at 8,000 and has now been reduced to around 5,700. A number of sickness leave within the team is due to end.</p>

	<p>A query was raised in relation to back to business as usual referred to in clinical letters. IG advised that the target is to issue letters within seven days after the appointment.</p> <p>The Chair asked for an update on Clinical Coding. IG provided an update noting the remainder of the coding backlog is due to be cleared by April 2026.</p> <p>Resolved: FTPC noted the M10 Integrated Performance Report.</p>
25/26/168	<p>National Cost Collection 2024/25 FTPC received the NCC results, noting that the Trust's index score was 100, in line with the national average and below peer averages. Improvements were attributed largely to data quality corrections.</p> <p>A discussion was held noting data available internally and how this could be used to support divisions more regularly. The Chair requested an update on progress at a future meeting.</p> <p>Action: GW/CMc</p> <p>Resolved: FTPC noted the National Cost Collection 2024/25.</p>
25/26/169	<p>Medium Term Plan AB reported MTP had been submitted. The biggest challenge is likely to be around the reduced level of financial surplus. A further summary will be provided once feedback has been received.</p> <p>Resolved: FTPC noted the submission of the Medium Term Plan.</p>
25/26/170	<p>Digital Futures Strategy IG went through the circulated report highlighting:</p> <ul style="list-style-type: none"> • The launch of new IPC documentation and workflows to improve or mitigate the spread of infection through better documentation and earlier awareness. • Updated EPPF document which will help improve RTT accuracy. • Patient portals progressing well, the first phase of technical delivery is now complete before aiming to launch across CYP in March. • Expedition of Lyrebird to focus on engagement with those remaining users who've not yet transitioned over. • Data warehouse is still on track for summer completion. Both data centre projects are coming on well and hoping to complete in March. • Future initiatives at capital prioritisation group continue. • The wider operational performance across the departments is steady; through some of how we want to work in the future remodelling, it is hoped to improve some of the operational performance with a bigger focus on customer experience for staff and CYP. • An opportunity has become available for us to bid on external funding through the frontline productivity programme, which is a national scheme. • Shortlisted for two awards, HTN and HSJ for Lyrebird and for the Clio implementation in the community. <p>Resolved: FTPC noted good progress against the Digital Futures Strategy.</p>
25/26/171	<p>Transformation update NP provided the above update highlighting:</p>

	<ul style="list-style-type: none"> • Digital strategy and how they improve the experience for staff and outcomes for young people. Digital strategy is the core component of our transformational programme. • Newly inaugurated Transformational Board meeting was held, further detail included in the report as well as the Chair report from that meeting and action plans. I think the committee will be pleased to hear that we will move into one single plan which allows resources to be allocated in a single and unified way, a single scorecard which starts first with the needs of our children, young people and then works back to the financial benefits and the benefits to the broader system. <p>The Chair asked if this would lead to one transformation team now? NP said yes, as part of how we'll work in the future programme.</p> <p>The Chair asked for an update in relation to resources to set up capability. JG noted the active discussions with the commissioners around redeploying some of their Human Resource into this programme. The other angle is that the Beyond Transformation programme was cut quite heavily this year as part of the ICB and cost cutting.</p> <p>The Chair asked if resources was an item at the next Growth and Opportunities Committee taking place this Thursday. MJ said this wasn't on the agenda however private patients and also some of the observations was to be discussed. MJ agreed for further funding be pursued.</p> <p>Resolved: FTPC noted good progress against Transformation Programme.</p>
<p>25/26/172</p>	<p>Liverpool Neonatal Partnership</p> <p>CL highlighted:</p> <ul style="list-style-type: none"> • Successful recruitment the last two months, particularly with surgical clinical lead roles from the paediatric surgery team. • Joint governance arrangements have been approved now by Trust Board at Liverpool University Hospitals Group and Alder Hey • The full leadership team had a site visit in January where actually it was great to see a lot of the progress, conversations on the day were around patient flow and actions that were taken away to feed into the simulation work. • To note, the interim payments have been agreed with commissioners in terms of the year end forecast, liaising continues around the value and the finalisation of that. • Additional scrutiny has been received in terms of bill delays and the impact that has in terms of recruitment plans. • Further conversations with commissioners around the future of critical care bed numbers across both sites, particularly wider than the NICU to also include PICU etc, currently ongoing. • In terms of a couple of other financing equipment highlights to note, significant progress has been made in terms of ordering critical equipment, orders have now been placed for some of the key monitoring kit. • The outcome on two bids are still awaited from the national capital scheme around maternity and neonatal funding. • Bids across both sites have also been completed for some of the high cost equipment that's still outstanding on that cost pressure list for the new NICU. Hopefully confirmation will be received at the end of February. • Agreement has been received to transfer kit from the women's aligned to

	<p>their cot closures, the full list to be signed off between the two sites.</p> <ul style="list-style-type: none"> • business critical equipment to order remains a high risk. • There is also a significant storage risk that's now been logged on in phase, particularly around receipt of new incubators as there are no further storage options across Alder Hey. That is something EBME have now put on the risk register and is being reviewed, there is potentially some unused critical care space and options around the equipment library. <p>Resolved: FTPC noted good progress against Liverpool Neonatal Partnership.</p>
25/26/173	<p>Board Assurance Framework ES highlighted:</p> <ul style="list-style-type: none"> • In relation to Campus, risk is to be updated, in particular Friends of Springfield Park. • Strategy delivery and how we work in the future project to the delivery of Vision 20-30. <p>JH said the team are working through the risks to also incorporate water safety.</p> <p>Resolved: FTPC received and noted risks within the BAF.</p>
25/26/174	<p>PFI Contract update/NICU JH went through the contractual report noting:</p> <ul style="list-style-type: none"> • Main reference is around the meeting held on 9th of February, with the Department of Health, Project Co and funders to assess ongoing issues with the defects and also with NICU. • In terms of Neonatal, Mighty are due to respond with the electrical solution and also project help and payment T&Cs. • Senior executives to support significant issues that we've got technically <p>AB provided an update from the above meeting noting funders attended and it was likely NICU would be delayed. Main areas covered included; the NICU being completed and addressing the defects. It is helpful to have the support of the Department of Health with us on that and supporting our approach. A further meeting was due to take place on Wednesday. FTPC would receive an update at the next meeting.</p> <p>Resolved: FTPC received and noted the PFI position.</p>
25/26/175	<p>Corporate Division Quarterly Update M10 Corporate reported a forecast overspend, driven primarily by energy, water, legal fees, and estates-related costs. CIP delivery was reported as over-achieved on a non-recurrent basis.</p> <p>FTPC requested a deep dive into corporate non-pay budgets, including defect-related cost drivers. Action: ES/Cristina Puccini</p> <p>Resolved: FTPC received and noted the Corporate Divisional quarterly update</p>
25/26/176	<p>Treasury Management Policy Resolved: An updated Treasury Management (Cash) Policy was presented and approved. The minimum cash balance was set at ten days or payroll plus unitary charge.</p>

25/26/177	Any Other Business No further business was discussed.
25/26/178	Review of the Meeting The Chair noted the meeting had overrun with good discussions on year-end risks, recurrency and coding.
	Date and Time of Next Meeting: Wednesday 25th March at 1:30 via Teams

25/26 Key Risks – Month 11 Position

M11 top 5 risks	Initial Risk	Initial RAG	Latest Position	RAG M11
Trust Financial performance	<p>Challenging 25/26 plan for AH with additional stretch included, Risk increased costs and inability to deliver activity plan. System plan is deficit and risk of further restrictions and controls that will retract resources/time.</p> <p>Plan assumes delivery of £22.7m recurrent savings. Highest level set in any one year. Delivery contingent on both BAU and transformation savings</p>	<p>High</p>	<p>Month 11 position reported £0.9m surplus in month and £2.1m surplus YTD which is in line with plan (£0.2m). ICB forecast (SW) at M11 reported likely forecast of £6m surplus position (£1m improvement from M10) for the year and a best-case forecast of £7.2m surplus. Following resolution with ICB on outstanding income issues the most likely forecast is now at the plan of £7.2m.</p> <p>PBR/ERF in month performance is estimated ahead of plan by £0.4m in-month. YTD PBR overperformance is £1m within divisional positions.</p> <p>CIP is on plan in M11 (£2m) and on plan YTD largely due to non recurrent savings identified in M11. Total savings of £22.3m have been transacted (green) , forecasting to deliver the full £22.7m target in year. There is a £9.6m gap (fully developed/amber/red/black) on recurrent plan as at M11. Work is ongoing through FIP to support the development of further schemes to ensure that full target is delivered in 26/27 (including 25/26 non recurrent).</p>	<p>Moderate</p>
System financial performance	<p>Challenging 25/26 plan for C&M System plan is deficit and risk of further restrictions and controls that will retract resources/time.</p>	<p>High</p>	<p>Key data shared on M11 indicates that C&M are adverse to plan ytd (after excluding DSF), and are forecast to remain off plan by year end. Resulting in DSF continuing to be withheld.</p>	<p>High</p>
Campus and Capital Programme	<p>Limited CDEL allocation in 25/26 Complex campus programme across multi sites, with several key buildings opening in year (Neo/Alderpark).</p>	<p>High</p>	<p>Capital – Following conclusion of funding discussions with ICB, the funding available for CDEL for the year is now confirmed at £19.4m . Initial CDEL forecast indicated a £0.5m underspend against this envelope. With this in mind circa £1m of 26/27 prioritised spend has been given approval by executive to accelerate purchases.</p> <p>Capital prioritisation output has been updated to reflect latest phasing of nicu forecast, strategic funding which we have been shortlisted for (subject to business case), and pull forward of 26/27 spend into 25/26 as above. Based on this of the £16.3m CDEL available, £4.6m has been approved, and a further £12m is subject to further discussion. A high level estimate of total requirement once discussions conclude is £14.9m - suggesting that as long as strategic capital approved, the capital position should be manageable in 26/27. Prioritisation process will continue at national funding process concludes, with a paper to be brought back to Executive/FTPC to confirm funding in Q1. . Awaiting outcome of other national capital bids.</p> <p>Campus – Ongoing review of delayed schemes: NICU, Elective Surgical Hub and CT Scanners. Equipment procurement to commence for long lead items, and where suppliers can store at nil cost. Opportunities for beneficial access (NICU) to be progressed with contractor. Cost pressures highlighted on 4-year plan as priority for '26/'27 including further Estates Safety Fund bidding. Demolition, infrastructure, car park and site completion works currently being managed within approved budgets.</p>	<p>High</p>
Transforming Alder Hey	<p>Transforming Alder Hey (ways of working, futures, AI & Digital)</p>	<p>High</p>	<p>Transformational work continues in line with the now-approved 2026/27 Transformation Plan, alongside the ongoing development of a new operating model that will define the future shape of Alder Hey.</p> <p>The emerging scope of the programmes for next year, includes a mixture of legacy programmes that were always multi-year; alongside the How we will work in the Future (Operating Model) - which is profiled across the 25/26- and early quarters of 26/27. In the short term there is a resource gap in Transformation driven by MARS / Maternity. Short term reallocation of current staff roles are managing the risk in the short term.</p>	<p>High</p>
Operational performance	<p>National focus on productivity and benchmarking to drive down costs. Efficiency programme contingent on driving up productivity in order to reduce costs.</p>	<p>Medium</p>	<p>The trust's performance regarding patients waiting over 52 weeks continues to be a challenge. A proposal has been submitted and approved that includes strategies for increasing productivity and determining an optimal level of substantive recruitment to meet the standard and achieve CIP.</p>	<p>Medium</p>

BOARD OF DIRECTORS

Thursday, 2nd April 2026

Paper Title:	Board Assurance Framework Report (February 2026)
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision <input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Information <input type="checkbox"/> Regulation <input type="checkbox"/>
Action/Decision Required:	To note <input checked="" type="checkbox"/> To approve <input type="checkbox"/>
Summary / supporting information	Monthly BAF Reports
Strategic Context	
This paper links to the following:	Outstanding care and experience <input checked="" type="checkbox"/> Collaborate for children & young people <input checked="" type="checkbox"/> Revolutionise care <input checked="" type="checkbox"/> Support our people <input checked="" type="checkbox"/> Pioneering breakthroughs <input checked="" type="checkbox"/>
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
If "No", is a new risk required? Yes No

Risk number	Risk description	Score
As detailed in the report	This report provides an update against all Board Assurance Framework Risks for the month of February 2026	As detailed in the report

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



Board Assurance Framework 2025/26

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 13 principal risks aligned to the Trust's strategic objectives and delivery of Vision 2030.

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

The Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

BAF Risk		Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people not having timely and safe access to elective, urgent and follow up care.	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Finance, Transformation and Performance Committee
1.4	Increased waiting times for Specialist Mental Health community services.	Finance, Transformation and Performance Committee
		Safety & Quality Assurance Committee
2.1	Failure to maintain a sustainable workforce which impacts on the trust's ability to deliver high quality care for children and young people	People Committee
2.2	Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families	People Committee
2.3	Failure to successfully embed workforce equality, diversity and inclusion across the organisation	People Committee
3.1	Failure to fully realise the Trust's Vision for the Alder Hey Campus	Finance, Transformation and Performance Committee
3.2	Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment	Finance, Transformation and Performance Committee
3.4	Failure to meet financial targets, changing NHS regime and inability to meet the Trust's ongoing capital commitments.	Finance, Transformation and Performance Committee
3.5	System Working to deliver 2030 Strategy	Trust Strategy Board
4.1	Failure to deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People	Growth and Opportunities Committee
4.2	Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families	Finance, Transformation and Performance Committee

3. Summary of the BAF at 10th March 2026

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Outstanding care and experience				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x1
1.2 AB	Children and young people not having have timely and safe access to elective, urgent and follow up care	FTPC / SQAC	5x3	3x3
1.3 RL	Building and infrastructure defects that could affect quality and provision of services	FTPC	4x4	2x3
1.4 LC	Increased waiting times for Specialist Mental Health community services.	FTPC / SQAC	3x5	3x3
STRATEGIC 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	FTPC	3x2	2x2
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.	Growth and Opportunities	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 updates to end of February 2026:

- ***Inability to deliver safe and high-quality services (NA).***

This risk has been reviewed and assurance measures are monitored through SQAC, including any gaps in assurance. The risk is currently under review in light of the external operating environment and the financial challenges. The risk will be updated accordingly following this review in time for the new financial year and will be discussed at SQAC.

- ***Children and young people not having timely and safe access to elective, urgent and follow up care (AB).***

February performance against 2025/26 targets

- Acute (78%) - ED performance remained above target at 80%

- RTT (63% by March 2026) - 63.5% in month

- Pts >52 weeks (1% by March 2026) - Currently 1.5% with the majority under dentistry

- DMO1 (95%) - Performance dropped from compliant to 93%. This is primarily due to reduced capacity in Gastro.

- ***Building and infrastructure defects that could affect quality and provision of services (RL).***

Water Safety

Water Safety Group meetings continue alongside operational forums to monitor and manage out-of-range water temperatures. A further report from the SPV Board has been received and is currently under review. Further action relating to the dosing system is being pursued and, if unresolved, Trust step-in may be required.

Tap Filters

It has been agreed that Project Co will fund the installation and replacement of tap filters as a mitigation measure, with filters to be changed on a 30-day cycle. Discussions with legal advisers are ongoing regarding the contractual position in relation to defects. The Trust is also awaiting the updated defects tracker from Project Co.

Chillers

Ongoing performance issues with the chillers remain unresolved. A project plan outlining the proposed approach to full reinstatement has been received; however, confirmed timelines have not yet been provided.

Combined Heat and Power (CHP)

The CHP unit has been out of operation for almost 18 months. The Trust continues to await confirmation from Project Co regarding the status of the unit and the proposed plan for reinstatement.

Summary

A formal notification covering the above matters has been issued to Project Co. Responses remain outstanding at the time of this update.

- ***Increased waiting times for Specialist Mental Health community services. (LC).***

BAF risk reviewed. Risks remain the same and controls in place.

- Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people (MS).***

The risk score remains unchanged. The WTE continues to be closely monitored and reported to both FTP Committee and People Committee. Target Operating Model, will also address the Trust workforce plan and consultation on wave one is close to completion. Impact and plans to mitigate associated risk are reviewed regularly and have been raised in a recent extraordinary Risk management meeting and an extraordinary People Committee. Trust Voluntary Redundancy Scheme has just been launched and will close April 2026.
- 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. New control added relating to organisational restructure with gaps identified in real-time culture monitoring data and cultural integration plan. Two new actions added to address gaps. All other actions reviewed. No current change to risk rating with full review of risk and consideration of risk rating planned.
- Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation (MS).***

All actions reviewed and remain on track.
- Failure to fully realise the Trust's Vision for the Alder Hey Campus (RL).***

Risk reviewed, score remains. A preferred contractor has been identified through the appropriate tender process to construct the new ED car par. this with the final works in this area will complete the 9.4 hectares of the park. hand back to LCC Summer 2026.
- Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment (KW).***

The How We Will Work in the Future (HWWWITF) programme has now entered its implementation phase. The programme is delivering the Trust's new operating model in support of Vision 2030, with the expectation that it will generate significant organisational efficiencies and financial savings. There is a risk that the programme is unable to deliver the full level of savings required within the planned timeframe, which could result in a financial gap against the Trust's Cost Improvement Programme (CIP) targets. This risk arises in part because implementation is occurring alongside ongoing operational pressures and organisational capacity constraints.

The Trust Board has approved the Medium-Term Plan, which aligns strategic, operational, workforce and financial priorities into a single three-year programme and provides clarity on sequencing and affordability. The Transformation Board, chaired by the Chief Executive, met for the first time in March and provides strengthened oversight of the transformation portfolio.

New programmes within the transformation portfolio are currently being mobilised, with Programme Initiation Documents (PIDs) in development for initial approval through the FIP prior to full mobilisation.

Mitigations include strengthened governance through the Transformation Board, prioritisation of programmes with the greatest in-year and recurrent financial benefit, clear benefit tracking, and active programme oversight to enable reprioritisation where delivery risks emerge.
- Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments (RL).***

No change to risk score of 20.

The year end forecast submitted to NHSE last month remains with weekly monitoring in place to ensure grip and control continues with a focus

on activity delivery to meet Q4 stretch targets.

The medium term plan was submitted in February and awaiting feedback. Development of the CIP plans is underway with a plan to ensure all PIDs are completed and approved by end of March.

- **System working to deliver 2030 Strategy (DJ).**
Risk, control and actions reviewed and updated. 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 whilst final actions for comms and capacity building are completed. Finance back on track to break even (forecast £49k surplus) and Futures Management Board action is complete.
- **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 but has hit some small delays and is now expected to be completed in April. Key items supported at Capital Prioritisation Group. Good progress being made via Digital, Data and AI Collab with Patient Portal due to go live in March. HWWWITF work in progress and consultation due to be launched in March with expected completion date of April.

5. Corporate risks (15+) linked to BAF Risks (as at 5th March 2026)

There are currently 31 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)	5x4	Medicine	2.1	Jul 2021	Mar 2024
529	Named Doctor for Safeguarding Children (NEW)	4x5	Community		Feb 26	Feb 26
027	Fragility of Inherited Metabolic Disease Service (IMD)	5x4	Medicine	1.2	Jun 2023	Dec 2024
038	No neurophysiology consultant in post	5x4	Medicine	2.1	Jul 2023	Oct 2025
455	Breaching waiting time standards in the Eating Disorder Service (EDYS) service	3x5	Community	1.2	Oct 2025	Jan 2026

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
513	Insufficient Capital funding	4x4	Surgery	3.4	Aug 2022	Feb 2024
355	Lack of Nursing staff within the Gastroenterology service (NEW)	3x5	Medicine	2.1	Apr 2025	Feb 2026
510	Inability to provide a safe and effective service - Medical Engineering & Equipment Library	4x4	Surgery	2.1	Dec 2025	Jan 2026
199	Insufficient funding to provide a 52-week radiology service to report images with current imaging demand	4x4	Medicine	3.4	May 2025	Jul 2025
238	Clinical Coding	4x4	Corporate Services	3.4	May 2025	Nov 2025
491	Risk Stratification Process for whole of Neurodevelopmental service caseload (NEW)	5x3	Community	2.1	Feb 2026	Feb 2026
522	Gi Physiology Service Unavailability and Fragility (NEW)	3x5	Medicine	2.1	Jan 2026	Feb 2026
287	Radiology consultant on-call is at risk of failure	4x4	Medicine	2.1	May 2025	Sept 2025
534	Risk of transmission of waterborne pathogens in the healthcare environment (NEW)	4x4	Corporate Services		Feb 2026	Feb 2026
293	Staffing in Biochemistry	4x4	Medicine	2.1	Dec 2024	May 2025
297	Transcription delay and increase of turnaround times	4x4	Corporate Services	2.1	Dec 2024	Apr 2025
341	Named Doctor for Children in Care	4x4	Community		Apr 2025	Apr 2025
399	Three Anti Barricade doors not opening outwards on patient bedrooms and faulty swipe entry on patients bedrooms	4x4	Community		Jun 2025	Aug 2025
409	Inability to provide safe staffing levels	4x4	Corporate Services	2.1	Jan 2020	*Apr 2023
444	Then there is a risk the organisation will be unable to provide an effective and timely service for tertiary Neurology patients	4x4	Medicine	2.1	Apr 2023	June 2024
458	Disruption in patient's supply of medication and / or treatment	4x4	Community	2.1	Oct 2025	Oct 2025
464	Reduced Haematology consultant workforce	4x4	Medicine	2.1 & 2.2	Aug 2022	Jan 2024
492	NICU go live delay	4x4	Corporate Services	3.1	Nov 2025	Nov 2025
288	CAMHS Planned Safeguarding Supervision	3x5	Community	2.1	Nov 2024	Nov 2024
318	Failure to deliver the Appropriate Places of Care programme	5x3	C&M CYP Programme		Feb 2025	Sept 2025

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
520	Pharmacy Capacity	4x4	Medicine	2.1	Dec 2025	Dec 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	4x4	Community	1.4	Jul 2021	*Apr 2023
455	Breaching waiting time standards in the Eating Disorder Service (EDYS) service	3x5	Community	1.1	Oct 2025	Jan 2026
1.3 Building and infrastructure defects that could affect quality and provision of services (4x4=16)						
1.4 Increased waiting times for Specialist Mental Health community services. (3x5=15)						
462	Children and young people will not receive their ASD assessment within the agreed timescale	4x4	Community	1.2	Jul 2021	*Apr 2023
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)						
485	Potential for no laboratory haematology/transfusion service due to Increased workload pressures, inadequate staffing levels (training/sickness/vacancies)	5x4	Medicine	1.1	Jul 2021	Mar 2024
038	No neurophysiology consultant in post	5x4	Medicine	1.2	Jul 2023	Oct 2025
522	Gi Physiology Service Unavailability and Fragility (NEW)	3x5	Medicine	1.1	Jan 2026	Feb 2026
355	Lack of Nursing staff within the Gastroenterology service (NEW)	3x5	Medicine	1.1	Apr 2025	Feb 2026
510	Inability to provide a safe and effective service - Medical Engineering & Equipment Library	4x4	Surgery	1.1	Dec 2025	Jan 2026
491	Risk Stratification Process for whole of Neurodevelopmental service caseload (NEW)	5x3	Community	1.1	Feb 2026	Feb 2026
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	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	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	4x4	Corporate Services	1.1	Jan 2020	*Apr 2023
288	CAMHS Planned Safeguarding Supervision	3x5	Community	1.1	Nov 2024	Nov 2024

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
027	Fragility of Inherited Metabolic Disease Service (IMD)	5x4	Medicine	1.2	Jun 2023	Dec 2024
293	Staffing in Biochemistry	4x4	Medicine	1.2	Dec 2024	May 2025
520	Pharmacy Capacity	4x4	Medicine	1.2	Dec 2025	Dec 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	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)						
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)						
513	Insufficient Capital funding	4x4	Surgery		Aug 2022	Feb 2024
199	Insufficient funding to provide a 52-week radiology service to report images with current imaging demand	4x4	Medicine	1.2	May 2025	Jul 2025
238	Clinical Coding	4x4	Corporate Services	1.1	May 2025	Nov 2025
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)						
STRATEGIC OBJECTIVE: Revolutionise Care						

Risk	Risk Title	Score (CxL)	Division	Linked	Date opened	Increased to Corporate
4.2 Failure to deliver a digital and data strategy to place Alder Hey at the forefront on paediatric healthcare and provide high quality resilient IT services to staff, children, young people and their families (4x4=16)						
229	P-MIP end-of-life server which is no longer supported by the supplier	4x4	Corporate Services		Jul 2024	Sep 2024
292	Inappropriate sharing of demographics	5x3	Corporate Services		Dec 2024	Dec 2024
368	Digital infrastructure capacity and age	4x4	Corporate Services		May 2025	May 2025
501	Home Reporting Hardware (Radiology)	3x5	Medicine		Dec 2025	Dec 2025

* risk movement data not available pre-move to InPhase

6. Recommendation

The Board/Committee is asked to note the updated position with regards to management of the BAF risks.

Erica Saunders
Chief Corporate Affairs Officer

Inability to deliver safe and high quality services.				
Risk Number			Strategic Objectives	
1.1			Outstanding care and experience	
CQC Domains	Linked Risks	Owner	Risk Rating	
Safe		Nathan Askew	Actual	Target
			9	4
Assurance Committee				
Safety and Quality Assurance Committee				

Description
Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards in the current challenging financial environment.

Control description	Control assurance (How is this control monitored?)
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
Administration of IV antibiotics within 1hr for CYP with suspected sepsis	Monitored monthly through SQAC
Brilliant Basics	Formal and informal training and coaching available to support departments to make positive changes. Reported to board bi-annually including update against NHS Impact Self-Assessment.
Clinical Effectiveness and Outcomes Group in place to monitor improvement and assurance across a range of workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Internal: Patient safety meeting actions monitored through SQAC External: Care Quality Commission (CQC), MIAA
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC
Proactive programme of work in place to reduce medication errors	Monitored via Patient Safety Board
Programme of quality assurance rounds, ward and departmental accreditation is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC. Triangulation of data through Aggregated Analysis Reports to SQAC.
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I)	Annual QIA assurance report and reporting into SQAC as directed by the Chair. Clinical Cabinet in place to review all EQIAS

Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Internal: Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed via Audit & Risk Committee minutes. 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	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> 1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis	1. Continue to monitor KPI's at SQAC and within divisional governance structures (no further controls required, monitoring controls are in place)	31/03/2026	(no further controls required, monitoring controls are in place)
<input checked="" type="checkbox"/> 2. Medication Errors and Near Misses	2. Proactive programme of work in place to reduce medication errors (no further controls required, monitoring controls are in place)	31/03/2026	(no further controls required, monitoring controls are in place)
<input checked="" type="checkbox"/> 3. New CQC Assessment Framework	3. The Trust will need to engage in the new assessment process and work collaboratively through engagement meetings during this change.	31/03/2026	Trust continues to engage with CQC through regular engagement meetings
<input checked="" type="checkbox"/> 4. Patient Experience	4. Experience Strategy Group established to evaluate resource required. SQAC will have oversight of ambition and achievements of the Group	31/03/2026	PEG continues to report into SQAC

Children and young people not having timely and safe access to elective, urgent and follow up care.				
Risk Number			Strategic Objectives	
1.2			Outstanding care and experience	
CQC Domains	Linked Risks	Owner	Risk Rating	
Effective		Adam Bateman	Actual	Target
			15	4
Assurance Committee				
<ul style="list-style-type: none"> Finance Transformation & Performance Committee Safety and Quality Assurance Committee 				
Description				
<p>With a growth in demand for elective, urgent and follow-up care maintaining timely access to high quality care and meeting national access standards is challenging. This is compounded by a tight financial environment and our NHS contract has limited scope for growth in income to fund additional capacity; productivity improvements are insufficient to meet demand and lower waiting times. Our approach is centred on providing enhanced support to departments with significant demand or service issues, helping them to create centre of excellence; innovating; seizing productivity opportunities; and collaborating with providers and system partners to modernise and optimise our patient pathways and service models.</p>				

Control description	Control assurance (How is this control monitored?)
<p>Controls for improving access to follow-up care: - Real time report on the follow-up waiting list, waiting times and risk categories - Patient Initiated Follow Up (PIFU) pathway and system initiated - Patient portal for ISLA Care supports waiting list validation and PIFU</p>	<p>Weekly Executive Summary</p> <ul style="list-style-type: none"> - 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
<p>Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Monthly access to care with General Managers from the divisions - Activity plans for 25/26 adjusted to achieve national access targets - Real time reporting of RTT waiting list and tracking tool which highlights patients that could breach monthly / quarterly targets - Transformation programme to re-imagine elective care services to create centres of excellence</p>	<ul style="list-style-type: none"> - 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
<p>Our controls for delivering timely care in the Emergency Department (ED) includes: - Acute response Team and Patient Flow - Emergency Department staffing rotas, establishment and skill mix reviews support staffing levels to meet minimum safe standards and align to demand - Safety huddles and patient handover huddles - A new Paediatric Assessment Unit and Urgent Care Centre - Winter Plan with flow and escalation procedures - Two transformation collaboratives driving service improvement: i) Neighbourhood Care supporting prevention and more care in the community - ii) Acute, Diagnostics and Urgent Care</p>	<p>Daily reports to NHS England</p> <ul style="list-style-type: none"> -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
<ol style="list-style-type: none"> 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	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> Recruit a Locum Consultant in ENT	The executive board have approved a paper which allows the department to recruit a Locum Consultant	31/10/2025	The department have a locum consultant post advertised and at least one interested candidate. However one of the locum consultants who is currently working for the department has resigned therefore the department may recruit however it may not lead to an increase in capacity
<input checked="" type="checkbox"/> Restart weekend theatres in ENT	Weekend operating ceased when the AHP local pay rate was reduced from 1st July. The division have been working to reinstate weekend operating as it will increase capacity in ENT.	31/10/2025	The first weekend operating list since June is scheduled for 18th October.
<input checked="" type="checkbox"/> 2. Open Same Day Emergency Care Centre	Expanded Paediatric Assessment Unit	30/03/2026	Delays related to building and estate works for ground floor expansion. Current anticipated opening of SDEC August 2026.
<input checked="" type="checkbox"/> 3. Deploy Ambient Artificial Intelligence to improve productivity	Deploy Ambient Artificial Intelligence to improve productivity	30/03/2026	Building delayed. Identifying pathways to test before building open however will not be until Spring/summer due to required to ave low bed occupancy
<input checked="" type="checkbox"/> 4. Move to a self-check in model for some patients, using a digital solution	Move to a self-check in model for some patients, using a digital solution	30/03/2026	Draft paper in progress currently meeting with suppliers to identify most suitable opportunity.
<input checked="" type="checkbox"/> 5. Establish performance reports on the number of patients seen per clinician	Establish performance reports on the number of patients seen per clinician	30/03/2026	
<input checked="" type="checkbox"/> 1. Improve timeliness of care and experience through a same day emergency care centre	Expanded Paediatric Assessment Unit	31/03/2026	The Medical and ACP model is now in place as of Jan 26 and provides 7 day cover including bank holidays. Not currently in expended dedicated bed space due to delayed building update on build expected spring 2026.
<input checked="" type="checkbox"/> Overbook outpatient clinic with new patients	Roll out overbooking to clinicians whose clinic utilisation consitute it requires an additional patient booked to increase actual clinic utilisation to as close to 100% as possible.	31/03/2026	<p>The following services are now live with overbooking</p> <ul style="list-style-type: none"> - Dentistry - Plastic Surgery - Community Ophthalmology and Ophthalmology <p>The following services go live from 13th October</p> <ul style="list-style-type: none"> - Urology - Paediatric Surgery - Gynaecology
<input checked="" type="checkbox"/> Request mutual aid for dentistry patients	Mutual aid request submitted which asks for 35 patients to be transferred to the community dentists. The trust is also exploring whether MFT can accept 25 patients. This option was explored but no patients were transferred. C&M regional colleagues have now asked if there is a new cohort of patients which could be transferred. Divisional team reviewing	31/03/2026	

Building and Infrastructure defects that could affect the quality and provision of services				
Risk Number			Strategic Objectives	
1.3			Outstanding care and experience	
CQC Domains	Linked Risks	Owner	Risk Rating	
Safe		Rachel Lea	Actual	Target
			16	4
Assurance Committee				
<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> - 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.	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - 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)	<ul style="list-style-type: none"> - 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
<ul style="list-style-type: none"> - 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	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> Appropriate Legal Advice	Continue to seek appropriate legal, commercial and technical advice	31/03/2026	Legal advice remains ongoing with Bevan Brittan.
<input checked="" type="checkbox"/> Corroded pipework report	Report from Project Co on corroded pipe work and plans to resolve.	31/03/2026	still awaiting detailed plans from Project Co. Discussions are ongoing, although progress continues to be challenging due to difficulties engaging with the SPV.
<input checked="" type="checkbox"/> Defect Survey	Output from defect survey	31/03/2026	The defect survey now 31 March 2026 to allow for SPV coordination

Increased waiting times for Specialist Mental Health community services.									
Risk Number		Strategic Objectives							
1.4		Outstanding care and experience							
CQC Domains	Linked Risks	Owner	Risk Rating						
<ul style="list-style-type: none"> Caring Effective Responsive Safe Well-Led 		Lisa Cooper	<table border="1"> <thead> <tr> <th>Actual</th> <th>Target</th> <th>Assurance Committee</th> </tr> </thead> <tbody> <tr> <td>15</td> <td>4</td> <td>Finance Transformation & Performance Committee</td> </tr> </tbody> </table>	Actual	Target	Assurance Committee	15	4	Finance Transformation & Performance Committee
Actual	Target	Assurance Committee							
15	4	Finance Transformation & Performance Committee							
Description									
<p>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.</p>									

Control description	Control assurance (How is this control monitored?)
Business case for investment submitted to Liverpool and Sefton Place and approved. This is now being fully implemented.	Business case (attached)
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software
Existing BI Dashboard developed to support management of open caseload	Open caseload dashboard routinely reviewed by clinical leads and assistant clinical leads with practitioners
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required. Meetings and regular meeting with commissioners to update on service delivery and any challenges.	<p>Monthly assurance processes include:</p> <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<p>Monitored through</p> <ul style="list-style-type: none"> 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.	Weekly allocation meetings
Weekly performance monitoring in place for operational teams which includes: Weekly Tuesday/Wednesday meeting with PCOs Divisional Waiting Times Meeting each Thursday Trust Access to Care Delivery Group fortnightly This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)

Gaps in Controls / Assurance

1) Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to reduction in capacity. This is due to difficulties recruiting as a result of national workforce shortages; increased sickness, and delays with recruitment processes due to vacancy control. There is also an increase in maternity leave, with backfill being fixed term and less hours than substantive post which can be difficult to fill.

Action	Description	March 2026	
		Due Date-	Action Update
<input checked="" type="checkbox"/> Aligning processes across locality CAMHS Services	To align all processes across Liverpool and Sefton with the aim of seamlessly working as one service working across two localities including psychiatry to provide assurance from a governance perspective.	31/03/2026	work ongoing to streamline services, introduction of risk and triage calls to Liverpool CAMHS in Aug 2025 regular meetings to be scheduled with clinical leads to progress
<input checked="" type="checkbox"/> MHSDS data reporting	lack of / incomplete data for mental health services flowing to MHSDS - work on going Please see risk 214	31/03/2026	work ongoing, crisis document development meeting now prioritised for Sept 2025 (delayed from July 2025) - meeting scheduled with developers for w/c 6.10.2025

31/03/2026

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 within 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

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

ROMS collection and reporting

improve recording and reporting of routine outcome measures

31/03/2026

work ongoing -meeting scheduled with ROMS lead, CXIO, GM and Director for Oct 2025

78+ week waits

To review CYP reported as 78+ weeks without a ROM - to ensure all CYP have ROM attached

30/04/2026

Failure to maintain a sustainable workforce which impacts on the Trust's ability to deliver high quality care for children and young people.

Risk Number		Strategic Objectives		
2.1		Support our People		
CQC Domains	Linked Risks	Owner	Risk Rating	
<ul style="list-style-type: none"> Safe Well-Led 		Melissa Swindell	Actual	Target
			16	4
				Assurance Committee
				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	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 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 portal 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	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> 2. Sickness absence levels higher than Trust Target	A detailed review of sickness absence has been undertaken and presented to people committee and Executives, and the next action is to implement a 90-day attendance Improvement Programme, based on the principles of the improvement project undertaken at East Cheshire NHS Trust, through appreciative inquiry. In addition 3 members of the HR team have been repurposed solely to support the management of sickness absence.	31/03/2026	The 90-day improvement programme has concluded. The outputs of appreciative inquiry through the programme have provided the sickness team with enhanced feedback, thus ensuring that the targeted interventions remain appropriate.
<input checked="" type="checkbox"/> 4. Lack of Robust talent and succession planning	The Professional Development hub to establish a comprehensive talent and succession management programme, aligned to vision 2030. Identifying both talent and skills gaps and addressing priority organisational need over the next 12 months, as well as establishing longer term plans, that will complement the 3-year workforce plan	31/03/2026	Established
<input checked="" type="checkbox"/> 6. Lack of inclusive practises to increase diversity across the organisation	A comprehensive EDI plan is in place, which is aligned to the NHS England high impact changes.	31/03/2026	EDI Plan is monitored at both People Committee and EDI Steering group and is progressing against plan.
<input checked="" type="checkbox"/> 5. Lack of a robust Trust wide Recruitment Strategy	The next stage of the people Plan 24/25 there is a key work stream related to the Future Workforce, which addresses accessible and diversified recruitment and the Trust recruitment strategy. This action is addressed through the 24/25 People Plan.	03/03/2027	Recruitment plans are aligned to the new target operating model.

Failure to develop and sustain an organisational culture that enables staff and teams to thrive and deliver outstanding care to children and families				
Risk Number			Strategic Objectives	
2.2			Support our People	
CQC Domains	Linked Risks	Owner	Risk Rating	
<ul style="list-style-type: none"> ▪ Caring ▪ Safe ▪ Well-Led 		Melissa Swindell	Actual	Target
			12	4
			People Committee	

Description
<ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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
Executive-led organisational change programme governance	
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 Connected Leadership managers and leaders briefings and all staff Connecting Alder Hey 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	2025 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 Director of Culture & OD and enables shared thinking about teams in need of support and joint working where indicated.	Newly revised People Paper to include data relating to fragile teams
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered

Gaps in Controls / Assurance
<ul style="list-style-type: none"> - lack of embedded safety culture across the organisation - lack of understanding about a just and restorative culture approach <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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 - potential for cultural deterioration during organisational restructuring

Action	Description	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> Cultural change and integration plan	Cultural integration plan to be developed to support and enable effective merging of services and teams and support transition to new empowered clinical leadership model for the organisation.	06/03/2026	
<input checked="" type="checkbox"/> Real-time cultural monitoring during transition	Regular qualitative and quantitative data relating to organisational culture to be collated and analysed to enable real-time monitoring of culture impact during organisational restructure. Data source to include: staff engagement scores, safety culture metrics, sickness absence and retention, FTSU data, SALS data, and feedback gathered through formal consultation events during restructure.	06/03/2026	
<input checked="" type="checkbox"/> Safety culture programme	Safety culture programme of work to be agreed and developed with the Patient Safety leads and Chief People Officer to reflect need for an integrated safety culture including both patient safety as staff safety as key to an adaptive safety culture. Safety culture training to be developed and implemented with teams as part of this wider programme to include training on: Psychological safety, teamwork, civility, inclusivity, leadership and restorative just & learning culture plus human factors.	30/03/2026	Draft training programme outline agreed with content now in development for safety culture training. Programme to be ready for piloting at end of March this year.
<input checked="" type="checkbox"/> 2. Financial environment and culture	Attend Financial Improvement Programme tactical command meetings to reflect evolving understanding of the impact of financial controls on staff and work with the group to try and address these impacts. Ensure executive team are well briefed as to intelligence gathered from staff via listening routes such as SALS that pertain to the financial environment to help to shape communications and relevant interventions	31/03/2026	
<input checked="" type="checkbox"/> Identifying, understanding, and supporting "fragile" teams	Ensure mechanisms are in place to identify "fragile" teams, i.e. teams with adverse culture, provide effective interventions and provide robust assurance regarding impacts, actions and outcomes. Agree reporting mechanism and process where there are issues of concern. Develop effective tools to empower leaders to assess and understand their team culture and source appropriate support where needed.	31/03/2026	Staff survey team level data analysed by Thriving category and being used to target interventions in challenges areas following discussions in Thriving Teams MDT. Data has also been shared with execs and divisional leads and will be used to target team and leader support during organisational restructure
<input checked="" type="checkbox"/> OD capacity and capability review	Review of OD resource in OD team and other functions to establish full capacity to address demand for culture work across organisation	31/03/2026	
<input checked="" type="checkbox"/> Responsive communications	Links to be strengthened with communications team to ensure that communications are responsive to organisational need, values based and aligned to the culture. To be achieved via attendance at newly developed Communications Board and via closer links with comms team in values working group and other relevant fora	31/03/2026	Team connect aspect of Connected Leadership approach now operational. To be reviewed as part of PDSA approach when impact and outcome data available. Approach being monitored by monthly group comprising director of culture, SALS rep, OD rep and internal communications team
<input checked="" type="checkbox"/> 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	Staff survey team level data analysed according to Thriving categories and shared with execs and divisional leads. Data being used to scope interventions in challenges areas in discussion with wider Thriving Teams MDT. Data will also be used to inform targeted support plan for teams and leaders during the organisational restructure.
<input checked="" type="checkbox"/> Values and behavioural framework review, update and implementation	New values and behavioural framework to be developed and embedded across the organisation.	31/07/2026	Implementation plan agreed via Values Working Group in January 2026. First action is to develop a new values in action framework. Group met to develop draft framework on 5th February. Draft to be agreed at the next working group in February before being shared for consultation with relevant stakeholders including a reference group comprising clinical and non clinical staff.
<input checked="" type="checkbox"/> Restorative just and learning culture	Restorative just and learning principles to be embedded through patient safety work and all people practices. Consultation on approach to be provided to patient safety leads and investigators to support the implementation of PSIRF and to help to facilitate learning reviews where indicated. Work to be progressed about Avoidable Employee Harm with HR, staffside and other key stakeholders through workshops, consultation, policy review and training	28/09/2026	Avoidable Employee Harm workshop with staff side colleagues agreed for 11th February. Operational debriefing now in place with HR with pathway for requesting staff support/psychological debriefing in cases where there has been identified adverse impacts on staff/investigators. Learning to inform improved people practices and approaches that are consistent with restorative just and learning principles Safety culture training programme outline agreed and now in development with a view to finalising draft programme at the end of March to begin the pilot. Safety culture training programme agreed by execs with Patient Safety Lead. Group meeting in November to develop the programme and pilot with evaluation. Second AEH workshop planned with HR, Staffside and FTSUG to progress this work

Failure to successfully embed workforce Equality, Diversity & Inclusion across the organisation				
Risk Number			Strategic Objectives	
2.3			Support our People	
CQC Domains	Linked Risks	Owner	Risk Rating	
<ul style="list-style-type: none"> Effective Well-Led 		Melissa Swindell	Actual	Target
			12	4
			Assurance Committee	
			People Committee	
Description				
<ul style="list-style-type: none"> - 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.

Gaps in Controls / Assurance

1. Recruitment practices are not accessible and inclusive and do not target diverse communities
2. Lack of inclusive leadership behaviour and accountability for embedding cultural change.
3. Informal processes that limit equitable access to career development and advancement of opportunities.
4. Limited organisational awareness, training, and governance around legal duties.

Action	Description	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> Informal processes that limit equitable access to career development and advancement of opportunity	<p>Launch: - Mutual Mentoring programme. - LCR Leadership Shadowing programme. - Grow to Lead Leadership Programme targeted at International recruited staff, including sponsors to support candidates. Closer monitoring of uptake of CPD uptake</p>	06/04/2026	<p>Mutual Mentoring Programme is progressing well. The LCR Leadership Shadowing Programme has now ended and Alder Hey will continue to work in partnership with LCR to identify any further opportunities. The 'Grow to Lead' international staff development programme is due to launch in April 2026 with expression of interest to go out to staff Feb 2026.</p> <p>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</p>
<input checked="" type="checkbox"/> Lack of inclusive leadership behaviour and accountability for embedding cultural change	<p>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.</p>	31/07/2026	<p>'Thriving Leaders' programme continues and incorporates The Anthony Walker Foundation Anti Racism Training in the programme. There is also a module on EDI which is delivered alongside staff with lived experiences. We continue to focus actions based on our equality data and feedback from our staff networks. The EDI Improvement Plan High Impact actions continue to be implemented and progress is being made. We have executive sponsors for all staff networks and a EDI executive champion. We are currently training 12 individuals Train the Trainer with a plan to deliver Active Bystander training across the organisation</p> <p>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.</p>
<input checked="" type="checkbox"/> 1. Multi-factorial issues spanning training and education	<p>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.</p>	31/10/2026	<p>We continue to identify opportunities to support staff with education and training related to EDI. Working closely with Learning & Development to develop new training and incorporate EDI into existing training. We are due to launch Active Bystander training using a train the trainer model which will be rolled out across the trust. Online EDI Plus training programme is available for staff.</p> <p>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</p>

Failure to fully realise the Trust's Vision for the Alder Hey Campus				
Risk Number			Strategic Objectives	
3.1			Collaborate for children & young people	
CQC Domains	Linked Risks	Owner	Risk Rating	
<ul style="list-style-type: none"> Effective Safe 		Rachel Lea	Actual	Target
			6	4
Assurance Committee 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 FTFC via Project Update
Executive Design group to seek input into plans	- Quarterly 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 FTFC 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	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> CAMPUS 1: Stakeholder Engagement	Engage with LCC, Friends of Springfield Park and community stakeholders and issue regular Comms	31/03/2026	Stakeholder engagement with LCC continues
<input checked="" type="checkbox"/> PARK 1: Adoption of the SWALE by United Utilities	Engage with planning consultants to assist with planning requirements.	31/12/2026	Engagement with planning consultants continues.

Failure to execute the 2030 Vision and make a positive impact on children and young people given the current operating environment

Risk Number		Strategic Objectives							
3.2		Collaborate for children & young people							
CQC Domains	Linked Risks	Owner	Risk Rating						
Well-Led		Kate Warriner	<table border="1"> <tr> <th>Actual</th> <th>Target</th> <th>Assurance Committee</th> </tr> <tr> <td>16</td> <td>4</td> <td>Finance Transformation & Performance Committee</td> </tr> </table>	Actual	Target	Assurance Committee	16	4	Finance Transformation & Performance Committee
Actual	Target	Assurance Committee							
16	4	Finance Transformation & Performance Committee							

Description
Risk of failure to: - continue to deliver the ambitions of Vision 2030 given multiple competing demands of the system coupled with variable capacity, balancing short-term versus long-term decision making on priorities and investment.

Control description	Control assurance (How is this control monitored?)
Assurance and support mechanism framework for transformational collaboratives	
Executive Portfolios all incorporate elements of Vision 2030 delivery	
Executive sponsor roles within the programme	
Operational Plan incorporates Vision 2030 deliverables (2025/26)	Operational Plan
Portfolio Board	Portfolio Board
Reports to Board and FTPC	
Transformational collaboratives with Divisional SROs	Programme assurance framework

Gaps in Controls / Assurance
1. Shift of focus to meet demands 2. Failure to develop capacity for delivery 3. Failure to build capacity and skills within our workforce to deliver the 2030 Strategy 4. Failure to deprioritise to enable requisite focus on areas of need and transformational change 5. Risk of 'mission creep' associated to the Strategy

Action	Description	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> 1. Developing skills and capacity to deliver the Strategy 2030	The approval of the People Plan by the Trust Board marks a significant milestone in ensuring we understand the skills and capabilities needed for our Future Workforce (2030). The upcoming phase in our strategic plan, Shape of Alder Hey 2030, will further allow us to assess the broader skills and capabilities our workforce will require to meet future needs.	31/03/2026	The development of the How we will work in the future - is a significant decision and will ensure that the organisations skills and structures - support the delivery of Vision 2030. Development of our Strategic Blueprints has allowed us to identify the future skills and capabilities required to support successful delivery of Vision 2030
<input checked="" type="checkbox"/> 2. Failure to deprioritise to enable requisite focus on areas of need and transformational change	Focus on transformational change	31/03/2026	Draft of new Strategic Programme 2026-2030 has been developed and is going through further iterations
<input checked="" type="checkbox"/> 3. Risk of mission creep associated to the Strategy	Sharp focus at Strategy Board on core mission	31/03/2026	Continue to manage as a responsibility of the Transformation Board. Continue to manage as a duty of the Portfolio Board

Failure to meet financial targets, changing NHS financial regime and inability to meet the trust's ongoing capital commitments.

Risk Number			Strategic Objectives		
3.4			Collaborate for children & young people		
CQC Domains	Linked Risks	Owner	Risk Rating		
<ul style="list-style-type: none"> Effective Responsive Safe Well-Led 		Rachel Lea	Actual	Target	Assurance Committee
			20	4	Finance Transformation & Performance Committee
Description					
Failure to deliver financial targets in particular the level of efficiency and cost reduction required. 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 FT&P 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 FT&P 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 FT&P 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 FT&P 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.
Monthly monitoring of FT&P Top 5 risks	Risks monitored through FT&P
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 FT&P) - Monitored through IPR and the monthly financial report that is shared with FT&P 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 FT&P as a top 5 key risk. Enhance reporting through FIP and strategic command for 2 of the areas to accelerate in year financial savings.

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations including a cap on growth and overall financial position of Trust.
2. Inequity of CYP in prioritisation in national funding .
3. Devolved specialised commissioning and uncertainty impact to specialist trusts
4. Current system spending is above fair share funding allocation
5. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
6. Funding models not aligned to 2030 creating a shortfall.
7. Deliverability of high risk recurrent CIP programme
8. Increasing inflationary pressures outside of AH control
9. Divisional budget positions are not achieved due to emerging cost pressures.
10. Challenged system financial position and additional controls to be followed by providers

Action	Description	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> Changing financial regime	1. Close monitoring of financial directions from NHS England to ensure the Trust delivers its Plan 2. Working closely with the ICB	31/03/2026	Monitoring continues through Trust Board and FT&P
<input checked="" type="checkbox"/> Delivery of 5 year capital programme	Risks around Capital Plan to be monitored closely. Capital management group established and regular reporting from capital leads. Reporting into FT&P and Board. Capital remains a key risk on FT&P	31/03/2026	Risks around Capital Plan continue to be monitored closely via Capital management group. Reporting into FT&P and Board. Capital remains a key risk on FT&P
<input checked="" type="checkbox"/> 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
<input checked="" type="checkbox"/> High risk recurrent Efficiency programme	Transformation programme to be established reporting into the portfolio board and weekly execs. New reporting dashboards to be put in place reporting weekly to execs and into FT&P showing the latest CIP position with focus on recurrent schemes.	31/03/2026	Transformation programme now in place with weekly check ins on collaboratives reporting into the portfolio board and weekly execs.
<input checked="" type="checkbox"/> 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.	31/03/2026	Inflationary pressures for non pay are monitored by HPL, with cost avoidance savings logged when inflationary increases avoided. Inflationary pay pressures are monitored at the point of pay award, when pay award funding compared to pay award costs are compared, and any variance escalated to NHSE and ICB as required. Monitor closely impact of inflation increases working with HPL to obtain data on supplier increases and inflation avoidance through negotiations.
<input checked="" type="checkbox"/> Shortfall against Long Term Financial Plan	LTFM produced to e shared with FT&P and Board and submitted to ICB. Annual planning process complete and bridge completed by Division. however, further delays to the completion of LTFM and the productivity work has resulted in this not being completed in the time frame initially set. This will form part of the 2030 financial strategy to be completed in Q2	30/09/2026	

System working to deliver 2030 Strategy									
Risk Number		Strategic Objectives							
3,5		Collaborate for children & young people							
CQC Domains	Linked Risks	Owner	Risk Rating						
Well-Led		Danielle Jones	<table border="1"> <thead> <tr> <th>Actual</th> <th>Target</th> <th>Assurance Committee</th> </tr> </thead> <tbody> <tr> <td>16</td> <td>4</td> <td> <ul style="list-style-type: none"> Growth and Opportunities Committee Strategy Board </td> </tr> </tbody> </table>	Actual	Target	Assurance Committee	16	4	<ul style="list-style-type: none"> Growth and Opportunities Committee Strategy Board
Actual	Target	Assurance Committee							
16	4	<ul style="list-style-type: none"> Growth and Opportunities Committee Strategy Board 							
Description									
<p>Risk of inability to control execution of 2030 Vision due to system complexities, constantly evolving statutory and political and system environment.</p> <p>Impact of membership of a system that is in national financial recovery.</p> <p>Risk of failure to keep CYP prioritised in the wider NHS context and competing priorities, and therefore risk to delivery of Vision 2030.</p> <p>Risk of constantly changing relationships and key personnel due to destabilisation of the commissioning environment.</p>									

Control description	Control assurance (How is this control monitored?)
Alder Hey and Manchester Children's working in partnership on excellent resilient specialist services for the North West	<p>MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (biannually).</p> <p>March 26 Update: The two executive teams have now met and had a positive discussion on how to refresh our working relationship and continue to work in partnership for CYP across the NW. A review of the MOU and governance between the two organisations is now needed, and a commitment was made to bring together colleagues in ~ 2 months to scope our priority areas.</p>
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	<p>Beyond Programme recurrently funded by ICS - update: funding confirmed for 25/26 March 25 Beyond Board fully established and reporting into ICS, North West region and Alder Hey Trust Board.</p> <p>March 26 Update: Control is unchanged - remain hosts of the Beyond programme.</p>
C&M ICS CYP Committee	<p>C&M ICS CYP Committee established. Alder Hey supporting committee and CYP Strategy.</p> <p>March 26 Update: Control is unchanged - we continue to work with the C&M ICB on the optimal structure for CYP in the system.</p>
Capacity and capability building for the implementation of Vision 2030 is being captured in the forthcoming clinical strategies (blueprints) and target operating model work, to ensure Alder Hey have the ability to deliver in the new system environment. This requires both capacity in the central strategy team and wider distribution of system-working leadership and capability across divisions and corporate teams.	<p>Incorporated into Executive Away Day planning discussions and development of 2025+ transformation plan</p> <p>March 26 Update: The How We Will Work in the Future programme is ongoing.</p>
Continual reflection of the impact of delegation of specialist services into ICBs. Routine reflection of the risks / opportunities for CYP.	<p>Children's Hospital Alliance proposals (under development). On current CHA agenda in March 25.</p> <p>March 26 Update: control is unchanged, still awaiting further clarity on structure and phases of delegation</p>
Engagement and working relationships with ICS and partners	<p>For example peer to peer arrangement such as C&M DoF meetings.</p> <p>March 26 Update: We continue to prioritise our working relationships and partnerships locally and regionally. ICS leadership changes are still developing and we continue to monitor these changes.</p>
Growth and Opportunities Committee oversight of growth element of Vision 2030.	<p>March 26 Update: The GO Committee met last week and had a positive and productive meeting focused on robotic surgery and global observerships. The committee is developing well and its role in the growth element of Vision 2030 is embedding.</p>
Horizon scanning - tracking of system / legislative developments, continued engagement and action planning	<p>Regular Presentations to Trust Board & CoG, Strategy Board</p> <p>March 26 Update: we continue to track developments and report back into relevant forums.</p>
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	<p>Reporting through Strategy Board</p> <p>March 26 Update: Partnership assurance / governance is under development.</p>
Joint development of new models of care to enable 10 year plan 3 shifts / Vision 2030 on a wider footprint	<p>Get me well: Lung Health respiratory co-created with partners across Liverpool.</p> <p>Sept 25 update: Recent Lung Health event took place, organised by Tripartite: Alder Hey, MerseyCare and LUHG.</p> <p>Neighbourhood Model - system wide development with Place Partners</p> <p>March 26 Update: Control is unchanged and joint working continues.</p>
Maintain existing relationships and continually build new ones with system regulators	<p>Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December</p> <p>March 26 Update: relationships are consistently maintained.</p>
Membership of CMPC Provider Collaboratives - to ensure CYP voice high on agenda	<p>Membership of CMPC provider collaboratives.</p> <p>March 26 Update: Control is unchanged - membership remains in place.</p>
PLACE Partnerships - Alder Hey representation at Liverpool, Sefton and Knowsley	<p>Engagement on Vision 2030 with PLACES</p> <p>Partnership Plans developing with CYP focus.</p> <p>March 26 Update: Alder Hey continue to represent at Place; significant local work re: Neighbourhood/CYP model ongoing.</p>

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	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> 1. Uncertainty over future commissioning intentions	1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2026	Still awaiting clarity from Commissioners (March 26)
<input checked="" type="checkbox"/> 2. Impact of delegation of Specialist Commissioned services into ICBs	2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals	31/03/2026	Awaiting further clarity on delegation in March 26
<input checked="" type="checkbox"/> 3. CYP System and Partners	3. NHS England's Medium Term Planning guidance has clarified the NHS Operating Model including a re-set of the foundations in which to transform care and deliver on the 3 shifts of the 10 Year Health Plan. This will need to be done in collaboration / partnership across the CYP system.	31/03/2026	We continue to proactively engage with multiple partners across the system with an aligned ambition around the three shifts in the 10 year health plan
<input checked="" type="checkbox"/> 4. National mandates & system finance forcing us to prioritise unexpected programmes of work	4. Horizon scanning. System scanning (e.g. via assigned ICB leads in turnaround) and local capacity scanning (via Portfolio Board, TX Programme & Executives)	31/03/2026	No further update for March 26

Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.			
Risk Number		Strategic Objectives	
4.1		Pioneering Breakthroughs	
CQC Domains	Linked Risks	Owner	Risk Rating
<ul style="list-style-type: none"> Caring Effective Safe Well-Led 		John Chester	Actual
			Target
			Assurance Committee
			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 Futures Management Board
Data governance via Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOP adherence
External communications via internet, social media etc facilitated through Marketing and Communications team	Communications Strategy and Brand Guide
External performance targets mandated (by NIHR for research, LCR Combined Authority for Paediatric Open Innovation Zone)	Reports to Futures Management Board
Futures Management Board Delivery and performance measurement of R and I activities plus education and digital elements of Futures	Reports to GO Committee
Growth and Opportunities (GO) Committee Additional oversight of financial and commercial aspects of R&I activity	Reports to Trust Board
Protection +/- exploitation of intellectual property	Adherence to Trust policy - escalations to Futures Management Board
Risk registers	Reports to Risk Management Forum and Future Management Board
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 Management Board
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	March 2026	
		Due Date	Action Update
<input checked="" type="checkbox"/> 5. Comms Strategy for Futures	Development of Futures comms approach	30/09/2025	No updates in month - awaiting final comms plan for Futures
<input checked="" type="checkbox"/> 4. Capacity and capability	Create an R&I enabled workforce through the Futures Develop Pillar	31/03/2026	Workshop to capture realistic deliverables for developing capacity across R&I took place on 3rd March and KB tasked with creating a revised 26/27 plan taking reduced resources into account - to be agreed before 31st March. Proposal to develop innovation champions/ambassadors approach alongside IDEA framework to build clinical capacity in innovation (using AH Charity funds already assigned to Futures) IDEA framework postponed for timebeing following develop pillar group discussions. Capacity building internal funding call launch with 2nd March closing date Next develop pillar meeting planned for last week of Jan to align all activities 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

M11 finance update shows favourable year end position with RPA and MRI financial pressures mitigated by other income streams. Action will be complete once M12 position is confirmed but current forecast is £49k surplus.

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

Financial gap remains for RPA and MRI - progress with FIP actions is ongoing with reduced gap for RPA but no change to MRI forecast yet (JT working on converting opportunities to concrete income)

Financial gap closed in month due to overachievement in other areas (commercial and non-commercial research income, AVT income) - remains under review

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 achieving 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.

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 other external funding which attracts indirect costs (Grow, Discover and Develop Pillar) - Supporting cost saving initiatives across the Trust through adoption of innovative technology (Transform Pillar)

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

Risk Number			Strategic Objectives		
4.2			Revolutionise Care		
CQC Domains	Linked Risks	Owner	Risk Rating		
<ul style="list-style-type: none"> Effective Safe 		Kate Warriner	Actual	Target	Assurance Committee
			16	4	Finance Transformation & Performance Committee
Description					
Failure to deliver a Digital and Data Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare as part of our journey to 2030. Failure to provide high quality, resilient digital and Information Technology services to staff, children, young people and their families.					

Control description	Control assurance (How is this control monitored?)
Clinical and Divisional Engagement in Digital Strategy	Divisional CCIOs and Digital Nurses in place.
Digital Centre of Excellence in place & fully resourced - Chaired by Trust CCIO	Digital Centre of Excellence tracking delivery
Digital Data and AI Collaborative Established as part of transformation programme	Multidisciplinary leadership roles identified. Delivery programme in place.
Digital Strategy refresh underway to reflect changing environment. Digital Data and Insights key components of Vision 2030 and associated governance and plans	Digital Centre of Excellence. Relationship with Futures. Digital and Data Collaborative established.
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Executive level CIO in place	Commenced in post April 2019, Deputy CDIO in place across iDigital Service
External oversight of programme	Strong links to system, regional and national digital governance via internal and external relationships.
Formal change control processes in place	Weekly Change Board in place
High levels of externally validated digital services	HIMSS 7 Accreditation
Monthly digital performance meeting in place	iDigital performance meeting in place. Performance reported as part of Corporate Collaborative.
Regular update to Trust Board on digital developments, Monthly update to FTP	Board agendas, reports and minutes

Gaps in Controls / Assurance
<ol style="list-style-type: none"> Cyber security investment for additional controls approved - dashboards and specialist resource in place. Continual review underway to assess additional requirements. Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs Issues securing experienced resources in some services Aging hardware/device estate and financial restrictions preventing all equipment being replaced, most notably in clinical areas Capital investment anticipated lower than required Optimizing user experience of digital systems review

Action	Description	March 2026	
		Due Date	Action Update
<input type="checkbox"/> Cyber Assurance Framework & Strategic review of Cyber Security with Recommendations and Outputs	This has replaced the action around Cyber Essentials +. Links to the Cyber continual review gap in control	27/03/2026	New governance to be established on the back of review. Sub committee of FTFC to be created and chaired by Non Executive Director. First meeting in April
<input checked="" type="checkbox"/> Review of Benefits from Digital, Data and AI Collab and produce report.	Produce a report on realised benefits. Links to Transformation at Pace gap in control	27/03/2026	Patient Portal due to go live in March. Benefit report being collated.
<input checked="" type="checkbox"/> Replace all aging hardware and infrastructure	Completion of business cases and deployment of refreshed technology in 4 key areas: End user Devices, EPR Data Centre, Core Data Centre and Hospital Network. This links to the Aging infrastructure gap in control.	31/03/2026	Data centre completion now April due to issues at other sites in shared pool. Network refresh tender due to commence in April.
<input checked="" type="checkbox"/> Experienced Resources - Complete Target Operating Model	Assess workforce and develop options appraisal for impacted services. Work is ongoing around future options for iDigital and workforce. This will now be completed through the Target Operating Model workstream. Links to experience resource gap in control.	30/04/2026	HWWWITF paper being submitted 11.03 for approval
<input checked="" type="checkbox"/> Digital systems review	Digital systems review	30/10/2026	EMIS Data Migration is complex and will need a detailed approach to ensure safe continuity of care and maintaining national reporting. Plan being revised based on this.

BOARD OF DIRECTORS

Thursday, 2nd April 2026

Paper Title:	Corporate Risk Register Report (CRR)
Report of:	Associate Director of Nursing and Governance
Paper Prepared by:	Risk Management Manager / Facilitator

Purpose of Paper:	Decision <input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Information <input type="checkbox"/> Regulation <input checked="" type="checkbox"/>
Action/Decision Required:	To note <input checked="" type="checkbox"/> To approve <input checked="" type="checkbox"/>
Summary / supporting information	Corporate functions' risk registers via the InPhase electronic risk management system. Divisions' risk registers via the InPhase electronic risk management system.
Strategic Context	Outstanding care and experience <input checked="" type="checkbox"/> Collaborate for children & young people <input checked="" type="checkbox"/> Revolutionise care <input checked="" type="checkbox"/> Support our people <input checked="" type="checkbox"/> Pioneering breakthroughs <input checked="" type="checkbox"/> Strong Foundations <input checked="" type="checkbox"/>
Resource Implications:	Resources identified to support management of risks as required.
Does this relate to a risk? Yes R No <input checked="" type="checkbox"/> If "No", is a new risk required? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

Risk number	Risk description	Score

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



1. Purpose

This paper provides the Trust Board with the opportunity to scrutinise and discuss the current Corporate Risk Register (CRR) for the reporting period 1st – 31st December 2025.

2. Summary CRR:

Total number of open high risks = **26** (excluding BAF, Cheshire & Merseyside Children’s & Young People’s Partnership and network risks).

High risks	1st - 31st December 2025	1st - 30th November 2025	1st October - 31st October 2025	1st September - 30th September 2025	1st June - 31st July 2025	1st May - 31st May 2025	1st March - 30th April 2025	1st - 28th February 2025
Number of new high risks reported	2	2	2	2	3	2	5	0
Number of high risks closed or removed	0	1	0	0	1	0	0	0
Number of high risks with increased risk score	1	0	1	4	3	1	3	2
Number of high risks with decreased risk score	2	1	2	3	1	2	3	2
Number of high risks overdue review	2	2	1	0	0	0	1	0
Number of high risks with no agreed action plan	0	0	2 (288 & 462)	0	1 (2643)	5 (289, 341, 297, 140, 292)	5 (289, 341, 297, 140, 292)	1 (229)
Number of high risks with actions past expected date of completion	5	10	2	3	5	8	5	6
Number of high risks with static risk scores	20	22	20	16	21	22	18	18

Table 2

Alder Hey - Corporate Risk Register											
Community & Mental Health	Rare	Unlikely	Possible	Likely	Almost Certain	Almost Certain	Likely	Possible	Unlikely	Rare	Medicine
Negligible											Negligible
Minor											Minor
Moderate					0	2					Moderate
Major				4	0	0	6				Major
Catastrophic			1	0	0	0	3	0			Catastrophic
Catastrophic			1	0	0	0	0	0			Catastrophic
Major				7	0	1	1				Major
Moderate					0	0					Moderate
Minor											Minor
Negligible											Negligible
Corporate & Research	Rare	Unlikely	Possible	Likely	Almost Certain	Almost Certain	Likely	Possible	Unlikely	Rare	Surgery

Table 3: THEMES

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Compliance and Regulatory							
199 Medicine 07/05/2024	Radiology	16 (4x4)	Insufficient funding (42 weeks of funding instead of 52 weeks required) to provide a radiology service to report images with current imaging demands	Contract with Medica - external reporting company - will provide OPCS1 reporting to ensure Alder Hey is within national target of 4 weeks.	16	16	16
Risk continues. Now having 3 weekly check in with execs, an amber week will be implemented in January, and less attendances at MDT will be fulfilled.							
341 Community & Mental Health 28/02/2025	Rainbow - Children In Care	16 (4x4)	Trust is not compliant with Intercollegiate Document: Looked After Children (Children in Care) December 2020	Clinical Director for Safeguarding and Statutory Services in post from 01/12/2024 is providing support to the Associate Director for Safeguarding and Statutory Services and Named Nurse for Children in Care in respect of urgent medical queries.	16	16	16
Risk title updated following RMF meeting. Named Doctor role was advertised on NHS jobs. Unable to shortlist as no suitable candidates despite extending the submission date. Plan to meet with senior Divisional leaders and leaders from Safeguarding and Statutory Services to determine next steps.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Financial - Investment							
513 (Legacy Risk ID 2643) Surgery 15/08/2022	Biomedical Engineering	16 (4x4)	<p>The Trust is now in year 7 since Alder Hey in the park building became operational. Most of the Trust medical devices were purchased or replaced at the time and most devices have an Original Equipment Manufacturer (OEM) suggested working life of either 7 or 10 year. This means that circa £34m medical equipment is due for replacement between 22/23 and 26/27 financial years. Approximately £27m of this is capital replacement.</p> <p>This year (22/23) the plan was to replace £6.3m of this equipment. However external capital expenditure restrictions have been placed upon the Trust by the ICS which means the Trust only have £2.3m allocated for device replacements. The remaining £4m is "at risk" and will roll over into next year's replacement budget that will then stand at £9.5m</p>	<p>There is access to Charity funding.</p> <p>£50k Emergency equipment fund.</p> <p>A process has been developed to risk assess the priority of device replacements.</p> <p>Ongoing concerns requiring escalation will be reported via the Capital Committee. Area leads will be given more responsibility for identifying and managing their capital replacement priorities.</p>	16	16	16
The equipment replacement plan has been re-profiled and all items RAG rated based upon current information. A 5-year plan has been submitted via the capital management group (CMG). Equipment will be continuously monitored and re-assessed for escalation/ de-escalation as and when more information is forthcoming. 26/27 prioritisation plans will be shared and discussed with service leads in December 2025 with any changes to be escalated through CMG. Discussions are ongoing with charity, to seek support wherever possible.							

368 Corporate Services 22/05/2025	IM&T	16 (4x4)	The Trust's digital infrastructure is due for renewal. This currently causes a number of issues in terms of support, capacity and reliability. The infrastructure is ageing which will result in hardware dropping out of support with its vendors, and also, increases the likelihood of failure	<p>Prioritised servers so system criticality taken into account in event of data centre loss.</p> <p>Intercity to produce an 18-month plan for resolution but will require investment from the Trust. Work will shortly commence on producing a Business Case to support for both core switches and wireless.</p> <p>Work planned with Intercity to replace the telephony switchboard hardware and upgrade to the latest version.</p> <p>Databases backed up to Rubrik.</p>	12	16	16
EPR Data centre work due to complete end of January. Core data centre to be completed end of February and both on track. Network refresh business case in progress ready for next financial year.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Controls	Risk Score			
				Sep-25	Oct-25	Dec-25	
Workforce - Sustainability							
38 Medicine 06/07/2023	EEG	20 (5x4)	<p>2 vacant Neurophysiology consultant posts from 24th July 2023. Job adverts received no applicants</p>	<p>Activated bedside ports to allow data review for acute work remotely. This improves efficiency and allows us to obtain a more timely report.</p> <p>Nerve conduction studies (NCS)/Electromyography (EMG): Private company (Mediservices Ltd) to provide on-site consultant every fortnight to perform all inpatient/ outpatient NCS/EMG.</p> <p>Electroencephalography (EEG) reporting (outpatients): Rota of two Neurophysiologists has been changed as we now only have 1 Neurophysiologist available. Non-accredited Neurophysiologist contract has not been renewed. The remaining Neurophysiologist continues to work remotely on 0.4WTE.</p> <p>The gap in reporting EEG activity including urgent work is now being outsourced to private companies at a extensive cost to the Trust.</p> <p>Home Video Telemetry (HVT): Both consultants are to report all HVT recordings remotely.</p> <p>Video telemetry are to be reported by our accredited Neurophysiologist.</p>		20	20
The post of Consultant Neurophysiologist is waiting for exec approval at their next forum. Risk manager has placed the job description on TRAC.							
362 Medicine 17/05/2025	Emergency Department	15 (3x5)	Lack of psychology support for staff in the Emergency Department	<p>Until a resolution is found, the Emergency Department (ED) will need to request ad-hoc debriefs for cases.</p> <p>The department has an established wellbeing team consisting of different staff groups.</p>	15	15	15

				Daily highlighting of nursing staff affected by difficult cases in the allocation book, so as to assist with them not going back to similarly challenging cases (whether that be resus/ NAI/ mental health) and to aid recognition by well-being team of those staff needing support.			
<p>Psychology support has been agreed 0.2 WTE (7.5 hours per week) Funding transferred to child health psychology. Psychologist in post as at 12/01/2026 Risk score reduced to target score (6). Risk has been closed on 08/01/2026.</p>							
409 Corporate Services 31/01/2020	Human Resources	16 (4x4)	Staff ill health higher than the Trust absence target of 5% (2024/25). Inability to provide safe staffing levels due to absence (legacy risk ID 2077)	<p>Sickness Absence Policy in place HR Business Partners and Advisors provide support to managers across the divisions within the Trust, managing absence in accordance with policy.</p> <p>Additional Staffing is made available through the bank, which is provided by NHSP. This provides cover largely for registered and unregistered nurses.</p> <p>Corporate report monitors Trust absence level. Occupational Health Service available to all staff.</p> <p>Early intervention available via team prevent.</p> <p>Monthly Health and Wellbeing team meetings, which focus on improving employee wellbeing. Reviewing analysis of current data and feedback through, Staff, Managers, Occupational Health, HR, Psychological Services and Health and Safety.</p> <p>A staff availability group has been set up and chaired by the HR Director, specific actions are in place and monitored by this group - which reviews the impact of sickness amongst other factors contributing to staff availability.</p>	16	16	16
<p>Sickness levels in December 7.35%, increase from November (6.69%) and October (6.5%), dedicated resource now fully in place and working through sickness activity and actions to improve the position.</p>							
287 Medicine 18/11/2024	Radiology	16 (4x4)	Radiology consultant on-call is under increasing pressure and at the brink of failure. There will be a significant impact on the team and a number of crucial clinical services in the Trust if we are unable to continue in a safe manner	<p>Introduction of locum cover - 1 ongoing slot for vacant IR post and an additional one recently introduced for the injured colleague.</p> <p>An email will be sent to all clinical teams reiterating that between 10pm and 7am, all urgent referrals for ultrasound, fluoroscopy and CT/MRI should be made on a consultant-to-consultant basis.</p>	12	16	16
<p>No incidents or complaints. 2 radiologists to share a spot on the roster. 1 additional part time radiologist and 1 full time to participate. Medics on-call review has begun to determine whether there is anyone who can phase back on to the on-call rota.</p>							
464 (Legacy Risk ID 2650) Medicine 26/08/2022	Haematology	16 (4x4)	If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4	<p>Lead for haemoglobinopathies and laboratory being covered by other haematology consultants.</p> <p>Additional waiting list initiative clinics put on to ensure elective work is completed in a safe and timely fashion.</p> <p>1x substantive haematology consultant post advertised.</p> <p>Additional Specialty Doctor and 2 WTE Fellow recruited.</p>	16	16	16
<p>Due to the delay in getting the locum post approved, this will now not go out until late December, early January 2026.</p>							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Quality - Safety							
179 Surgery 08/04/2024	Major Trauma	20 (4x5)	Lack of compliance with major trauma standards	Peer review action plan in place-working through since 2023. Trust was 80% compliant with Major trauma standards with an action plan to work towards compliance of the remaining 20%. The action plan has now stalled, and evidence now shows a decline in our compliance with standards from the 80% position. Compliance with these standards and incidents are monitored through TQSG and escalated through the division.	15	20	20
SLAs are being worked on and taken forward..							
293 Medicine 10/12/2024	Laboratory Medicine	16 (4x4)	Staffing in Biochemistry. POC devices can be used for urgent electrolyte testing. Clinical scientist on-call can support with advice around other testing requirements and off-site referral if needed	POC devices can be used for urgent electrolyte testing. Clinical scientist on call can support with advice around other testing requirements and offsite referral if needed.	16	16	16
2 new BMS trained and on rota from February. Decrease in STP trainee contribution to OOH, and staff absence continues to put significant pressure on the rota. Current support from band 7 seniors has prevented service failure. Organisational change will progress in the new year to address issues with rota and add resilience.							
288 Community & Mental Health 21/11/2024	Rainbow - Safeguarding	15 (5x3)	CAMHS practitioners who hold specific and ongoing responsibility for safeguarding children may not receive timely and reactive safeguarding supervision and will not receive planned supervision they require to support safe and effective safeguarding practice	Communications have been sent to all CAMHS Practitioners to advise that planned supervision has been temporarily suspended, however reactive supervision is still available daily via the Safeguarding Duty Team. CAMHS Practitioners have been directed to seek immediate and reactive safeguarding supervision as required via the Safeguarding Duty Team which is available Monday - Friday between 8am-6pm.	15	15	15
Risk reviewed, currently minimal change to safeguarding supervision offer. Band 7 Safeguarding practitioner has returned to role and completed phased return. Further MDT and planned supervisions now being picked up as capacity and demand allows. Further correspondence sent to CAMHS clinical leads by Named Nurse for Safeguarding to advise of current plan for supervision. Reactive supervision continues to be requested and delivered via duty at this time.							
229 Corporate Services 20/06/2024	IM&T	16 (4x4)	Alder Hey Pathology reports are sent electronically to primary care organisations. This process utilises an end-of-life server which is no longer supported by the supplier	Pathology IT team monitor the reporting systems daily to ensure they review any failed reports.	16	16	16
Capital Management Group meeting scheduled for January to discuss potential funding streams for the replacement of Labcomm..							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Quality - Safety							
27 Medicine 20/06/2023	Metabolic Disease	20 (5x4)	The Metabolic Disease service is fragile and could fail to deliver the appropriate standard of care needed by our patient cohort	<p>Hub and Spoke model with Manchester Consultant attendance at Alder Hey 2/7 days.</p> <p>The metabolic service has identified patient cohorts in order to safely manage the patients moving forwards.</p> <p>A patient database of all metabolic prescriptions has been established.</p> <p>Sourced 2PA worth of General Paediatrics consultant time for the Metabolic Service.</p>	20	20	20
<p>There have been some incidents since the last update but no PALS or complaints. The incident is around psychological support for Metabolic patients and is being dealt with accordingly. Appointment to B6 Nurse Specialist has happened and recruitment process underway. Senior Nurse time also into the service as 1 day per week to stabilize nursing support. Ongoing discussion with Manchester re: clinic support from Manchester. Ongoing discussion within Division and Exec and with Commissioners team.</p>							
399 Community & Mental Health 08/07/2025	Tier 4 Inpatient Unit	16 (4x4)	Inability to meet NHS England contractual obligation of having 10 accessible beds. Inability to admit young people due to reduced capacity	No patients to be nursed in the three bedrooms in which anti barricade is not working. A communication has been shared with the staff team to provide an overview of the issues with each bedroom door.	12	16	16
<p>All anti-barricade doors tested. Bedroom 6 needs door jamb ironmongery to maintain integrity of system. Bedroom 1 door sticking when opening outwards, unable to open door fully. Diner anti-barricade door not working, unable to activate the lever with the key to pull door open outwards. Reported to project manager.</p>							
485 (Legacy Risk ID 2419) Medicine 06/07/2021	Pathology	20 (5x4)	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion including cardiac surgery, ED, ICU, oncology, haematology, theatres and ECMO	<p>Close working established with Cardiac surgery team, ECMO and PICU, and Liverpool Womens (neonatal unit).</p> <p>2 x Band 7 staff filling 1 rota place to help ensure service continuity.</p> <p>1 x Band 5 BMS is being trained in blood transfusions and will undertake out of hours shifts in the presence of the Acting Haematology Manager later in October. 1 x Band 6 BMS has just started and is being fast tracked through competency assessments in haematology.</p> <p>Fortnightly meeting with HR support and divisional management.</p>	20	20	20
<p>1 in 8 rota. Training in progress to move to 1 in 9 April 2026 at which point we can progress with organisational change to introduce on call to reduce risk.</p>							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Quality - Safety							
292 Corporate Services 04/12/2024	IM&T	15 (5x3)	Inappropriate sharing of demographics	<p>Process in place for adding Safeguarding flags to records e.g. confirming who information should be shared with.</p> <p>Safeguarding Policies and Procedures in place.</p> <p>Information Governance Policies and Procedures in place.</p> <p>Mandatory Safeguarding Training.</p> <p>Mandatory Information Governance Training.</p>	15	15	15
Patient Portal project on track to deliver for February 26 and will mitigate current risk.							
297 Corporate Services 23/12/2024	Transcription Pool	16 (4x4)	Transcription delay and increase of turnaround times	<p>Daily reporting on activity levels, and also the fulfilment of bank hours to cover vacant hours impacting on productivity.</p> <p>Cease further onboarding of additional clinicians onto Lyrebird until the new year to reduce impact of manual transcription.</p> <p>Resolution of remote access solution for Transcription Team to be able to undertake bank hours from home which will increase productivity and support increased uptake of bank hours.</p> <p>Ensure as much dictation as possible is managed via the outsourced transcription workflow to mitigate as much in-house transcription as possible at this point in time.</p>	16	16	16
Risk remains 16 - additional bank approved by Execs in December. Backlog position has reduced from 9,875 letters to 7,558 letters since 19/12/25. Continue to track and monitor.							
458 (Legacy Risk ID 2455) Community & Mental Health 16/09/2021	Developmental Paediatrics	16 (4x4)	Disruption in patient's supply of medication and / or treatment	<p>Prescription rota in place.</p> <p>Online form in place to allow timely requesting of prescriptions by parents/carers - promoted at parent information session and in clinic letters. Also reinforced with a letter that goes out with the prescription.</p> <p>Additional capacity can be provided by Registrars to do prescriptions if required.</p> <p>BI Report in place to monitor prescription requests and turnaround time for medication.</p> <p>Cleo system introduced which allows for electronic transfer of completed prescriptions, reducing delay in prescriptions being accessed by families.</p>	16	16	16
Medication shortages are beginning to stabilise. The EPS system, Cleo, went live on 30/09/2025. This system ensures that once a prescription is issued, it reaches the pharmacy immediately for processing, which is expected to improve turnaround times. However, an increase in prescription requests combined with issues in the RPA prescription logging process has prevented these improvements from being fully realised. Once these issues have been resolved this risk will revert to a workforce/capacity and demand issue.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Quality - Safety							
462 (Legacy Risk ID 2431) Community & Mental Health 23/07/2021	ND Assessment Service	16 (4x4)	Children and young people will not receive the outcome of their ASD assessment within the agreed timescale (90% of cases within the 65 weeks Trust standard)	<p>Clinical review of waiting list completed monthly and appointments allocated to longest waiters first.</p> <p>Regular performance reports provided to ICB to monitor compliance with standard.</p> <p>Service is fully staffed to capacity (recurrent funding).</p> <p>ASD Administrative Staff Review completed and additional Assistant Operational Manager post is in place to oversee the Admin Team.</p> <p>Bank staff being used to cover any gaps in clinical rota.</p> <p>SOPs in place to standardise assessment.</p>	16	16	16
Transformation is now complete and both ASD and ADHD waiting lists have been merged to create a new Neurodevelopmental assessment team. Risk remains high as the service holds 14000 cases which is well over the capacity available within the team. Paper submitted to Trust board to update on progress and current level of risk. Added to documents.							
444 (Legacy Risk ID 2685) Medicine 04/11/2022	Neurology	16 (4x4)	There is a risk to being unable to provide a safe, effective and timely service for tertiary Neurology patients. This includes the ability to diagnose, treat and manage patient demand	<p>Permanent post in place. Locum consultant in post (0.6 WTE). Locum sessions to existing consultants for on-call controlled out of hours provision.</p> <p>Trust Improvement programme to review current provision and support development of alternative Neurology model.</p> <p>Additional consultant appointment will offset leaver.</p> <p>Locum consultant in post and Specialist Doctor.</p> <p>Introduction of Patient Pass to support local DGH timely review for urgent requests.</p> <p>Current consultant workforce to provide extra clinics to reduce waiting times.</p>	20	16	16
Risk remains the same currently. 1WTE long-term sick (LTS) still present. 0.6 WTE consultant commenced post 8/10/25. Recruited 2WTE end of October and 6/12 Locum post to mitigate LTS. Review with Consultant job plans ongoing and review for longer term plan with the team with 2WTE from April. Continued DGH MDTs until end of March and DGHs updated with current provision.							
520 Medicine 16/12/2025	Pharmacy Clinical Services	16 (4x4)	Pharmacy capacity is severely hampered at the present time. This creates increased risk of errors causing serious harm to patients, reputational damage and challenges to reaching targets for cost-improvement and prescription turnaround times	<p>Discharge Service - Dedicated team process TTOs for 3A, 4A, 4C, 1C to prevent delayed discharges - Monday to Friday.</p> <p>Rota oversight by Senior Team ensures available staff are allocated to critical care and priority areas.</p> <p>Vacancy panel requests for pharmacists and MARS scheme skill mix review.</p> <p>Escalation of risk associated with outsourcing outpatient pharmacy to Board.</p> <p>Management of long-term and short term sickness.</p>			16
Risk approved 22/12/2025. Further decline in available staffing has now resulted in the service being unable to cover 4A with a clinical pharmacist. Details of risk updated.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Quality - Effectiveness							
501 Medicine 08/04/2024	Radiology	15 (3x5)	Radiology home reporting laptops and reporting screens are now past warranty and do not have enough RAM to support reporting, this problem has developed and significantly deteriorated since windows 11 rollout and radiologists are now unable to work efficiently from home. new PACS rollout has already confirmed from other trusts that new system is more RAM intensive	Radiologists come on site where possible. Urgent scans are prioritised.			15
Radiology have been told they are unlikely to be eligible for replacement as assumed to be <5 years old. They have also been added to the capital replacement log for the next 5 years, however there is a shortfall here between required equipment across the Trust and allocated funding.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Commercial							
492 Corporate Services 11/11/2025	Campus	16 (4x4)	NICU go live delay due to commercial agreement not being reached	Board to Board meetings between Trust and SPV.			16
Risk approved 11/11/2025. The discussions are still happening at Board-to-Board level and escalated to NHS England.							
496 Corporate Services 11/11/2025	Campus	16 (4x4)	NICU delay due to isolation of live services and service connections	Ongoing discussions with Morgan Sindall to agree scale of delays.			16
Risk approved 11/11/2025. Board-to-Board level discussions ongoing and escalated to NHS England.							

Risk / Division/ Date Added	Service	Risk Score (consequence x likelihood)	Risk Title	Controls	Risk Score		
					Sep-25	Oct-25	Dec-25
Financial - Compliance							
238 Corporate Services 03/07/2024	Clinical Coding	16 (4x4)	Risk of financial income due to various issues relating to coding Risk of clinical reporting	Regular tracking of overall coding backlog to monitor volumes of uncoded activity, particularly towards Freeze activity positions.	12	12	16
<p>Risk increased from 12 to 16. November freeze position on track for completion by freeze deadline however now in cycle 4-5 weeks turnaround to complete a month which will not be eradicated without extra resource. AI coding undergoing testing for high volume/low complex activity.</p>							

Table 4: NEW HIGH RISKS

Risk ID	Risk Description	Date Opened	Risk Score	Risk Category	Reason / Comment
Medicine					
520	Pharmacy capacity is severely hampered at the present time. This creates increased risk of errors causing serious harm to patients, reputational damage and challenges to reaching targets for cost-improvement and prescription turnaround times	16/12/2025	16	Quality - Safety	Risk approved 22/12/2025.
Further decline in available staffing has now resulted in the service being unable to cover 4A with a clinical pharmacist. Details of risk updated.					
501	Radiology home reporting laptops and reporting screens are now past warranty and do not have enough RAM to support reporting, this problem has developed and significantly deteriorated since windows 11 rollout and radiologists are now unable to work efficiently from home. new PACS rollout has already confirmed from other trusts that new system is more RAM intensive	08/04/2024	15	Quality - Effectiveness	Risk approved 15/12/2025.
Radiology have been told they are unlikely to be eligible for replacement as assumed to be <5 years old. They have also been added to the capital replacement log for the next 5 years, however there is a shortfall here between required equipment across the Trust and allocated funding.					

Table 5: CLOSED HIGH RISKS

There are no closed high risks to report in this reporting period.

Table 6: RISKS WITH DECREASED SCORES

Risk ID	Risk Description	Score	Reason for Decrease
Corporate			
173	Business Continuity Incidents disrupting the Trust's ability to maintain statutory duties. The risk is the potential for the Trust being unable to meet its obligations in alignment with legislation, NHS England national policy, local guidance, and good practice, impacting on staff, patients, finance, reputation, and the wider health economy	8 DECREASED from 15	This risk has been reviewed and the risk has reduced to an 8 score on 03/12/2025 due to increasing compliance of organisational business continuity planning. Ongoing work through EPG and enhanced reporting and SQAC oversight in place to support assurance.
Risk ID	Risk Description	Score	Reason for Decrease
Community & Mental Health			
448	Failure to comply with the standards for 'Medical Laboratories - Requirements for Quality and Competence' (ISO 15189:2012) Accreditation	12 DECREASED from 16	Building work to secure a forensic pod within Rainbow has been completed. Accreditation assessment date has been planned for the week of the 23rd March 2026. Discussed in Divisional Risk Review Meeting and risk score reduced from 16 to 12 on 16/12/2025.

Table 7: RISKS WITH INCREASED SCORES

Risk ID	Risk Description	Risk Score	Reason for Increase
Corporate			
238	Risk of financial income due to various issues relating to coding Risk of clinical reporting	12 INCREASED to 16	Risk upgraded from 12 to 16 following flex data incurring high volume U codes and backlog growing.

Table 8: LONG-STANDING HIGH RISKS (greater than 12 months since identification as a high risk)

Risk	Risk Owner	Risk Score	Risk Description	Date Identified	Progress Update
Community & Mental Health					
462 (Legacy Risk ID 2431)	Lisa Cooper	16	Children and young people will not receive the outcome of their ASD assessment within the agreed timescale (90% of cases within the 65 weeks Trust standard)	Jul-21	Transformation is now complete and both ASD and ADHD waiting lists have been merged to create a new ND assessment team. Risk remains high as the service holds 14000 cases which is well over the capacity available within the team. Paper submitted to Trust board to update on progress and current level of risk. Added to documents. Theme: Capacity and demand
458 (Legacy Risk ID 2455)	Lisa Cooper	16	Disruption in patient's supply of medication and / or treatment	Sep-21	Medication shortages are beginning to stabilise. The EPS system, Cleo, went live on 30/09/2025. This system ensures that once a prescription is issued, it reaches the pharmacy immediately for processing, which is expected to improve turnaround times. However, an increase in prescription requests combined with issues in the RPA prescription logging process has prevented these improvements from being fully realised. Once these issues have been resolved this risk will revert to a workforce/capacity and demand issue. Theme: National drug shortage outside of organisational control
288	Lisa Cooper	15	CAMHS practitioners who hold specific and ongoing responsibility for safeguarding children may not receive timely and reactive safeguarding supervision and will not receive planned supervision they require to support safe and effective safeguarding practice	Nov-24	Risk reviewed, currently minimal change to safeguarding supervision offer. Band 7 Safeguarding practitioner has returned to role and completed phased return. Further MDT and planned supervisions now being picked up as capacity and demand allows. Further correspondence sent to CAMHS clinical leads by Named Nurse for Safeguarding to advise of current plan for supervision. Reactive supervision continues to be requested and delivered via duty at this time. Theme: Quality - Safety
Medicine					
464 (Legacy Risk ID 2650)	Urmi Das	16	If we continue with a reduced haematology consultant workforce, then the Trust will be unable to deliver a high-quality paediatric haematology service (non-malignant and malignant, including lab work) resulting in 2 WTE covering the on-call service instead of 4	Aug-22	Due to the delay in getting the locum post approved, this will now not go out until late December, early January 2026. Theme: National workforce shortage
485 (Legacy Risk ID 2419)	Adam Bateman	20	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	Jul-21	1 in 8 rota. Training in progress to move to 1 in 9 April 2026 at which point we can progress with organisational change to introduce on call to reduce risk. Theme: Workforce shortage
27	Urmi Das	20	The Metabolic Disease service is fragile and could fail to deliver the appropriate standard of care needed by our patient cohort	Jun-23	There have been some incidents since the last update but no PALS or complaints. The incident is around psychological support for Metabolic patients and is being dealt with accordingly. Appointment to B6 Nurse Specialist has happened and recruitment process underway.

					Senior Nurse time also into the service as 1 day per week to stabilize nursing support. Ongoing discussion with Manchester re: clinic support from Manchester. Ongoing discussion within Division and Exec and with Commissioners team. Theme: Quality - Safety
Surgery					
513	Chloe Lee	16	<p>The Trust is now in year 7 since Alder Hey in the park building became operational. Most of the Trust medical devices were purchased or replaced at the time and most devices have an Original Equipment Manufacturer (OEM) suggested working life of either 7 or 10 year. This means that circa £34m medical equipment is due for replacement between 22/23 and 26/27 financial years. Approximately £27m of this is capital replacement.</p> <p>This year (22/23) the plan was to replace £6.3m of this equipment. However external capital expenditure restrictions have been placed upon the Trust by the ICS which means the Trust only have £2.3m allocated for device replacements. The remaining £4m is "at risk" and will roll over into next year's replacement budget that will then stand at £9.5m</p>	Aug-22	<p>The equipment replacement plan has been re-profiled and all items RAG rated based upon current information. A 5-year plan has been submitted via the capital management group (CMG). Equipment will be continuously monitored and re-assessed for escalation/de-escalation as and when more information is forthcoming. 26/27 prioritisation plans will be shared and discussed with service leads in December 2025 with any changes to be escalated through CMG. Discussions are ongoing with charity, to seek support wherever possible.</p> <p>Theme: Financial outside of organisational control</p>
Corporate Services					
409 (Legacy Risk ID 2077)	Melissa Swindell	16	Staff ill health and absence higher than the Trust absence target of 5% (2024/25). Risk of inability to provide safe staffing levels due to absence	Jan-20	Sickness levels in November 6.69%, increase from October (6.5%), dedicated resource now fully in place and working through sickness activity and actions to improve the position. Theme: Staffing
229	Ian Gilbertson	16	Alder Hey Pathology reports are sent electronically to primary care organisations. This process utilises an end-of-life server which is no longer supported by the supplier	Jun-24	Funding stream still unavailable. Theme: Quality - Safety
292	Ian Gilbertson	15	Inappropriate sharing of demographics	Dec-24	Patient Portal project on track to deliver for February 26 and will mitigate current risk. Theme: Quality - Safety

BOARD OF DIRECTORS

Thursday, 2nd April 2026

Paper Title:	Directors' Register of Interests
Report of:	Chief Corporate Affairs Officer
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision <input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Information <input type="checkbox"/> Regulation <input type="checkbox"/>
Action/Decision Required:	To note <input checked="" type="checkbox"/> To approve <input type="checkbox"/>
Summary / supporting information	The Declarations of Interests Register enables all staff to be as open as possible and declare any actual or potential conflict of interest.
Strategic Context	
This paper links to the following:	Outstanding care and experience <input checked="" type="checkbox"/> Collaborate for children & young people <input checked="" type="checkbox"/> Revolutionise care <input checked="" type="checkbox"/> Support our people <input checked="" type="checkbox"/> Pioneering breakthroughs <input checked="" type="checkbox"/> Strong Foundations <input checked="" type="checkbox"/>
Resource Implications:	

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

Risk number	Risk description	Score

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



**REGISTER OF DIRECTORS' INTERESTS
2025/26**

	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
Dame Jo Williams (Trust Chair)		✓
John Grinnell (Chief Executive)	<p>Declaration Type: Loyalty Interests</p> <p>Body/Organisation/Individual name: Playworld Ltd./Grinnell Holdings Ltd</p> <p>Relationship: Company Secretary (no dealings with hospital)</p> <p>Description of loyalty interest: Spouse companies</p> <p>When did business interest begin: 19/11/2019</p>	
Nathan Askew (Chief Nursing Officer)		✓
Alfie Bass (Chief Medical Officer)		✓
Adam Bateman (Chief Operating Officer/Deputy Chief Exec)		✓
Fiona Beveridge (Non-Executive Director)	<p>Declaration Type: Loyalty Interest</p> <p>Body/Organisation/Individual name: University of Liverpool</p> <p>When did loyalty interest begin: 01/04/2022</p>	

	<p>How is this relevant to the Trust: Employed at University of Liverpool in senior role which could, on occasion, give rise to Loyalty conflict of interest. Managed by transparent dealing and declaration where relevant and by agreement with Chair of Alder Hey NHS Trust and Vice Chancellor, University of Liverpool.</p> <p>END DATE: 01/10/2025</p>	
<p>Kerry Byrne (Non-Executive Director)</p>	<p>Declaration Type: Outside Employment Outside Employer: Ernst & Young LLP Outside Employer Description: Internal auditor in the financial services team of Ernst & Young based in their London office.</p> <p>I do not believe there are any conflicts with this role as it ended in 2014, some years before I joined Alder Hey as a Non-Executive Director.</p> <p>When did business interest begin: 2012-2014</p> <p>***ACTUAL EMPLOYMENT DATES 03/01/2012 to November 2014***</p> <p>End Date: November 2014</p> <p>How is this relevant to the Trust: No conflicts of interest. This has been declared as I am Chair of ARC and E&Y are our external auditors.</p>	
<p>John Chester (Director of Research & Innovation)</p>	<p>Declaration Type: Outside Employment Outside Employer: University of Leeds/ Leeds Hospitals Charity Outside Employer Description: Chair of External Strategic Advisory Board for CHORAL - panel of independent experts advising on CHORAL (Children's Health Outcomes Research at Leeds) health research programme</p> <p>Uncertain amount of work, at present, as the Advisory Board has not yet had its first meeting (as of 11th Sept 2023)</p> <p>Not expected to be more than a dozen or so hours per year, associated with an annual meeting NB The work is conducted outside of contracted hours.</p> <p>When did business interest begin: 14/04/2023</p>	

How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.

The work being undertaken is to support a partner in the Children's Hospital Alliance

This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours.

Declaration Type: Outside Employment

Outside Employer: Imperial College London - Clinical Trials Unit

Outside Employer Description: Independent Data

Monitoring Committee - panel of experts overseeing data from the REFINE-Lung trial New role, from Sep 2022

A few hours per year, associated with annual meeting

NB The work is conducted outside of contracted hours, as below.

When did business interest begin: 01/09/2022

How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.

The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust.

This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours.

Declaration Type: Outside Employment

Outside Employer: Institute for Cancer Research

Outside Employer Description: Independent Data Monitoring Committee of international experts overseeing data from InPACT trial in penile cancer

Continuation of long-standing role, pre-dating my employment with the Trust - chair of Committee for several years

A few hours per year, associated with annual meeting
NB The work is conducted outside of contracted hours, as below.
When did business interest begin: 01/04/2022
How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.
The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust.
This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours.

Declaration Type: Outside Employment
Outside Employer: Medical Research Council Clinical Trials Unit at University College London
Outside Employer Description: Trial Steering Committee for cancer trials - panel of experts overseeing a portfolio of clinical trials
Continuation of long-standing role, pre-dating my employment with the Trust Asked to step up to chair the Committee, July 2023
A few hours per year, associated with annual meeting
NB The work is conducted outside of contracted hours, as below.
When did business interest begin: 01/04/2022
How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.
The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust.
This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours.

	<p>Declaration Type: Outside Employment</p> <p>Outside Employer: University College London - Cancer Trials Centre</p> <p>Outside Employer Description: Trial Steering Committee of experts overseeing a portfolio of cancer trials - mainly haematological malignancies and brain tumours</p> <p>Continuation of a long-standing role, pre-dating my appointment with the Trust - as Chair since October 2018</p> <p>A few hours per year, associated with an annual meeting NB The work is conducted outside of contracted hours, as below.</p> <p>When did business interest begin: 01/04/2022</p> <p>How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.</p> <p>The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust.</p> <p>This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours.</p>	
	<p>Declaration Type: Outside Employment</p> <p>Outside Employer: Stratified Medicine Paediatrics (Cancer Research UK/University of Birmingham)</p> <p>Outside Employer Description: Chair of Study Steering Committee Continuation of long-standing role, pre-dating my employment with the Trust Only a few hours per year</p> <p>NB The work is conducted outside of contracted hours, as below.</p> <p>When did business interest begin: 01/04/2022</p> <p>How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.</p> <p>The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust.</p>	

This is pro bono work - no salary or honorarium – and the work undertaken is either done in my spare time, or made up outside of contracted hours.

Declaration Type: Outside Employment

Outside Employer: Cancer Research UK - Protocol Safety Review Board

Outside Employer Description: Panel of expert clinicians advising CRUK's Centre for Drug Discovery on development of clinical trial protocols for studies of new anti-cancer drugs

Appointment taken up, following standing down from CRUK's New Agents Committee in December 2022

Few hours per month and attendance at short monthly meeting Unpaid and no honoraria, to date

NB The work is conducted outside of contracted hours, as below.

When did business interest begin: 01/01/2023

How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.

The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust.

This is pro bono work - no salary or honorarium - and the work undertaken is either done in my spare time, or made up outside of contracted hours.

Declaration Type: Outside Employment

Outside Employer: Cancer Research UK - Clinical Research Monitoring Panel

Outside Employer Description: Panel of clinical experts who review progress against time and targets of a broad panel of clinical trials supported (funded or endorsed) by CRUK

Approx 8 hours' work, 3 times per year

NB The work is conducted outside of contracted hours, as below.

When did business interest begin: 01/04/2022

	<p>How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.</p> <p>The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust.</p> <p>Honoraria to a total of £600 were paid in 2022-23, but the work undertaken is either done in my spare time, or made up outside of contracted hours.</p> <p>Declaration Type: Outside Employment</p> <p>Outside Employer: Royal Marsden Hospital/Institute for Cancer Research</p> <p>Outside Employer Description: Independent external examiner for MSc Oncology course (post-graduate taught course for specialist trainees in oncology, across the UK)</p> <p>Approx 16 hours per year, divided into 2 segments, aligned with the twice-yearly course management board meetings.</p> <p>NB The work is conducted outside of contracted hours, as below.</p> <p>When did business interest begin: 01/04/2022</p> <p>How is this relevant to the Trust: No perceived conflicts of interest; I am submitting this for full declaration purposes.</p> <p>The skills and experience which enable me to undertake this role were gained prior to my employment with the Trust.</p> <p>An honorarium is paid (£500, twice a year), but the work undertaken is either done in my spare time, or made up by additional work for the Trust, outside of contracted hours.</p>	
<p>Lisa Cooper (Director of Community and Mental Health Services)</p>		<p>✓</p>
<p>Garth Dallas</p>		<p>✓</p>

(Non-Executive Director)		
Urmi Das (Director of Medicine)		✓
Mark Jennings (Non-Executive Director)	<p>Outside Employer: Strasys Ltd.</p> <p>Outside Employer Description: Chief Solutions and Services Officer for Strasys Ltd</p> <p>When did business interest begin: 14/07/2025</p> <p>How is this relevant to the Trust: Mark Jennings is a Non-Executive Director of Alder Hey Children’s NHS Foundation Trust and is also employed by Strasys Ltd, a consultancy that has previously provided services to the Trust and may do so again in the future. To manage this potential conflict of interest:</p> <ul style="list-style-type: none"> - Mark has no involvement in the procurement, commissioning, or oversight of any work undertaken by Strasys for the Trust. - He will recuse himself from any Trust Board or committee discussions or decisions relating to current or potential engagements involving Strasys. - Within Strasys, Mark has no access to any materials or discussions relating to Alder Hey, and internal confidentiality protocols have been implemented to ensure strict separation. <p>This arrangement has been agreed with the Chair and Chief Executive of the Trust and is subject to ongoing review to ensure the conflict continues to be appropriately managed.</p> <p>Outside Employer: Towsu Ltd.</p> <p>Outside Employer Description: Mark is the Founder and CEO of Towsu Ltd, a company providing IT and strategy advisory services to UK public sector organisations and their suppliers.</p> <p>When did business interest begin: 14/07/2025</p> <p>How is this relevant to the Trust: Towsu will not work with Alder Hey NHS Trust or any suppliers to Alder Hey (current or at the point they become prospective future suppliers) on any matters related to Alder Hey. To manage any future potential conflict of interest:</p> <ul style="list-style-type: none"> - Mark will have no involvement in the procurement, commissioning, or oversight of any work 	

	<p>undertaken by organisations that are clients of Towsu.</p> <ul style="list-style-type: none"> - Mark will recuse himself from any Trust Board or committee discussions or decisions relating to current or potential engagements involving any suppliers that are clients of Towsu. - Within Towsu, Mark has no access to any materials or discussions relating to Alder Hey, and internal confidentiality protocols have been implemented to ensure strict separation. Mark will not engage in any discussions with clients or potential clients about Alder Hey or any matters relating to Alder Hey. <p>This arrangement has been agreed with the Chair and Chief Executive of the Trust and is subject to ongoing review to ensure the conflict continues to be appropriately managed.</p>	
Dani Jones (Director of Strategy and Partnerships)		✓
John Kelly (Non-Executive Director)		✓
Rachel Lea (Chief Finance Officer)		✓
Gerald Meehan (Non-Executive Director)	<p>Declaration Type: Outside Employment</p> <p>Outside Employer: Liverpool City Council</p> <p>Outside Employer Description: Independent Chair of Liverpool's Children's Services Improvement Board.</p> <p>When did business interest begin: 02/04/2024</p> <p>How is this relevant to the Trust: I will declare this interest if specific consideration is given at Board or Committee to the work of Children's Services at Liverpool City Council. I will not take part in discussion of Liverpool City Council services. I will declare my position as a NED at the next meeting of the Liverpool Children's Services Improvement Board-completed on 7th March 2024.</p>	

<p>Bola Owolabi (Non-Executive Director)</p>	<p>Declaration Type: Outside Employment Outside Employer: Care Quality Commission Outside Employment Description: Chief Inspector - Primary Care & Community Services When did business interest begin: 07/07/2025</p> <p>Declaration Type: Outside Employment Outside Employer: Wordsmiths Global Limited Outside Employment Description: Director When did business interest begin: 01/07/2025</p>	
<p>Benedetta Pettorini (Director of Surgery)</p>		✓
<p>Jo Revill (Non-Executive Director)</p>	<p>Declaration Type: Outside Employment Outside Employer: Mosaic – supporting bereaved children Outside Employer Description: I am CEO of a charity supporting bereaved children and young people across the county of Dorset. My role involves advocacy, fundraising, governance and financial management and overseeing referrals for counselling of children. I became CEO in November 2023. I report to a Board of Trustees and follow Charities Commission guidance and best practice. When did business interest begin: 01/04/2024 How is this relevant to the Trust: No conflict. If an issue relating to bereavement of children were to arise, I would declare an interest. Mosaic charity only supports children in Dorset, not more widely, so there is very unlikely to be a conflict.</p>	
<p>Erica Saunders (Chief Corporate Affairs Officer)</p>		✓

Melissa Swindell (Chief People Officer)		✓
Kate Warriner (Chief Digital and Transformation Officer)	Declaration Type: Loyalty Interests Body/Organisation/Individual name: Primary Care 24 Description of loyalty interest: Husband has a bank role as a driver for Primary Care 24 When did business interest begin: 01/02/2026	

BOARD OF DIRECTORS

Thursday, 2nd April 2026

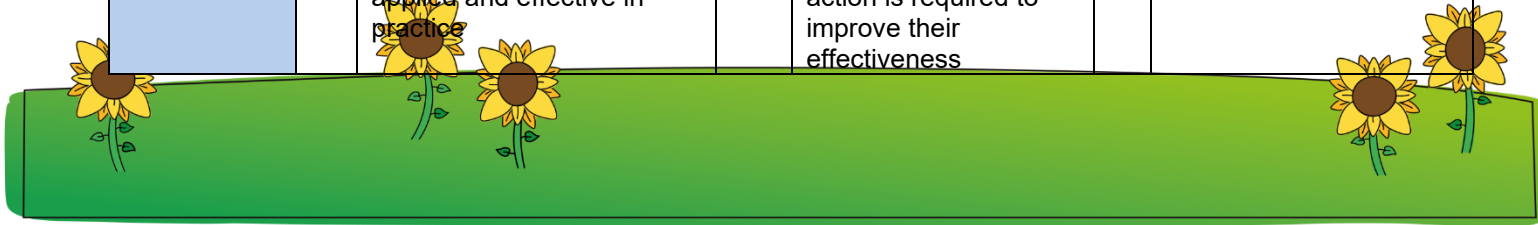
Paper Title:	Winter 2026 Governor Election Results
Report of:	Erica Saunders, Chief Corporate Affairs Officer
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision <input type="checkbox"/> Assurance <input type="checkbox"/> Information <input checked="" type="checkbox"/> Regulation <input type="checkbox"/>
Action/Decision Required:	To note <input checked="" type="checkbox"/> To approve <input type="checkbox"/>
Summary / supporting information	The purpose of this report is to provide the Council with the outcome of the summer governor election round.
Strategic Context	
This paper links to the following:	Outstanding care and experience <input checked="" type="checkbox"/> Collaborate for children & young people <input checked="" type="checkbox"/> Revolutionise care <input checked="" type="checkbox"/> Support our people <input checked="" type="checkbox"/> Pioneering breakthroughs <input checked="" type="checkbox"/>
Resource Implications:	The cost of running the winter election round is estimated at £7,900.

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 <small>(as defined against the risk in InPhase)</small>	<input type="checkbox"/>	Fully Assured Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	Partially Assured Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	Not Assured Evidence indicates poor effectiveness of controls
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1. Executive Summary

The purpose of this report is to provide the Council with the outcome of the recent governor election round.

2. Background and current state

In October 2025 the Trust issued election notifications for the following governor seats:

Constituency:

- Public: Merseyside (1 to elect) (*Becky Moore's first term of office concluded*)
- Patient: Merseyside (1 to elect) (*vacant*)
- Patient: Rest of England and North Wales (1 to elect) (*vacant*)
- Staff: Nurses (1 to elect) (*Smitha Joseph resigned from the Trust*)
- Staff: Other Staff and Volunteers (1 to elect) (*John Ashton's first term of office concluded*)

Following a successful election process which concluded on Friday 13th February 2026 we would like to welcome the following Governors to the Council:

Elected unopposed:

Patient: Merseyside – Victoria Adetunji

Elected via a public/staff vote

Public: Merseyside – Paul Denny

Staff: Other Staff and Volunteers – John Ashton (re-elected)

Staff: Nurse – Raji Thomas

One vacancy remains within the patient constituency representing the Rest of England and North Wales.

Appointed Governor Update

The Council will recall that resignations were received from Councilor's Lila Bennet and Liz Parsons; these vacancies were discussed at the Liverpool City Council meeting in September 2025, and we have been advised that Councilor Tom Cardwell has been appointed to one of these positions.

Erica Saunders
Chief Corporate Affairs Officer